RECLAIMING LIVES:
A Seven-Point Plan for Reducing Substance Abuse and Its Associated Negative Consequences

Developed by:
The Coalition of Alcohol and Drug Associations (CADA)

Research Evidence to Support the Seven Point Plan Compiled by:
The Pacific Southwest Addiction Technology Transfer Center
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CADA Membership

Alcohol and Drug Policy Institute (ADPI)
California Association of Addiction Recovery Resources (CAARR)
California Association of Alcohol and Drug Program Executives, Inc. (CAADPE)
California Association for Alcohol/Drug Educators (CAADE)
California Association of Alcoholism and Drug Abuse Counselors (CAADAC)
California Association of Drinking Driver Treatment Programs (CADDTP)
California Opioid Maintenance Providers (COMP)
California Perinatal Treatment Network (CAPTN)
California Society of Addiction Medicine (CSAM)
California Therapeutic Communities (CTC)
County Alcohol and Drug Program Administrators Association of California, Inc. (CADPAAC)
Drug Policy Alliance (DPA)
Pacific Southwest Addiction Technology Transfer Center (PSATTC)

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1. Ensure access to treatment for every addict

2. Institute parity of both access and benefits for private sector health insurance

3. Reduce crime and enhance public safety by sustaining the Crime Prevention and Substance Abuse Treatment Act of 2000 (Proposition 36); expanding drug courts; and expanding in-custody treatment

4. Ensure high treatment standards for all providers

5. Initiate, at the cabinet level, a Governor's Interagency Council on substance abuse

6. Maximize state efforts to capture California's share of federal alcohol and other drug abuse services funding

7. Implement the five recommendations of the Little Hoover Commission's March 2003 report, "*For Our Health & Safety: Joining Forces to Defeat Addiction*"

Research Evidence to Support CADA's Seven-Point Plan

1. ENSURE ACCESS TO TREATMENT FOR EVERY ADDICT

CADA's Position:

CADA believes that anyone who seeks treatment should receive it. Only 17% of adults and 10% of children and youth in California have access to alcohol and other drug treatment. Research shows that Treatment Works! There is a compelling case for recovery through effective treatment. Individuals are transformed from tax-users to taxpayers and there is a 7-to-1 return on the public's investment in treatment. Young children have the best hope of reaching their potential when they and their families have access to treatment.

Supporting Information:

All segments of society are affected by substance abuse and its consequences – men, women, (people of all age groups, racial and ethnic groups, and education levels smoke, drink, and use drugs licit and illicit) (Schneider Institute, 2001).

"An array of behavioral and pharmacological treatments that can effectively reduce drug use, help manage drug cravings and prevent relapses, and restore people to productive functioning in society" currently exist (Leshner, 1999; O'Brien, 1997; Simpson, 1997; O'Brien & McLellan, 1996).

According to estimates from the 2005-06 National Survey on Drug Use and Health, California had a high percentage of residents who needed but did not receive treatment for an illicit drug problem in 2005-2006, at 2.7% of all persons age 12 or older (Hughes, Sathe, & Spagnola, 2008). California also had a high percentage of residents who needed but did not receive treatment for an alcohol problem in 2005-2006, at 7.9% of all persons age 12 or older (Hughes, Sathe, & Spagnola, 2008).

"Recent studies estimate that drug dependence costs the United States approximately $67 billion annually in crime, lost work productivity, foster care, and other social problems (McLellan et al., 2000)."

The California Treatment Outcome Project (CalTOP) study found that significant improvements in clients' key life areas (including drug and alcohol use, psychiatric status, family and social relationships, legal status, medical status, and employment) were observed 9 months post-admission to treatment (Hser et al., 2003). The main study question examined in the study regarding cost and cost-offset was whether substance abuse treatment is cost-saving when compared with no treatment. Hser and colleagues found that "the ratio of benefits to costs shows that the provision of substance abuse treatment is not only budget-neutral (i.e., does not increase net costs), but represents a good investment with each dollar invested in treatment resulting in more than $7 saved (Hser et al., 2003)." The study also found that expenditures for substance abuse treatment result in society avoiding greater costs in related criminal justice and other social services. "The benefits were primarily due to reductions in the costs of crime (including incarceration) and increases in employment wages (Hser et al., 2003)." Finally, based on initial cost-offset analyses, "our best estimate is that substance abuse treatment costs $1,521 on average and is associated with an average benefit to taxpayers of $10,931 (Hser et

al., 2003)." For more information on the final CalTOP study report, please refer to http://www.uclaisap.org/caltop/FinalReport/index.html.

The California Drug and Alcohol Treatment Assessment (CALDATA) was the product of an initiative launched by the California Department of Alcohol and Drug Programs in the early 1990s to determine the epidemiology of substance abuse and the outcomes of substance abuse treatment. CALDATA documented that treatment and recovery programs are a good investment. Several key findings resulted, including the following:

- Treatment is cost beneficial to taxpayers (for every dollar invested in substance abuse treatment, $7 in cost savings are returned);
- Criminal activities and alcohol and drug use declined significantly from before treatment to after treatment; and
- Significant improvements in health and corresponding reductions in hospitalizations were found during and after treatment (Gerstein et al., 1994).

The Center for Substance Abuse Treatment-commissioned National Treatment Improvement Evaluation Study (NTIES) examined several of the important issues related to substance abuse treatment. The study found that outcomes related to drug and alcohol use, mental and physical health, homelessness, criminal activity, and employment were measurably better among individuals who completed their treatment plans, received more intensive treatment, and were in treatment longer (http://www.health.org/govstudy/f027/treat.htm).

According to recent findings from SAMHSA's 'Alcohol and Drug Services Study Cost Study,' the average cost for "treatment of alcohol or drug abuse in outpatient facilities was an estimated $1,433 per course of treatment in 2002. Further, residential treatment cost about $3,840 per admission, and outpatient methadone treatment cost $7,415 per admission in 2002 (SAMHSA, 2004)."

Former SAMHSA Administrator Charles Curie stated "treatment is a bargain compared to expenditures for jails, foster care for children, and health complications that often accompany addiction. Rarely do we have public initiatives that can save society as much as substance abuse treatment and recovery support services. Treatment provides an opportunity for recovery for the individual, better homes for children, and improved safety for our communities (SAMHSA News Release, May 25, 2004)."

Access to Recovery (ATR) is a three-year competitive discretionary grant program funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. ATR is a presidential initiative, which provides vouchers to clients for purchase of substance abuse clinical treatment and recovery support services. The goals of the program are to expand capacity, support client choice, and increase the array of faith-based and community based providers for clinical treatment and recovery support services. Two of the 2007 ATR grantees are located in California.

The State of California was awarded approximately $14.5 million over three years. The state is expanding the California Access to Recovery Effort program to provide service resources to youth between 12-20 years of age, some of whom are struggling with methamphetamine problems. The new program will build on the established infrastructure, model program framework, and standards of practice that have been successfully implemented in the large metropolitan areas of Los Angeles and Sacramento counties to improve and enhance the ATR services and provider networks in those areas.

In addition, the California Rural Indian Health Board, Inc. was also awarded approximately $14.5 over three years. The CRIHB, the lead agency managing the California American Indian Recovery (CAIR) program, plans to expand a voucher system that provides culturally appropriate clinical treatment and recovery support services targeting American Indian/Alaska Native people with substance abuse disorders, to build system capacity, expand access and choice, improve efficiency and service quality, and establish a sustainable health care service-delivery model that supports life-long recovery. CRIHM plans to collaborate with the Northwest Portland Area Indian Health Board to extend access to 43 additional tribes across California, Oregon, Washington, and Idaho. For more information on ATR, please visit http://atr.samhsa.gov/.

The National Association of State Alcohol and Drug Abuse Directors, Inc. released the following key NASADAD Policy Priorities for 2008: (1) strengthen state substance abuse systems and the office of the Single State Authority (SSA); (2) expand access to prevention and treatment services; (3) implement an outcome and performance measurement data system; (4) ensure clinically appropriate care; and (5) promote effective policies relating to co-occurring disorders. For more information regarding NASADAD’s policy priorities, visit http://www.nasadad.org/index and click on the “public policy” link.

2. INSTITUTE PARITY OF BOTH ACCESS AND BENEFITS FOR PRIVATE SECTOR HEALTH INSURANCE

CADA's Position:
The private sector needs to be an active participant in providing access to substance abuse treatment through employer-based health insurance.

Supporting Information:
The costs of treatment for health problems attributed to alcohol and drug use are significant. Over two-thirds of drug abuse costs are HIV/AIDS related; and 10% of alcohol costs are for the care of fetal alcohol syndrome (Schneider Institute, 2001). Furthermore, nearly $1 of every $4 Medicare spends on inpatient hospital care is associated with substance abuse (Schneider Institute, 2001).

In 1999, the majority (64%) of substance abuse treatment admissions reported no health insurance. The most frequently reported type of insurance was Medicaid (14% of admissions). Private insurance was reported by 13% and all other forms of insurance totaled 9% (SAMHSA, 2002).

Private insurance spending on mental health/substance abuse treatment did not keep pace with total health care spending or with general price inflation. Mental health/substance abuse claims as a proportion of all health care claims dropped from 7.2% in 1992 to 5.1% in 1999 (Mark & Coffey, 2003).

The following information is abstracted from a Research Report from the George Washington University Medical Center entitled, "*Workplace Solutions: Treating Alcohol Problems through Employment-Based Health Insurance*." Please note that the study focused on treatment specifically for alcohol problems. The major findings of the study are as follows:

- "***State insurance laws make a difference***. In states where insurance laws require that alcohol treatment coverage be the same as that for other illnesses, people are much more likely to get the services they need. Only seven states have such requirements. In states without laws or with nominal requirements, there are huge gaps in the care that employees and their family members can expect to be covered (Goplerud and Cimons, 2002)."
- ***"There are great gaps in the coverage offered by large, self-insuring employers***. One-half of the 177 million Americans who have employment-based insurance work for employers who "self insure" or administer their own health plans. The plans there employers (mostly large companies) offer their workers and their family members do not cover critical parts of the alcohol treatment services that would be recommended based on scientific evidence (Goplerud & Cimons, 2002)."
- ***"The costs of untreated alcohol problems are enormous***. About one of every 13 adults has a serious problem with alcohol and more than half of all American adults have a close family member who is alcohol dependent or has a history of alcoholism. Alcohol problems cost each man, woman, and child in the U.S. $683 each year (Goplerud & Cimons, 2002)."
- ***"The cost of significantly improving health coverage for alcohol problems is very small***. Actuarial estimates by the Substance Abuse and Mental Health Services Administration (SAMHSA) suggest that upgrading employment-based health insurance coverage would increase premiums by 0.2 percent (Goplerud & Cimons, 2002)."

"Studies have suggested that medical services may benefit substance abuse treatment outcomes if medical staff is knowledgeable about addiction disorders and involved in treatment (Samet, Friedmann, & Saitz, 2001)."

Researchers from the University of California, San Francisco, Kaiser Permanente Medical Care Program, and Kaiser Permanente Chemical Dependency Recovery Program examined differences in treatment outcomes and costs between integrated and independent models of medical and substance abuse care, as well as the effect of integrated care in a subgroup of patients with substance abuse-related medical conditions (SAMCs). The randomized study was conducted in a "real world" setting in a large HMO. "Among non-SAMC patients, although integrated services were not significantly higher, there were no differences in abstinence between the two programs. However, SAMC patients randomized to integrated services had higher abstinence rates and longer periods of abstinence, and their costs were not significantly higher relative to patients in the independent services group (Weisner et al., 2001)." According to the authors, "these findings are relevant given the high prevalence and cost of medical conditions among substance abuse patients, new developments in medications for addiction, and recent legislation on parity of substance abuse with other medical benefits (Weisner et al., 2001)."

In a document entitled, *Substance Abuse Insurance Parity: A Guide for Advocates*, background information and negotiation strategies are provided for advocates who are working to achieve substance abuse parity. "In some states, obtaining parity for substance abuse/addiction coverage will entail advocating for additional legislation to complement existing mental health parity laws. In other states without mental health parity, this information is designed to support advocacy efforts for comprehensive mental health and substance abuse parity, or separate substance abuse parity legislation (Coridan & Heffron, 2000)."

3. REDUCE CRIME AND ENHANCE PUBLIC SAFETY BY SUSTAINING THE CRIME PREVENTION AND SUBSTANCE ABUSE TREATMENT ACT OF 2000 (PROPOSITION 36); EXPANDING DRUG COURTS; AND EXPANDING IN-CUSTODY TREATMENT

CADA's Position:
CADA believes that reduced crime and enhanced public safety can be achieved by sustaining Proposition 36, and expanding drug courts and in-custody treatment.

CADA recently added its support for the need for accountability and the general principles of reform as recommended in the *UCLA Integrated Substance Abuse Programs Report Evaluating Proposition 36*, dated April 5, 2006:

> *Briefly stated, recommendations cover six areas, requiring the involvement of multiple systems and agencies: Statewide collaboration and coordination, offender eligibility and alternative procedures and practices for high cost offenders, systems integration, criminal justice, drug treatment, and strategic planning. Activities to achieve the following goals should yield a more efficacious program, with attendant cost benefits: (1) increased collaboration and coordination within and across state and county government, (2) improved system integration by all involved agencies within the counties, including greater utilization of probation and program urine test results; (3) more attention to suitability screening for and higher acceptance and participation rates by offenders referred to drug treatment under SACPA, as well as increased use of strategies to improve offender accountability; (4) improved matching of severity of dependence to intensity of services; (5) more accessible and culturally relevant services for special populations (e.g., those with psychiatric problems, minorities); and (6) more attention to continuity of care and treatment aftercare services.*

The above referenced reforms are projected to improve the effectiveness of Proposition 36 treatment. CADA believes that such reforms will result in more individuals having access to treatment, more individuals successfully completing treatment, and even greater savings to the taxpayers.

Supporting Information:
"The link between alcohol or illicit drug use and crime is visible every day in courtrooms, jails, and prisons across the country (Schneider Institute, 2001)."

"Drug offenders increasingly fill the nation's prisons. From 1985 to 1995, the proportion of drug offenders in state prisons increased from 9% to 23% of all prisoners, and the percentage of federal inmates sentenced for drug offenses rose from 34% to 60% (Schneider Institute, 2001; US DOJ, 1997)."

Drug addiction treatment significantly decreases criminal activity during and after treatment (Hubbard et al., 1997).

NTIES respondents reported significant decreases in many indicators of criminal involvement, including: a 78% decline in selling drugs; an 82% decline in shoplifting; a 48% decrease in illegal sources of income/support; and a 64% reduction in arrests for any crime (http://www.health.org/govstudy/f027/treat.htm).

Sustaining the Crime Prevention and Substance Abuse Treatment Act of 2000 (Proposition 36)

Supporting Information:

The first report of findings from the statewide evaluation of SACPA (covering the time period of July 1, 2001 to June 30, 2002) showed that a total of 53,697 offenders were found (in court) to be eligible for SACPA. Of those who opted for SACPA in court, 69% entered treatment. This overall "show rate compares favorably with 'show' rates in other studies of drug users referred to treatment by criminal justice or other sources (Longshore et al., 2003)."

The Evaluation of the Substance Abuse and Crime Prevention Act: Cost Analysis Report (for the first and second years of SACPA) was released on April 5, 2006. The full report is available at: www.uclaisap.org. UCLA ISAP conducted three studies to assess the cost implications and benefit-cost ratios of SACPA. "Study 1, using a before SACPA comparison group and all first-year SACPA eligible offenders, found a net savings of $2,861 per offender (N=61,609), yielding a benefit-cost ratio of nearly 2.5 to 1 (i.e., $2.50 was saved for every $1 invested). Study 2 determined that SACPA participants who completed the program achieved a benefit-cost ratio of approximately 4 to 1 (i.e., "completers" saved $4 for every $1 allocated). And Study 3 found that cost savings for the second year of SACPA were similar to Study 1, with a benefit-cost ratio of 2.3 to 1. Three conclusions result from the cost analyses:

1. SACPA substantially reduced incarceration costs;
2. SACPA resulted in greater cost savings for some eligible offenders than for others; and
3. SACPA can be improved."

Further, "recommendations encompass actions within and across multiple areas:

1. Statewide collaboration and coordination;
2. Offender eligibility criteria and alternative practices for high-cost offenders;
3. Systems integration, criminal justice, drug treatment, and strategic planning."

The fourth and final annual report from the five-year independent statewide evaluation was released in April 2007. The following are a sampling of key findings:

1. A total of 48,473 offenders were referred for treatment during SACPA's fourth year. Of this total, 36,285 (~75%) entered treatment;
2. Characteristics of SACPA clients have not changed through the first four years;
3. About one-third (32%) of participants who entered treatment in SACPA's third year went on to complete treatment; and
4. SACPA implementation was not associated with a significant increase or decrease in statewide crime trends (UCLA ISAP, 2007).

In a cost-benefit analysis, three studies showed that SACPA yielded cost savings to state and local governments: (1) taxpayers saved nearly $2.50 for every $1 invested; (2) treatment completers saved $4 for every $1 allocated; and (3) cost savings for the second year of SACPA were similar to those seen in year one. Three conclusions can be drawn from the cost-benefit analysis: (1) SACPA substantially reduced incarceration

costs; (2) SACPA resulted in greater cost savings for some eligible offenders than for others; and (3) SACPA can be improved (UCLA ISAP, 2007)."

Seven main conclusions were drawn by the UCLA evaluation team:

1. SACPA was a sound investment for taxpayers;
2. A small number of offenders are responsible for a large percentage of new crimes committed;
3. Treatment completion was associated with better outcomes;
4. SACPA implementation was not associated with a significant increase or decrease in statewide crimes;
5. Treatment differences exist;
6. SACPA can be improved; and
7. An infrastructure for evaluation should be established (UCLA ISAP, 2007).

Expanding Drug Courts

<u>Supporting Information</u>:

Drug courts "succeed in placing offenders in treatment and keeping them there; that monitoring of drug court participants is, as intended, more intensive than monitoring of offenders placed in other forms of community supervision; that drug use and criminal behavior are sharply curtailed when offenders participate in drug court; and that offenders who complete drug court may be less likely than noncompletors to recidivate (Belenko, 1998; Harrell, 1998; Longshore et al., 2001)."

"Drug courts have been more successful than other forms of community supervision in closely supervising drug offenders in the community through frequent monitoring and close supervision including mandatory frequent drug testing, placing and retaining drug offenders in treatment programs, providing treatment and related services to offenders who have not received such services in the past, generating actual and potential cost savings and substantially reducing drug use and recidivism while offenders are in the program (Belenko, 1998)."

"Drug courts have demonstrated the feasibility of employing a team-based, problem solving approach to adjudicating offenders with drug problems in a way that appears to reduce system costs and improve public safety (Belenko, 1998)."

"Drug courts reduce recidivism for participants after they leave the program (Belenko, 1998)." According to a 2003 study released by the National Institute of Justice, "from a sample of 17,000 drug court graduates nationwide, within one year of program graduation, only 16.4 percent had been rearrested and charged with a felony offense (Roman, Townsend, & Bhati, 2003; Huddleston, Freeman-Wilson, & Boone, 2004)."

"Drug courts save money. A state taxpayer's return on the upfront investment in drug courts is substantial (Huddleston, Freeman-Wilson, & Boone, 2004)."

"Past research has generally shown that drug courts are reaching their target offenders and that program participants are rearrested at a lower or equivalent rate than comparison offenders. Few analyses have been conducted to test the relative effects of different drug court elements, however. The current research takes a closer look at the

two main components of the drug court, supervision and treatment, to determine whether one is more effective at preventing failure, or whether the combination of both is necessary to observe a decreased risk of failure. Attending treatment significantly decreased the risk of failure over a two-year follow-up period, while receiving supervision did not. Offenders who received both supervision and treatment had the longest survival times, but not significantly longer than those who received treatment only (Banks & Gottfredson, 2003)."

In another study that examined the effects of increasing the number of times misdemeanor drug court clients appeared before a judge, "drug offenders who satisfied DSM-IV criteria for antisocial personality disorder (APD) achieved more weeks of urinalysis-confirmed drug abstinence when assigned to more frequent judicial status hearings, whereas subjects without APD achieved more abstinence are were more likely to graduate successfully from the program when assigned to less frequent hearings (Festinger et al., 2002).

According to the St. Louis City Felony Drug Court Cost-Benefit Analysis, "various benefits (i.e., cost savings) were found for drug court graduates compared to probationers during and after drug court and probation, including the following:

- Costs of jail time were less overall;
- Costs of pretrial detention were dramatically less;
- Wages of drug court graduates were higher during and after drug court;
- Health care costs and mental health services were significantly lower; and
- Costs to the criminal justice system and costs to victims of crime were lower (Institute of Applied Research, 2004)."

"Family treatment drug courts (FTDCs) are a rapidly expanding program model designed to improve treatment and child welfare outcomes for families involved in child welfare who have substance abuse problems." Results of a four-site national study show that "FTDC parents, compared to comparison parents, entered substance abuse treatment more quickly, stayed in treatment longer, and completed more treatment episodes. Furthermore, children of FTDC parents entered permanent placements more quickly and were more likely to be reunified with their parents, compared to children of non-FTDC participants (Green et al., 2007)."

In a study assessing the long-term impact of drug court participation on recidivism, investigators found that "participation in drug court was associated with a significant decrease in the likelihood of being arrested in the 12-18 months post-baseline time period. Although the drug court effect was somewhat delayed (it was not significant prior to 12 months) and short-lived (it was not significant after 18 months), the fact that significant program effects were observed during a time period that coincides with the conclusion of drug court participation for graduates and a time period well beyond initial program exposure, suggests that drug court participants are more likely than comparable offenders not exposed to drug court to remain arrest free when no longer under community supervision (Krebs et al., 2007)."

With regards to juvenile drug courts, a recent review article examined the effectiveness of juvenile drug courts and suggested priorities for juvenile drug court research. Findings suggest that "juvenile drug court is more effective than family court in decreasing participants' criminal behavior and substance use. In addition, the integration of

evidence-based substance abuse treatments into juvenile drug court enhanced participant substance-related outcomes and rates of juvenile drug court completion (Henggeler, 2007)."

Expanding in-custody treatment

Supporting Information:

Therapeutic community and cognitive behavioral programs are the two main types of drug abuse treatment that have been developed within a prison setting (Prendergast & Wexler, 2004).

An ongoing evaluation of the effectiveness of the Amity prison therapeutic community (TC) and aftercare program for substance abusers found that reductions in reincarceration rates were found for the group that completed TC plus aftercare (Wexler, et al., 1999). In addition, those who attended aftercare had a longer time to incarceration and higher levels of employment (Prendergast et al., 2004).

According to results from an evaluation of the Forever Free in-prison, residential, substance abuse treatment program (which employed a cognitive behavioral model), "treated women had significantly fewer arrests, less drug use, and greater employment than the comparison group (Hall et al., 2004)."

With regards to multi-stage therapeutic community models for drug-involved offenders, those who receive treatment in a 2-stage (work release and aftercare) or 3-stage (prison, work release, and aftercare) have significantly lower rates of drug relapse and criminal recidivism than those who received prison-based TC only (Inciardi et al., 1997).

As stated above, research that has focused on correctional programs that have combined prison- and community-based treatment has shown that participation in both types of treatment is associated with better outcomes. But these studies also suggest that prison-based treatment in and of itself may have a "time-limited effect on treatment (Wexler, Prendergast, & Melnick, 2004)."

"If most of the longer term effects on recidivism and drug use result from the community phase of treatment, as some studies seem to suggest, for many offenders, prison treatment may serve more as preparation for community treatment than as primary treatment (Wexler, Prendergast, & Melnick, 2004)."

Additional studies, which utilize prospective research designs and random assignment, are needed to "better assess the effects of the separate and combined role of prison and community treatment (Wexler, Prendergast, & Melnick, 2004)."

Findings from a study by Martin and colleagues involving inmates in the Delaware Correctional System (DCS) highlight the value of treating prisoners for substance abuse problems during and after incarceration. The DCS program featured a continuum of care in which some inmates transitioned back into the community through a work-release program involving therapeutic communities (TC). The investigators found that "after one year, a significantly higher percentage of inmates who had participated in any aspect of the program were drug free and arrest free than those assigned to the usual work release program. And after three years, those who had continued with the TC aftercare had significantly less drug use and re-arrests than those who dropped out of the program (Martin et al., 1999)."

4. ENSURE HIGH TREATMENT STANDARDS FOR ALL PROVIDERS

CADA's Position:
The state is the appropriate authority to set minimum standards of quality of care for all treatment programs, including faith-based programs. The state is also the appropriate authority for setting a minimum standard of professional practices including licensing and certification for all workers who provide treatment, regardless of the setting. The state has the responsibility for fostering initiatives that will help develop a workforce to meet the standards.

Supporting Information:

The California Department of Alcohol and Drug Programs finalized a set of counselor certification regulations (more information available at http://www.adp.ca.gov/Licensing/LCBhome.shtml). As of April 2005, the counselor certification regulations (Title 9, Division 4, Chapter 8) specifically name ten counselor certifying organizations (Section 13035) for the purpose of certifying alcohol and drug counselors working in California. These regulations allow currently-employed counselors five years in which to become certified. Certification will be based upon the Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice (TAP 21), published by the Center for Substance Abuse Treatment, available through the ADP, Resource Center. TAP 21 includes understanding addiction, treatment knowledge, application to practice, and professional readiness.

Nine of the original ten organizations responsible for certifying alcohol and drug counselors in California have now received accreditation by the National Commission for Certifying Agencies (NCCA), as listed alphabetically below:

- Association of Christian Alcohol & Drug Counselors
- Breining Institute
- California Association for Alcohol and Drug Educators (CAADE)
- California Association of Alcoholism and Drug Abuse Counselors (CAADAC)
- California Association of Addiction Recovery Resources (CAARR)
- California Association of Drinking Drivers Treatment Programs (CAADTP)
- California Certification Board of Chemical Dependency Counselors (CCBCDC)
- Forensic Addictions Corrections Treatment (FACT)
- Indian Alcoholism Commission of California, Inc.

The American Academy of Health Care Providers (referred to as the Academy) has not yet been accredited by the NCCA.

The regulations allow currently-employed counselors five years in which to become certified. One option that will be allowed for currently-employed counselors is to “test out” with one of the organizations in order to obtain certification. Certification will be based upon the Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice (TAP 21), published by the Center for Substance Abuse Treatment. TAP 21 includes understanding addiction, treatment knowledge, application to practice, and professional readiness.

In 2006, the California Department of Alcohol and Drug Programs convened a committee known as the Counselor Certification Advisory Committee (CCAC). The CCAC was created to provide recommendations to CA ADP during the implementation of the ADP Counselor Certification Regulations. Through members' on-going professional involvement in alcohol and other drug abuse treatment, the CCAC provides input on maintaining quality standards, education, training, and experience for those seeking to obtain certification as an addiction counselor. In addition, the CCAC identifies current and emerging issues and proposes recommendations based on input from ADP stakeholders. The last meeting of the CCAC was held in November 2007. Minutes from this meeting are available at: http://www.adp.ca.gov/Licensing/pdf/11-20-08%20CCAC%20Meeting%20Minutes.pdf.

Additional Information:
According to figures from the U.S. Bureau of Labor Statistics, an estimated 8,382 Californians were employed as substance abuse counselors in 2006. This corresponds to a state rate of 2.54 substance abuse counselors per 10,000 CA residents, which is slightly higher than the national average of 2.2 counselors per 10,000 U.S. residents (http://www.bls.gov).

The substance abuse workforce faces several challenges, including: high turnover, staff shortages, lack of general education, inadequate specialized training and continuing education, and barriers to organizational change and training.

The Pacific Southwest Addiction Technology Transfer Center (PSATTC) conducted a survey of substance abuse agency directors and staff in the three state region (Arizona, California, and New Mexico) to obtain additional information about workforce related issues. Survey respondents were asked about workforce demographics, their educational and professional background, agency characteristics, professional experience and compensation, and training preferences, needs, and barriers. The full report for California is now available (visit www.psattc.org for more information). The following bullet statements are meant to provide the reader with highlights from the CA-specific workforce survey sample:

- Nearly 2/3 of CA substance abuse counselors are in recovery.
- Forty-six percent of substance abuse counselors have education experience ranging from some college to an AA degree; an additional 17% have a Bachelor's degree, and 28% have a Master's degree.
- Nearly equal percentages of program staff entered the substance abuse field either because of previous experience (63%) or personal interest (62%).
- Client-centered and AA/12-Step approaches were the most frequently mentioned treatment models by both directors and staff.
- Over 60 percent of the CA treatment programs are privately (not for profit) owned.
- A variety of training and technical assistance needs were indicated by respondents, including: evaluating program staff performance and organizational functioning, obtaining information to document program effectiveness, improving client problem solving skills, providing culturally competent services, and accessing effective training programs and resources.

5. INITIATE, AT THE CABINET LEVEL, A GOVERNOR'S INTERAGENCY COUNCIL ON SUBSTANCE ABUSE

CADA's Position:
The Council could coordinate state policy on alcohol and other drug abuse services and advise policy-makers. It could coordinate programs and assess the effectiveness of statewide efforts to reduce the consequences of addiction.

Supporting Information:
At one time, such a Council was active. The Coalition recommends that a Governor's Interagency Council on Substance Abuse be reinitiated at the Cabinet level.

6. MAXIMIZE STATE EFFORTS TO CAPTURE CALIFORNIA'S SHARE OF FEDERAL ALCOHOL AND OTHER DRUG ABUSE SERVICES FUNDING

CADA's Position:
California has many opportunities to expand treatment through increased participation in federal initiatives. To maximize these opportunities, the state should examine the efficacy of further investment of state matching dollars and program waivers.

Supporting Information:
Several types of federal funding are available to expand existing treatment services (the following is not meant to be an exhaustive list of all available funding):

- State Incentive Grants (COSIG) – [CMHS and CSAT – SAMHSA] for the purpose of developing and enhancing the infrastructure of States and their treatment service systems to increase the capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring substance abuse and mental health disorders, and their families.

- Screening, Brief Intervention, Referral, and Treatment (SBIRT) – [SAMHSA] for the purpose of expanding and enhancing State substance abuse treatment service systems by: expanding the State's continuum of care to include screening, brief intervention, referral, and brief treatment (SBIRT) in general medical and other community settings (e.g., community health centers, school-base health clinics and student assistance programs, occupational health clinics, hospitals, emergency departments); supporting clinically appropriate treatment services for nondependent substance users (i.e., persons with a Substance Abuse Disorder diagnosis) as well as for dependent substance users (i.e., persons with a Substance Dependence Disorder diagnosis); improving linkages among community agencies performing SBIRT and specialist substance abuse treatment agencies; and identifying systems and policy changes to increase access to treatment in generalist and specialist settings.

- Funding from local, state, and national foundations, including the California Endowment, the Charles and Helen Schwab Foundation, and the Robert Wood Johnson Foundation.

In addition, over 1,000 CA-based researchers receive funding from several Institutes within the National Institutes of Health (e.g., National Institute on Drug Abuse, National Institute of Mental Health, and the National Institute on Alcohol Abuse and Alcoholism) for the purpose of conducting a wide variety of research relating to substance abuse. To identify substance abuse researchers in your local region, please refer to the Computer Retrieval of Information on Scientific Projects (CRISP) database[1] on the NIDA website (www.nida.nih.gov).

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[1] A searchable database of federally funded biomedical research projects conducted at universities, hospitals, and other research institutions. The database, maintained by the Office of Extramural Research at the National Institutes of Health, includes projects funded by the National Institutes of Health (NIH), Substance Abuse and Mental Health Services (SAMHSA), Health Resources and Services Administration (HRSA), Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDCP), Agency for Health Care Research and Quality (AHRQ), and Office of Assistant Secretary of Health (OASH). Users, including the public, can use the CRISP interface to search for scientific concepts, emerging trends and techniques, or identify specific projects and/or investigators.

7. IMPLEMENT THE FIVE RECOMMENDATIONS OF THE LITTLE HOOVER COMMISSION'S MARCH 2003 REPORT, "*FOR OUR HEALTH & SAFETY: JOINING FORCES TO DEFEAT ADDICTION*":

<u>Supporting Information</u>:
The following recommendations are drawn directly from the 2003 Little Hoover Commission Report:

Recommendation 1:
> *The State should establish a council to develop a unified strategy to cost-effectively reduce the expense, injury and misery of alcohol and drug abuse. The council should advise policy-makers, coordinate programs and assess the effectiveness of statewide efforts to reduce the consequences of addiction.*

Recommendation 2:
> *Working with counties, the State should set broad goals for treatment programs and help counties to ensure that treatment is available to those whose substance abuse imposes the greatest harm on their communities.*

Recommendation 3:
> *The State should implement outcome-based quality control standards for treatment personnel, programs, and facilities and encourage continuous quality improvement.*

Recommendation 4:
> *The State should facilitate the integration of alcohol and drug treatment with other social services to effectively reduce abuse and related public costs.*

Recommendation 5:
> *The State should immediately maximize available resources that can be applied to treatment. As the treatment system improves, the State also should consider new funding sources to provide more stable funding.*

In 2007-08, the Little Hoover Commission decided to revisit its 2003 study "because of its strong belief that a successful strategy for fighting addiction has tremendous leverage in reducing the social ills fueled by substance abuse (Little Hoover Commission, 2008)." The 2008 report contains two major conclusions: "first, California can reduce substance abuse, but it must adopt a new model to transform the way counties deliver treatment. Second, Proposition 36 has shown promise despite its flaws, and rather than throw it out, California can and should fix it (Little Hoover Commission, 2008)."

The Executive Summary contained within the 2008 LHC report identifies four critical problems that the state of California must address:

1. California lacks a coherent substance abuse treatment system;
2. State leaders have not used their influence and power to control funding to drive improvements in the system;
3. Treatment advances are not systematically implemented in the field; and
4. Funding is limited and not used strategically.

The following recommendations are drawn directly from the 2008 Little Hoover Commission Report:

Recommendation 1:

The State should transform substance abuse treatment into a performance-driven system based on a comprehensive model of care through the use of incentives and mandates to improve quality, transparency, and outcomes.

Recommendation 2:

The State should institutionalize understanding, leadership, and oversight of substance abuse issues to provide a more cohesive, cost-effective statewide substance abuse policy. Specifically, the state should: create a substance abuse policy council; require annual substance abuse reports; and make the Assembly Select Committee on Alcohol and Drug Abuse a permanent, joint committee.

Recommendation 3:

The State should transform programs for nonviolent drug offenders by tying funding to outcomes, requiring drug court models where appropriate, and requiring counties to tailor program to offenders' individual risks and needs. Specifically, the state should: work with judiciary to develop standards for a continuum of services; adapt the goal of the Offender Treatment Program (incentivizing best practices) into Proposition 36 and use guidelines to define success; coordinate Proposition 36 and Proposition 63; the Department of Corrections and Rehabilitation should place more focus on parolees in Proposition 36 programs; and redesign and contract between the Department of Alcohol and Drug Programs and UCLA to allow UCLA to publish reports independently of the department.

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