

**RECLAIMING LIVES & TAXDOLLARS:
Urgent Policy Priorities for Reducing Substance Use
and Associated Costs and Consequences**

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

**Research and Empirical Support Compiled by:
The Pacific Southwest Addiction Technology Transfer Center
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Pacific Southwest

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CADA Membership

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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 Drinking Driver Treatment Programs (CADDTP)
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Pacific Southwest Addiction Technology Transfer Center (Pacific Southwest ATTC)

CADA is a statewide coalition of consumers, providers, educators, and advocates representing the voice for alcohol and drug abuse services

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CADA urges California policy makers to begin now to put into place the investment and infrastructure necessary to provide, in the long term, access to quality, evidence-based care for all Californians suffering from the chronic disease of Substance Use Disorder (SUD). It is essential that California work toward a day when all persons with substance use disorders will have access to the appropriate care based on medical necessity.

Given the current economic and prison overcrowding pressures, as well as the imminent expansion of health care coverage for millions of Californians, CADA recommends that the Governor and State Legislature tackle the following urgent, cost-effective policy priorities in 2010:

1. Maximize state efforts to capture California's share of federal funding for SUD services and strategically identify federal policies that will increase federal funding. These include:

- Advocate for repeal of the Federal Medicaid policy of excluding residential treatment from federal reimbursement for residential treatment (Institute for Mentally Disabled, IMD exclusion);
- Advocate for use of the actual CSI (Cost of Service Index) in the federal funding formulas for SAMHSA's Substance Abuse Prevention and Treatment (SAPT) Block Grant; and

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- Advocate for inclusion of workforce development and federal incentive programs in conformance with parity and other health care reform opportunities.

2. Inventory the areas of greatest state spending, identify barriers to SUD services, and strategically invest state resources in SUD services to improve the health and functioning of impacted Californians and their families, while also reducing costs/realizing savings to the state.

Redirect spending from criminal justice, foster care, and emergency room and urgent care to treat SUDs. Such redirection will bend the cost curve and produce cost savings 2 to 4 times greater than the cost of actually providing SUD services.

- Reduce crime and enhance public safety by providing Californians with appropriate community-based treatment instead of jail or prison.
- Reduce welfare and children's services costs by providing SUD treatment to the entire family.
- Reduce health care costs by instituting SBIRT (Screening, Brief Intervention, and Referral to Treatment) in emergency room, urgent care, primary care, and school-based settings.

3. Institute a plan to fully integrate SUD services into health care reform and ensure access and benefits to all eligible Californians suffering from a SUD.

- Review the role of SUDs in the state's 1115 waiver and ensure a plan for coverage and integration of services as California moves toward full implementation of the Affordable Care Act in 2014.
- Develop a benchmark benefit that will not only meet federal parity laws, but will ensure care based on medical necessity and desired outcomes.

4. Assure the implementation of statewide quality, evidence-based standards for SUD services and the SUD prevention, treatment, and recovery workforce, including the following:

- Administrative
- Clinical – utilization of evidence-based practices
- Consumer information
- Workforce – licensing/certification, continuing education, and staff development
- Market rates, billing and payments

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Research and Empirical Evidence to Support CADA's Four-Point Plan

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SUPPORTING INFORMATION

Nationally, SAMHSA's SAPT Block Grant serves two million people annually, and accounts for approximately 42 percent of public funds spent at the state and local level on substance use disorders prevention and treatment activities (Vaughn & de la Gueronniere, 2009).

In FY 2010-2011, the state of California received a total of \$399.8 million in SAMHSA funding. Of this amount, \$251.7 million came from the SAPT Block Grant and \$66.3 million came from the mental health block and formula grants (SAMHSA, 2011).

The full breakdown is available at:

<http://www.samhsa.gov/statesummaries/StateSummaries.aspx>

The remainder of California's funding in FY 2010-11 (\$81.7 million) came from one of several SAMHSA discretionary programs. A sampling of the discretionary programs includes: Children's Services (mental health); Child Mental Health Initiative; Targeted Capacity Expansion (areas include jail diversion, service capacity building in minority communities; HIV/AIDS, SBIRT, American Indians/Alaska Natives, campus screening/colleges and universities, and rural populations); Statewide Family Networks (mental health); Statewide Consumer Networks (mental health); Supportive Housing (mental health); Campus Suicide; National Child Traumatic Stress Initiative—Treatment and Service Adaptation Centers; Post-Traumatic Stress Disorder in Children; Post-Traumatic Stress Disorder—Treatment Centers; Community Treatment and Services Centers of the National Child Traumatic Stress Initiative; Youth Suicide Prevention and Early Intervention; SAMHSA Conference Grant; Drug-Free Communities; HIV/AIDS Services; HIV—Strategic Prevention Framework; Strategic Prevention Framework State Incentive Grant; Prevention of Methamphetamine Abuse; Drug-Free Communities—Mentoring; Access to Recovery; Homeless Addictions Treatment; Effective Adolescent Treatment; Pregnant and Post-Partum Women; Recovery Community Support—Facilitating; Methamphetamine Populations (substance abuse treatment); Juvenile Drug Courts; Young Offender Reentry Program; Addiction Technology Transfer Centers; Family Drug Courts; and Recovery Community Support—Recovery (SAMHSA, 2011).

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Complete details are available at:

<http://www.samhsa.gov/statesummaries/detail/2010/CA.aspx>

Another important source of funding is that available through 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 use disorders. To identify researchers in your local region, please refer to the NIH Research Portfolio Online Reporting Tools (RePORTer) searchable database¹ available on the NIDA website (www.nida.nih.gov).

The following information related to the IMD exclusion is excerpted, in full, from a California Association of Alcohol and Drug Program Executives, Inc. fact sheet:

“The Institutions for Mental Disease (IMD) exclusion serves as a barrier for drawing down much-needed federal Medicaid dollars. Current Medicaid statute defines IMD as ‘a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases [42USC 1396d].’ The law prohibits all payments for services to IMD patients between the ages of 21 and 65. However, nothing in the statute refers to addictive disorders or substance abuse treatment. The only reason that residential substance abuse treatment programs have been caught up in the IMD net is that the government has chosen to use a system of categorization that classifies all addictive disorders as mental disorders. We believe that this decision is erroneous and falls outside of the intent of Congress in enacting the statutory exclusion.

As described above, current federal interpretation of the IMD exclusion prohibits Medicaid payment for patients in substance abuse treatment facilities, as well as those in psychiatric facilities. Therefore, it denies Medicaid eligibility to the clients of residential drug treatment programs of more than 16 beds. Further, payment is prohibited not only for services provided within the treatment program also for any other services provided outside of the treatment agency (e.g., tests or treatment for tuberculosis, HIV, or sexually transmitted diseases; medical or surgical services in a general hospital). This exclusion is an administrative decision of the federal government. If this exclusion is removed by the federal government it would greatly benefit public health, child welfare, and public safety systems with their respective (and often overlapping) populations.”

¹The information found in RePORTER is drawn from several extant databases—eRA databases, Medline, PubMed Central, the NIH Intramural Database, and iEdison—using newly-formed linkages among these disparate data sources. The comprehensiveness of these databases varies, as does the quality of the linkages formed among them. We expect that the quality of RePORTER data will improve over time as a result of changes in both data collection (e.g., implementation of the NIH Public Access policy) and the increased ability to identify missing information that comes from making these data accessible to more people.

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SUPPORTING INFORMATION

Untreated substance use disorders cost California taxpayers an estimated \$58 billion annually. These costs include, but are not limited to, lost productivity, incarceration, criminal activity, substance use disorder-related illness, and premature death. In addition, significant burdens are placed on the foster care and welfare systems. The majority of public resources are spent countering illegal drugs. To put this cost into perspective, \$58 billion is more than half of the state's total \$93 billion budget for FY 10-11. It is greater than state spending on K-12 education and is greater than the combined cost of health and human services, higher education, and corrections (CADA, 2009).

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).

Drug addiction treatment significantly decreases criminal activity during and after treatment (Hubbard et al., 1997). And substance use disorders treatment is more cost effective than incarceration or emergency medical care (Physician Leadership on National Drug Policy, 2000; Marwick, 1998).

In 2007-08, an estimated 3.1 million Californians reported alcohol or other drug abuse or dependence, according to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2010). During the same time period, however, just 174,066 Californians were admitted into treatment, according to the California Department of Alcohol and Drug Programs (CA ADP, 2009). In other words, only about 5% of Californians who needed treatment received it in 2007-08.

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The American Medical Association, National Institutes of Health, and other leading health authorities recognize and define alcohol and drug addiction as a preventable and treatable disease. Treatment works. Without appropriate treatment, individuals are likely to relapse as they do with other chronic diseases. Decades of research show that addiction treatment is successful – at reducing drug use and arrests, and increasing employment, among other measures. As with sufferers of other chronic conditions, people with addiction problems have a treatment compliance rate (or “success rate”) of about one-third. From the 1994 CALDATA study to the 2006 UCLA cost-benefit analysis of Proposition 36, research documents that treatment works and saves tax dollars in California. This science should drive state alcohol and drug policy and budgets (CADA, 2009).

According to “*Shoveling Up II: The Impact of Substance Abuse on Federal, State, and Local Budgets*,” a report released by the National Center on Addiction and Substance Abuse at Columbia University (CASA), in 2005, federal, state, and local government spending as a result of substance abuse and addiction totaled approximately \$468 billion. For each dollar spent on substance abuse and addiction, nearly 96 cents went towards “shoveling up the wreckage,” and less than 3 cents went towards prevention, treatment, interdiction, research, taxation, and regulation (CASA, 2009). In other words, more than 95 percent of taxpayer dollars were used to remediate the negative consequences associated with tobacco, alcohol, and drug abuse and addiction, and less than 2 percent was put to use in prevention and treatment efforts. Furthermore, for every dollar spent on preventing and treating substance abuse and addiction, federal and state governments spent nearly \$60 on public programs designed to address the negative consequences of substance abuse and addiction (CASA, 2009). In 2005 in California, 98 cents of the “substance abuse dollar” were spent on funding public programs, and of those, the programs that were most greatly impacted by this burden were justice (40%), education (30%), and health (19%; CASA, 2009).

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>.

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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 \$1 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).

Three additional studies illustrate the notion that cost savings can result from the provision of addiction treatment services. In an Oregon-based cost study that examined the utilization of a variety of services, including criminal justice, unemployment, food stamps, child welfare, and health care, for every \$1 invested in addiction treatment, the state saved \$5.60 in addiction-related costs (Finigan, 1996). In a Washington State-based study that looked solely at Medicaid expenses, addiction treatment clients incurred approximately \$4,500 less in expenses than their untreated counterparts over course of a 5-year follow-up period (Wickizer & Longhi, 1997). And in a second Washington State-based study that looked specifically at the medical expenses of Supplemental Security Income (SSI) clients who received addiction treatment vs. those who needed addiction treatment but did not receive it, the medical expenses of the addiction treatment group were \$6,480 less per person per year than the expenses of the untreated group (Estee & Nordlund, 2003).

Reducing Crime and Enhancing Public Safety

California embarked on the largest expansion of a state prison system in US history during the 1980s, increasing the number of incarcerated nonviolent drug offenders from 2,000 in 1980 to almost 45,000 in 1999 – a 25-fold increase in just 20 years. The current cost of incarceration per prisoner per year is \$46,000 (CADA, 2009). Finding effective alternatives to incarceration, such as in-custody or community-based substance use disorders treatment, would greatly reduce this extreme cost burden to the state.

A 2008 study of parole violations and revocations indicated that 35 percent of the state's adult prison population is serving terms for drug offenses. An even higher percentage has underlying substance abuse problems (Grattet, Petersilia, & Lin, 2008). Further, a 2006 California Policy Research Center study estimated that 42 percent of California inmates have a high need for alcohol treatment and 56 percent have a high need for drug treatment, but a significantly smaller percentage (8 percent for alcohol and 9 percent for drugs) receive the necessary in-custody treatment (Petersilia, 2006). These figures suggest that anywhere between one-fifth and one half of the \$10 billion CDCR budget is driven by substance abuse. Therefore, all appropriate substance abuse treatment protocols should be utilized and adequately funded to maximize recidivism prevention. This includes in-custody, post release and treatment as an intervention for

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technical parole violation (e.g. substance abuse). Community-based treatment should be expanded as it is a major component in recidivism prevention efforts (CADA, 2009).

The Evaluation of the Substance Abuse and Crime Prevention Act (SACPA): Cost Analysis Report (for the first and second years of SACPA) was released in April 2006. UCLA Integrated Substance Abuse Programs conducted three studies to assess the cost implications and benefit-cost ratios of SACPA. In Study 1, which involved the use of a 'before SACPA comparison group' and all first-year SACPA eligible offenders, a net savings of \$2,861 per offender (N=61,609) was found, which yielded 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). Lastly, 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 (Longshore, Hawkins, Urada, & Anglin, 2007). Three conclusions resulted from these 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 (Longshore et al., 2007).

Further, the UCLA ISAP SACPA Evaluation Team's recommendations encompassed 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 (Longshore, Hawkins, Urada, & Anglin, 2007).

Seven main conclusions were drawn by the UCLA ISAP SACPA Evaluation Team in their Final Evaluation Report released in April 2007:

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).

Reducing Welfare and Children's Services Costs

Grella and colleagues (2009) studied the impact of mothers' participation in substance abuse treatment on reunification with their children (in out-of-home care). Mothers who presented with more severe employment and psychiatric problems were less likely to be reunified with their children (Grella, Needell, Shi, and Hser, 2009). Further, those

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mothers who completed at least 90 days of substance abuse treatment were twice as likely as the mothers who completed less than 90 days of treatment to be reunified with their children (Grella, Needell, Shi, and Hser, 2009). Lastly, “the mothers who were treated in programs providing a ‘high’ level of family-related or education/ employment services were approximately twice as likely to reunify with their children as those who were treated in programs with ‘low’ levels of these services” (Grella, Needell, Shi, and Hser, 2009).

In 2006, the state of California was awarded a five-year waiver from federal government spending restrictions with regards to children and family services. Los Angeles County (under the auspices of the Department of Children and Family Services) was one of two counties that chose to participate in this waiver, and while the waiver did not provide new funds, it gave the county flexibility with how they could spend existing child welfare funds (Edgar, 2009). One stipulation of the waiver was that any cost savings would need to be re-invested in child welfare services. SHIELDS for Families, Inc., served as DCFS’ lead community partner in conducting up-front assessments as part of Point of Assessment (POE). Throughout 2008, DCFS was able to reduce the number of children in “out-of-home” care, and at the end of January 2009, there were 16,429 children in care vs. 18,304 in July 2007. With regards to the number of children residing in group homes, there were 937 children in group homes throughout the county at the end of January 2009, a 30 percent decrease from July 2007, when there were 1,343 children in group homes (Edgar, 2009). In addition, in the first year of the federal flexible funding waiver, DCFS generated \$28.9 million in re-investable funds (Edgar, 2009).

The Los Angeles County Probation Department was another DCFS partner in the federal waiver. The Department used approximately 1,100 fewer group home bed days during the first year of the federal flexible funding waiver, and between July and December 2008, the number of probation youth in group home care decreased by approximately 8 percent (Edgar, 2009).

The provision of family-centered treatment promotes the well-being of the entire family unit, not just the parent/caregiver with a substance use disorder. The connections and relationship between a parent/caregiver and her children is critical to positive outcomes with regards to treatment and recovery (Brown & Finkelstein, 2008). Oftentimes, family-centered interventions involve the collaboration of several agencies, including schools, health clinics/physician offices, juvenile justice, child welfare, and behavioral health (Brown & Finkelstein, 2008). The SAMHSA-funded Women, Co-Occurring Disorders, and Violence (WCDVS) study examined an integrated services approach for women with co-occurring substance use and mental health disorders who also had a history of violence.

The WCDVS study involved a Children’s Subset Study that examined the effectiveness of trauma-informed, culturally relevant, and age-specific intervention models for children of mothers who were enrolled in the main study (Noether et al., 2004). Short term findings (six months post-baseline) of the Children’s Subset Study indicated that the mother’s overall treatment outcome played a stronger role in children’s outcomes than involvement in the experimental intervention. Furthermore, longer term findings (12

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months post-baseline) indicated that participation in the experimental intervention led to sustained positive improvement in emotional and behavioral strengths regardless of mother's treatment outcome, and younger children displayed a greater degree of positive change than older children (Noether, Morris, Russell, & Finkelstein, 2004). One of the major research-to-practice implications was the importance of providing concurrent services for the mother and child (Noether, Morris, Russell, & Finkelstein, 2004), and provision of specific services to children provides additional benefits (Brown & Finkelstein, 2008).

In 2005, Young and colleagues reviewed Child and Family Service Review (CFSR) reports for 50 states, the District of Columbia, and Puerto Rico. According to the review, "parental substance abuse was reported as a factor [primary or otherwise] in cases in 32 states. It was identified as a factor that brought a child to the attention of the child welfare agency in 16 to 61 percent of cases" (Young et al., 2005). The reviewers report that the "relatively low percentage of cases with specific mention of substance abuse as a factor in the case needs further investigation, as it contrasts with general practice knowledge that the majority of [child welfare] cases are affected by familial substance abuse" (Young et al., 2005).

The SAFERR model (Screening and Assessment for Family Engagement, Retention, and Recovery) was developed by the National Center on Substance Abuse and Child Welfare (NCSACW) to help public and private agency staff members respond to families affected by substance use disorders. "SAFERR is based on the premise that when parents misuse substances and maltreat their children, the only way to make sound decisions is to draw from the talents and resources of at least three systems: child welfare, alcohol and drugs, and the courts" (Young et al., 2006).

Reducing Health Care Costs by Instituting Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Substance use-related problems have long been identified as a major cause of morbidity and mortality (McLellan et al., 2005; McGinnis & Foege, 2003; NIAAA, 2003; McLellan, Lewis, O'Brien, & Kleber, 2000). However, the National Survey of Drug Use and Health indicated that in 2009, out of more than 23 million Americans aged 12 and older who indicated problematic substance use and were in need of treatment, only 2.6 million (approximately 11% of those in need) received any treatment (SAMHSA, 2010). Of the 20.9 million Americans who needed treatment but did not receive it in the past year, only 1.1 million (~5%) persons reported a perceived need for treatment for their alcohol or other drug problem. Of those individuals, only 371,000 made an attempt to enter treatment (SAMHSA, 2010). In other words, the vast majority of problem substance users (~95%) in the United States neither perceives a need for nor attempts to access available treatment services. Routine screening and early identification of problematic substance use, followed by the appropriate level of intervention, can help to identify and reduce substance abuse problems.

Implementation of screening and brief intervention (SBI) within health care settings works. Many studies of brief interventions have focused primarily on alcohol consumption. These studies have shown that SBI is an effective strategy for modifying

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problematic alcohol consumption in primary care settings (Bertholet et al., 2005; Fleming, et al. 2002; Dunn, Deroo, & Rivara, 2001; Wilks, Jensen, & Havighurst, 1997). More recent randomized controlled studies conducted in US-based emergency department settings have demonstrated that significant reductions in drinking behaviors occur when SBI techniques are employed with patients (Academic ED SBIRT Research Collaborative, 2007).

In addition to reducing alcohol use, SBI may also reduce drug use significantly (Whitlock et al., 2004; Burke, Arkowitz, & Menchola, 2003). SBI can also reduce accidents, injuries, trauma, emergency department visits, depression, and substance use-related mortality (Schermer et al., 2006; Cuijpers, Riper, & Lemmers, 2004; Fleming et al., 2002). In a study involving trauma center patients by Gentilello and colleagues (1999), there were 48 percent fewer re-injuries in an 18-month period following SBI, and those trauma patients who were administered SBI were 50 percent less likely to re-hospitalize than their counterparts. Furthermore, SBI may reduce work-impairment, reduce DUI cases, and improve neo-natal outcomes (Schermer et al., 2006; Burke, Arkowitz, & Menchola, 2003).

Multiple cost studies and meta-analyses have indicated that SBI for alcohol saves approximately \$2 to \$4 for every dollar spent. In a randomized trial of brief treatment in the United Kingdom, reductions were seen in one-year health care costs. Specifically, \$2.30 was saved for each \$1 spent on intervention (UKATT Research Team, 2005). In Project TREAT (Trial for Early Alcohol Treatment), a randomized clinical trial involving screening and brief counseling in 64 primary care clinics of non-dependent alcohol misuse, reductions were seen in future health care costs. Specifically, \$4.30 was saved for each \$1 spent in intervention (at 4-year follow-up) (Fleming et al., 2002). Lastly, in a randomized control trial of SBI in a Level 1 trauma center involving alcohol screening and counseling for more than 700 trauma patients, reductions were seen in medical costs. Specifically, \$3.81 was saved for each \$1 spent on intervention (Gentilello et al., 2005).

A manuscript that was published in September 2010 in the Substance Abuse Research Consortium (SAR) special issue of the *Journal of Psychoactive Drugs* describes, in detail, several SBIRT-related initiatives that have occurred throughout California in recent years (Davoudi & Rawson, 2010). The initiatives have focused on SBIRT implementation in primary health care, emergency room, and trauma centers (San Diego CASBIRT and UC Davis Trauma Center Project), college campuses (UCLA Access to Care), county jails (Los Angeles City and County Jails Project), and prenatal centers and Healthy Start divisions (Contra Costa County Alcohol and Drug Service Division Project). In addition, past and current training initiatives have focused on workforce development for primary care, emergency room, and trauma center staff, organizations that serve American Indians and Alaska Natives, college counseling center staff, alcohol and other drug assessment center staff, and mental health providers (Davoudi & Rawson, 2010). The article includes a description of identified barriers/challenges to SBIRT implementation (e.g., leadership support, staff availability and skills, client retention, and data monitoring systems), as well as recommendations for expanding SBIRT in California (e.g., sharing successful implementation models,

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promoting SBIRT among health care leaders, and providing tailored training and ongoing technical assistance; Davoudi & Rawson, 2010).

An effort is underway in Colorado to implement SBIRT in primary care settings. A total of 22 sites are funded through this effort, and include Federally Qualified Health Centers (FQHCs), rural and urban hospitals, rural and urban clinics, and a dental clinic (additional unfunded sites are involved, as well). So far, out of more than 95,000 screenings, 11 percent (~10,450) of individuals screened have gone on to receive a brief intervention, 2 percent (~1,900) have received a brief treatment, and 3 percent (~2,850) have been referred to more intensive treatment (Esquibel, 2010). Several recommendations have been made with regards to service integration as it relates to SBIRT implementation, and include:

- Improved communication and understanding between primary care staff and substance use disorders treatment staff;
- Openness to new modalities, such as brief intervention and brief therapy;
- Expanded scope of focus to include high-risk alcohol and other drug users (not just those dependent upon alcohol or other drugs);
- Establishment of interdisciplinary teams; and
- Improved information exchange (Esquibel, 2010).

In 2009, the University of California, San Francisco, was one of six US-based universities to receive an SBIRT Medical Residency Program grant from SAMHSA. The purpose of the 5-year grant is to train medical residents on the use of SBIRT, and involves curriculum development, resident and faculty training, clinical implementation, and follow-up to examine adherence to intervention and treatment plans for identified hazardous use” (McCance-Katz, 2010).

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- *Develop a benchmark benefit that will not only meet federal parity laws, but will ensure care based on medical necessity and desired outcomes.*

SUPPORTING INFORMATION

In March 2010, President Obama signed into law historic health care reform legislation that will extend insurance to currently uninsured and under-insured Americans. The legislation supports previous legislation requiring that substance use disorders and mental illness benefits are on par with those for medical illnesses. SUD services will be seen as an “essential health benefit” (Alcohol and Drug Policy Institute (ADPI), 2010). These new policies will dramatically change how SUD treatment is funded and the types of services that are reimbursed. With health care reform, the provision of SUD treatment services will move from community-based alcohol and other drug specialty treatment programs to primary care settings, and payment for such services will shift from a heavy reliance on SAPT Block Grant funds to public and private insurance (ADPI, 2010). The SUD treatment and recovery workforce will need additional skills to navigate this much broader (and perhaps integrated) health care system.

The Patient Protection and Affordable Care Act (ACA) includes “several provisions that are aimed at improving coverage for and access to substance use disorder and mental illness prevention, treatment, and recovery services” (NIATx & SAAS, 2010). Key provisions include:

- Substance use disorder and mental health (SUD/MH) services will be included in basic benefit packages.
- All plans in the health insurance exchange will be required to adhere to the provisions of the Wellstone/Domenici Parity Act.
- Medicaid enrollees, including newly eligible childless adults, will receive adequate health coverage, including SUD/MH coverage.
- SUD/MH will be included in chronic disease prevention initiatives.
- The SUD/MH workforce will be included in health workforce development initiatives.
- SUD prevention, treatment, and MH service providers will be eligible for community health grants aimed at supporting medical homes.
- Medicaid coverage will be expanded for all Americans below 133 percent of the federal poverty level.
- Health insurance exchanges will be created for individuals and small employers to pool risk and purchase insurance (NIATx & SAAS, 2010).

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Several specific administrative and clinical services are likely to be employed in future substance use disorders, mental health and primary care integration, and include: screening and brief intervention, medication-assisted treatment, brief treatments (to be defined), “warm hand-off” techniques, and behavioral enhancement techniques, such as motivational enhancement therapy, motivational interviewing, and the NIATx process improvement model (Rawson & Freese, 2010).

NIATx and SAAS recently released a document entitled, *“Implementing Healthcare Reform: First Steps to Transforming Your Organization – A Practical Guide for Leaders.”* The purpose of this guide is to assist organizations with: (1) recognizing the need to transform; (2) helping boards of directors, managers, and staff to understand the elements of transformation and why change is crucial to the survival of the organization; (3) realistically assessing the strengths and weaknesses of the organization at every level; (4) developing a strategic and/or business plan to address all aspects of the organization’s culture, practices, and processes; (5) developing or enhancing partnerships with primary health clinics, physician group practices, and hospitals; and (6) implementing the plan, assessing its effectiveness, and identifying areas for sustainment and improvement (NIATx & SAAS, 2010). Visit www.saasnet.org to download a full copy of the Guide.

The Legal Action Center recently released a two-page document entitled, “Implementing the Medicaid Substance Use Disorder Provisions of the Affordable Care Act” (Belnap & de la Gueronniere, 2011). Included in the document are the following recommendations for states to consider as they prepare for statewide implementation of Medicaid coverage for newly-eligible adults:

- Recognize the requirements of the ACA and work with HHS to ensure beneficiaries receive sufficient SUD and MH coverage.
- Recognize the significant health needs of low-income adults and utilize their authority under Section 1937(b)(D) of the Social Security Act (the Secretary-approved coverage option) to design a comprehensive Medicaid benefits package that includes a robust benefits package for the full continuum of substance use disorder and mental health prevention, treatment, and recovery support services.
- Recognize that individuals with untreated mental health and/or substance use disorders may be less likely to have stable, long-term employment and are more likely to be involved in the criminal justice system.
- Utilize the presumptive eligibility option of the law to allow certain qualified providers to grant short-term Medicaid eligibility and receive federally matched Medicaid reimbursement for care provided to individuals who appear eligible.
- Work with substance use disorder service providers to ensure they are prepared for the likely increase in demand as a result of the Medicaid expansion and that they understand Medicaid requirements and are prepared to participate in the Medicaid program (Belnap & de la Gueronniere, 2011).

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In October 2010, Mancuso and Felver released a report entitled, “*Health Care Reform, Medicaid Expansion, and Access to Alcohol/Drug Treatment: Opportunities for Disability Prevention.*” Included in the report were several recommendations for the state of Washington to consider regarding positioning the state to ensure the necessary SUD service capacity to adequately treat the new Medicaid population. The recommendations include: (1) preserving current SUD treatment funding for low-income adults who become part of the Medicaid expansion population; (2) financing SUD treatment for Medicaid populations in such a way that funding will adjust based on caseload growth; (3) implementing workforce development strategies to build SUD treatment provider capacity; and (4) expanding the use of SBI for substance using clients who are not yet substance dependent (Mancuso & Felver, 2010). These same recommendations can be put forth for consideration in California.

The Integration Policy Initiative (IPI) is a collaboration of the California Institute for Mental Health (CiMH), the California Primary Care Association (CPCA), and the Integrated Behavioral Health Project (IBHP). The purpose of this Initiative is to “address the pressing need for improved linkages between the physical, mental, and substance use healthcare systems serving California’s Safety Net Population” (CiMH, 2009). A report entitled, “*California Primary Care, Mental Health, and Substance Use Services Integration Policy Institute Volume I: Report,*” is available for viewing and downloading from www.cimh.org, and includes detailed information on the overview, vision, and principles of the IPI, barriers and opportunities for integration, and recommendations to support IPI’s vision, principles, and continuum. With regards to examples of integration initiatives occurring within California, Shasta County has contracted with two FQHCs to provide mental health services within a primary care setting, and Santa Clara County Mental Health is involved in integrating psychiatrists and social workers into three FQHCs to increase access to the mental health system (CiMH, 2009).

Ingoglia and Jarvis (2010) describe three possible integration models for implementing health care reform in California. All three models build on existing design of California’s counties and are as follows:

- Single County Organized Health System Mode (8 counties)
- County Organized Health System + Private Health Plan Model (9 counties)
- Small County Collaboration Model (31 counties)

According to Ingoglia and Jarvis (2010), “all three models are organized around the idea that each county would have an integrated design for the four Priority Populations (at a minimum) identified in the [1115] Waiver Renewal Plan, bringing current MediCal FFS populations into managed care and expanding coverage for indigent uninsured.” To clarify, the four Priority Populations are seniors, children with special needs, dually diagnosed individuals, and individuals with serious mental illnesses (Ingoglia & Jarvis, 2010).

In April 2010, Treatment Research Institute hosted a *Forum on Integration: A Collaborative for States* with state leaders to “discuss the challenges and opportunities they have faced in planning, implementing, and sustaining effective substance use

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screening and treatment programs in general health care settings.” Several themes arose from the Forum, and are summarized here:

- Theme #1: The integration of substance use condition screening and treatment/intervention within general health care is important.
- Theme #2: Many different primary care/substance use disorders integration models exist, and can be implemented with a wide variety of patient populations.
- Theme #3: The existing workforce can be re-tooled and new roles can be created to facilitate the integration of substance use conditions within primary care and other health care settings.
- Theme #4: Financial barriers exist that may impact the initiation and/or sustainability of integrated programs.

A *TRI Issue Brief* is available for viewing and downloading from:

<http://www.tresearch.org/centers/LessonsLearned.pdf>.

In fall 2009, the Northwest Frontier ATTC published a three-part *Addiction Messenger* series on integrating substance abuse and mental health services. Part 1 focused on the provision of integrated care, and described the Dual Diagnosis Capability in Addiction Treatment instrument. The instrument was developed by the Robert Wood Johnson Foundation and the SAMHSA Co-Occurring State Incentive Grant Program to assess addiction treatment programs' capacity to deliver services to clients with co-occurring disorders (McGovern, Matzkin, & Girard, 2007). Part 2 focused on screening and assessment, and Part 3 focused on effective client care. The three-part series is available for viewing and downloading at:

<http://www.nattc.org/regcenters/c1.asp?rcid=10&content=CUSTOM1>

In 2003, the National Council for Community Behavioral Healthcare (a.k.a., The National Council) released a background paper entitled, *“Behavioral Health/Primary Care Integration Models, Competencies, and Infrastructure.”* In the paper, Mauer describes several principles for integration, which include:

- Focus on consumers and their families
- Promote health, overcome disparities, and address chronic illness
- Standardize quality and outcome measures for use in research and practice
- Promote collaboration and co-location
- Redesign financing, the regulatory environment, and contracting methods
- Develop best practice service delivery models
- Invest in training
- Assure information technology (Mauer, 2003).

Mauer also describes the *Four Quadrant Clinical Integration Model*, which “builds on the 1998 consensus document for mental health (MH) and substance abuse/addiction (SA) service integration, as initially conceived by state mental health and substance abuse directors (NASHMHPD/NASADAD), and further articulated by Ken Minkoff and his colleagues” (Mauer, 2003). The Model is divided into severity for each disorder:

- Quadrant I: Low MH-low SA (served in primary care)

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- Quadrant II: High MH-low SA (served in MH system by staff with SA competency)
- Quadrant III: Low MH-high SA (served in SA system by staff with MH competency)
- Quadrant IV: High MH-high SA (served by a fully integrated MH/SA program)

Several studies conducted in the past decade have documented cost savings in a variety of systems/areas, as a result of the receipt of substance use disorders treatment. Two studies by Parthasarathy and colleagues (2001 and 2003) documented that the cost of medical care in general, and the per capita cost of inpatient and emergency room care, specifically, declined following receipt of substance use disorders treatment. Luchansky and Longhi (1997) found that the Medicaid costs for individuals in Washington State who received substance use disorders treatment were 5 percent lower than Medicaid costs for individuals who did not receive treatment. And Walter and colleagues (2005) studied Medicaid patients in a “comprehensive HMO” setting, and found that substance use disorders treatment “was associated with a reduction of just under one third of medical costs per treatment member.” Lastly, for individuals who remained abstinent after treatment, “family members’ health care utilization and costs were similar to that of control families, 5 years after treatment” (Weisner, Parthasarathy, Moore, & Mertens, 2010).

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 use disorders treatment, 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).

A comprehensive listing of health care reform-related resources (publications, presentations, and fact sheets) can be found by visiting:

- http://cadpaac.org/health_care_reform.html
- http://www.thenationalcouncil.org/cs/healthcare_reform
- <http://www.uclaisap.org/cossr-pilots/html/health-care-reform/integration.html>.

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4. Assure the implementation of statewide quality, evidence-based standards for SUD services and the SUD prevention, treatment, and recovery workforce, including the following:

- *Administrative*
- *Clinical – utilization of evidence-based practices*
- *Consumer information*
- *Workforce – licensing/certification, continuing education, and staff development*
- *Market rates, billing and payments*

SUPPORTING INFORMATION

Quality, Evidence-Based Standards

The National Quality Forum (NQF), funded by the Robert Wood Johnson Foundation and SAMHSA-CSAT, endorsed a set of 11 national standards for the treatment of substance use disorders. The *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices* are organized into four domains, most with one or more sub-domains. The standards are outlined as follows:

- Identification of Substance Use Conditions
 - Screening and Case Finding
 - Diagnosis and Assessment
- Initiation and Engagement in Treatment
 - Brief Intervention
 - Promoting Engagement in Treatment for Substance Use Illness
 - Withdrawal Management
- Therapeutic Interventions to Treat Substance Use Illness
 - Psychosocial Interventions
 - Pharmacology
- Continuing Care Management of Substance Use Illness (NQF, 2007).

These practices are “applicable across a broad range of populations (e.g., adolescents and adults), settings (e.g., primary care and substance use treatment settings), and providers (e.g., counselors and physicians)” (NQF, 2007).

In 2009, Treatment Research Institute and UCLA Integrated Substance Abuse Programs partnered on an Implementation of NQF Treatment Standards dissemination project, and many resulting informational papers (e.g., FAQs, summary of the Standards, SUD treatment performance measures, NQF Standards and existing performance measures crosswalk, and NQF standards algorithm) are available at: http://www.tresearch.org/centers/cpbp_policy_group.html

The Program Services Division within the California Department of Alcohol and Drug Programs is in the process of developing two documents, *California’s Best System*

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Practices and Treatment Standards for Substance Use Disorders. The documents are based, in large part, on the NQF's Voluntary Consensus Standards, and will serve as a guide to new and established substance use disorders treatment programs within the state of California to ensure the delivery of high-quality SUD services, with a focus on continuous quality improvement. The documents will provide SUD treatment agency staff with guidance on establishing minimal service requirements, and guidelines on adopting client-responsive, efficacious services and supports. Draft versions of both documents are available for viewing and downloading from ADP's Treatment Standards development page: <http://www.adp.ca.gov/treatment/standards/ts.shtml>. Next steps will include finalizing the content of the documents and statewide roll-out of the final set of practices and standards.

SUD Workforce Issues, Opportunities, and Challenges

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>). The counselor certification regulations (Title 9, Division 4, Chapter 8, Subchapter 2) 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.

Ten organizations responsible for certifying alcohol and drug counselors in California are accredited by the National Commission for Certifying Agencies (NCCA), and are listed alphabetically below:

- American Academy of Health Care Providers in the Addictive Disorders (AAHCPAD)
- 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 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

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Abuse Treatment. TAP 21 includes understanding addiction, treatment knowledge, application to practice, and professional readiness.

The substance use disorders treatment workforce faces several challenges, including: high turnover, staff shortages, lack of general education, burnout, inadequate specialized training and continuing education, and barriers to organizational change and training (Knudsen, Ducharme, & Roman, 2006; Gallon, Gabriel, & Knudsen, 2003; Kaplan, 2003; Knudsen, Johnson, & Roman, 2003; Lacoursiere, 2001).

Further, a report from the Annapolis Coalition on the Behavioral Health Workforce states that the national workforce crisis is “characterized, in part, by problems of recruitment and retention; minimal workforce diversity; inadequate access to training; the questionable relevance and effectiveness of many educational programs; and a lack of cultural competence among those providing care.” A document entitled, “*Action Plan for Behavioral Health Workforce Development*” (Hoge, et al., 2006) is available at: <http://www.samhsa.gov/Workforce/Annapolis/WorkforceActionPlan.pdf>.

Staff turnover in the substance use disorders treatment field has been documented to range from 19% to 50% (Johnson & Roman, 2002; Gallon, Gabriel, & Knudsen, 2003; Knudsen, Johnson, & Roman, 2003; McLellan, Carise, & Kleber, 2003). Eby and colleagues (2010) recently conducted the first longitudinal study designed to examine actual turnover amongst counselors and clinical supervisors through the use of organizational data collected from substance use disorders treatment centers. The researchers found that the annual turnover rate was approximately 33% for counselors and 23% for clinical supervisors. While specific reasons for turnover varied across the two groups, a “new job or opportunity” was the most commonly reason respondents for leaving their position (Eby, Burk, & Maher, 2010).

In 2003, the Pacific Southwest Addiction Technology Transfer Center (Pacific Southwest ATTC) conducted a survey of substance abuse agency directors and staff in a 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 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.

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- 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 (Pacific Southwest ATTC, 2007) .

The Pacific Southwest ATTC will be participating in the forthcoming rollout of a newly designed National ATTC workforce survey. Data collection is slated for summer 2011. Results will be released as they become available in 2012.

In a document entitled, "*Substance Abuse Treatment Workforce Environmental Scan*," Kaplan (2003) concludes, "it is the workforce that will implement the priorities and uphold the principles for substance abuse treatment. Expanding substance abuse capacity, eliminating disparities, developing cost-effective strategies, and providing the many services needed for diverse populations depend on a well-trained, effective, competent workforce. Given the complexities of the changes facing the substance abuse treatment field, investing in human capital takes on an urgency that has not been experienced previously."

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