State of California

LITTLE HOOVER COMMISSION

March 11, 2003

The Honorable Gray Davis
Governor of California

The Honorable John L. Burton
President pro Tempore of the Senate
and members of the Senate

The Honorable James L. Brulte
Senate Minority Leader

The Honorable Herb J. Wesson, Jr.
Speaker of the Assembly
and members of the Assembly

The Honorable Dave Cox
Assembly Minority Leader

Dear Governor and Members of the Legislature:

One in nine Californians suffers from an addiction to alcohol or other drugs. But few addicts suffer alone. Drug addiction underlies the abuse and neglect of more than 100,000 children in California and is a factor in a majority of domestic assaults.

Eight in 10 felons who are sent to prison abuse drugs or alcohol. But the costs are not limited to the criminal justice system. Some $11 billion is spent from the state General Fund responding to the problems created by abuse or addiction. The expenditures and economic losses to individuals, corporations and public agencies that result from abuse and addiction in California are estimated to top $32 billion.

Much of the public resources are spent countering illegal drugs. But at least half of the health consequences, half of the violence and half of the economic losses are attributable to the abuse of alcohol – the drug that most of our children will abuse first.

A majority of Californians have come to realize the insidious nature of addiction, as well as the ineffectiveness, disparate and at times overly punitive response to those trapped in addiction. Proposition 36, approved by voters, reflected a clear choice – one supported by academic research and practical experience – that treatment can be a cost-effective, socially responsible and humane solution.

But the voter initiative did not go far enough. It did not make sure that the State was strategically using prevention, treatment and enforcement tools to reduce the consequences of addiction. And it did not ensure that the publicly-funded treatment programs perform to their potential to change lives. Those tasks still await state and local policy-makers and program administrators.

In this report, the Commission recommends how state and community leaders could embrace the will of voters and employ sound science to better respond to one of the most costly and harmful problems facing California. Specifically, the State must develop a strategy that uses prevention, treatment and law enforcement where those tools have proven they can do the most to reduce the consequences of abuse and addiction. That strategy must be developed, implemented and monitored by a council of talented and committed professionals and political leaders. In turn, state and community officials must be given clear direction to make treatment programs grow in quality and quantity.

The consequences of abuse and addiction are so severe, and the potential for treatment so great, that the ultimate goal should be to ensure quality treatment for everyone who could benefit. This goal cannot be obtained by government action alone. Rather, civic leadership will be essential to muster public and private resources, build public understanding and support, and engineer the necessary changes in treatment and other supportive programs.

In addition to refocusing policies on treatment, Proposition 36 provided additional funding and gave local officials a clear mandate. In many counties, the challenge has reinvigorated judges, attorneys, treatment providers and others who understand the problem. They had been saddled by conflicting mandates, restricted funding and narrowly defined responsibilities, but the voters defined for them a clear and common purpose.

The State needs to reinforce that victory by establishing an overarching drug and alcohol policy focused on the shared goal of reducing the cost and misery of addiction, and it should align government and community-based resources toward that end. A top priority must be to stop the intergenerational infection of drug and alcohol abuse, and to target those whose addiction most injures others, especially our children.

Reducing abuse and addiction needs to be a government-wide fight. While individual drug control programs may be excellent, the overall effort is unfocused and undisciplined. Treatment – clearly one of the best responses – is undervalued and under-used. And the stakes are too high not to honestly measure how well policies are working and then expand, modify or abandon policies based on the evidence. Through a statewide council, California will have a mechanism to direct resources to the most effective responses.

But treatment programs also have not been managed in a way that fully seizes the potential to heal lives. In documenting the benefits of treatment, researchers also have revealed the need for providers to faithfully replicate proven strategies. Social service workers frustrated by the complex difficulties of troubled families know they need to tailor the services those families need to become safe, healthy and self-sufficient.

Conquering addiction also will require public leaders to look beyond government. Employers, health care providers and insurance carriers – if they want to hold down costs and have a healthy workforce – will have to help workers who abuse alcohol or drugs. Foundations and philanthropists who want to heal communities will have to help the addicted recover. Some of this expanded treatment will be publicly funded, some treatment will be privately funded, and some treatment will be self-supporting, like the thousands of Alcoholics and Narcotics Anonymous groups that provide peer support every hour of every day somewhere in California.

If you are concerned about public safety, address addiction. If you are worried about the cost of government, address addiction. If you are worried about abused children, homelessness, struggling families, address addiction. If you are worried about economic productivity and prosperity, address addiction. Drug and alcohol abuse is not the source of all problems, but it is a cancer in our communities that is sapping our resources and limiting our potential.

In his 2003 State of the Union speech, President Bush declared that the addiction of some is worth the attention of all:

“For those who are addicted, the fight against drugs is a fight for their own lives,” the President said. “Let us bring to all Americans who struggle with drug addiction this message of hope: The miracle of recovery is possible and it could be you.”

The Commission was sincerely impressed by the committed and earnest individuals working in state and local agencies, as well as for private providers. Some of them were candid – even adamant – about the shortcomings of current treatment and other drug control efforts. It is clear that they want to change lives and are making personal sacrifices to stay in a field that is undervalued. The following recommendations are intended to help them help California.

Sincerely,

Michael E. Alpert, Chairman

For Our Health & Safety:
Joining Forces to Defeat Addiction

March 2003

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Executive Summary

Alcohol and drug abuse underlie many of our greatest concerns: Persistent poverty and homelessness. Violence in living rooms and in neighborhoods.[1] The neglect by parents and the squandering of youth. Carnage on highways. Overcrowded jails, prisons, emergency rooms, and foster care systems. In many neighborhoods, the addiction and abuse of alcohol and other drugs are nothing less than a scourge, the plague of our day that is stripping communities of potential, ambition and hope.

Recovery, however, is possible. Treatment works. Managed correctly, alcohol and drug treatment is a cost-effective response to these expensive maladies – saving $7 for every dollar spent, by two analyses.[2] As part of a larger effort to reduce drug and alcohol abuse, treatment can restore lives, revive communities and reduce the growing demand on public programs. But the enormity of the problem and the potential for change are not well understood.

No matter how the accounting is done – public dollars spent, private dollars lost, lives wasted, families destroyed – abuse and addiction exact a disastrous and unsustainable toll. The University of California at Los Angeles estimated in 2001 that some 2.3 million Californians needed treatment for drug or alcohol abuse.

The National Institute for Drug Abuse estimates the annual economic impact of substance abuse to be $373 billion.[3] This figure includes the costs of health care, social services, and criminal justice systems, as well as the losses due to crime and diminished productivity, and spending on prevention, treatment and law enforcement. California's share of the national tab is estimated to be more than $32.7 billion.[4]

Those figures fail to capture the anguish. In 2001, 31,806 people were injured and 1,308 people were killed on California roadways in collisions involving alcohol alone.[5]

No one is immune from these consequences. Abuse and addiction are frustrating our social and economic goals, compromising our personal safety, draining our resources and limiting our future. And for all of the repercussions associated with the prevalence of illegal drug use, at least half of the losses can be attributed to alcohol.[6]

If these consequences could be blamed on others, we would consider it an attack. We would recruit and train the best talent, ensure they have effective technology, and expect performance and accountability. We would build an alliance and focus public support. Above all, we would demand the kind of public leadership that it takes to protect our children and to help our neighbors when faced with such an insidious danger.

In this report the Commission focuses on reducing the consequences of abuse and addiction associated with alcohol and other drugs. The term "substances" is used occasionally to connote both alcohol and other drugs.

It's not that we haven't tried. For more than a generation we have fought a "war on drugs." We have an Office of National Drug Control Policy and a national drug control strategy. In California, law enforcement agencies have task forces. The State has a department dedicated to prevention and treatment programs. And every county administers services to help the addicted and those affected by addicts.

The most controversial aspects of this "war" have been the violent crime associated with drug trafficking, the consequences of this drug trade on impoverished neighborhoods, and the high rates of incarceration in some communities, particularly those of color.

But while we have always made more room in prisons, the treatment system is chronically under-funded. The most recent UCLA estimate indicates that some 330,000 Californians could be expected to seek or be directed to publicly-funded treatment in any given year. And of those, 130,000 would be served. The other 200,000 would be placed on waiting lists – some of them while their children sit in foster care, or while their addiction lands them on the streets, in jail, an emergency room or the morgue. In December 2001, nearly 11,000 people were on a waiting list for publicly-funded treatment.[7]

Because of its earlier work on criminal justice, mental health and child abuse, the Commission began this study with the understanding that alcohol and other drug treatment could change lives and is essential to safe, healthy and productive communities. In the course of this study, the Commission was impressed by the dedication and professionalism of the people working to help the addicted recover.

But ultimately the Commission was struck by the evidence that we could do much more to coordinate drug control efforts, target our resources, improve the quality of treatment, integrate necessary interventions to improve effectiveness, and make the most of available funding.

While our resolve should be based on the consequences of addiction, our goals should be guided by the compelling case for recovery through

effective treatment. The 7-to-1 return on treatment funding is the result of reduced crime, enhanced productivity and lower health care costs. Even in good economic times, the prison and health care systems pressure public budgets and preclude investments in education, infrastructure and the environment. In times like these, controlling those costs becomes urgent.

In recent years, the public – recognizing the limited and sometimes damaging outcomes of a jail-based policy – has decided a different approach should be taken to drug abuse. In 2000, more than 60 percent of the voters approved Proposition 36, which dedicates $120 million a year to treat, rather than incarcerate, those arrested for drug offenses. In five counties alone, some 12,000 drug abusers were diverted from jail to treatment in the first nine months of the program.[8]

Proposition 36, it turns out, is more than a shift in the popular wind. It is an enormous opportunity for local and state agencies that really do share a common goal to coordinate their efforts to change lives and improve public safety. If successful, the implementation of Proposition 36 will not only demonstrate the government's faithful response to the public will, but it will document how treatment can be an effective defense against the costly consequences we now endure.

This teamwork needs to move beyond those targeted by Proposition 36. The State needs to bring together the well-intended but disparate programs and agencies – at the state and local level, in prevention, treatment and law enforcement, in the executive, legislative and judicial branches – to surgically attack this cancer. This statewide strategy must be focused on reducing alcohol and drug abuse and must employ the most effective prevention, treatment and enforcement tools, with resources directed to where the evidence shows they will do the most good.

Particular attention must be given to the needs of our young people. As important as it is to expand alcohol and drug treatment for those who are arrested or imprisoned, the paucity of treatment for young people – who have so much to lose and who could cost us so much – is irrational.

And finally, community leaders – private and public – must help everyone understand how alcohol and drug abuse affects us, and what we can do to solve the problem. If nobody wants to be hit by a driver under the influence of alcohol or drugs, we have to be willing to have treatment facilities in our neighborhoods. If we want safe and healthy communities, we have to support treatment and demand that it be well managed.

Given the consequences – and the potential for recovery – the ultimate goal should be treatment on demand. If quality can be improved and demonstrated, the necessary public and private resources should be redirected toward treatment.

After careful review of the research and existing policies – and after consulting with researchers, administrators, providers and clients – the Commission offers the following recommendations:

Finding 1: The State's efforts to reduce alcohol and drug abuse through prevention, treatment and law enforcement programs are fragmented and not focused on cost-effectively curtailing the expense and misery of abuse and addiction in California.

California and the nation have struggled for decades to control illicit drug abuse – and respond to the violence, illness and other problems caused by drug and alcohol abuse. These policies have involved a combination of law enforcement efforts to reduce the supply of illegal drugs, and to punish those involved in the trafficking and possession of drugs and those who hurt others while under the influence of drugs or alcohol. To a lesser extent, government has tried to reduce the demand through prevention – primarily aimed at discouraging young people from trying alcohol and other drugs – and treatment for those who become addicted.

A persistent and growing controversy has emerged over the effectiveness of some parts of this approach, and of enforcement efforts in particular. Arresting drug users has overcrowded jails and prisons with little evidence that this strategy deters the demand for drugs and success has been sporadic in limiting the price, availability or purity of illicit drugs.

More importantly, there is growing consensus among prevention, treatment and law enforcement professionals that a strategic combination of all three components is essential to reducing alcohol and drug abuse and its costly consequences.

Some coordination is necessary because dozens of public agencies have a role in some aspect of drug control efforts or serve a portion of the population. Some 17 different state agencies have drug-related responsibilities, and every county has its own array of prevention, enforcement and treatment entities – from school districts and police departments, to community groups and service providers.

But coordination also is important because, from drug to drug, the most effective strategy is likely to be a different combination of prevention, enforcement and treatment. Raiding methamphetamine labs in California, for example, has been far more effective in reducing supplies

than attempts to stop international smuggling of cocaine. In turn, research shows cocaine and heroin usage can be reduced more through treatment than enforcement efforts.

California recognized the need for a strategic effort when the Legislature and the Governor in 1989 established detailed drug control goals for all counties and 13 state agencies, and authorized a master plan. The plan, published in 1991, identified specific actions for local communities and the State, guided by a coordinating council. But true partnerships were never formed and the plan was never fully implemented.

Other states have successfully developed multiple-agency responses. Florida has vested interagency authority in a drug czar reporting directly to the governor. Washington has a governor's council to recommend state and local strategies to combat substance abuse and the budgets to support them. In Oregon and Arizona, governors' councils advise on prevention and treatment matters. Among these four states, only Florida has concentrated the authority to coordinate all three components of the drug control strategy – prevention, treatment and law enforcement.

Proposition 36 required local agencies to coordinate services for diverted abusers. In turn, state agencies created an interagency committee to review implementation efforts and advise state leaders on policy or funding changes necessary for success. The administration and Legislature have been responsive – demonstrating the benefits of bottom-up partnerships. Early assessments are encouraging.

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. The Council should:

- ***Involve prevention, treatment, and law enforcement leaders.*** State and local leaders need to come together to link alcohol and drug prevention, treatment and law enforcement efforts into a statewide strategy guiding a three-pronged attack on substance abuse. The council should elect a chair from among its members, hire a small staff and tap the resources of member agencies to support its analyses. The strategy should set quantifiable goals, such as those in the National Drug Control Strategy, for reducing abuse and include ways to measure progress toward those goals. (A listing of proposed members is included on page 42.)
- ***Institutionalize a planning and coordination process.*** The council should develop a statewide strategy for controlling drug and alcohol abuse that includes quantifiable goals like those in the National Drug

Control Strategy, and ways to measure progress toward those goals. The council should submit the strategy to the Governor and the Legislature for enactment. The council also should ensure that state alcohol and drug control efforts are aligned with local, regional and federal efforts.

- ***Guide the allocation of resources.*** As a guide to the budget process, the council should present an annual plan to the Legislature and Governor for reallocating resources from the least cost-effective to the most cost-effective drug control strategies. Recommendations should be based on progress toward outcome-based goals of prevention, treatment, and law enforcement efforts as they apply to individual drugs, their availability and consequences.
- ***Advance evaluation and accountability.*** The council should have access to the necessary data from state and local agencies to identify emerging trends in substance abuse, assess the performance of the drug control strategy, and report progress and problems to policy-makers and the public.
- ***Focus on youth.*** The statewide strategy should identify specific goals and objectives for reducing the alcohol and other drug abuse of youth.

The State Should Consider Eliminating OCJP

After examining the role of the Office of Criminal Justice Planning (OCJP) in this and previous studies, the Commission concludes that OCJP has consistently failed to exercise the leadership and policy-making role in criminal justice and delinquency prevention that was envisioned by the Legislature.

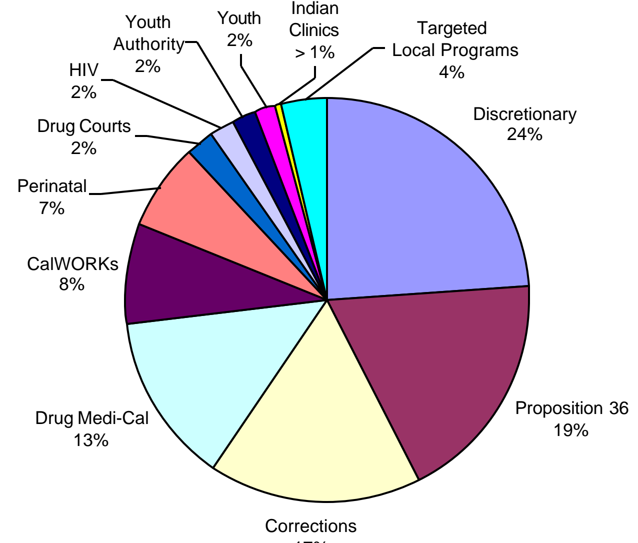
The number of criminal justice and juvenile delinquency-related programs the Legislature has awarded to other state departments in recent years suggests its loss of confidence in OCJP's ability to be an effective steward of public funds.

The Commission believes policy-makers should seriously consider whether this office should be eliminated and its functions distributed among existing and related entities, such as the Board of Corrections or the Department of Justice. The Commission intends to review the office and how these functions might be better performed.

Finding 2: The State does not make the most of available resources by prioritizing treatment to serve those whose drug and alcohol abuse imposes the greatest consequences on Californians and their communities.

Communities currently do not have adequate resources to satisfy the demand for publicly-funded treatment, and so access to care has been

limited. Some of the choices have been made at the federal or state level, or directly by voters. But these choices have not been made after considering all of the needs and as a result, the allocation of scarce services is neither equitable nor rational.



Sources: Department of Finance, Department of Alcohol & Drug Programs, Department of Corrections.

Both the federal and state governments set aside funds for particular populations. In the 2001-02 budget year, for example, the federal government provided $268 million to California, of which $107 million, or 40 percent, was earmarked: $83 million for Medicaid clients, perinatal programs, HIV-infected clients, and the incarcerated. Another $24 million was allocated directly to counties and community-based organizations through one-time grants. The State then set aside another 6 percent of the federal allocation – $16 million – for youth treatment and drug testing of Proposition 36 clients.

Of the $414 million in State funds allocated during the same budget year, the State set aside $255 million (62 percent) for people who were arrested or incarcerated. Another $133 million (32 percent) was set aside for use by Medicaid, perinatal, CalWORKs and Indian Health Clinics. Only $26 million (6 percent) was unrestricted. Most counties use these limited unrestricted funds to provide treatment on a first come, first served basis.

While access to treatment has been greatly expanded for adults who have been arrested or incarcerated, most counties have dedicated very few resources to youth – whose addictions present a much more expensive long-term liability on public coffers. While perinatal programs are intended to protect the unborn and infants from exposure to alcohol and other drugs, foster care caseloads have swollen with children whose parents are addicted to drugs and do not have ready access to treatment.

Importantly, federal, state and local policy-makers have been putting some people in the front of the line for treatment – but those choices were not made by comprehensively examining who needs treatment, and then determining who will be served first.

Sacramento and San Francisco counties illustrate two different approaches to prioritizing caseloads. Sacramento County identified

which clients impose the greatest costs and consulted with community members about their priorities. The early benefits include improved relationships among social services agencies, a better use of existing resources, and the development of cooperative strategies.[9]

San Francisco's Treatment on Demand Planning Council identified 58 service needs, and then set priorities. The process was driven more by compromises than cost analysis, but it considered all of the needs and then the reality of limited resources.[10] Early results are promising: emergency room visits for substance abuse and deaths from heroin overdoses are declining.[11]

Limiting access to services is always difficult. The Commission believes the ultimate goal is for anyone seeking treatment to receive it. But in the near term, without periodic analyses of community and statewide needs and priorities, decision making is influenced by fleeting headlines and anecdotes rather than analyses that can maximize benefits.

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. Specifically, the State should:

- ***Establish State goals.*** In setting goals, the State should assess the impact of abuse and addiction on health, social service, criminal justice and other public systems. The assessment should be designed to enable counties to assess their specific needs, document the consequences of addiction in their communities and target resources to clients posing the greatest social and financial costs. Clients that fit the criterion on harm might include:
  - ✓ Clients whose substance abuse results in physical and emotional abuse to others and increases the burden on other public programs such as foster care and corrections.
  - ✓ Youth with substance abuse problems or who are at high risk of abusing drugs or alcohol and need help breaking the generational cycle of abuse.
- ***Require counties to assess community needs and concerns.*** With State goals in mind, counties should be required as part of the annual funding process to document treatment needs and gaps and identify community resources. They should consider how available resources could be maximized to serve community members and align funding to meet local priorities and state goals. Counties should incorporate the assessment into budget and management decisions of other departments, including the siting of service providers.

- ***Shift resources to intervene earlier with substance abusers.*** State and community analyses need to consider how resources are spent on the continuum that includes prevention, treatment and enforcement to reduce abuse of alcohol and other drugs over the long term. In particular, prevention dollars need to be targeted to children with the highest risk factors for alcohol and drug use and other dangerous behaviors. County assessments should also be used by civic leaders to focus philanthropic and other private resources on effective treatment.

- ***Establish accountability for outcomes.*** The State should develop the means to measure outcomes, monitor and publicly report progress on state and community goals.

Finding 3: The State has not structured substance abuse treatment programs to provide a statewide basic level of quality or encourage continuous quality improvement.

While treatment can effectively help individuals change their lives, treatment programs are not always effective. Respected members of the medical and treatment community adamantly testified that the lack of quality controls diminished the benefits derived from available resources. One provider bluntly told the Commission that some providers were not competently administering treatment and suggested that the State needed to identify them and stop funding them. Another doctor suggested that quality needed to be systematically improved before funding is increased.

The tensions within the treatment profession over quality – and how to achieve it – are understandable. The profession has labored under a stigma held by many that addiction is nothing more than a lack of will power. Only in recent years have scientific researchers explained some of the biological aspects of addiction. And this information is helping to determine which treatment modalities are most effective with which clients, and how treatment can be more effective overall.

This growing knowledge of how to make treatment effective – and the growing consequences of addiction in California – require policy-makers, administrators and providers to agree on a strategy to ensure quality.

There are at least three opportunities to improve quality: ensuring a competent workforce, safe and supportive facilities, and the best available methodologies. But there are no qualifications required of counselors or program managers. The majority of treatment standards are included in county contracts with providers, resulting in variations in quality and effectiveness across the state. Without standards for

treatment programs, some providers employ unproven treatment practices and others do not faithfully replicate programs that have proven to be effective. Facility-related rules are limited to ensuring physical health and safety.

The Department of Alcohol and Drug Programs (ADP) oversees substance abuse treatment and prevention programs in California.[12] The Health and Safety Code charges the director with developing minimal statewide levels of quality provided by alcohol and other drug programs[13] This requirement involves setting standards for personnel, programs, and facilities providing alcohol and other drug abuse services.

But there are significant limitations on the director. The director must submit regulations to county program directors before adopting them. And the director does not have authority over treatment programs within the Department of Corrections.

Unfortunately, there is no agreed upon protocol for measuring quality. The profession relies primarily upon retention rates and length of stay in treatment to assess performance.[14] The National Institute of Medicine recommends the establishment of standard measures of quality, assessment of each care provider, and publication of comparative data to enable consumers to choose the best providers. It also recommends tying reimbursement levels to quality of treatment.[15]

As the primary purchaser of treatment services, the State has tremendous leverage to set quality standards and encourage providers to strive for continuous quality improvement by linking pay to performance.

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

- ***Define and enhance the director's authority.*** The director of ADP should be given clear authority to assess prevention and treatment efforts and advocate for high-quality treatment wherever it occurs, particularly in the Department of Corrections. Health and Safety Code Section 11835 should be revised to allow the director to establish regulations without approval from county administrators.
- ***Develop management tools.*** The State should accelerate the implementation of the California Outcomes Measurement System (CalOMS) to track the effectiveness of individual programs. ADP should establish an advisory board that includes stakeholders from all levels and areas of expertise to ensure the system will be an effective tool for consumers and providers, state and local administrators and policy-makers.

- ***Establish a strategy to develop a well-qualified workforce.*** ADP should ensure completion of an occupational analysis to establish knowledge, skills, abilities and other characteristics required of counselors and other key personnel. The department should establish a method for determining which candidates meet requirements. Requirements should be implemented gradually to allow incumbents to upgrade qualifications as necessary.

- ***Develop, promulgate and enforce treatment quality standards.*** The State should require counties to provide evidence-based treatments. The State should disseminate evidence-based best practices for each treatment modality. ADP should convene a group of providers, stakeholders, accrediting organizations and others to validate the goals of treatment, performance standards and outcome measures developed during the occupational analysis. The director should be required to report publicly on ineffective treatment programs.

- ***Tie provider reimbursement to outcomes.*** After establishing performance benchmarks and implementing CalOMS, the department should reward high-quality treatment providers with higher rates of reimbursement. Providers continually failing to meet specified outcomes should have their funding terminated.

- ***Ensure safe and suitable treatment facilities.*** The State should expand facility licensing to include outpatient facilities. An accreditation process similar to that used by the Joint Council on Accreditation of Hospital Organizations (JCAHO) or other accrediting organizations should be developed and implemented.

Improving Treatment in Prisons

Based on a pilot project that reduced recidivism, the State has expanded the use of therapeutic communities within prisons, and aftercare to those inmates when they are released. The Department of Corrections (CDC) now operates 8,500 in-prison beds at a cost of nearly $120 million a year.

But recent evaluations by UCLA show that the Department of Corrections is not faithfully replicating the pilot project. CDC's low-bid contracting rules preclude quality and prison administrators are putting inappropriate inmates in the program. The evaluators also concluded that CDC does not institutionally support the goals of treatment, frustrating the program in numerous ways. Steps can be taken:

- Restructure the contracting process to account for quality of treatment rather than lowest price.
- Specify in contracts the types of inmates who can participate in the program.
- Monitor and report return to custody rates resulting from continued addiction.
- Promote a drug-free prison system including drug testing of inmates and staff as suggested in previous Commission studies.

Finding 4: To be effective, substance abuse treatment must be coordinated and integrated with other social services to effectively reduce the social and financial costs of alcohol and drug abuse.

Treating someone's addiction without treating the contributing causes is akin to healing homeless pneumonia patients and sending them back into the winter cold. Recovery requires resolving the problems that cause or contribute to abuse.

While people from all walks of life and professional backgrounds become addicted to drugs and alcohol, those who seek help from the public system often have overlapping and related problems. According to ADP, 77 percent of public clients are unemployed and 39 percent do not have a high school education. Some 21 percent are homeless, and 8 percent also have a mental illness. Looking more broadly, UCLA researchers estimate that 75 percent of California's 360,000 homeless have substance abuse problems. And 50 percent of the mentally ill suffer from substance abuse.[16]

Recovering from addiction may require help with housing, education, job training, physical and mental health services, family counseling and legal assistance. As with treatment, eligibility rules for these programs are restrictive. And ultimately, clients may get some, but not all, of what they need to become healthy and self-reliant.

Benefits of Service Integration

- Addresses multiple needs to return clients to productive citizen status.
- Reduces or eliminates barriers to obtaining all needed services, particularly categorical funding.
- Supports families.
- Improves outcomes and reduces social service expenditures.

Two federally funded studies document the wide-ranging benefits of effective treatment in reducing drug use, medical visits, welfare dependency, homelessness, criminal activity and unemployment.[17] But to capture these benefits, the National Institute on Drug Abuse found that treatment must be linked with the other services that respond to the underlying causes of abuse.[18]

From its work on foster care, criminal justice and mental health, the Commission recognizes that integrating services is often held up as the Holy Grail of effectiveness. For more than 20 years, administrators and policy-makers have tried to weave together substance abuse, mental health, and social services.[19]

But public agencies struggle to overcome the regulatory, fiscal and cultural barriers that make it difficult to respond to a person's entanglement of needs. And incremental changes tend to add more categories for funding, more specific eligibility rules, and more complex accounting requirements. The resulting maze makes it difficult if not impossible to tailor needs to the individual, undermining the effectiveness of efforts to help children and families with a variety of challenges.

There are examples in California of public agencies or service providers overcoming the institutional obstacles. SHIELDS for Families, Inc. operates 17 programs that provide a continuum of services for families afflicted by substance abuse in south central Los Angeles. Besides help

with substance abuse, the Exodus residential treatment program offers transitional housing, on-site child care, parenting classes, mental health counseling, family counseling, prevention and early intervention for children, physical health assessments, vocational training and job placement assistance, transportation and aftercare services. To provide this one-stop shopping service for its clients, Shields will tap into 33 different public funding sources in its current fiscal year.

Because the State does not adequately coordinate its effort, the hard work of integration is either left to counties or individual providers. If counties or providers fail to take on the job, weaving together the necessary services for recovery is left to the client. If the client fails, the benefits of recovery are lost – along with the public investment in their recovery.

At a time of growing demands on the public system and declining resources, integrating already available public services to increase performance should be of the highest priority. At the very least, state agencies need to be responsive to valid suggestions from counties and providers on ways to reduce reporting and other paper-based obstacles to integration. In turn, counties can demonstrate leadership – as some already have – by mustering public and private resources in their community to meet the most crucial needs. Working together, counties – or the professional associations representing social service directors – could identify the incremental steps necessary to make it easier to integrate at the provider level and seek outside resources to develop skilled administrators and replicate proven strategies.

The teamwork demonstrated in implementing Proposition 36 shows that local and state agencies can work together to get the job done, and to systematically remove barriers to integrating services.

Los Angeles County Sheriff's Initiative

In November 2000, Los Angeles County Sheriff Leroy Baca established a Community Transition Unit to provide inmates who are military veterans with the educational, vocational, and other life skills needed to successfully reintegrate into the community. The unit has partnered with public and private community-based agencies. Before release, a discharge plan is developed for each inmate and contacts lined up in the community.

Early results are encouraging, including substantial initial reductions in recidivism rates. But the custody staff also reports a reduction of violence within the Community Transition Unit.

The unit provides a model beyond the custodial setting for making the most of available community resources to meet the multiple needs of clients.

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. Ways to promote integration include:

- ***Replicate and reinforce success.*** The Health and Human Services Agency – or in its absence, the counties – needs to encourage the replication of successful integrated programs by documenting how they work, how they have navigated the system, and training other providers to do the same.
- ***Develop leaders.*** Given that most integration occurs at the hands of individual and inspired leaders, the State should work with counties, professional organizations and foundations to provide formal leadership development for agency managers and service providers.
- ***Create a process and a venue to facilitate change.*** ADP should develop a forum allowing for state and local government, treatment providers, educators and job trainers, mental health providers, and social services personnel to systematically identify and remove barriers to integration. Specifically:
  - ✓ They should identify ways to share data to understand demands on the system and to document performance.
  - ✓ They should identify which measures would most easily increase flexibility in funding, such as a waiver process or a single reporting format, and align funding for all social services with outcomes.
  - ✓ They should detail and prioritize regulatory and legislative changes necessary to streamline and integrate services.

While the State should take on this mission, the counties should do so on their own if necessary.

Finding 5: Even if the State integrated its drug control efforts and improved alcohol and drug treatment services, as presently funded, available treatment would be inadequate to respond to the costs and misery inflicted on California communities by substance abuse.

The State needs to make sure it is maximizing federal funds and can use those resources to improve outcomes and expand the availability of treatment. By providing a sufficient state match, for example, California could ensure that it draws down federal Healthy Families funds to serve those families mired in addiction. The Robert Wood Johnson Foundation has documented how other states have scrutinized their systems to make sure they were making the most of federal Medi-Cal dollars. And other states have sought waivers so that federal funds could be used more

effectively to respond to alcohol and other drug-related problems. Delaware, for example, has received a waiver to use federal foster care funds for alcohol and drug treatment of parents, potentially reducing foster care costs as well as alcohol and drug abuse.[20]

While publicly-funded providers can charge clients to pay for part of their treatment, few do – in part because of how the reimbursement system is structured and in part because there is no incentive to do so. While the goal should be to help those who need help, that goal will only be reached if services can be offered to those who want help. If clients can help pay for recovery or have insurance, those resources should be tapped.

Cost savings resulting from successful treatment also can be used to expand treatment. In Washington State, for example, the medical expenses for each welfare recipient completing substance abuse treatment declined by $900 a year. Those savings were used to increase treatment. Savings from treating rather than incarcerating Proposition 36 clients should also be transferred from the Department of Corrections to treatment. Annual savings could be as high as $20,000 per client.

As a large employer, the State could make sure the benefits it provides effectively respond to addiction – curtailing the problems within its ranks while providing a model to other large employers. Seventy-percent of all substance abusers are employed, and turnover among personnel is a major hidden cost to all employers. In 1996, the cost to employers nationally for absenteeism, lost productivity, accidents and medical claims due to drug abuse was $60 billion. Adding alcohol costs raises employers' ante to $140 billion.[21] Treatment reduces these costs to employers.[22] Demonstrating to the business community the costs of substance abuse and documenting how to effectively structure benefits to include drug and alcohol treatment has the potential to reduce abuse, help the economy and reduce the demand for public services.

Finally, at least half of the addiction problems imposed on Californians are the result of alcohol abuse.[23]

Alcohol is a particular threat to our children. One in ten youth is a binge drinker. Two-thirds of drinkers begin drinking between the ages of 12 and 17. It is not uncommon for the first drink to come before the 12th birthday. Even delaying the initial use of alcohol can reduce chemical dependency later in life.[24]

Alcohol abuse also is a common factor in violent crimes. For example, a review of people arrested for domestic violence in Sacramento County

revealed a heavy use of alcohol, and far more abuse of alcohol than illicit drugs.[25] Surveys of jail and prison inmates reveal that more violent crimes are committed under the influence of alcohol than illicit drugs.[26]

Alcohol abuse costs California close to $15 billion a year. Yet, with the exception of the penny-a-drink tax enacted by the Legislature in 1991, taxes on beer and distilled spirits have not been raised in more than three decades. New taxes are never popular. But in the same way that government imposes fees on polluters to pay for the public harm they cause, California should consider seeking reimbursement from alcohol producers to respond to the costs imposed by alcoholism, even if those costs are imposed by a minority of drinkers.

As described earlier, California should seize opportunities to reallocate money from less effective drug control efforts to treatment. Communities should set priorities to serve those imposing the greatest costs on society. The State should develop the quality controls that will ensure treatment dollars are well spent, and resources should be directed to the most effective providers. Savings yielded by improving the system should be reinvested in the system until much more of the demand for treatment can be satisfied. And when the treatment system can document it is working efficiently and effectively with all available resources, additional resources should be considered.

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.

- ❑ ***Make the most of available federal funds.*** The State and counties should ensure that they are using all available matching funds to leverage federal dollars – including Medi-Cal, Early Periodic Screening, Detection and Treatment, State Children's Health Insurance Program, Social Security and Social Security Disability, and federal foster care funds. The State also should explore the possibility of a federal waiver on the use of Title IV-E foster care funds for alcohol and other drug treatment.
- ❑ ***Seek reimbursement from clients.*** The State should provide incentives to counties to seek reimbursement from clients based on their ability to pay for treatment.
- ❑ ***Reinvest in treatment.*** The State should reallocate cost savings from substance abuse treatment successes. Cost savings and cost avoidance figures should be used to guide transfers of funding from agencies with reduced demands to expand treatment opportunities.
- ❑ ***Expand private sector participation.*** The State should demonstrate to employers and private sector health insurers the benefits of

providing adequate coverage for alcohol and drug treatment. The State also should reform the Public Employees Retirement System treatment standard to create a model for employer-based benefits.

- ***Identify new sources of revenue.*** Once policy-makers are confident that resources devoted to treatment are being well spent, they should explore ways to generate revenue from the sale of alcoholic beverages to fund treatment, including increasing alcohol excise taxes or instituting a fee on beer and distilled spirits' producers to fund youth treatment.

Introduction

During the past decade, the Little Hoover Commission has taken a comprehensive look at the most expensive public problems plaguing California. In its various analyses, the Commission has found alcohol and drug abuse and addiction to be a common denominator in the rising and complex demands on many health, social and criminal justice programs.

In responding to abused and neglected children, the State and counties struggle with the violence and despair of addicted parents. Healing these families requires recovery for the parents, and dealing with the heightened probability that the victim children will become addicted and neglectful parents themselves.

The Commission's examination of youth crime and violence documented the role that alcohol and drug abuse plays in diverting young people from the academic, athletic and social activities that lead to productive adulthood.

The Commission's review of mental health policies focused on the overlapping needs of many individuals served by public agencies, the consequences of not providing the right response at the right time, and the necessity of coordinating disparate public efforts attempting to serve the same clients.

Related Commission Studies

Never Too Early, Never Too Late… To Prevent Youth Crime & Violence, June 2001

Being There: Making a Commitment to Mental Health, November 2000.

Now in Our Hands: Caring for California's Abused & Neglected Children, August 1999.

Beyond Bars: Correctional Reforms to Lower Prison Costs & Reduce Crime, January1998.

The Juvenile Crime Challenge: Making Prevention a Priority, September 1994.

Putting Violence Behind Bars: Redefining the Role of California's Prisons, January 1994.

These Little Hoover Commission studies can be downloaded without charge from the Commission's Web site:

http://www.lhc.ca.gov/lhc.html.

Twice in the past decade, the Commission analyzed the California prison system, and explored ways those resources could be better used to address the underlying substance abuse problem of those who were convicted for violent crimes and those who were imprisoned only for drug-related crimes.

The Commission initiated this study because it recognized that untreated alcohol and drug addiction undermines the success of so many of the State's most expensive programs. It also recognized the importance of the public's overwhelming support for the Substance Abuse and Crime Prevention Act of 2000, the voter initiative that provides treatment as an alternative to incarceration for non-violent drug offenders.

The Commission examined the State's alcohol and drug treatment programs by conducting two public hearings, receiving testimony from

the nation's leading experts on addiction, the State's alcohol and drug program leaders, local administrators, citizens in recovery from addiction and treatment providers. The witnesses are listed in Appendix A.

The Commission convened an advisory committee comprised of a diverse group of alcohol and drug abuse stakeholders. The advisory committee met four times as a whole. Smaller workgroups from the advisory committee met seven times to review critical subject areas, including funding, integration of services, standards and accountability, capacity, public awareness and leadership, Proposition 36 and other criminal justice treatment programs, and youth treatment. Participants in the advisory committee and workgroups are listed in Appendix B.

In the course of the study, the Commission determined that treatment needed to be evaluated in the context of the complete drug control strategy, including prevention and enforcement efforts. The Commission convened a third public hearing to analyze the effectiveness of California's overall drug control strategy. State and local law enforcement leaders, judges, economists and representatives from the alcoholic beverage industry provided testimony on the State's drug control strategy. These witnesses are also listed in Appendix A.

To better understand the treatment system, the Commission toured a youth treatment facility, a free treatment clinic and met with local alcohol and drug treatment leaders in San Francisco. The Commission visited an in-custody treatment program and met with law enforcement officials in Los Angeles County. Finally, the Commission toured a comprehensive treatment facility located in Compton that provides a full continuum of services for substance abuse treatment, including counseling, job training, housing and child care.

This introduction is followed by a personal recovery story and a Background, which details the scope of the problem and identifies treatment research and trends. The background is followed by five findings and recommendations. All written testimony submitted electronically for each of the three hearings and the executive summary and complete report are available online at the Commission web site, http://www.lhc.ca.gov/lhc.html.

The Commission's conclusions are based on the evidence and evaluations provided by experts and administrators. But its work was guided by the tragedies that drugs and alcohol can inflict on Californians, as well as the potential for recovery, as courageously documented by those in recovery.

"I had other dreams..."

Dellena Hoyer-Johnson's story begins in the Oak Park neighborhood of Sacramento where she lived with her eleven brothers and sisters until age seven, when the Child Protective Services removed her from her physically and sexually abusive parents. "From that point on," she testified, "it was inevitable for me to put something in my body to numb everything. At eight, I tried a cigarette. It gave me a rush. Then I found nail polish. I would inhale it in a bag. It took away that bad feeling for a brief moment."

From the time she was removed from her biological family until age 13, the State was responsible for her care. "During that time I skipped school all the time. I continued to be sexually abused by men. I was smoking cigarettes, drinking, popping speed. All the things that happened to me when I was a child were never addressed when I was in the system."

President Bush has declared that the miracle of recovery is possible. The life of Dellena Hoyer-Johnson is one such story.

At 13, Ms. Hoyer-Johnson ran away from the foster care system and began her life as a prostitute, twelve city blocks from the Capitol. Her earnings supported the drug addiction of her 22-year-old pimp. "There was a period where I didn't use any drugs. When I was 14, I had my first son by that pimp. The only reason he wasn't born toxic was because I was locked up in juvenile hall because it was a crime to be a runaway."

At 16, Ms. Hoyer-Johnson's pimp was convicted of murder and sentenced to life in prison. She found another abusive man and moved to San Francisco, where she discovered heroin. "I was smoking crack, snorting cocaine and heroin, drinking alcohol regularly and prostituting to support my habit. My son didn't go to school regularly because I was too high to get up and send him. For 12 years he watched me get beat up every day by the man I was with at the time, who was also an addict. He was put into foster care until he was eighteen. In that 12 years, I went to jail an average of 62 times per year. All the judges knew me. They would ask me … what are you doing here again? Nobody ever thought to ask me why. I didn't make the choice to start prostituting. That wasn't my dream when I was little, I had other dreams. I had dreams of being a professional dancer. That didn't happen." Despite repeated arrests for prostitution and drug possession, Ms. Hoyer-Johnson was not referred to treatment.

During that time, she became pregnant and gave birth to another child. "I was in jail, pregnant and needed a fix. That's when they found out I was a drug addict. I was going to lose the baby. So they put me on methadone and I didn't use heroin, but I did use crack cocaine." At birth, her baby tested positive for cocaine.

Ms. Hoyer-Johnson first attempted treatment when she was 18. After contacting a Sacramento detox program, she waited two months to get in. "The waiting was difficult because I never knew when I would be called. Sometimes, when the program called, I wouldn't go because of circumstances with my kids, or because I had spent my co-payment on drugs. I also didn't want to go because I was afraid of being sick from kicking heroin and I was afraid of the unknown.

At my first admission, I stayed seven days and left. I went back to the same people and places and started using drugs within 24 hours. I went back to detox 11 times. The counselors would try to talk me into entering a long-term residential treatment program, but I refused because I didn't think I was that bad. Little did I know that residential treatment was exactly what I needed."

"When I got clean, I was 30-years-old. I left San Francisco and that abusive relationship -- I thought he was the problem. I came back to Sacramento and started smoking crack cocaine more. I was kicked out of all the shelters from Sacramento to Placerville because I couldn't stop using. I was going to be homeless. I went into treatment so I would have a roof over my head and food to eat. I had to wait three weeks to get in because there was no bed available. I called the program every day -- two and three times a day begging them to let me in. I stayed for 90 days. I relapsed once. I went back to San Francisco …because I wanted to see my little boy. I realized I couldn't go back. That was it. I was done. I have been celebrating my recovery ever since.

I have been clean and sober for 10 1/2 years. When I began my life in recovery, I owed $13,000 for my son being in foster care and $3,000 for my son being in juvenile hall. I have paid it all back. I have paid all of my past due income taxes, and I look forward to purchasing my own home."

Ms. Hoyer-Johnson's oldest son, a chronic marijuana user, is serving a prison sentence for domestic violence. Ms. Hoyer-Johnson believes that if she hadn't been a drug addict and a domestic violence victim, he would not be in prison. Her second child, who is aware of his mother's history, but never saw her use drugs, is a healthy 15-year-old.

"My life is more than I ever imagined. I am now married, and I have worked for the past 10 years. I never thought there would be a day where I would be saving for retirement, saving so my grandchildren could go to college. That was unheard of in my family. I am the first one to change the cycle of addiction. That's how it starts. We have to stop the cycle. I enjoy my life with my children and my grandchildren, teaching them and others about addiction. My life is dedicated to helping other people with all the issues related to addiction."

Dellena Hoyer-Johnson testified at a Little Hoover Commission public hearing on April 25, 2002.

Background

The abuse of alcohol and other drugs is the plague of modern America. Substance abuse and addiction cut through every facet of society and every community in California, leaving enormous human and economic damage in their wake.

Abuse and addiction are the root causes of a myriad of social ills – child abuse and neglect, domestic violence, unemployment, crime, illness, disabilities and death. The economic impact of abuse and addiction is in the hundreds of billions annually – and includes such indirect costs as lower worker productivity.

The epidemic infects all socioeconomic classes and no age, gender or race is immune. Some 2.3 million Californians need treatment each year for alcohol and other drug abuse and addiction, and about half of those individuals qualify for publicly-funded treatment.[27]

Scientists have proven that addiction is not simply a lack of willpower on the part of the user. Over time, alcohol and other drug use changes the chemistry of the brain, making the user incapable of stopping their addiction without treatment. Research also has proven that treatment works. In addition to reducing the human misery, treatment has proven to be the most cost-effective solution for taxpayers.

In 2001-02, approximately $733 million in federal, state and local funds were spent on alcohol and drug abuse treatment. The majority of the funds flow from federal and state coffers through a variety of categorical funding streams to local programs. Often, available funding does not match local needs and priorities. While spending on treatment has grown in recent years, it is still a small percentage of what is spent addressing the consequences of addiction.

Enormous Costs and Consequences

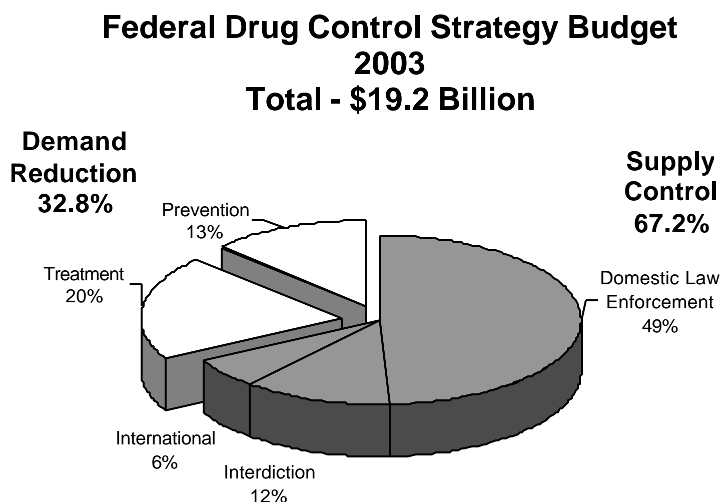
The consequences of substance abuse and addiction reach far beyond addicts themselves – families, neighborhoods and communities also are affected. In one way or another substance abuse and addiction touches every Californian. Certain populations of abusers and addicts inflict more consequences – human suffering and financial costs – but all impact the well being of California.

While precise data on the economic impact of abuse and addiction are not available, all experts agree the costs are enormous. One study estimates that nationally, the annual economic impact of alcohol and

drug abuse is $373 billion.[28] This astonishing figure is based on updates to a 1992 report commissioned by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) that looked at all federal, state and local spending as well as private sector spending. This figure includes the direct costs of enforcement, prevention and treatment efforts, as well as the costs of responding to the other maladies resulting from abuse and addiction – lost productivity, health care expenses, social service costs, criminal justice costs and losses due to crime. California leaders estimate the State's share of the national tab to be $32.7 billion.[29]

Direct Expenditures in Billions

A large portion of the direct expenditures associated with abuse and addiction is spent on supply reduction, typically enforcing laws to reduce the importing, manufacturing and selling of illegal drugs and the incarceration of those who engage in these illegal activities. A smaller portion of these expenditures is spent on efforts to reduce the demand for alcohol and illegal drugs through prevention and treatment. Of the $19.2 billion allocated to drug control in the 2003 federal budget, two-thirds will go to supply reduction strategies and one-third to demand reduction efforts.[30]



Source: The White House Office of National Drug Control Policy, *National Drug Control Strategy, FY 2003 Budget Summary.* February 2002

California's alcohol and drug control budget cannot be easily compared to national spending trends. Budget analysts estimated that $3.8 billion in state and local funds were spent in California on drug enforcement in 2001.[31] Approximately $466 million in state and local funds were spent

on treatment in 2001-02.[32] A detailed breakdown of treatment funding and allocations is described later in this background.

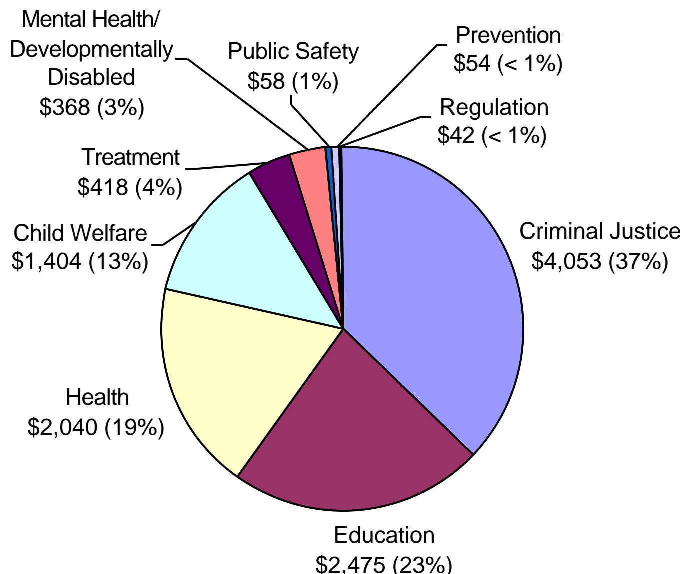
Spending for prevention efforts in California is particularly hard to determine. Much of the alcohol and drug prevention funding comes from federal sources. The Department of Alcohol & Drug Programs (ADP) allocated approximately $64 million in 2001-02 for prevention efforts. But many prevention efforts have multiple goals, including drug control, and the programs are administered by many different agencies.[33] The Department of Education, for example, has 19 programs.[34] The Commission previously identified more than 50 programs costing $2.1 billion. However, it is difficult to pinpoint efforts targeting alcohol and drug abuse since many programs attempt to prevent a variety of dangerous behaviors.

Indirect Expenditures Are Even Greater

While considerable public funds are spent directly addressing alcohol and drug abuse and addiction, an even larger sum is spent responding to the social and criminal justice problems resulting from substance abuse. A recent study by the National Center on Addiction and Substance Abuse at Columbia University (CASA) examined the impact of substance abuse on state budgets. The CASA study did not include federal, local or private spending. CASA concluded that in 1998 California spent nearly $11 billion, slightly more than 15 percent of the $68 billion budget that year, addressing substance abuse – a cost of $339.63 per Californian.[35] More than 95 percent of this was spent by agencies dealing with the consequences of abuse and addiction, as reflected in the chart below.[36]

Economic Costs of Alcohol and Drug Abuse to the State Budget (1998)

(Dollars are in millions)



Source: The National Center on Addiction and Substance Abuse at Columbia University. *Shoveling Up: The Impact of Substance Abuse on State Budgets.* January 2001.

The authors concluded that "substance abuse and addiction is the elephant in the living room of state government, overwhelming social service systems, impeding education, causing illness, injury, death and crime, savaging our children – and slapping a heavy tax on citizens."[37]

Children Are Often the Victim

Addiction severely impacts California's most precious resource – its children. Some children are affected by alcohol and drug abuse from the moment they are conceived. Others are abused by addicted parents or friends and associates of their parents. Still more are neglected due to their parents' chemically impaired judgement. A parent's alcohol and drug abuse and addiction often directly impacts a child's ability to succeed at school.

Unborn Children. A 1992 study by ADP indicated more than 11 percent of all births (69,000 infants) in California were exposed to alcohol or drugs in the womb. Infants born addicted to drugs suffer health issues that immediately threaten their lives and jeopardize their future development.

Abused and Neglected Children. Substance abuse and addiction is the primary cause of the dramatic rise in child abuse and neglect and an immeasurable increase in the complexity of child welfare cases since the mid-1980s.[38] Each year in California, there are approximately 125,000 substantiated cases of child abuse or neglect.[39] It is estimated that 80 percent of all child abuse cases are caused or exacerbated by substance abuse. Children whose parents abuse drugs and alcohol are almost three times likelier to be physically or sexually assaulted and more than four times likelier to be neglected than children of parents who are not substance abusers.[40]

Children in Foster Care. The most severe neglect and abuse cases end up in the overcrowded and expensive foster care system. In 2002, there were more than 90,000 children in foster care in California.[41] The Department of Social Services estimates that drug and alcohol abuse is a significant factor in up to 80 percent of foster care cases.[42]

In 1997, the federal government enacted the Adoptions and Safe Families Act, a law that "fast tracks" permanent placement for foster care children. The law creates an urgency for treatment of parental substance abuse that is not matched by the availability of these services.[43] Parents who cannot access timely treatment risk permanently losing their children much faster than before.

Children in School. Substance abuse increases the challenges of educating millions of children from diverse backgrounds. Children exposed to alcohol and drugs in the womb frequently develop learning disabilities requiring special education classes. Students who abuse or are addicted to drugs increase disciplinary actions and disrupt learning.[44] Children who miss school because of their parents' substance abuse lag behind their classmates and reduce their school's income.

Alcohol and drug abuse and addiction robs California's youngest citizens of their childhood and often their futures. Many of these children develop a plethora of learning and social problems. Research shows that children of addicts are four times more likely to follow their parents' footsteps into addiction.[45]

Substance Abuse Increases Health Care Costs

Alcohol and drug abuse and addiction drive up the cost of health care in many ways. Accidents, illnesses, infectious diseases and overdoses all impose additional burdens on an overcrowded health care system.

- ***Emergency Room Visits.*** Abuse and addiction place a tremendous burden on the health care system by crowding emergency rooms with patients suffering from trauma and illness resulting from alcohol and drug abuse.
- ***Hospital Admissions***. The serious physical complications that occur when substance abuse and addiction go untreated often lead to hospital stays. In 2000, more than 164,000 people were admitted to hospitals in California due to illnesses resulting from alcohol and drug use.[46] Alcoholics alone, excluding those addicted to other drugs, consume 15 percent of the health care budget nationally. Alcoholism is directly related to 13 percent of breast cancers, 40 percent of traumatic injuries, 41 percent of seizures and 72 percent of the cases of pancreatitis.[47]
- ***Infectious Diseases.*** Intravenous drug use causes the spread of many highly contagious diseases such as Hepatitis C, HIV and AIDS. As of October 2002, 13,297 cases of AIDS, more than 10 percent of all cumulative AIDS cases in California, were directly attributable to injection drug use.[48]
- ***Traffic Accidents and Fatalities***. In 2001, there were nearly 32,000 injuries and 1,300 deaths resulting from traffic collisions involving alcohol. Prior year data indicate that while alcohol was involved in slightly more than 4 percent of all traffic collisions, accidents involving alcohol accounted for 37 percent of those

resulting in death.[49] Data for traffic accidents involving drug use only are not available. However, more than 8 million people responding to a national survey on drug use indicated they had driven under the influence of illegal drugs during the past year.[50]

- ***Overdoses and Deaths***. While state data is unavailable, federal researchers estimate that in 2000, nearly 15,000 people died in Los Angeles, San Francisco and San Diego due to substance abuse.[51] The incidence of fatal drug overdoses quadrupled in California between 1980 and 1997. Estimates from the national Center for Disease Control suggest that 1,400 to 2,200 Californians have died from a drug overdose each year since 1998.[52] SB 1695 (Escutia), enacted in 2002, requires the State to begin publishing data on rates of overdoses within California counties.

Substance Abuse Increases Crime

Alcohol and drug use is involved in most criminal activity. In a 1997 national survey of state prison inmates, 33 percent of the inmates indicated they were under the influence of drugs at the time of their offense.[53] The National Institute of Justice tracks drug use among urban arrestees through voluntary testing at the time of arrest. For the first nine months of 2001, 52 to 77 percent of adult males tested positive at the time of arrest.[54]

A recent study of alcohol and drug use among arrestees in Sacramento County revealed that those individuals reporting heavy use of alcohol had the highest percentage of arrests for domestic violence. Illicit drug users had the lowest percent of arrests for violent crime, but the highest percent of arrests for property crime.[55]

The prison population in California grew by 554 percent during the past two decades, from nearly 25,000 inmates to nearly 160,000 inmates, resulting in a massive expansion in prison construction and operations costs.[56]

While there were fewer than 2,000 drug offenders in California state prisons in 1980, by 2000 there were more than 46,000 – a 23-fold increase. Of the nearly 11,000 females incarcerated in California prisons, approximately 44 percent are serving time for a drug offense.[57]

Considering the annual cost to house an inmate is estimated at $28,500, the cost to taxpayers for these 46,000 incarcerated drug offenders is more than $1.3 billion annually.[58] Eventually, 95 percent of all prisoners are released back into communities, most without treatment for their

addiction. Upon release, they often commit more crimes and re-enter the prison system.

Who Uses, Abuses or is Addicted?

Approximately 2.3 million Californians need treatment for substance abuse each year, nearly 9 percent of the population. That estimate was derived by the UCLA Drug Abuse Research Center and is based on the California data from the National Household Survey on Drug Abuse, a national survey of drug use by the general population, as well as surveys of California arrestees and youth in and out of school. The UCLA estimate does not include the incarcerated or the homeless populations.[59] The UCLA study provides a breakdown of people in need of treatment by age and by involvement with the criminal justice system.

Alcohol & Drug Use in California

Each year the federal Substance Abuse & Mental Health Services Administration (SAMSHA) conducts a national survey of drug use among Americans. Below is a comparison of the percentage of Californians reporting alcohol and drug use within the month prior to the survey versus the national average.

	California	U.S.
Any illicit drug use	7.8%	6.4%
Marijuana use	6.0%	4.9%
Drug use other than marijuana	3.2%	2.8%
Alcohol Use	47.4%	46.4%
Binge Alcohol Use (more than 5 drinks on one occasion)	18.8%	20.2%

Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. National Household Survey on Drug Abuse, 1999.

Adults. The UCLA study estimates approximately 1.4 million non-institutionalized adult Californians are in need of substance abuse treatment.[60] Of these, approximately 45 percent would not qualify for publicly-funded treatment, indicating they are employed or privately insured through a spouse or relative.[61]

Youth. There were 220,000 youth aged 12 to 17 in need of substance abuse treatment in California in 2001.[62] Data from the 2001 National Household Survey on Drug Abuse indicate that 10.6 percent of youth aged 12 to 17 were binge drinkers (had five or more drinks on the same occasion at least once in the past month) and 2.5 percent were heavy drinkers (had five or more drinks on the same occasion on at least five different days in the past month). Nearly 11 percent of youth aged 12 to 17 were illicit drug users.[63]

Analysis of prior national household surveys indicates that youth who drink alcohol are much more likely to use illicit drugs than non-drinkers. One in three youth who used alcohol also used illicit drugs, compared to only one in 34 of the non-drinking youth. Of the youth who are binge drinkers, half used illicit drugs also and nearly two-thirds of the heavy drinkers were illicit drug users.[64]

Criminal Offenders. About 61 percent of the 1.29 million adult arrestees in California in 1997 (789,000) were believed to be in need of alcohol or drug treatment.[65] Within the California Youth Authority, as many as 85 percent of the 5,700 wards have a substance abuse problem.[66]

Special Needs Populations

Among adults in need of treatment, there are certain populations with special needs, including seniors, the mentally ill and the homeless.

Seniors. Seniors are a growing percentage of the population in need of substance abuse treatment. The most recent census indicates there are 3.6 million Californians over the age of 65. According to the American Society on Aging, 17 percent of the people 60 and over in this country misuse alcohol and medications. Seniors consume 25 to 30 percent of all prescription drugs and 25 percent of all over-the-counter drugs. Often, symptoms of substance abuse are mistaken for common signs of aging or dementia.[67]

Mentally Ill. Approximately half of the population with severe mental illness also has a substance abuse disorder.[68] People with mental disorders often mask their symptoms with drug use, abuse and addiction. They are clinically referred to as co-morbid or dually-diagnosed.

Homeless Individuals. There are an estimated 360,000 homeless people in California.[69] National data indicate that alcohol and drug dependence among the homeless is as high as 75 percent.[70]

Why Do People Use Drugs?

Scientists know more about drug abuse and the brain than ever before. They know that the immediate decision to use drugs is driven by one of two factors – people use drugs to "feel good" or to "feel better." The first group seeks novelty and excitement – they are using drugs simply to have a good time. The second group uses drugs to try to compensate for untreated mental disorders like depression, or to ease the pain of terrible living situations, dysfunctional families or to deal with life's everyday problems.[71]

Addiction Defined

Prolonged use of alcohol and other drugs eventually changes the brain in fundamental and long-lasting ways explaining why most addicts cannot just quit on their own – why treatment is usually essential. There are many commonalities in addictions, whether the addiction is to nicotine, alcohol, amphetamines, cocaine or heroin. All these substances elevate an important brain chemical called dopamine that enables people to feel the sensation of pleasure.

With repeated abuse, drugs take over the brain's normal pleasure and motivational systems causing the individual to prioritize seeking and using drugs above everything else, despite the negative consequences. In an addict, the behavioral choice of whether or not to use a drug is no longer voluntary.[72]

Because addiction is tied to changes in brain structure and function, it is fundamentally a brain disease. However, it is a brain disease expressed as compulsive behavior. Developing the disease and recovering from it are dependent upon a variety of factors including biological, behavioral and social issues.

Initial drug use and later abuse can be influenced by certain environmental cues, including people, places, events or emotional states such as anger or depression. Long after an addict has been free from drug use, these environmental cues can cause persistent or recurring drug cravings and drug use relapses even after successful treatment.

Recognizing alcohol and other drug addiction as a chronic, relapsing disease of the brain has broad implications. Successful treatment for substance abuse and addiction must be approached like treatment for other common chronic medical disorders such as diabetes, hypertension and asthma. Effective treatment in all chronic diseases relies on a lifelong commitment by the patient. And with addiction, not only the underlying disease must be treated, but the other behavioral and social factors must be addressed as well.[73]

Stages of Alcohol & Drug Involvement

Abstinence -- no use at all.

Experimental Use -- minimal use, typically associated with recreational activities; often limited to alcohol use.

Early Abuse -- regular and frequent use, often involving more than one drug; greater frequency than experimental use; adverse personal consequences begin to emerge.

Abuse -- regular and frequent use over an extended period of time; several adverse consequences emerge.

Dependence -- continued regular use despite repeated severe consequences; signs of tolerance; adjustment of activities to accommodate drug seeking and drug use.

Recovery -- return to abstinence; some may relapse and cycle through the stages again.

Source: Physician Leadership on National Drug Policy. Adolescent Substance Abuse: A Public Health Priority, August 2002.

What Is Treatment?

There is no permanent "cure" for alcohol and other drug dependence. Those who attempt to reduce their use on their own are likely to have problems maintaining "controlled use." However, National Institute of Drug Abuse (NIDA) research shows that addiction treatment does work.[74] Treatment modalities differ depending on the individual, the severity of the addiction and the type or types of drug involved.

Comprehensive treatment that focuses on the whole person and not just the drug use has the highest success rates. The most effective programs combine behavioral treatments, medications, and other services, including medical and psychological counseling referrals and training in job and other life skills. The array of services must be tailored to the needs of the individual and a complete continuum of care is critical.[75]

Determinants of Success

Some patients have a greater chance at successful treatment than others. In general, patients who comply with the recommended regimen of education, counseling and medication have the most favorable outcomes during, and for at least six to 12 months after treatment. Successful outcomes include improved health, maintaining a stable home life, employment and reunification with family.

One-year follow-up studies have typically shown that about 40 to 60 percent of treated patients are continuously abstinent. An additional 15 to 30 percent have used alcohol or drugs, but have not resumed dependent use during this period. Poverty, mental illness and the lack of family or social support are key predictors of less favorable outcomes during and following treatment.

Relapse rates for this disease are similar to relapse rates for other chronic illnesses, particularly for those patients living in poverty or lacking social support. The relapse rate for Type 2 diabetics is 60 percent, for hypertensives 40 percent and for asthmatics 30 percent.[76]

Alcohol & Drug Dependence Defined

Alcohol and drug dependence is a pathologic condition manifested by a compulsive desire for a drug or drugs despite serious consequences. Three of seven specific criteria must be satisfied for a valid diagnosis of dependence. Two of these criteria -- tolerance and withdrawal -- are considered evidence of neurological and behavioral adaptation to a drug. Whether a patient has reduced or eliminated previously pleasurable activities in order to concentrate on obtaining drugs and/or whether the individual has used the substance instead of, or while performing important responsibilities are also criteria.

Source: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, (4th edition).* Washington D.C. 1994.

Barriers to Effective Treatment: Stigma

Despite the growing body of evidence regarding addiction and treatment, inaccurate perceptions of alcohol and drug abuse and addiction often impede the success of individuals seeking treatment and the advancement of the field as a whole. Many policy-makers have been slow to embrace the research indicating that addiction is not a moral failing or a lack of will power, but a legitimate illness that can be treated. Individuals addicted or in recovery are perceived to have caused their own illness and are deemed unworthy of a publicly-funded response.

The public stigma of alcohol and other drug abuse and addiction impedes treatment success:

- Counselors and health professionals who treat addicts are not highly regarded, affecting the number of people willing to work in this field.
- Treatment providers have difficulty locating facilities as neighbors and communities fear a negative impact, despite evidence to the contrary.
- People in need of treatment do not seek treatment for fear of losing employment, their children or government funds.
- Those who have completed treatment and are in recovery do not discuss their success, thereby limiting the awareness that addiction cuts across every echelon of society and that treatment works.

Redefining public understanding of addiction and treatment has been difficult. The National Institute on Drug Abuse (NIDA) and the Office of National Drug Control Policy (ONDCP) have made significant efforts to educate society on current research. The federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) annually sponsors Recovery Month, an opportunity for public and private addiction treatment organizations to utilize national funding to promote substance abuse treatment and recovery within the local community.

Citizens in some states have begun to show signs of favoring treatment over incarceration for non-violent drug offenders. Voters in Arizona and California overwhelmingly supported this shift. In recent years, California legislators have substantially increased the budget for alcohol and drug treatment within prisons, recognizing the need to treat the underlying cause of certain criminal activities. Policy-makers, however, have been slow to dedicate limited public resources to programs that treat addiction outside the criminal justice system despite growing evidence that treatment saves seven dollars for every dollar spent.

Private and public insurers are reluctant to cover more than a limited number of outpatient visits, despite proof that longer treatment equates to more effective outcomes. Insurers that do provide coverage for effective treatment modalities have found savings in other health cost areas making addiction treatment not just a nicety, but a sound financial necessity.

There is no simple panacea to reduce and eliminate the stigma associated with alcohol and drug abuse and addiction. The public and policy-makers need to understand:

- Addiction is not a poor moral choice, it is a brain disease.
- Alcohol and drug abuse is preventable, and addiction is treatable.
- Treatment not only saves lives, it also saves money.

Treatment Availability

Those at the lowest levels of the economic rung, who lack insurance benefits or the financial means to afford treatment are often turned away or put on a waiting list when they attempt to access the limited number of publicly-funded treatment slots. As of March 31, 2002, there were 18,789 beds in 773 residential treatment facilities licensed by ADP. There were 41,852 treatment slots in 148 licensed narcotic replacement programs. There were 717 outpatient treatment programs certified by ADP. The actual number of outpatient programs and the quantity of treatment slots in these programs is unknown, as outpatient certification is voluntary.[77] An ADP report from January 2002 indicated there were 6,300 people on waiting lists for treatment in California at that time.[78]

A recurring issue that is complicating expansion of treatment facilities is the NIMBY (Not In My Back Yard) response of many communities. Such issues make siting of facilities difficult, costly and time consuming.

Treatment Modalities

Detoxification

Outpatient - Used primarily for people addicted to methamphetamine, crack cocaine, and other drugs that require some supervision during detoxification. Average participation time is seven to10 days.

Residential - Primarily for people addicted to alcohol. People usually stay for 72 hours and are encouraged to enter a recovery program.

Methadone - A 21-day outpatient program utilizing a tapered dosage of methadone to help clients overcome addiction to heroin.

Recovery

Outpatient - The least intensive treatment, providing group and individual counseling sessions. Participants attend approximately five sessions per month and are encouraged to stay in treatment at least 120 days.

Residential - Clients are removed from the environment that promotes or enables their addictive behavior. Average length of stay is 90 days. There is typically an aftercare component where participants return for outpatient counseling.

Day Treatment - Participants attend counseling sessions and classes three to four days a week for four to five hours per day.

Narcotic Replacement Treatment - An outpatient program that utilizes methadone or other replacement therapy to help clients remain free of narcotics. This is generally a long-term treatment method, with average participation of one year.

Source: Legislative Analyst's Office, *Substance Abuse Treatment in California*, July 1999.

Who Receives Treatment?

UCLA estimated in 2001 that 2.3 million Californians were in need of treatment for substance abuse. Some of these would seek treatment outside of the publicly-funded system, using personal resources or insurance to pay for treatment. Many others would participate in Alcoholics Anonymous and Narcotics Anonymous meetings held in thousands of communities throughout the state.

Approximately 1.3 million non-incarcerated Californians in need of treatment would qualify for a publicly-funded program. Of these, approximately 10 percent or 130,000 were enrolled in treatment programs in 1997, the year evaluated by UCLA. An estimated 15 percent, or 200,000 people, potentially sought treatment but were turned away or put on a waiting list. Many do not seek publicly-funded treatment for various reasons including the unavailability of

appropriate treatment programs, long waiting lists, lack of transportation, discrimination, inadequate screening and linkage to services, and real or perceived social and legal barriers, such as the fear of losing custody of children. Additionally, some needing treatment do not perceive themselves to be in need of treatment [79]

Priorities for publicly-funded treatment include people who are arrested for non-violent drug crimes, people enrolled in Medi-Cal or CalWORKs and pregnant women. Treatment availability in California is determined more by where and how federal and state funds are allocated than by who needs or should receive priority for treatment. Some funding categories deplete rapidly while other funding categories are not fully tapped. The system is so complex that resources often are not available where research indicates a need for treatment.

In 2001-02, more than $733 million in public funding was allocated for alcohol and drug abuse treatment in California. Until fairly recently, the majority of public funding spent on treatment came from the federal Substance Abuse Prevention and Treatment (SAPT) block grant.

In recent years, state funding for alcohol and drug treatment has shifted to focus on those arrested for non-violent drug offenses and the incarcerated. In 2000, voters passed Proposition 36, an initiative that allocates $120 million annually from the state General Fund to treat people arrested for non-violent drug offenses. The Legislature has increased funding for treatment programs within the state prisons, which have proven to reduce recidivism. As a result of these expansions, the State now spends more on treatment than the federal government in California.

Most funding is allocated through categorical funding streams. Approximately 41 percent of the federal funding is restricted for specific target populations through federal mandates. The State also mandates specific uses for approximately 6 percent of the federal funding. Approximately 94 percent of the state General Fund expenditures on substance abuse treatment target specific populations and programs. Of the total federal and state allocations for substance abuse treatment, 76 percent is limited to specific populations.

NIMBYism in San Diego

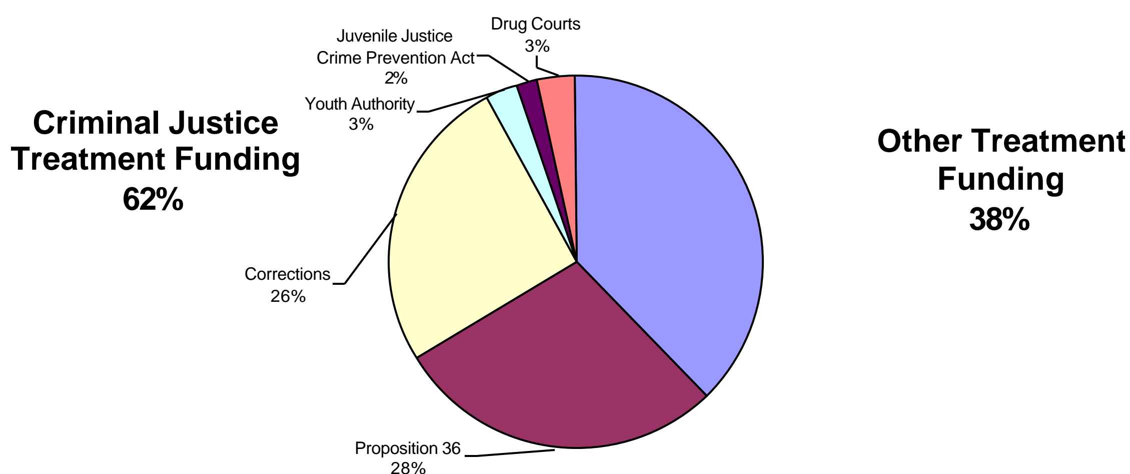
In San Diego County, there are currently 1,091 county-contracted residential beds in substance abuse treatment centers for adults and 96 beds for adolescents. These beds have waiting lists. The July 1, 2001 implementation of Proposition 36 required an additional 350 adult beds. Existing county-contracted beds cannot be used for Proposition 36 requirements. If Proposition 36 clients are willing to go to treatment and there is no treatment available for them, their addiction will progress unchecked, as will the behaviors that got them arrested.

San Diego County has been able to increase availability of alcohol and other drug abuse treatment services, but only to a limited degree due to NIMBYism. There are funds available to increase services, and there are several treatment providers willing to do it. However, the community response of NIMBY has blocked development of these vitally needed programs. Some residential treatment providers expanded their current facilities to their fullest capacities in the second half of 2001 to add Proposition 36 beds but over 200 beds are still needed.

Issue Briefing, *"Solutions for Treatment Expansion Project (STEP),"* prepared by the Institute for Public Strategies, undated.

Of the $414.7 million in state General Fund expenditures for treatment, 62 percent goes toward treatment in the criminal justice system. Despite this, treatment within the prison system still is very limited compared to the need. However, treatment outside of the criminal justice system is even more limited and anecdotal evidence indicates some people, particularly youth, get arrested so that they can access treatment.

State Priorities for Alcohol & Drug Treatment
2001-02 Total – $414.7 million



Sources: Department of Finance, Department of Alcohol & Drug Programs, Department of Corrections.

Other state priorities include perinatal treatment. Approximately 12,000 of the estimated 70,000 pregnant women in need of substance abuse treatment were enrolled in publicly-funded treatment programs in 2001. In recent years the State also has prioritized CalWORKs clients – those who need to address substance abuse problems before they can land and maintain employment.

Two fairly recent programs target approximately $10 million in federal funding toward youth treatment. In 2001, there were 21,000 adolescents admitted to alcohol and drug treatment programs, less than 10 percent of those identified as needing treatment by the UCLA researchers. More than half of those in treatment were on probation.[80]

Policy Development

National Trends

For roughly the first 130 years of U.S. history, an American's right to life, liberty and the pursuit of happiness included the right to ingest whatever chemicals an individual desired. Thomas Jefferson, in criticism of France, said that a government that controls what its citizens eat and the kind of medicine they take will soon try to control what its citizen's think.[81]

Alcohol and drug use and abuse has fluctuated during the past century in response to social trends and shifts in public perceptions and policies. Federal policy addressing substance abuse was first implemented in the early 1900s in response to rampant cocaine and opiate use. In the late 1800s, cocaine and opiates were inexpensive, widely available in many nonprescription products and touted by the medical profession for their healing qualities. As the negative consequences of cocaine and opiate addiction became apparent, society rejected drug use and in 1914, Congress passed the Harrison Narcotics Act that led to the criminalization of drugs. Prior to this law, addiction was viewed as a public health nuisance.

Throughout most of the 20th century, illicit drug use remained relatively dormant until the 1950s and 1960s when heroin emerged as a problem. Throughout the 1960s and 1970s, use of illicit drugs grew among the general population. Illicit drug use peaked in the late 1970s and then declined steadily through 1990. During the most recent decade, drug use has remained stable.

Alcohol use increased and then declined during the past century. The 1920s brought the brief and unsuccessful era of prohibition. During the Great Depression, alcohol consumption was at its lowest. Alcohol use peaked in the 1980s following a period when more than half of the states lowered the legal drinking age to 18. Beginning in the early 1980s, the legal drinking age reverted to 21 and alcohol use declined. Alcohol use remained fairly stable through the past decade.

Federal Milestones

1914
Harrison Narcotics Act made drug use illegal.

1919
Prohibition of alcohol enacted.

1933
Prohibition repealed.

1970
Hughes Act created the National Institute on Alcohol Abuse & Alcoholism (NIAAA).

1971
President Nixon declared "War on Drugs."

1972
Drug Enforcement Agency created.

1974
National Institute on Drug Abuse (NIDA) created to research abuse and addiction, prevention and treatment.

1988
White House Office of National Drug Control Policy (ONDCP) created to establish policies, priorities and objectives for the National Drug Control Strategy.

1992
Substance Abuse and Mental Health Services Administration (SAMSHA) created to improve the quality and availability of prevention and treatment services.

California Milestones

1954
Alcoholic Rehabilitation Commission

1957
California Department of Public Health, Division of Alcohol Rehabilitation, created to coordinate state efforts and funding of public alcohol programs.

1967
"Summer of Love" - A patchwork of local clinics sprang up to respond to the rise of recreational drug use.

1971
State Office of Narcotics and Drug Abuse Coordination established in the Health and Welfare Agency to develop a statewide drug treatment policy. A separate Office of Alcoholism is located within the Department of Health.

1977
State Office of Narcotic and Drug Abuse moved into the Department of Health.

1978
Alcohol & drug offices combined into Department of Alcohol & Drug Programs.

Source: Kathy Jett, Director, ADP. Testimony to the Little Hoover Commission, May 23, 2002.

State Responses

California's response to alcohol and drug abuse and addiction began in the 1950s. The State Alcoholic Rehabilitation Commission was established in 1954, setting a pattern for state agencies to make contractual arrangements with local alcohol clinics for services.

Today, the Department of Alcohol and Drug Programs (ADP) is the designated agency responsible for the oversight of substance abuse treatment and prevention programs in California. With more than 300 employees, ADP has expertise in the areas of prevention, treatment, and recovery services. ADP works in partnership with county governments, private and public agencies, organizations, groups and individuals.[82]

Public Funding for Treatment

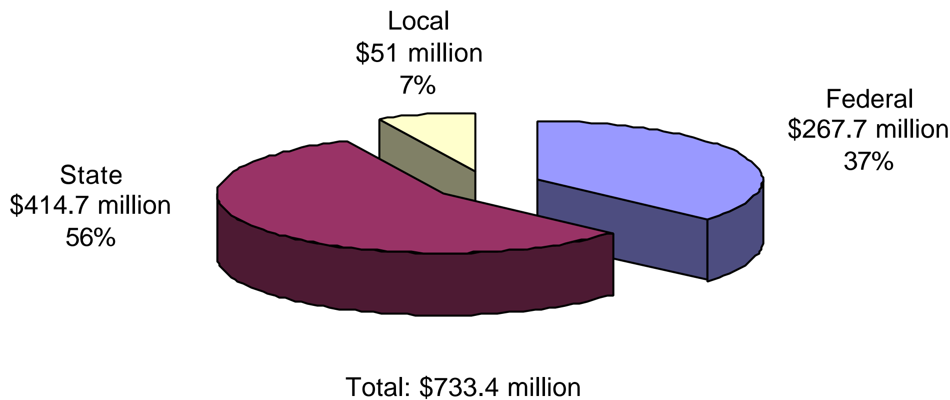
As described earlier, treatment is a small, but growing portion in the overall drug control budget. Of the $733 million in public funding spent in 2001-02 on treatment in California, $267.7 million were federal funds, $414.7 million were state funds and more than $51 million were local funds.

Federal Funding for Treatment

The federal government is responsible for approximately 37 percent of treatment funding in California. The largest source of federal funding is the SAPT grant distributed by SAMHSA. In 2001-02, $181 million from the SAPT block grant was allocated for treatment through ADP to county alcohol and drug program administrators.

Another significant source of federal funding is Medicaid, which funds 51 percent of the Drug Medi-Cal benefits. This funding is distributed by the U.S. Centers for Medicaid and Medicare to the California Department of Health Services, which then provides the funds to ADP through an interagency agreement. In 2001-02, $45 million in federal Medicaid funding was allocated for general Drug Medi-Cal treatment and an additional $2.8 million in federal Medicaid was targeted specifically for perinatal Drug Medi-Cal.

Public Spending on Alcohol & Drug Abuse Treatment in California 2001-02

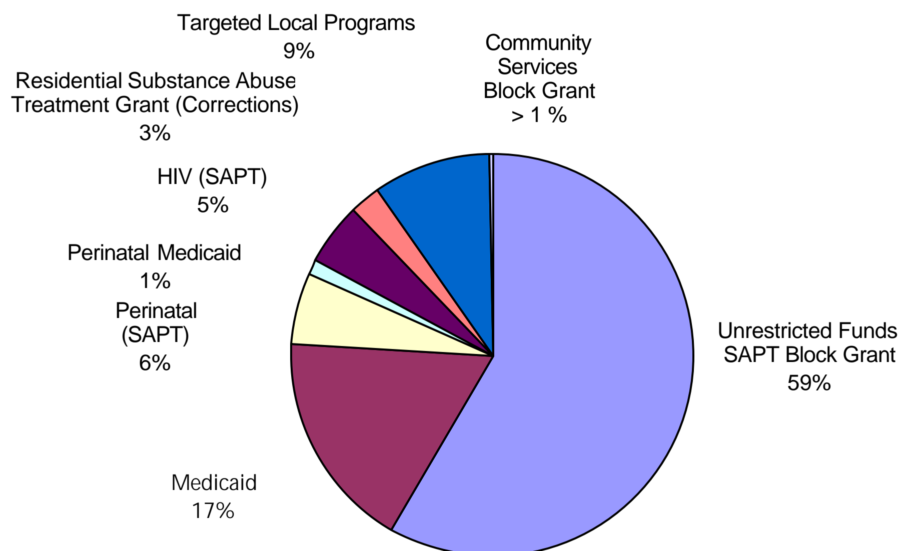


Sources: Department of Finance, Department of Alcohol & Drug Programs, Department of Corrections, Survey of California Counties by the County Alcohol & Drug Programs Administrators Association of California.

The federal government provides a limited amount of funding for substance abuse treatment through the U.S. Department of Labor Workforce Investment Act ($3 million) and the SAMHSA Mental Health Block Grant ($1.1 million). These funds are allocated along with $975,000 from the SAPT block grant to seven California counties participating in the Youth Development and Crime Prevention Initiative pilot program.

The federal government also provides a limited amount of funding for substance abuse treatment within the criminal justice system. The U.S. Department of Justice provided $6.5 million in Residential Substance Abuse Treatment (RSAT) grants in 2001-02. This funding is distributed to the Office of Criminal Justice Planning, which then allocates a portion to the Department of Corrections, the California Youth Authority and local law enforcement agencies. Additionally, the Federal Bureau of Justice Assistance provides $1.3 million in funding through its Anti-Drug Abuse Treatment Program to the Office of Criminal Justice Planning. The State allocates $2 million in Workforce Investment Act funding to the Department of Corrections for criminal justice treatment programs.

The U.S. Administration for Children & Families allocates the Community Services Block Grant (CSBG) through the California Department of Community Services & Development (CSD). This grant can be used to fund a variety of services to address the needs of low-income individuals and ameliorate the causes and conditions of poverty.
CSBG funds are used for education and job training, to help find employment, secure housing, temporary emergency assistance, nutrition



Sources: Department of Finance, Department of Alcohol & Drug Programs, Department of Corrections.

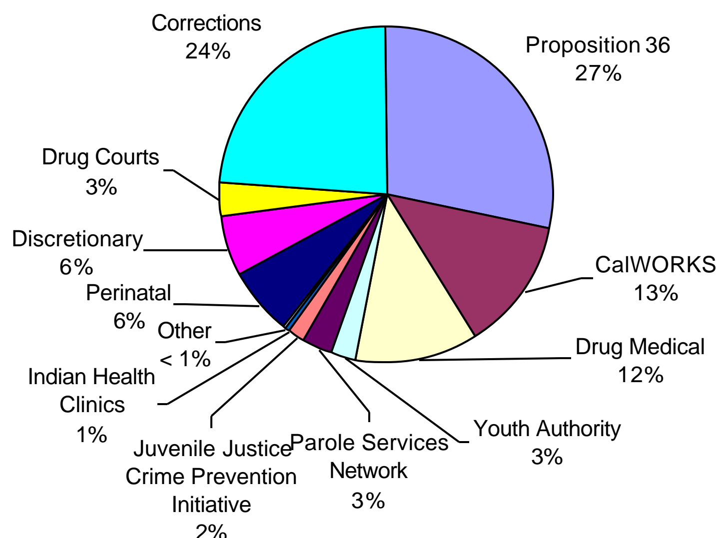
and health. Funding use is determined by the local agency – either a local government or community-based organization. CSD estimates that $500,000 of the $53 million allocated in 2001-02 were used for local alcohol and drug treatment programs.

Some federal block grant funding is distributed directly to county programs. In 2001-02, SAMHSA allocated approximately $24.5 million in targeted discretionary funding from the SAPT block grant directly to California county alcohol and drug program administrators and local treatment providers.

State Funding for Treatment

In 2001-02, the State allocation of funds for alcohol and drug treatment programs was $414.7 million, approximately 56 percent of all public treatment funding. All but approximately $25 million of state General Fund allocations are targeted for specific programs. The chart on the following page displays how that money was allocated.

State Funding for Treatment by Category 2001-02
Total – $414.7 million



Sources: Department of Finance, Department of Alcohol & Drug Programs, Department of Corrections

The table on the opposite page lists the major alcohol and drug treatment programs administered by the State. It does not include local programs funded directly by the federal government or by local revenue. It does not include some $160 million that is allocated for the general population or funding for short-term special projects.

Local Funding for Alcohol & Drug Abuse Treatment

Due to the complexity of the various federal and state mandates, county administrators often have difficulty addressing the most prominent local needs. Some localities allocate local funds into the system to overcome these barriers, while others creatively tap federal grants or specialized state funds not specifically targeted for alcohol and drug treatment.

The State does not track how much local governments spend on treatment. In a 2002 county survey of expenditures conducted by the County Alcohol and Drug Program Administrators Association of California (CADPAAC), 38 counties responded, indicating a total of $51 million in local general fund spending on treatment. Because not all counties responded, including several large counties, this figure is a conservative estimate. Many local governments also employ a variety of special state funds for alcohol and drug treatment programs, including Proposition 10, Tobacco Litigation Settlement funds and Juvenile Justice Crime Prevention Act funds.

State Alcohol & Drug Treatment Programs	Agency	Funding (in millions)
Criminal Justice Treatment Programs		
Proposition 36. The Substance Abuse and Crime Prevention Act of 2000 authorized substance abuse treatment for drug offenders.	Alcohol & Drug Programs (ADP)	$125 (Includes testing)
Office of Substance Abuse Services, CDC. Provides in-prison treatment programs -- 30 programs in 22 prisons with 8,500 beds.	Corrections (CDC)	$117
Youth Authority. Operates 1,300 treatment beds, including those at the Karl Holton Drug and Alcohol Treatment Facility.	California Youth Authority (CYA)	$13
Drug Courts. As of 2001, there were 128 drug courts providing court supervised drug treatment.	ADP	$14
Parolee Services Network. Four Parolee Services Networks provide treatment and recovery services in nine counties.	ADP/CDC	$11
Social Service Treatment Programs		
Drug Medi-Cal. Provides health care for low-income families and disabled persons lacking health insurance. There are 830 clinics certified by ADP to accept Drug Medi-Cal.	ADP	$90
CalWORKs. County welfare departments receive funds for treatment for individuals participating in welfare-to-work.	Social Services (DSS)	$54
Special Population Programs		
Perinatal. Statewide, 249 publicly-funded programs annually serve 12,000 pregnant and parenting women and 18,400 children.	ADP	$47
HIV Positive Clients. Federal law specifies a portion of the SAPT block grant be targeted toward services for HIV positive clients.	ADP	$13
Indian Health Clinics. Funding provides a substance abuse clinician in each of the 33 Indian health clinics in the state.	ADP/DSS	$2.6
Youth Programs		
Adolescent Treatment Program. AB 1784 (Baca) allocated federal funds for pilot programs for youth in 20 counties.	ADP	$5
Youth Development & Crime Prevention Initiative. Targets federal Workforce Investment Act, mental health and SAPT block grant funds into seven county programs for youth.	ADP	$6
Juvenile Justice & Crime Prevention Act. Counties can utilize this $240 million fund for a variety of adolescent programs including alcohol and drug treatment.	Board of Corrections	$7
Foster Care. Youth on probation who are sentenced to residential alcohol and drug treatment programs receive services through out-of-home foster care placement.	DSS	N/A

Some counties collect fees from clients who have the ability to pay for treatment services and allocate these funds for substance abuse treatment programs. Additionally, some counties provide infrastructure for treatment programs although this type of expenditure is difficult to quantify on a balance sheet. San Francisco, for example, allows several treatment providers to utilize former navy buildings on Treasure Island. Contra Costa County issued general obligation bonds to finance a new 40-bed residential treatment facility.

Private Funding Sources

While this review examines primarily publicly-funded treatment, privately financed treatment plays an important role in reducing public costs of responding to addiction.

- ***Insurance.*** Many private health insurance providers cover substance abuse treatment. Typically, coverage is limited to 20 outpatient visits each year, as is the case with the state's Public Employee Retirement System (PERS) health coverage and Healthy Families Program. Some insurers, such as Kaiser Permanente, provide a more complete continuum of care using a managed care approach.

- ***Non-Profit Foundations and Volunteers.*** Another source of treatment funding is non-profit foundations through donations to treatment providers. Additionally, an incalculable amount of treatment occurs through volunteer 12-step type treatment organizations such as Alcoholics Anonymous and Narcotics Anonymous. Meeting rooms are loaned free-of-charge by local churches, community centers and various other neighborhood organizations. Countless hours of volunteer time are donated for these social model programs.

"There were 164 women on that list that had been there long before me."

Ms. Verdia Nix was incarcerated a half a dozen times in the county jail before anyone in the system realized she was a drug addict. Her crimes included shoplifting and petty theft, habits she developed to pay for her 20-year addiction to crack cocaine.

"My addiction took me so far, I thought I was invisible. I thought I could go into stores and take anything I wanted and that I would never get caught. I had gotten to the point in my addiction where I would take orders from people on the street. People would buy anything that was new -- clothing, towels, shoes. The very first time I went to county jail, I stayed for four days. I thought.. oh, that's nothing. And they sent me back out on the streets. Eventually, I started doing a little time, up to months. I lost my family. I lost my children, not to the system, but my family took over my children. They saw that I wasn't taking care of my kids. While I was in jail, I really didn't know anything about recovery homes where I could get help. I had no education, no GED…I was running the streets."

During one incarceration at the county jail, Ms. Nix enrolled in a treatment program. "I took it upon myself to enroll in the drug program… I completed that program. What that program taught me was what the drugs were doing to my brain. It scared me. The reason why I enrolled into the program was because you got five days off your sentence. That was my main purpose of going into that program. But I got so involved in what they were saying about what the drugs were doing to me, and they told me how it takes your self-esteem and your family. I saw that. My self-esteem was gone. My family didn't trust me. They didn't want anything to do with me. When I finally graduated from the program I was proud of myself. I felt something other than having to have drugs. Still, when I got out, I ended up going right back to the streets… to the same place where I started my drug use. There I was, right back on the street using drugs, knowing what it was doing to me."

Eventually, Ms. Nix was arrested again and sentenced to 16 months in prison. "That was my first, my last and my only time of going to prison…. I started thinking that if I could go into the county jail and learn all that stuff about drugs…then I could go into this prison and come out with something a little more positive for myself, too. So I enrolled in a school program and got my GED."

When Ms. Nix got out of prison, she briefly went to live with her sister, but soon realized she needed help for her addiction. She called her parole officer to inquire about the Frederick Ozanam Center, a women's residential treatment facility she had heard about in jail.

"I called … and he told me I couldn't come in that day. I told him that I needed to come in right now. I was still an addict. I had been clean for eight months because I was in prison, but I knew when I got out I would be right in the same setting. I knew for a fact if I stayed in Richmond, I would be using… I went in anyway. He told me to put my name on a waiting list. Well, there were 164 women on that list that had been there long before me. By the grace of God, I got lucky. Accidentally, I overheard a man pleading with another female that there was a bed open. She was fighting it. I knocked right on his door. I told him, I'm ready. I'll go."

Through luck and perseverance, Ms. Nix was placed through the BASN program into the Ozanam Center. After completing the program, she was fortunate to be placed in transitional housing where she could live in a clean and sober environment. Ms. Nix stayed in the house for two years, getting a job in retail. During that time, she never used drugs, never violated her parole. Today, she works as a counselor at a homeless shelter. She is attending college to earn a certificate and associate's degree in drug and alcohol counseling. She has been clean and sober for over three years.

"Today I am proud of myself. I've got my children back in my life. My family trusts me. I've completed just about every goal I set for myself."

Verdia Nix testified at a Little Hoover Commission public hearing on April 25, 2002.

Creating a Strategy for Reducing Abuse

Finding 1: The State's efforts to reduce alcohol and drug abuse through prevention, treatment and law enforcement programs are fragmented and not focused on cost-effectively curtailing the expense and misery of abuse and addiction in California.

National and state drug control strategies have evolved into distinct efforts to control the supply and demand for primarily illegal drugs. Law enforcement efforts work to reduce the supply by arresting smugglers, growers and manufacturers of illicit drugs, as well as dealers and users. Social service, education and community-based organizations attempt to prevent drug and alcohol abuse by making the dangers known to the public, and young people in particular, and by treating those with addictions.

Advocates of these seemingly divergent approaches often compete for resources, and have tried to separately document the essential role they individually play in breaking the cycle of addiction and reducing costly and dangerous behaviors.

Law enforcement officials assert they support recovery goals by reducing the availability of illicit drugs and motivating users to seek treatment with the threat of arrest. Treatment and prevention advocates, in turn, assert that reducing the number of customers undermines the profitability of the drug trade.

Reducing both the supply and demand for illicit drugs is important to protecting public safety and reducing the harm resulting from abuse and addiction. But from the State's perspective, the focus must be on reducing the expense and misery resulting from abuse of both illicit drugs and alcohol. Prevention, treatment and enforcement can be reinforcing components of a state drug and alcohol control strategy.[83]

Prevention, treatment and enforcement define a continuum of responses to substance abuse – each dealing with the limitations of the other. Prevention tactics discourage drug use. Treatment deals with those who are addicted. Law enforcement deals with those whose addiction hurts others. As the President's National Drug Control Policy notes, "A clearer example of symbiosis is hard to find in public policy."[84]

But the agencies that perform these three critical functions have radically different philosophies and are funded through different channels. In reality, the three components do not act in concert and they do not share common goals. Enforcement is considered the primary

response, with prevention and treatment playing secondary roles for some of those who fail to control themselves.

Prevention can reduce demand. Prevention is any activity intended to reduce or minimize drug abuse and its negative consequences.[85] Most prevention professionals are guided by the tenets of public health and social services. They see substance abuse as a threat to public health and everyone is vulnerable. Many prevention-oriented programs target multiple threats, including substance abuse, crime and violence. Regardless of goals, many organizations are guided by similar principles.

Federal prevention activities are the purview of the Center for Substance Abuse Prevention (CSAP) within the Substance Abuse and Mental Health Services Administration (SAMHSA). In California, the Department of Alcohol and Drug Programs (ADP) coordinates prevention efforts. The Governor's new Interagency Coordinating Council for the Prevention of Alcohol and Other Drug Problems, chaired by the director of ADP, consists of representatives from law enforcement, health and education agencies. While the State spends hundreds of millions on various prevention activities, ADP alone allocated more than $60 million to substance abuse prevention efforts in 2001-02. Most funds come from SAMHSA; the State does not keep track of total spending on prevention.

Treatment can reduce demand. Addiction is a complex disorder that can involve family, work and community relationships, and substance abuse treatment reflects that complexity. Some aspects focus on the individual's drug abuse while others focus on restoring the individual's productivity.[86] Federal, state and local governments fund programs, with most treatment provided by private contractors. Like their prevention colleagues, public health and social service models guide the staff.

At the federal level, treatment is the purview of SAMHSA's Center for Substance Abuse Treatment (CSAT). In California, ADP is responsible for allocating public treatment funds. In 2001-02, more than $733 million in federal, state and local funds were spent on treatment. In recent years the State has increased funding for treatment, but most of that expansion has been for adults in the criminal justice system.[87] A complete discussion of treatment funding is provided in the Background.

Law enforcement can reduce supply. Federal, state and local law enforcement agencies target drug trafficking and use a variety of enforcement strategies, including efforts to curtail the manufacturing and trafficking of drugs. From this perspective, drug abuse is a crime and a public safety threat that requires aggressive enforcement.

At the federal level, law enforcement agencies fall under the purview of the U.S. Attorney General and include the Drug Enforcement Administration (DEA), the Customs Service, and the Coast Guard. DEA handles most federal enforcement efforts and concentrates on large drug trafficking organizations. At the state level, the Department of Justice coordinates the activities of over 500 state and local law enforcement agencies.[88] The Office of Criminal Justice Planning distributes grants to law enforcement and other agencies. The Highway Patrol and the National Guard also play enforcement roles. Funding comes from federal, state and local governments; California and local governments spent an estimated $3.8 billion on drug-related enforcement in 2001.[89]

Current Emphasis: Enforcement First

In recent years, national policy has shifted slowly from an almost exclusive focus on enforcement to one that recognizes the importance of prevention and treatment as part of a comprehensive drug control strategy. The 2002 National Drug Control Strategy calls for:

- Stopping Use Before It Starts: Education and Community Action.
- Healing America's Drug Users: Getting Treatment Resources Where They Are Needed.
- Disrupting the Market: Attacking the Economic Basis of the Drug Trade.

However, the federal government still spends 67 percent of the $19 billion drug control budget on supply reduction or enforcement activities, compared to 33 percent on demand reduction, or prevention and treatment. At state and local levels an estimated 80 percent of spending is devoted to enforcement.[90]

Treatment as Crime Control

Iowa Attorney General Tom Miller, in his call for the state Legislature to increase funding for drug treatment through a 25 cent increase in the cigarette tax, stated:

> *The number one thing we can do to fight crime is to fight drugs, and the number one thing we can do to fight drugs is to do a better job with drug treatment. This is a crucial public safety measure.*

Source:. Schwab Foundation Substance Abuse News Online Newsletter, January 14, 2003. http://www.iowaattorneygeneral.org/latest_news/releases/jan_2003/Drug.html

The emphasis on enforcement has meant that those involved in the drug trade, as well as the addicted, have largely been dealt with through arrest, adjudication and incarceration. Nationwide, the number of state prisoners serving time for drug offenses soared from 19,000 in 1980 to nearly 237,000 in 1998.[91] In California, 46,000 inmates are incarcerated in state prison for drug-related crimes. Another 33,500 inmates, a majority of them drug abusers, are incarcerated for property crimes.[92]

There is growing doubt that America can incarcerate its way out of its drug problem.[93] The availability of many illegal drugs remains the same and the street price – widely believed to impact use – has declined.[94]

Drug use among the nation's 8th, 10th and 12th graders is close to record highs and is not declining.[95] Similarly, the 9th Biennial California Student Survey, 2001-02, found little change in youth drug use since 1999. The data does suggest that the use of alcohol and cigarettes are now lower among California youth than their peers nationally.

There is a growing sentiment among Americans that arresting and incarcerating non-violent drug users is an ineffective and costly way to control drugs. Californians expressed those concerns by passing Proposition 36. Treatment and education alternatives to prison have been considered or enacted in Arizona, New Mexico, Minnesota and Hawaii. Some polls show that more people support legalization than believe an enforcement-based "War on Drugs" will succeed.

Similarly, as costs have soared and the problem has persisted, even conservative law enforcement and judicial officials have criticized enforcement-based policies. Joseph McNamara, the former police chief of San Jose and now a fellow at the Hoover Institution, testified that federal appropriation for drug control has increased from $101 million in 1972 when President Nixon declared a war on drugs to $40 billion. If the average social security check had increased at the same pace, he said, the $177 monthly check that retirees received in 1972 would be $30,000 today – not the $900 they actually receive. But the greater consequence, McNamara said, has been the damage to police-community relations resulting from a control strategy founded on arresting dealers and users:

> *The government is forced to concede that despite interdiction efforts, ninety percent of the drugs arrive in the U.S. undetected. The United States, as well as most of the world, is awash in illegal drugs, violence of the $500 billion illegal drug black market, and unprecedented police and political corruption resulting from the roughly 17,000 percent mark-up caused by the prohibition of cheaply produced chemical substances.*[96]

Indeed, the Office of National Drug Control Policy concedes that "our drug fighting institutions have not worked as effectively as they should."[97] The most recent report on National Drug Control Strategy concludes that national goals are not being met and the drug czar has called for integrating prevention, treatment and enforcement efforts.

Some researchers assert that drug use has the characteristics of an epidemic and that responses to individual drugs in individual communities will be more effective if the right intervention, prevention, treatment or law enforcement, is used at the appropriate stage of the epidemic. Drug-related behavior varies by drug. As a general rule, prevention can head off the use of a particular drug. Law enforcement is more effective in the early stages of epidemics, before widespread use overwhelms the ability of enforcement agencies to control distribution and use. Treatment is effective in all stages of epidemics and the most successful tactic as epidemics mature.[98]

Most of the substances abused in California – alcohol, cocaine, marijuana, methamphetamine – are at the epidemic stage, where the benefit of enforcement is limited and treatment is essential to reducing the negative consequences. Ecstasy and other "rave" drugs are examples of drugs at the earlier stages of an epidemic, where targeted prevention and enforcement can be more successful.

Stages of An Epidemic

Initiation	*Growth*	*Epidemic*
▪ Drug use is identified. ▪ Emergency room admissions begin. ▪ Treatment admissions begin. ▪ Arrests begin.	▪ Use expands. ▪ Emergency room admissions increase. ▪ AOD admissions increase. ▪ Arrests increase. ▪ Drug seizures begin.	▪ Use explodes. ▪ Public health costs increase. ▪ Emergency room costs increase. ▪ AOD treatment costs increase. ▪ HIV spreads. ▪ Accidents increase. ▪ Foster care/CPS cases increase. ▪ Public safety costs increase. ▪ Criminal justice costs increase. ▪ Seizures increase.

Continuum of Responses

Initiation	Growth	Epidemic
1. ***Prevention*** Programs to educate public and dissuade use. 2. ***Law Enforcement*** Efforts to identify supply sources. Funding transfers to buttress prevention. 3. ***Treatment*** Programs to reduce demand.	1. ***Law Enforcement*** Efforts to reduce supply sources. 2. ***Treatment*** Programs to reduce demand. 3. ***Prevention*** Programs targeted to stem growth of epidemic.	1. ***Treatment*** Expansion to reduce demand. 2. ***Law Enforcement*** Efforts to reduce supply and provide incentives for treatment. Funding transfers to buttress treatment. 3. ***Prevention*** Efforts to avoid next drug epidemic that is already building.

A 1995 RAND study identified treatment as the most cost-effective of the three drug control strategies by a margin of seven to one for reducing cocaine consumption. The study pointed out that treatment reduces the economic, legal, and personal costs of substance abuse. More importantly, it reduces demand for drugs by reducing consumption both during and after treatment. Drug traffic is demand driven. Reducing demand holds out the possibility of reducing supply to levels that law enforcement agencies can cope with effectively.[99] Meanwhile, a combination of responses must be used to effectively control drugs.

Past Attempts to Coordinate Drug Efforts

While treatment and law enforcement advocates often argue for an either or policy, many professionals within these agencies recognize the need for a coordinated approach – something the State has tried, but failed to do. Some notable attempts:

Governor's Policy Council on Drug and Alcohol Abuse (1988-92). The council was created to coordinate drug and alcohol treatment services, and restructured in 1991 to coordinate prevention, treatment and law enforcement. Participants report that the council reflected the administration's resolve to do something to reduce substance abuse, but it lacked committed leadership and foundered. True partnerships were not established between key participants. Few actions were agreed upon and implemented across the spectrum of organizations.

SB 2599 (1988). Established comprehensive goals for a dozen state agencies and a host of other state, county and private organizations, demonstrating the wide distribution of drug control responsibilities. The goals were "advisory," not mandatory. The State Auditor reported in 1993 that state agencies had achieved 13 of 40 goals, partially achieved 22 goals and made no progress on five goals.[100] Many of the goals were included in the 1991 Master Plan to Reduce Drug and Alcohol Abuse.

The 1991 Master Plan to Reduce Drug and Alcohol Abuse. The master plan identified 31 state agencies administering more than 100 drug control programs.[101] Of these, 17 agencies have responsibilities for all three drug control tools – prevention, treatment and law enforcement.[102] Other agencies administer programs in more than

1991 Master Plan Major Goals

1. Promote a system of coordinated alcohol and drug service planning among health, social services, education and criminal justice organizations.
2. Foster the involvement of communities in determination of local service priorities.
3. Transition from a five-year plan to a permanent, continuous planning process.

Source: Master Plan for Reduction of Drug and Alcohol Abuse, 1991.

one of the three components. The list of programs, which has not been updated since, documents the fragmentation of the State's efforts to address drug and alcohol abuse. Federal involvement, mainly through funding, adds another level of complexity.

The Master Plan was a framework for coordinating efforts among prevention, treatment and law enforcement organizations and for setting goals for agencies involved. But leadership and support for coordination were lacking and the effort withered after a series of inconclusive meetings.

The Office of Criminal Justice Planning's State Plan. The Governor's Office of Criminal Justice Planning (OCJP) describes itself as the "lead California agency in crime prevention, crime suppression, and criminal justice planning." By statute, OCJP is charged with developing the state plan to coordinate criminal justice activities, administer federal funds and provide grants and technical assistance to local agencies.[103]

In September 2002, the then-interim executive director of OCJP, in written testimony to the Commission, claimed that OCJP aligns its activities to reduce the supply of drugs with the goals and priorities of the federal drug control strategy. He identified five goals for California's Drug Control Strategy.[104] Upon further inquiry, "California's Drug Control Strategy" was revealed to be a report prepared every three years as a requirement for receiving federal Byrne State/Local Law Enforcement Assistance funds. The document covers a variety of crime-related programs, not just drug control, and does not significantly address efforts to reduce the demand for drugs. Moreover, the document does not identify outcome measures. While it references the availability and purity of illicit drugs, it does not describe trends or attempt to credibly link enforcement efforts with these trends.

Office of Criminal Justice Planning

In other studies on crime, violence prevention and the criminal justice system, the Commission has identified a fundamental need for coordination among law enforcement and other entities that share common goals and serve the same populations. In each instance the Commission has been frustrated by the failure of OCJP to provide leadership or participate in coordination efforts vital to progress.

Shifting the Focus, an interagency partnership among state agencies that administer youth violence prevention programs is an example. It was an attempt to overcome barriers to collaboration at the state level to provide better, less fragmented service to communities. The Attorney General and Health and Human Services Secretary supported the effort by dedicating high level staff and resources. But despite encouragement, OCJP rarely sent a representative to meetings. It was an opportunity squandered by OCJP to fulfill one of its core missions – to support and coordinate the activities of juvenile justice and other agencies and respond to the needs of communities. It is but one example.

In recent years the Legislature has expressed its lack of confidence in OCJP by virtually ceasing to assign the administration of state-funded criminal justice programs to OCJP. For example, it awarded new domestic violence programs to the Department of Health Services, even though OCJP already administered similar programs, and it awarded a juvenile crime prevention program to the Department of Social Services. It assigned the Juvenile Crime Enforcement and Accountability Challenge Grant Program and Schiff-Cardenas Crime Prevention Act of 2000 to the Board of Corrections. Even if these agencies effectively administer these programs, the result is further fragmentation, duplication and confusion – because of OCJP's failures.

Also in its written testimony to the Commission, OCJP stated that it is the "lead agency responsible for formulating the Governor's Public Safety Allocation Plan."[105] It described the plan as a "comprehensive, systemwide approach designed to support criminal and juvenile justice agencies, local victim service programs, schools, community-based organizations, community crime prevention programs, and training programs for prosecutors and public defenders." When the Commission requested a copy of the plan, OCJP officials conceded that there was no such document and that the testimony referred to OCJP's informal consultations with the Governor's office on new initiatives.

While clearly the Office of Criminal Justice Planning has the authority – even the mandate – to coordinate at least the law enforcement aspects of drug control efforts, the office could not provide for the Commission any tangible contribution toward meeting this need. Moreover, the Commission felt misled into believing OCJP was conducting the analysis and facilitating the deliberative process necessary to make such a contribution.

Current Strategies to Coordinate Drug Efforts

While the State has no mechanism to coordinate all prevention, treatment and enforcement efforts, two state efforts within ADP testify to the need and the potential for a more strategic approach.

The Proposition 36 Advisory Council. The Substance Abuse and Crime Prevention Act of 2000 required the formation of an advisory council to evaluate the program and address needs. The council includes those implementing the initiative and those who benefit from it: the judiciary, prosecutors, public defenders, probation officers, offenders, professional organizations, and public advocacy groups. Chaired by ADP, the group meets monthly to review implementation efforts and advise the State on needed policy changes. The administration and Legislature have responded promptly to its recommendations, demonstrating the potential for an experience-based method of systematically reducing barriers to success. The group also has demonstrated the value of partnerships among prevention, treatment and law enforcement agencies.

Interagency Coordinating Council on Prevention. A recent ADP report concluded: "California's ATOD (Alcohol, Tobacco and Other Drugs) prevention actions emanate from an uncoordinated aggregation of policies set by different agencies."[106] The report notes that state agencies "all too often make decisions without sufficient evidence of need and without knowledge of the prevention activities of other agencies."[107] In

August 2002, the Governor established the Governor's Interagency Coordinating Council for the Prevention of Alcohol and Other Drug Problems. By working to coordinate prevention efforts, the council qualifies California for a $4 million federal grant in each of the next three years. While this is an encouraging first step, the council is not intended to coordinate prevention, treatment and enforcement efforts.

A Strategic Approach

The goal of an effective State drug and alcohol control strategy is to reduce the social and economic costs of addiction. The State and its communities have many resources and tools to pursue that goal. A strategic approach would set specific objectives and priorities, allocate resources to the most effective tools, and measure performance so the overall strategy and individual efforts could be continuously improved.

Setting shared goals and objectives. Requiring agencies to work together to achieve shared goals allows them to accomplish what they cannot do alone. For example, if the goal is for addicted parolees to reintegrate into society, law enforcement, or even the entire criminal justice system, cannot do that alone. Treatment and other supports will be essential. At the state and community level, the leadership of prevention, treatment and enforcement agencies must work together toward formally established goals.

Allocating resources wisely. Major funding decisions are made at the federal level, uninformed by community needs. The State often confounds that problem by allocating drug control resources without any analysis that examines how prevention, treatment and enforcement are working, or working together to reduce the consequences of addiction. Individual programs routinely seek more resources or defend their own allocation in a zero-sum game that is not based on evidence of actual performance.

Some California law enforcement agencies testified that the current process has provided the right allocation of resources. The director of the Department of Justice's Division of Law Enforcement testified: "I think empirically as we determine what has worked over the past 12 years, the dollars have flowed to those entities that have best utilized them." But the outcomes are not consistently measured – and where they are – the outcomes themselves do not support that level of confidence.

Measuring performance. To make the most of available resources, the performance of drug control efforts must be measured. This

How Does Law Enforcement Measure Drug Control Strategy Performance?

The Commission asked the California Department of Justice how it measures the success of its drug enforcement programs. In written testimony, the department used different measures for different drugs.

For methamphetamine, the department indicated that since the implementation of the California Methamphetamine Strategy in 1998, the price of methamphetamine increased from $4,000 to $8,000 per pound, purity declined from 80 percent to 30 percent, and the number of neighborhood labs seized declined, indicating decreased local availability.

For other drugs, such as marijuana and cocaine, the department provided data on seizures and arrests. For example, in 2001, more than 300,000 marijuana plants were eradicated at a wholesale value of $1.2 billion. In 2002, the department's CrackDown Program seized 367 pounds of cocaine and made 187 felony drug arrests.

Critics argue that seizure and arrest statistics do not accurately measure the impact of enforcement on the supply of drugs. While enforcement efforts are necessary to prevent a more plentiful supply of illegal drugs, the data indicates enforcement alone is not effective in controlling drugs.

DOJ subsequently provided information developed by the Drug Enforcement Administration for California that measured price, purity and availability for marijuana, methamphetamine, cocaine and heroin. The DEA's data on methamphetamine differed from DOJ's, reportedly as the result of differing methodologies.

These standards - price, purity and availability - are used in the federal drug control strategy and are considered the best available measures of enforcement efforts. They should be the standard by which California law enforcement measures its progress toward drug control goals for all drugs.

Source: Patrick N. Lunney, director, Division of Law Enforcement, California Department of Justice. Written testimony to the Little Hoover Commission, September 26, 2002.

measurement can improve the management of individual efforts, and guide changes to the overall strategy. It can help to identify unmet needs – such as the paucity of treatment for young people – as well as emerging threats to the public health and safety. Measurement is essential to wise resource allocation and public accountability.

Measuring Performance

While cooperation among officials can initiate a strategic effort, an integrated data system is required to track performance across agencies. Without data, decisions are more likely to be guided by opinion and ideology than knowledge and performance.

Data systems among the agencies often cannot share data. Where sharing is possible, it is often blocked by privacy concerns. So a combination of technical and legal barriers – sometimes real, sometimes imagined – prevent data from being used to make policy and manage programs.

This problem is not unique to California and hinders federal drug control efforts, as well.[108] The Office of National Drug Control Policy uses 12 outcome measures to assess progress toward five key goals: three in law enforcement, one each in prevention and treatment. Its most recent report includes 35 performance measures; data does not exist to assess a dozen of them. All 12 of these performance measures deal with efforts to suppress international and national drug trafficking, some of the most controversial aspects of the federal strategy.[109] California's ability to measure the performance of drug control programs also is inadequate.[110]

Two decades after it began in earnest, therefore, it is difficult to say who is winning the war on drugs. Law enforcement officials testified that they use several measures to gauge success in

the war on drugs.[111] Many of these statistics, such as drug seizures and arrests, do not accurately measure progress toward reducing drug use and crime.

More effective outcomes such as the price, purity and availability of drugs tend to show over time a stubborn and disappointing consistency despite the best efforts of law enforcement agencies.[112] Although law enforcement operations do reduce manufacturing capability and seize drugs, these efforts have not significantly impacted supplies of some of the major drugs. The price remains low enough and the purity and prevalence high enough for illicit drugs to remain a major public health threat, particularly for young Californians.

ONDCP concludes that the national strategy is "on track" in only two of the 12 areas: declines in drug-related crime and violence and reductions in the numbers of chronic drug users.[113] But only one of four statistics used to measure progress toward the first outcome actually tracks drug involvement in the crime.[114] The second successful outcome is a reduction of the number of chronic drug users, a treatment-related goal.[115] But only cocaine and heroin use are measured.[116]

How the Feds Measure Progress in the Drug War

Goals

1. Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.
2. Increase the safety of America's citizens by substantially reducing drug-related crime and violence.
3. Reduce health and social costs to the public of illegal drug use.
4. Shield America's air, land, and sea frontiers from the drug threat.
5. Break foreign and domestic sources of supply.

Outcome Measures

- Reduced availability of illicit drugs in the U.S.
- Reduced rate of shipments of illicit drugs from source zones.
- Reduced rate of illicit drug flow through transit and arrival zones.
- Reduced domestic cultivation and production of illicit drugs.
- Reduced drug trafficker success rates in the U.S.
- Reduced demand for illegal drugs in the U.S.
- Reduced prevalence of drug use among youth.
- Increased average age of new users.
- Reduced prevalence of drug use in the workplace.
- Reduced number of chronic drug users.
- Reduced rate of crime associated with drug trafficking and use.
- Reduced health and social costs associated with illegal drug use.

Source: Final Report on the 1998 Drug Control Strategy: Performance Measures and Effectiveness. White House Office of National Drug Control Strategy. February 2002.

It's Not Just Law Enforcement

Youth Treatment Opportunities

Researchers assert that the earlier young people start using drugs or alcohol the more likely they are to develop a disorder and continue that disorder as adults.

But few treatment programs outside the criminal justice system provide treatment for youth. Most youth programs rely on private funds or cobble together government dollars.

To be successful, youth treatment must address the developmental needs of children, such as education and socialization, which make these programs more expensive than adult treatment programs.

Treatment also is the best way to reduce drug abuse and other costly behaviors over the long-term. The National Center for Juvenile Justice estimates that a school dropout who opts for a life of crime and drug abuse costs sociey more than $1.7 million.

Source: Aftercare as Afterthought: Reentry and the California Youth Authority. Prepared for the California Joint Committee on Prison Construction and Operations by the Center on Juvenile and Criminal Justice, August 2002.

Absent an overarching strategy informed by reliable data, policy-makers have supported enforcement nearly 4 to 1 over treatment. Public reaction to crack cocaine epidemics of the 1980s fostered a perception that voters favor an enforcement approach. Recent initiatives like Proposition 36 suggest that public opinion is shifting toward treatment rather than incarceration. Law enforcement officials, judges and others are beginning to see that incarceration solves some problems and creates others. The impact of an incarceration-based policy on families and youth has been a catalyst in this awakening.

Other states have recognized and attempted to deal with this problem with a variety of organizational models. Florida, Washington and Arizona have all created mechanisms for developing a more strategic approach. Each has its advantages and disadvantages.

In Florida, a drug czar is responsible for creating a drug control strategy to coordinate prevention, enforcement and treatment efforts. The incumbent is the former director of strategy for ONDCP, and reports directly to the governor. In Washington, the Governor's Council on Substance Abuse is comprised of citizen experts. The council provides advice to the governor on policy matters related to prevention, treatment and law enforcement. In Arizona, a governor's council of concerned citizens advises on prevention and treatment matters. Law enforcement matters are the province of other advisory councils.

DRUG CONTROL STRATEGY COORDINATING MECHANISMS		
State/Structure	**Organization/Functions**	**Advantages/Disadvantages**
Florida ***Structure.*** Drug Czar ▪ Prevention ▪ Treatment ▪ Law Enforcement	***Organization.*** Reports directly to the governor. ***Functions.*** Create a drug control strategy to coordinate prevention, treatment and law enforcement efforts.	***Advantages*** ▪ Provides consistent, long-term knowledgeable leadership from a single state executive. ▪ Establishes single, small coordinating authority for all state drug control efforts. ▪ Provides a locus for continuing cooperation and coordination. ▪ Fosters continuous reassessment and accountability. ▪ Encourages a bottom-up planning process. ***Disadvantages*** ▪ Creates another state organization, however small. ▪ Lacks line authority over programs.
Washington ***Structure.*** Advisory Council ▪ Prevention ▪ Treatment ▪ Law Enforcement	***Organization.*** Citizen experts appointed by the governor. ***Functions.*** Advise the governor on prevention, treatment and law enforcement issues. Recommend AOD policies to state agencies. Recommend federal AOD funding allocations among state agencies.	***Advantages*** ▪ Creates an independent voice. ▪ Fosters continual reassessment and accountability. ▪ Increases influence of technical experts in the policy-making process. ▪ Avoids creating another state organization. ***Disadvantages*** ▪ Fosters an expert consultation rather than a cooperative, bottom-up planning process. ▪ Does not guarantee consistent, long-term knowledgeable leadership. ▪ Provides advice rather than strategy development and coordination.
Arizona ***Structure.*** Advisory Council ▪ Prevention ▪ Treatment	***Organization.*** Concerned citizens appointed by the governor. ***Functions.*** Advise the governor on prevention and treatment issues.	***Advantages*** ▪ Creates citizen oversight. ▪ Fosters periodic reassessment. ▪ Avoids creating another state organization. ***Disadvantages*** ▪ Fosters a citizen consultation rather than a cooperative, bottom-up planning process. ▪ Lacks a coordinating authority for state prevention, treatment and law enforcement. ▪ Does not provide consistent, long-term knowledgeable leadership. ▪ Provides advice rather than strategy development and coordination. ▪ Does not integrate law enforcement issues.

A Leadership Model for California

California does not need a new drug control agency. It does need a mechanism for existing agencies to work strategically toward public goals. As indicated previously, past coordinating councils have failed for a variety of reasons, mostly related to leadership and accountability.

As in Washington and Arizona, California could benefit from a multidisciplinary body that includes prevention, treatment and law enforcement authorities from the state and local level. But California needs more than advice from experts. It needs a mechanism for public leaders to align their efforts and to make specific recommendations for better using resources to the governor and the legislature.

Previous leadership and accountability problems could be overcome by requiring the strategic council to elect a chairman from its ranks and require annual progress reports.

Leadership will be the single most important ingredient, and will necessarily require law enforcement, education and social service agencies to be committed to the effort. The council should have a small staff, but be able to tap the resources of the participating agencies to encourage both efficiency and effectiveness.

Building Leadership

Learning from its own experiences and those in other states, California should create a council that would:

- Provide necessary executive-level leadership.
- Avoid creating another state bureaucracy.
- Provide a venue for establishing a statewide drug and alcohol control strategy and coordinate efforts and resource allocation.
- Provide continuing reassessment and accountability.
- Establish and encourage cooperative relationships among prevention, treatment, and law enforcement organizations.
- Require individual agencies to align their efforts with the overarching strategy.
- Require reporting of progress toward goals.

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. The Council should:

- ***Involve prevention, treatment, and law enforcement leaders.*** State and local leaders need to come together to link alcohol and drug prevention, treatment and law enforcement efforts into a statewide strategy guiding a three-pronged attack on substance abuse. The council should elect a chair from among its members, hire a small staff and tap the resources of member agencies to support its analyses. The strategy should set quantifiable goals, such as those in the National Drug Control Strategy, for reducing

abuse and include ways to measure progress toward those goals. (A listing of proposed members is included on page 42.)

- ***Institutionalize a planning and coordination process.*** The council should develop a statewide strategy for controlling drug and alcohol abuse that includes quantifiable goals like those in the National Drug Control Strategy, and ways to measure progress toward those goals. The council should submit the strategy to the Governor and the Legislature for enactment. The council also should ensure that state alcohol and drug control efforts are aligned with local, regional and federal efforts.
- ***Guide the allocation of resources.*** As a guide to the budget process, the council should present an annual plan to the Legislature and Governor for reallocating resources from the least cost-effective to the most cost-effective drug control strategies. Recommendations should be based on progress toward outcome-based goals of prevention, treatment, and law enforcement efforts as they apply to individual drugs, their availability and consequences.
- ***Advance evaluation and accountability.*** The council should have access to the necessary data from state and local agencies to identify emerging trends in substance abuse, assess the performance of the drug control strategy, and report progress and problems to policy-makers and the public.
- ***Focus on youth.*** The statewide strategy should identify specific goals and objectives for reducing the alcohol and other drug abuse of youth.

The State Should Consider Eliminating OCJP

After examining the role of the Office of Criminal Justice Planning (OCJP) in this and previous studies, the Commission concludes that OCJP has consistently failed to exercise the leadership and policy-making role in criminal justice and delinquency prevention that was envisioned by the Legislature.

The number of criminal justice and juvenile delinquency-related programs the Legislature has awarded to other state departments in recent years suggests its loss of confidence in OCJP's ability to be an effective steward of public funds.

The Commission believes policy-makers should seriously consider whether this office should be eliminated and its functions distributed among existing and related entities, such as the Board of Corrections or the Department of Justice. The Commission intends to review the office and how these functions might be better performed.

California Coordinating Council on Alcohol & Drug Control Strategy

Council Membership.

1. ***Ex officio members:***
   a. Attorney General
   b. Chief Justice of the California Supreme Court, or appointee
   c. Secretary of Health and Human Services
   d. Secretary of Youth and Adult Correctional Agency
   e. Superintendent of Public Education
   f. Commissioner of the California Highway Patrol
   g. Director, Department of Alcohol & Drug Programs
2. ***Appointed members:***
   A. Governor (3)
   1. One county sheriff
   2. One treatment service provider
   3. One representative from a prevention professional organization
   4. One public member
   5. One public member

   B. Senate (3)
   1. One county supervisor
   2. One county social services director
   3. One representative from a California addiction treatment association

   C. Assembly (3)
   1. One city council member from a large city
   2. One representative from a treatment accrediting organization
   3. One representative from a California addiction medicine association
3. ***Chair –*** elected by the council membership.

Council Functions.

1. Establish and institutionalize a rational process for information gathering, planning, strategic decision-making and funding to reduce alcohol and drug abuse in California.
2. Create an overarching drug control strategy to unify the efforts of the three strategy components, prevention, treatment, and enforcement and submit the strategy to the Governor and the Legislature for implementation.
3. Identify outcomes to be achieved by the strategy.
4. Coordinate drug and alcohol policies across state government agencies and departments to ensure that each component of the strategy has its activities and funding aligned with identified outcomes.
5. Report progress annually to the Governor and Legislature, and advise on resource allocation among prevention, treatment, and enforcement efforts.
6. Encourage the integration of state drug control efforts with local, regional, and federal efforts.

Setting Priorities

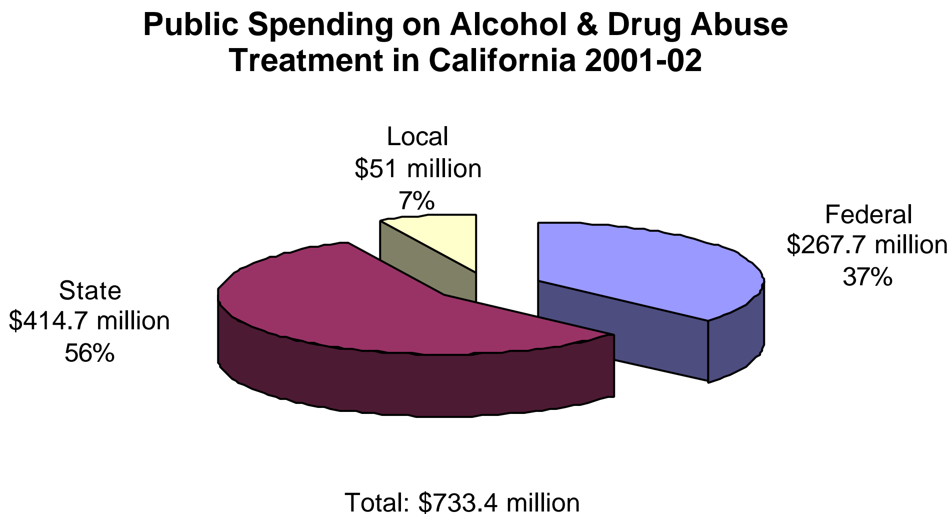
Finding 2: The State does not make the most of available resources by prioritizing treatment to serve those whose drug and alcohol abuse imposes the greatest consequences on Californians and their communities.

In 2001, the State provided substance abuse treatment for 359,000 people[117], a significant expansion over the 130,000 treated in 1997. [118] Although the treatment system expanded greatly with the infusion of Proposition 36 funding, it is still insufficient to provide treatment for all Californians seeking it. In December, 2001, nearly 11,000 people were on waiting lists for treatment. Thousands more have walked away when they were turned away and tens of thousands need treatment, but have not sought it. Because treatment represents the most effective means of reducing the expense and misery of drug and alcohol abuse and addiction, the ultimate goal is to provide treatment on demand. Until then, the State must use its limited resources as wisely as possible.

Funding Drives Access to Treatment

In most cases, the decision about who will receive treatment is made in the budget process. Public spending on alcohol and drug abuse treatment in California during fiscal year 2001-02 totaled over $733 million. As the chart shows, more than half of that funding comes from the State.

Public Spending on Alcohol & Drug Abuse Treatment in California 2001-02



Total: $733.4 million

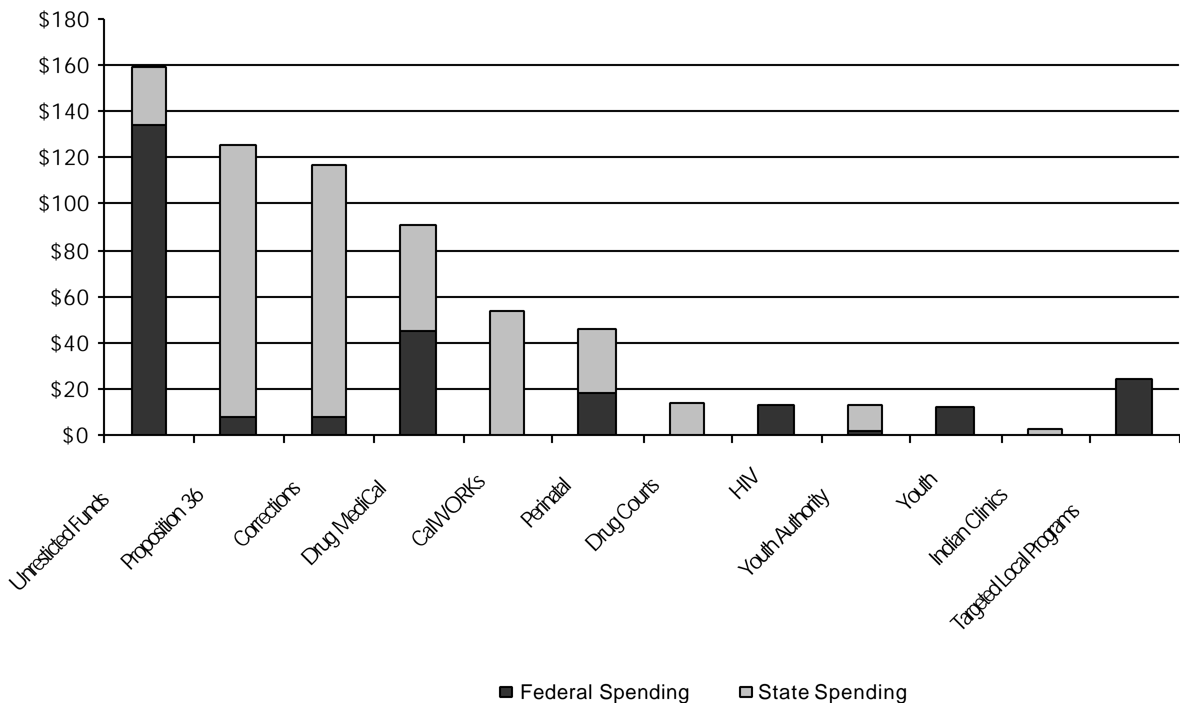
Sources: Department of Finance, Department of Alcohol & Drug Programs, Department of Corrections, Survey of California Counties by the County Alcohol & Drug Programs Administrators Association of California.

Most of the funds are allocated for specific populations of substance abusers. These funds are commonly referred to as "set asides." Federal set asides include funds for pregnant women and intravenous drug users who are AIDS/HIV positive. A significant portion of the state funds are allocated for prison inmates or those arrested for drug crimes. The State also sets aside a portion of unrestricted federal funding for special purposes, establishing additional set asides.

The chart below shows federal and State funding allocations for substance abuse treatment during 2001-02. The chart illustrates the extent to which funds are restricted to specific populations, limiting flexibility in the expenditure of those funds.

State and Federal Funding Allocations for Substance Abuse Treatment in California 2001-02

(Dollars are in Millions)



Sources: Department of Finance, Department of Alcohol & Drug Programs, Department of Corrections.

This "silo funding," officially known as categorical funding, has the advantage of ensuring that money is available to address the needs of certain groups. Often the money is insufficient to meet all of the needs of that group. Sometimes, too much money has been allocated, but those funds cannot be used for other groups. Funds not designated for specific populations are available to treat the general population. Of the $733.4 million available for substance abuse treatment in 2001-02, only

$159.3 million was available for the general population. Categorical funding creates a number of problems, including:

- ✓ Difficulty treating clients with co-occurring disorders who need to access resources from more than one state agency at the same time.
- ✓ Potential conflicts between federal and state categories and local needs.
- ✓ Added complexity of administration that does not add value for the client.
- ✓ Restrictive eligibility requirements that exclude some in need of treatment.
- ✓ Fluctuating funding based on the level of threat perceived at both the federal and state level.

Priorities are set currently through a series of decisions that are valid in isolation, but do not necessarily respond to those whose addictions impose the highest human and economic costs. Often, groups who do not have strong advocates go unserved.

Managing treatment programs at the county level requires navigating a labyrinth of restrictions on how and for whom federal and state funding may be used. No single agency or person is responsible to ensure this is done for clients, so the burden often falls on the client to navigate the system. These restrictions limit access to treatment by large numbers of Californians.

SAMHSA has recognized the problems inherent in this system. Responding to a congressional mandate in the Children's Health Act of 2000, SAMHSA has been working to increase flexibility and accountability in the Substance Abuse Prevention and Treatment (SAPT) block grant that provides the majority of federal funding for treatment. The agency has proposed shifting from eligibility requirements toward performance measures.

SAMHSA's efforts have the support of the National Governors' Association. The National Association of State Alcohol and Drug Abuse Directors, however, is concerned that the data system necessary to measure performance will be too expensive.[119]

SAMHSA Proposal to Transform the SAPT & Mental Health Grants

Creates Performance Partnership Grants:

- Is less formula driven.
- Avoids eligibility changes.
- Reduces set asides.
- Focuses more on achievement of outcomes such as improving retention in treatment rather than process. Performance measurements include:
  - ✓ Rates of drug use.
  - ✓ Completion rates.
  - ✓ Length of stay.
- Requires data driven evaluations.

Source: Charles & Helen Schwab Foundation's Online Substance Abuse News. January 14, 2003. http://www.jointogether.org/sa/news/features/reader/0,1854,556067,00.html

SAMHSA's proposal is an encouraging step toward the use of outcomes as measures of success. Focusing on outcomes introduces shared accountability across the spectrum of organizations participating in alcohol and drug control efforts and encourages cooperative endeavors. The outcome measures need further refinement, however, to incorporate indicators that treatment has benefited society, as well as clients by enabling them to become productive citizens. Indicators of improvement in family relationships, homelessness, unemployment, reliance on social services and involvement with the criminal justice system should be included.

The Need for Accountability

David Rosenbloom, director of Join Together, a resource center for communities taking action against addiction and gun violence, stated:

> *The list of performance measures is a good start, but without a mechanism for holding states accountable for measuring, reporting, and enforcing these standards, this exercise will have no effect on improving treatment. Congress has asked for years that agencies that receive federal money be held accountable for how they use it. Unless this happens in the addiction field, I believe that continued federal funding will be at risk.*

Source:. Schwab Foundation Substance Abuse News Online Newsletter 1/14/03. http://www.iowaattorneygeneral.org/latest_news/releases/jan_2003/Drug.html

Priority for Treatment

Because of the risks that drug abuse poses to pregnant women and their unborn children, pregnant women have high priority for treatment statewide. Injection drug users and individuals infected with HIV/AIDS are accorded priority because of the threat to public health and the cost of treating this disease.

A variety of groups either do not get treatment or experience delays in accessing treatment because they do not qualify for any of the categorical set asides. Among these groups are:

- ***Women with children in foster care.*** Women with children in foster care (or at risk of having their children removed) because of parental substance abuse do not receive priority for treatment, despite the fact that treatment may be a prerequisite for reunification or prevent the need for foster care. Delays in treatment add to the costs of the child welfare system and to the trauma of children.

- ***The working poor.*** The working poor often do not qualify for publicly-funded substance abuse treatment because they do not fall below the income threshold to qualify for services. Many California workers - nearly 10 percent - do not have incomes adequate to move a family of three out of poverty.[120] They often work in jobs without health benefits and cannot afford coverage on their own.

- ***Youth.*** Little treatment is available for youth outside of the juvenile justice system. There are an estimated 220,000 California youth aged 12 to 17 in need of substance abuse services.[121] Among the youth who need prevention and treatment services to avoid more extensive and costly interventions during their adult years are:

  - ✓ Youth in foster care or at risk of being placed in foster care because of their parents' substance abuse. They are four times more likely to become substance abusers than children of non-substance abusing parents. There were more than 90,000 young Californians in foster care in 2001.[122] An estimated 80 percent of these cases involve parental substance abuse.[123]

  - ✓ Abused and neglected children. Such children often turn to alcohol and drugs to dull the pain of their situation. California has approximately 125,000 substantiated cases of child abuse and neglect each year.[124] Twenty percent, or 25,000 of these children end up in foster care.[125]

  - ✓ Children with Other Risk Factors. Poverty, homelessness, gang affiliation and domestic violence can elevate a child's risk for substance abuse and addiction. One recent study revealed that in certain circumstances, children of single parents are twice as likely to develop serious psychiatric illnesses and addictions as children of two parent families.[126]

- ***The homeless.*** The homeless are one of the most difficult populations to treat. Many of them have mental illnesses in addition to their addiction. Also, their peripatetic lifestyles disrupt the continuity of treatment. There are an estimated 360,000 homeless people in California.[127]

Recently imposed federal guidelines for foster care require that children be reunited with parents within six months of entering foster care or be permanently removed from the custody of the parent. The only hope for these parents to meet this deadline is court-monitored treatment. Because they do not receive priority for substance abuse treatment and often must endure long waiting lists, however, reunification is delayed or made impossible. The consequences are costly for both the parent and the State, which must bear the burden of supporting, educating, and providing medical care for these children. Costs for each child can exceed $60,000 per year.

Unintended Consequences of Setting Priorities One At A Time

California has dramatically increased funding for treatment, but most of that additional funding goes to those arrested. The Substance Abuse and Crime Prevention Act of 2000 and the Department of Correction's Treatment Initiative provide a combined $255 million for treatment. Drug treatment for criminals provides significant benefits by increasing public safety and reducing future costs.

Another result, however, is that those involved with public safety institutions have better access to treatment than others. These allocations were not made after considering all of the needs for treatment. Because the populations served by these two programs are predominantly male, they are using resources that might otherwise go to parenting women or young people - an unintended consequence of considering one segment of the population in isolation of the entire community.

Source: Guy Klopp, policy, planning, evaluation & training manager, Sacramento County Alcohol & Drug Services Division, Personal Communication, October 30, 2002.

In short, priorities have been set one funding decision at a time to respond to a particular need without looking at the entire spectrum of problems caused by substance abuse and the continuum of responses available to deal with them.

Data-Based Priorities

A more direct way to ensure the best use of limited treatment funds is to review costs across all social service systems to determine which factors cause people to become dependent upon public support. This approach identifies all problems related to substance abuse and considers a range of options that allows coordination among agencies that deal with such problems. Sacramento County took this approach in the mid-nineties with significant results.

Sacramento County discovered that substance abuse was a significant factor among clients in almost every social service department. Most clients were part of multi-problem families needing services from different departments, and substance abusers were the most likely of all clients to require the services of various departments simultaneously and repeatedly.[128] In short, substance abusers were imposing significant costs on multiple social service agencies. For example, 70 to 80 percent of child welfare cases involved drug-abusing parents. Substance abuse was an issue in 50 to 70 percent of the mental health patients assessed and 70 percent of county jail inmates suffered from substance abuse.[129]

Based on such analyses, Sacramento County provided additional funding for substance abuse treatment and set priorities to treat high-cost populations first. The goal is to get people into recovery to rebuild their lives, reduce the demand on county services, and secure the greatest impact from the expenditure of limited funds. Some counties have prioritized their caseload based on social and financial costs imposed on the community, but most have not.

San Francisco took a different approach by creating the Treatment on Demand Planning Council. The council identified treatment needs based on community input.[130] Early results are promising. Emergency room

visits for substance abuse and deaths from heroin overdoses, key indicators of the severity of the drug epidemic, have declined steadily since program implementation five years ago.[131] San Francisco contributed approximately $36 million in general fund money to this effort in 2001, equal to 63 percent of the total county treatment budget.

Sacramento has previously provided and San Francisco continues to provide funding to augment state and federal allocations. Local funds do not have the restrictions that characterize most state and federal funds and can be used to provide services that meet local needs. Local officials believe that this flexibility is the most important factor in the success of the programs. But local planning is a prerequisite for success.

Sacramento County's Priority Clients

- ✓ Clients involved with Child Protective Services
- ✓ Multi-service users
- ✓ Criminal justice involved clients
- ✓ Pregnant women
- ✓ Juvenile offenders
- ✓ CalWORKs clients

Lessons Learned

These county experiences provide important insights. One lesson is that failure to address substance abuse drives up other social service costs. Another is that basing priorities on a comprehensive analysis of social and financial costs establishes priorities that may differ from current priorities and avoid long-term consequences. San Francisco relied on a public process to prioritize its efforts to reach a community goal of treatment on demand.

If treating parental substance abuse were effective in only half of the foster care cases, California could save hundreds of millions of dollars annually.[132] A continuum of services to address substance abuse and its causes would not eliminate the need for jails and prisons, but it would reduce growing demand from the correctional system on public budgets.

Similarly, substance abuse treatment holds out the promise of significantly reducing emergency room visits and public assistance caseloads, both expensive social costs imposed by addicts. The long-term benefits of establishing priorities based on a comprehensive analysis of social and financial costs include:

- ✓ Fewer broken families.
- ✓ Less crime.
- ✓ Decreased foster care costs.
- ✓ Better use of treatment funds.
- ✓ Decreased health care costs for substance abuse-related diseases.
- ✓ Decreased criminal justice costs.

Typical High Cost Populations	
Children in Foster Care Whose Parents are Addicted	Sacramento County discovered in 1994 that it had 36,985 reports of child abuse and neglect, a rate of 13.7 reports for every 100 children. These children are four times more likely than children of non-substance abusing parents to develop substance abuse problems themselves.[133] Frontline department workers estimated that 80 to 90 percent of parents involved with child protective services have substance abuse problems.[134] In addition to foster care, these cases impose treatment, criminal justice, public assistance, and lost productivity costs on the community.
Substance Abusing Pregnant Women	From 1990 to 1992 Sacramento County experienced a rise in drug involved births, from 9.2 to 15.2 percent, a total of 3,158 babies. [135] A 1997 study on the costs of treating drug abusing pregnant women showed that 37 percent of treated women tested positive for drugs at birth versus 63 percent of untreated women. Ten percent of treated women's babies required neonatal intensive care versus 26 percent of untreated women's babies. Care costs, including substance abuse treatment, averaged $14,500 for treated women and their babies versus $46,700 for untreated women and their babies.[136] Caring for a drug-addicted baby can cost the state from $750,000 to $1.4 million for hospital, medical and foster care expenses. [137]
Substance Using Youth	Intervening early in the lives of youth using alcohol and drugs raises the probability that they will not continue toward substance abuse and addiction and allows them to continue their development, socialization, and education. Youth treatment costs are somewhat greater than those for adult treatment, but is a good investment.[138] The lifetime cost of not treating substance-abusing youth can reach $1.7 million each.[139]
AIDS Patients	The cost of treating an AIDS patient can run more than twice as high, $34,000 per year, compared with treatment costs of $14,000 for an HIV positive patient.[140] In San Francisco, 98 percent of older injection drug users test positive for HIV.[141] While current medications can slow the progress toward AIDS, they cannot stop it.[142] HIV positive patients will become AIDS patients. A recent study showed the effectiveness of treatment in reducing the spread of AIDS among intravenous drug users, citing after seven years a 21 percent infection rate among the treatment group compared with a 51 percent rate for the control group.[143]
Incarcerated Non-violent Substance Abusers	Incarceration is costly, $28,500 per offender annually. [144] Treatment is not only cheaper but also more effective in resolving the underlying problem, addiction. Even if only 30 percent of the estimated 60,000 substance abusers among current parolees returned to custody in California state prisons had overcome their addiction and broken the cycle of reincarceration, the annual savings would have amounted to over $1.7 billion.[145] A 36-month study at California's R.J. Donovan Correctional Facility reported a recidivism rate of 27 percent for inmates completing treatment versus 75 percent for others.[146]
Unemployed Substance Abusers	Unemployment is among the most costly results of substance abuse to California, estimated at $18.2 billion a year. Employment is one of the greatest aids to recovery.

Community-based Priorities

Other counties are looking at how Sacramento County has prioritized access to substance abuse treatment. The State could facilitate this process by prioritizing desired outcomes based on social and financial costs and allowing counties discretion on how to achieve these outcomes.

If a desired outcome were to reduce foster care cases resulting from substance abuse, local authorities could reallocate resources to accomplish this goal. This approach allows the State to remove restrictions on eligibility, giving local government discretion on what services are needed to treat the addiction and address its underlying causes.

A local needs assessment can guide local planning by identifying treatment needs, gaps and resources and aligning funding with state and local priorities. Considerations include:

- ✓ Obtaining input from all key constituencies.
- ✓ Basing decisions on data.
- ✓ Involving other social service and health agencies that serve the same populations.
- ✓ Determining the extent to which substance abuse drives the demand for other public social services and the costs of not meeting these needs.

Community Planning Can Help Address NIMBY

One of the problems frequently encountered in establishing substance abuse programs is the NIMBY (Not In My Backyard) response of neighborhoods in which treatment providers seek to establish treatment facilities. The treatment provider's goal is to site the facility to be convenient to clients. Neighborhoods frequently resist the establishment of new facilities through local land use planning processes. By documenting the need for substance abuse treatment services and the population needing such services, a good needs assessment can serve as a planning tool for local land use. Needs assessments can be incorporated into the local land use plan. They could also provide the basis for a statewide needs assessment.

The needs assessment process also identifies areas where local philanthropy can be targeted. It will identify, for example, the priority that should be accorded to substance abuse treatment for youth, which can address this underlying cause of behavioral and development problems and avoid the social and financial costs of adult addiction.

Addressing the Unmet Need for Treatment

Given the consequences of addiction and the opportunity for recovery the State's ultimate goal should be that those needing treatment should receive it. Until then, the State needs to make sure that available resources are targeted at those whose addiction imposes the greatest consequences on public dollars and private lives.

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. Specifically, the State should:

- ***Establish State goals.*** In setting goals, the State should assess the impact of abuse and addiction on health, social service, criminal justice and other public systems. The assessment should be designed to enable counties to assess their specific needs, document the consequences of addiction in their communities and target resources to clients posing the greatest social and financial costs. Clients that fit the criterion on harm might include:
  - ✓ Clients whose substance abuse results in physical and emotional abuse to others and increases the burden on other public programs such as foster care and corrections.
  - ✓ Youth with substance abuse problems or who are at high risk of abusing drugs or alcohol and need help breaking the generational cycle of abuse.
- ***Require counties to assess community needs and concerns.*** With State goals in mind, counties should be required as part of the annual funding process to document treatment needs and gaps and identify community resources. They should consider how available resources could be maximized to serve community members and align funding to meet local priorities and state goals. Counties should incorporate the assessment into budget and management decisions of other departments, including the siting of service providers.
- ***Shift resources to intervene earlier with substance abusers.*** State and community analyses need to consider how resources are spent on the continuum that includes prevention, treatment and enforcement to reduce abuse of alcohol and other drugs over the long term. In particular, prevention dollars need to be targeted to children with the highest risk factors for alcohol and drug use and other dangerous behaviors. County assessments should also be used by civic leaders to focus philanthropic and other private resources on effective treatment.
- ***Establish accountability for outcomes.*** The State should develop the means to measure outcomes, monitor and publicly report progress on state and community goals.

Ensuring Quality Treatment

Finding 3: The State has not structured substance abuse treatment programs to provide a statewide basic level of quality or encourage continuous quality improvement.

Because of the extraordinary consequences of addiction and the limitations of public resources, California must ensure that treatment programs are of high quality and that funding is allocated to the highest performing providers. But with the expansion demanded by Proposition 36 and other revenue streams, the Department of Alcohol and Drug Programs has been more focused on expanding the supply of treatment rather than the quality of treatment.

There are no state quality standards for outpatient programs, which make up 70 percent of the treatment opportunities. And there are limited standards for residential programs, with the greatest emphasis on health and safety, not recovery.

The State is trying to define requirements for counselors and does some licensing of residential programs and facilities. But the State has left the job of quality assurance primarily to the counties, which use contracts with providers as a means for quality control.

Relying on county contracts results in variations in quality and effectiveness across the state. And without quality standards, some providers use proven treatment modalities, but deliver them in ways that preclude recovery.

While there is general agreement that quality treatment programs improve outcomes for clients, the research is limited on how to ensure and measure effectiveness. The treatment profession relies primarily upon retention rates and length of stay in treatment to assess program performance.[148] Protocols to measure the quality of treatment in a particular program are not in general use.[149] The federal emphasis on outcomes is pushing the field in the direction of performance measurements. But there also is inadequate research on how to develop a system that will produce the desired results.

From the limited research, however, elements of a quality treatment system can be distilled and are listed in the table on the following page. The 10 elements fall into four broad categories: workforce, facilities, treatment modalities and systemic considerations. Reviewing these elements identifies opportunities for improving the quality of treatment.

Elements of an Effective Statewide Treatment System

To document the elements of high quality treatment, the Commission reviewed the research and consulted with its advisory committee. The following list summarizes these elements, as well as the current policies and practices, and the potential for improvements.

Workforce - Ensure a qualified staff.

The policy: State regulations require that staff have "appropriate" skills, education, training and experience, but do not define "appropriate." ADP is meeting with stakeholders to define staff qualifications and methods for acquiring them.

The potential: An occupational analysis could define the outcomes to be achieved and the methods of achieving these outcomes. Using this information, ADP could identify the knowledge, skills, abilities, and other characteristics personnel should have and a performance-oriented test to measure these attributes.

Facilities - Ensure safe and suitable facilities.

The policy: The State is focusing its limited inspection resources primarily on licensing residential facilities, checking them for Health and Safety Code compliance and suitability for treatment programs. Licenses are renewed by mail every two years unless the facility fails a local health or safety inspection.

The potential: ADP could work with accrediting organizations such as the Joint Council on Accreditation of Hospital Organizations (JCAHO) to develop an accreditation process for treatment providers and their facilities.

Treatment Modalities

Provide comprehensive assessments.

The policy: ADP has required the use of the Addiction Severity Index (ASI) in pilot programs in 13 counties. But the staff in many of these treatment programs lack the skill to properly administer the ASI, compromising the data collection and analysis that is critical to continuous evaluation and improvement of outcomes.

The potential: ADP could require training of clinical staff to properly administer the ASI. Training is available from the Pacific Southwest Addiction Technology Transfer Center for the cost of transporting the instructional team. The software to track client outcomes using the ASI is available for free from the ASI developer, Thomas McLellan, Ph. D., at the University of Pennsylvania's Treatment Research Institute.

Match treatment modality to client needs.

The policy: Clients are often assigned to a treatment program based on vacancies rather than the most appropriate modality and are not always linked to supportive services they need to succeed. As a result, over 70 percent of treatment in California is drug-free outpatient treatment with completion rates less than 30 percent statewide.

The potential: Establish desired outcomes, such as a reduction in parolee recidivism or lower foster care placements, that require State agencies to develop partnerships with other agencies to succeed. Reduce eligibility restrictions on services that may be purchased with state funding to encourage partnerships among agencies and ensure clients receive the services they need.

Engage clients to persist in treatment.

The policy: Persistence in treatment around the state varies greatly. ADP has more than a dozen contracts with organizations that can help programs improve persistence. Addiction Technology Transfer Centers, funded by the National Center for Substance Abuse Treatment (CSAT), are also resources available to assist treatment providers. These resources are not widely used.

The potential: ADP could establish desired outcomes to be achieved by counties with federal and state funding. The need to achieve measurable outcomes to continue access to an undiminished funding stream encourages counties and contractors to utilize all training resources that contribute to that goal. ADP could also accord a high priority to development and implementation of CALOMS to increase availability of data on persistence in treatment statewide.

Elements of an Effective Statewide Treatment System

Treatment Modalities *(continued)*

Treat clients when they are motivated.

The policy: The initial window of opportunity often is missed because of waiting lists for treatment.

The potential: Some counties, like Sacramento County, are bridging the gap by conducting treatment readiness preparation classes to engage clients until treatment is available. These classes maintain and enhance client motivation for treatment and explain the treatment program. These and other efforts could be replicated.

Address the range of patient needs using proven techniques.

The policy: As described in Finding 4, substance abuse clients require a variety of services that are not well coordinated.

The potential: Change the focus from providing substance abuse treatment to returning the client to society as a productive citizen. Doing that requires addressing all the factors that retard the client's progress toward that goal. It also requires focusing on outcomes, not process, and establishing partnerships among agencies charged with addressing these problems.

Encourage relapsing clients to return to treatment.

The policy: Keeping clients involved in low intensity aftercare programs is the best way to identify early problems that lead to relapse and deal effectively with them. With few exceptions though, the State relies on programs such as Alcoholics Anonymous, Narcotics Anonymous and others to provide aftercare. The State does not track the return of relapsing clients, considering a relapsing client that returns to treatment as a new admission.

The potential: A focus on outcomes would encourage the State to find ways to improve aftercare. By prioritizing treatment for those who impose the greatest social and financial costs on their communities, counties will create savings that can be reinvested in treatment, including aftercare.

Systemic Considerations

Operate as part of a comprehensive State drug and alcohol strategy.

The policy: A variety of approaches to integrating drug and alcohol control efforts to support a comprehensive strategy have failed. There is currently little communication among the three components.

The potential: As described in Recommendation 1, a comprehensive drug and alcohol control strategy focused on outcomes would require the three components to work together.

Conduct data-based continuous quality improvements.

The policy: ADP relies on pilot data collection projects and periodic evaluations covering limited periods of time and targeting specific treatment efforts such as Proposition 36. Data system incompatibility and privacy issues limit data sharing with organizations in the other two components. These limitations render it difficult to focus on outcomes that span the efforts of the three components.

The potential: ADP could prioritize development of its Outcomes Management System (CALOMS) and expand it to collect prevention and law enforcement component data. The resulting system could be used to track performance of each component in achieving desired outcomes of the State's overarching drug and alcohol control strategy.

Sources: Department of Alcohol & Drug Programs. Licensing Fact Sheet. Personal Communiction: Dr. Richard Rawson, associate director, UCLA Integrated Substance Abuse Program, November 2002 and January 2003. Dr. Yih-Ing HSER, UCLA, November 2002. Dr. Tom Freese, co-director, Pacific Southwest Addiction Technology Transfer Center, UCLA, November 2002. Carmen Delgado, assistant deputy director, ADP, December 2002. Toni Moore, director, Alcohol & Drug Programs, Sacramento County, November 2002. Little Hoover Commission Alcohol & Drug Abuse Treatment Study Advisory Committee meetings. National Institute on Drug Abuse. *13 Principles of Effective Treatment.* U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. *Changing the Conversation. Improving Substance Abuse Treatment: The National Treatment Plan Initiative. Panel Reports, Public Hearings, and Participant Acknowledgements.* November 2000.

Current Quality Control Efforts Fall Short

While public treatment programs have gradually increased in response to the epidemic of drug abuse and addiction, the professional standards have lagged. Treatment counselors are often in recovery themselves and lack formal training. Treatment modalities range from AA meetings to drug replacement therapies such as methadone.

As medical science has advanced the biological understanding of addiction and as researchers have attempted to document the impact of treatment, the ability to systematically improve quality has increased.

There are three opportunities – personnel, programs and facilities – to improve and ensure the chances that clients will sustain their recovery.

Quality Personnel

Efforts to regulate or even set minimum standards for treatment personnel are complicated by the history of treatment. While some counselors have advanced degrees and are licensed in related fields, others start as peer counselors who are in recovery themselves, and use their experience to support others.

One concern is to make sure that public funds are spent in programs that actually lead to recovery. A second concern is that clients are not taken advantage of, given the confidential and vulnerable nature of treatment.

The Governor in October 2001 directed ADP to promulgate regulations requiring counselors to be certified.[150] The department is developing those regulations, attempting to find a compromise between competing associations representing different types of treatment programs and staff.

Consequences of Inadequate Workforce Qualifications Policy

Consequences of inadequate policy on workforce qualifications include:

Undefined client to counselor ratios. Because there are no State prescribed treatment outcomes or methodologies, client to counselor ratios cannot be logically determined. High client to counselor ratios are common among alcohol and drug abuse treatment programs.

Low wages. Because there has been no occupational analysis, the knowledge, skills, abilities, and other characteristics of counselors and program managers have not been prescribed by the State. Undetermined qualifications result in low wages and less effective treatment programs.

High turnover. Low wages and stressful work produce high turnover. Statewide, turnover is about fifty percent per year.

Negative public perception of the field. Occupational fields with undetermined qualifications, low wages, and high turnover generally are not regarded highly by the public. This factor exacerbates already high turnover. The fact that many counselors and some program managers are persons in recovery adds to the public's low esteem for the field, whether warranted or not.

Uneven program quality. The lack of standards for key treatment program personnel means that program quality is a function of chance. Those programs that manage to find and keep good leadership excel.

Some of these associations support a process-based certification for counselors that requires specified education and training. The associations representing counselors who are in recovery themselves oppose that approach because it would prevent many of them from becoming certified. Their strength is the ability to identify with clients, an attribute not reflected in educational degrees. They prefer a certification taking life experience into account.

These discussions, however, have centered on the process that should be required to become certified, rather than the requirements of the job. These approaches do not squarely identify the key issue: the knowledge, skills, abilities and other characteristics required of counselors to maximize recovery by clients.

The department has not defined the outcomes to be achieved by treatment programs, and the methods of achieving these outcomes. Without this analysis it is difficult to identify the attributes that staff should have or determine the best way to ensure that staff have those attributes.

This occupational analysis also could be used to establish a career ladder that will help counter several problems, including high turnover, low wages, and low public esteem for the field. The occupational analysis will not specify how people can attain the required knowledge, skills, abilities, and other characteristics. They may be acquired through any combination of education, training, or experience. Performance-oriented testing supplemented by written tests should be considered as the primary way to ensure that the people doing the job are qualified.

Quality Programs

The State licenses residential treatment facilities, but primarily to ensure that those facilities are safe places to work and live. The regulations require adequate staff, but do not set specific requirements.

The State certifies outpatient clinics, which comprise most of the treatment opportunities. Certification is voluntary and limited in scope.

Recently, the state has established standards for youth and perinatal treatment programs that are intended to actually ensure the quality of treatment.

Researchers have been able to document the benefits of different treatment methodologies and can guide providers on how to faithfully replicate proven practices. For example, research shows that patients

who do not stay in treatment for at least 90 days show little improvement. Content, duration and frequency of therapy sessions, and client-to-counselor ratios can all affect outcomes.

Some counties have used their contracts with private providers as a way to instill these components of quality. But each county is left on its own to determine which components are most valuable, particularly when resources are so limited, and how contracts can be used to ensure clients receive the intended benefits.

Some providers assert the nearly exclusive focus on safety ultimately limits the appreciation for treatment by the public and policy-makers. As one respected provider said: "Judge my program on the success of our clients in life, not on the temperature in the refrigerator."[151]

The trend – in contracts and in federal policy – is toward standards that require providers to achieve measurable outcomes. For example, contracts might require that a certain percentage of clients complete the treatment program and remain abstinent for 10 months, or that they obtain and keep a job for a year, or that they are not arrested for a new crime. These outcomes also offer a means of evaluating program quality. The difficulty is tracking clients after they leave the program.

A report on California's alcohol, drug, and mental health systems by SGR Health noted: "Publicly available information on California's behavioral health system is incomplete, fragmented and dispersed in electronic and manual systems that are not used to increase public, legislative or media awareness, support or understanding."[152]

Under these circumstances, it is difficult, if not impossible, to evaluate the effectiveness of treatment programs. To perform this level of evaluation, data must be shared among agencies.

Licensing & Certification

Mandatory residential facility licensing requires:

- Local fire inspection clearance.
- Plan of organization and functions.
- Bacteriological analysis of non-municipal water source.
- Sketch of the grounds.
- Floor plans.
- Sample menus and a schedule for one calendar week.

Voluntary outpatient facility certification involves:

- Local fire inspection clearance.
- Local use permit.
- Plan of organization and functions.
- Program evaluation plan.
- Continuous quality management plan.

Quality Facilities

The State spends more energy attempting to ensure minimum standards for residential facilities than the programs offered within those facilities. For outpatient clinics, the State's voluntary certification process is weighted more toward program than facilities.

Requirements for residential facilities focus primarily on health and safety concerns, such as fire safety, food service, personnel requirements, the physical environment, and personal rights.

ADP reports that there are some 390 certified outpatient facilities in the state. The department does not know how many uncertified outpatient facilities are in California. But as the number of publicly funded programs grows, the State will have a growing interest in making sure these environments are safe and conducive to recovery.

Licensing & Certification Are Not Focused on Program Quality

For residential treatment facilities, the licensing process is oriented 75 percent on bricks and mortar and 25 percent on program viability. Requirements focus primarily on health and safety considerations.

Certification rules for outpatient programs and their facilities are the opposite, with 75 percent of the considerations focused on program viability and 25 percent on the physical location. Applicants submit documentation that describes what they intend to do but not how they intend to do it. ADP personnel apply their professional judgement to estimate the chances of program success. There is no assurance that proven treatment methodologies will be used and faithfully replicated. Desired outcomes are not identified or quantified so success cannot be measured.

The emphasis on facilities is appropriate, especially for residential facilities where resident clients will spend significantly more time than those in outpatient facilities. For both residential and outpatient programs, the State needs to ensure that facilities are safe.

To improve the effectiveness of treatment programs, the State could publish standards. While the State should not be dictating what treatment methodologies should be used, it can require that:

- ✓ Only evidence-based treatment treatments be offered.
- ✓ Evidenced-based treatment methodologies be faithfully replicated.
- ✓ Quantifiable outcomes be used to gauge program success.

Sources: David Feinberg, Manager, ADP Residential & Outpatient Programs Compliance Branch, Personal communication, February 3, 2003. ADP web site www.adp.ca.gov/LCB/LCBhome.shtml.

Driving Quality

With the appropriate standards in place, the State could follow the recommendations of the national Institute of Medicine and tie reimbursement levels to quality of treatment. Although the recommendation in the institute's report was intended for Medicare providers, it is equally applicable to other providers, including substance abuse treatment providers.[153]

The institute recommends the establishment of standard measures of quality, assessment of each care provider, and publication of comparative data to enable consumers to chose the best providers. As the primary funding source of treatment services, the State has tremendous leverage to encourage providers to continuously improve quality by linking funding to performance. In addition to improving outcomes, that approach will counter stigma that is based on the belief that addiction is a failure of will by documenting the benefits of treatment.

Begin With the End in Mind

Any effort to improve quality should be based on desired outcomes and a realistic definition of success. Because substance abuse is a chronic, relapsing condition, not all clients will be cured, that is be permanently abstinent. Many abusers experience problems and relapse. The goal for such clients is to overcome these problems and regain recovery, and to experience longer periods of abstinence between relapses.[154]

Outcome-based goals for clients may include employment, reunification of families, crime free behavior, stability in living conditions, and improvement of physical and mental health. Establishing treatment program outcomes clears the way to determine what programs are required to achieve these outcomes. Among them:

- ✓ Employment preparation, including basic education such as reading and writing, and training, including employment readiness and specific job skills.
- ✓ Transitional housing.
- ✓ Health/mental health services.
- ✓ Family counseling.
- ✓ Legal assistance.
- ✓ Case management.

Steps for Changing Regulations

To make a change to the regulations governing alcohol and drug abuse treatment programs, Health and Safety Code Section 11835 requires the director of ADP to:

- Present to State Advisory Board justification for proposed regulations.
- Draft proposed regulations.
- Submit draft regulations to majority vote of designated county administrators.
- Appeal adverse votes to a five-member panel composed of:
  - ✓ Secretary of Health & Human Services
  - ✓ Director of ADP
  - ✓ State Advisory Board representative
  - ✓ County Alcohol Administrators representative
  - ✓ Secretary of Health & Human Services appointee
- Repeat the entire approval process for failed appeals.

Within each of these programs, quality standards can be established based on desired outcomes. For example, a desired outcome in employment preparation might be that 40 percent of clients completing treatment should gain and maintain a job for at least one year.

Historically, however, the State has not been assertive when it comes to quality, and the authority and expectations of the department to ensure quality have been limited. As one ADP official told the Commission: "The field has been regulating the department for years."

Establishing outcomes will require greater authority for the director of ADP. While ADP is the state agency responsible for the oversight of substance abuse treatment and prevention programs, it has limited authority to do so.[155] Under the Health and Safety Code, the director is charged with developing standards for ensuring minimal statewide levels of service quality provided

by treatment programs.[156] This requires setting quality control standards for personnel, programs, and facilities. The department's level of activity in this arena has increased markedly over the last two years.

Quality assurance, however, is both time consuming and difficult. The director does not have the authority to establish regulations without prior approval of a State Alcohol Advisory Board, which no longer exists, and agreement by a majority of county alcohol and drug program administrators. In other words, to regulate the field the director must first seek permission from those regulated.

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

- ***Define and enhance the director's authority.*** The director of ADP should be given clear authority to assess prevention and treatment efforts and advocate for high-quality treatment wherever it occurs, particularly in the Department of Corrections. Health and Safety Code Section 11835 should be revised to allow the director to establish regulations without approval from county administrators.
- ***Develop management tools.*** The State should accelerate the implementation of the California Outcomes Measurement System (CalOMS) to track the effectiveness of individual programs. ADP should establish an advisory board that includes stakeholders from all levels and areas of expertise to ensure the system will be an effective tool for consumers and providers, state and local administrators and policy-makers.
- ***Establish a strategy to develop a well-qualified workforce.*** ADP should ensure completion of an occupational analysis to establish knowledge, skills, abilities and other characteristics required of counselors and other key personnel. The department should establish a method for determining which candidates meet requirements. Requirements should be implemented gradually to allow incumbents to upgrade qualifications as necessary.

Improving Treatment in Prisons

Based on a pilot project that reduced recidivism, the State has expanded the use of therapeutic communities within prisons, and aftercare to those inmates when they are released. The Department of Corrections (CDC) now operates 8,500 in-prison beds at a cost of nearly $120 million a year.

But recent evaluations by UCLA show that the Department of Corrections is not faithfully replicating the pilot project. CDC's low-bid contracting rules preclude quality and prison administrators are putting inappropriate inmates in the program. The evaluators also concluded that CDC does not institutionally support the goals of treatment, frustrating the program in numerous ways. Steps can be taken:

- Restructure the contracting process to account for quality of treatment rather than lowest price.
- Specify in contracts the types of inmates who can participate in the program.
- Monitor and report return to custody rates resulting from continued addiction.
- Promote a drug-free prison system including drug testing of inmates and staff as suggested in previous Commission studies.

- ***Develop, promulgate and enforce treatment quality standards.*** The State should require counties to provide evidence-based treatments. The State should disseminate evidence-based best practices for each treatment modality. ADP should convene a group of providers, stakeholders, accrediting organizations and others to validate the goals of treatment, performance standards and outcome measures developed during the occupational analysis. The director should be required to report publicly on ineffective treatment programs.

- ***Tie provider reimbursement to outcomes.*** After establishing performance benchmarks and implementing CalOMS, the department should reward high-quality treatment providers with higher rates of reimbursement. Providers continually failing to meet specified outcomes should have their funding terminated.

- ***Ensure safe and suitable treatment facilities.*** The State should expand facility licensing to include outpatient facilities. An accreditation process similar to that used by the Joint Council on Accreditation of Hospital Organizations (JCAHO) or other accrediting organizations should be developed and implemented.

Treatment Works… But Is Not Enough

Finding 4: To be effective, substance abuse treatment must be coordinated and integrated with other social services to effectively reduce the social and financial costs of alcohol and drug abuse.

Substance abuse is a chronic, relapsing illness with many underlying causes. It often is accompanied by mental health, physical health, employment, legal and family problems. Treating the addiction alone is often insufficient. Recovery requires access to a full continuum of client-focused services.[157] These services are usually provided by different organizations, in different locations, with different eligibility rules. While most services are tax-supported, they are not unified or coordinated to ensure that client needs are met and resources are well spent.[158]

Two national studies have documented the potential effectiveness of treatment for drug and alcohol abuse.[159] The studies reported a 48 percent reduction in primary drug use, a 53 percent reduction in alcohol and drug-related medical visits, and an 80 percent reduction in criminal activity. Treatment also resulted in more clients becoming self-sufficient: employment increased 19 percent, welfare dependency decreased by 11 percent, and self-reported homelessness dropped by 43 percent.[160]

But these impressive outcomes were the result of drug treatment integrated with other existing services that supported recovery, and treatment is often a prerequisite to successfully ameliorating these other problems. It is unlikely that an addict will muster the personal resources to improve their health and mental health, complete education or job training, secure and maintain employment, establish and maintain a home, desist from the criminal activity that sustains their habit, and resolve their problems with the criminal justice system.

The associate director of the National Institute on Drug Abuse testified:

Comprehensive treatments that focus on the whole individual, and not just on drug use, have the highest success rates. These programs provide a combination of behavioral treatments, medications, and other services, such as referral to medical, psychological, and social services. The array of services must be tailored to the needs of the individual patient.

Indeed, while the need to provide comprehensive and tailored services is well-documented in research and has long been recognized as essential by professionals in the field, public agencies have struggled to integrate their efforts and improve outcomes for their clients.[161]

California's Response

The State's response to alcohol and drug abuse has been developed incrementally over time. The State attempted to coordinate these efforts with the creation of the Department of Alcohol and Drug Programs in 1978, but the department still does not have authority over all state-sponsored treatment and has limited authority to shape treatment programs at the local level.[162]

The system is even more fractured when viewed from the perspective of the client, who may need the services of several government agencies to recover from addiction and gain control of their lives. Some of their challenges are described in the box below.

Multiple Needs Related to Drugs and Alcohol Abuse

Mental Health. Estimates of co-occurring mental illness range from 30 to 50 percent of identified substance abusers. If only one illness is treated, both usually worsen and added complications often arise.

Health Care. Poor health often accompanies substance abuse because of neglect. Problems include major public health issues such as hepatitis and HIV. San Francisco, for example, reports that 40 percent of homeless young drug injectors suffer from Hepatitis C and 98 percent of older injectors are HIV positive.

Housing. Twenty-one percent of publicly funded substance abuse clients in California are homeless. National studies suggest that alcohol and drug dependence among the homeless is as high as 75 percent. Homeless people have trouble adhering to treatment regimens.

Education and Training. Over one-third of substance abusers entering publicly funded treatment in California lack a high school diploma. Many need to acquire basic literacy skills before they can successfully complete job skills training.

Employment Assistance. Nearly four-fifths of substance abusers entering publicly funded treatment in California are unemployed. Employment is a major predictor of success in treatment.

Legal Assistance. Violence often accompanies alcohol and drug abuse. In Sacramento County, for example, nearly two-thirds (66.5 percent) of arrestees for violent crimes in 2000 tested positive for alcohol or drugs at the time of their arrest. Among those arrested for domestic violence, the percentage who tested positive for alcohol or drugs at the time of their arrest was 69.2 percent.

Social Services. Nationally, parents with alcohol and drug abuse problems constitute as much as 80 percent of child abuse or neglect cases.

Sources: Refer to endnotes 11, 12, 16, 40 and 70. Also, U.S. Department of Justice. ADAM Preliminary 2000 Findings on Drug Use and Drug Markets: Adult Male Arrestees. December 2001.

California has attempted to integrate services, primarily by joining with other agencies on task forces and sponsoring pilot projects that would encourage local agencies to share resources and responsibilities. Some of the efforts:

- ***California System of Care Model (AB377, 1988).*** This model involved a needs assessment, interagency coalitions, family-professional partnerships, and accountability through evaluation of outcomes. Initial results were promising, but the model depended on committed leadership and the willingness of various agencies to collaborate. These weaknesses emerged as leadership changes occurred and the model failed to be institutionalized. [163]

- ***Youth Pilot Program (AB 1741, 1993).*** This project was intended to foster local planning and blend funding to serve high-risk and low-income youth and families. Some barriers to integration have been removed between the State and the six participating counties. Interim reports, however, have not identified how these benefits will be transferred statewide.[164]

- ***Adolescent Drug Treatment Program (AB 1784, 1998).*** This project was designed to increase collaboration among substance abuse treatment and other agencies serving youth. The first report noted some promising approaches and difficulties. Neither the report nor the legislation, however, specifies how the project will be used to change the State's method of funding and providing services.[165]

- ***Parolee Services Network.*** This project provides substance abuse treatment and other services to parolees. The project is limited in scope and availability and has not been evaluated. [166]

- ***Substance Abuse and Crime Prevention Act.*** (SACPA) Proposition 36 requires both drug treatment and other assistance needed to help drug offenders. Initial results are promising and illustrate the effectiveness of integrating various services.

Proposition 36 Supports Service Integration

Los Angeles and Santa Clara County representatives testified that integration of treatment and supportive services was essential to the successful implementation of Proposition 36. Among aspects of Proposition 36 implementation they cited as facilitating service integration were:

1. A shared commitment to collaboration among state and local treatment and criminal justice agencies.
2. Leadership by the courts through the Statewide Proposition 36 Workgroup.
3. Funding that allows the provision of a full continuum of treatment and supportive services without which treatment outcomes would be sharply limited.
4. Special services for dual diagnosis clients (those with both substance abuse and mental illness who require simultaneous rather than sequential treatment for their illnesses.
5. Co-location of all the treatment and supportive services required to address the issues of substance abuse, mental illness, trauma, HIV/AIDS and other health related issues.

- ***Drug Courts.*** Judges use their authority to order services necessary for client success, a back door approach to integrating services that has demonstrated considerable results.

- ***Dual Diagnosis Demonstration Project.*** This project to integrate services resulted from a 1995 Governor's directive that ADP and the Department of Mental Health develop integrated services. The project documented how federal funding restrictions and reporting requirements make integration difficult.

- ***California Work Opportunity and Responsibility to Kids.*** CalWORKs encourages county alcohol and drug programs to work with other agencies to help clients prepare for, obtain and maintain employment. The case management approach has helped clients obtain needed services. The Department of Social Services asserts that cooperation is the most important ingredient for successful implementation.[167]

Unfortunately, pilot projects seldom bring about meaningful change beyond project boundaries. While they satisfy the desire to make improvements, they seldom are systematically evaluated and used to make fundamental changes in how programs are funded, managed or held accountable.

Integrating services delivered by various agencies with different professional orientations and methods – but united by their clientele – requires a common philosophy. It also requires, as one researcher described, "a resource strategy that breaks out of the pilot project mentality to create and carry out a design for going to full scale."[168]

The Barriers to Integration

Most of the pilot projects to integrate services have attempted to get over some fundamental barriers. These barriers are legal and cultural. Some of the barriers are unintended consequences of well-intended policy decisions. No single one of them makes integration impossible. All of them can be changed. While ultimately the goal is to integrate services for children and families struggling with a variety of problems, two fundamental barriers prevent improvement in the drug control field alone.

✓ ***Fragmentation among state agencies.*** In the drug control field alone, the 1991 master plan identified 31 agencies and 100 programs. The expertise and core functions of many agencies may be

needed to serve Californians with a host of troubles. But without a concerted effort, this distribution of responsibilities results in duplicated efforts, gaps in services, higher administrative costs, conflicting and complicated rules and a lack of accountability.

- ✓ ***Categorical funding.*** Federal funds flow from a variety of sources through just as many state agencies: the Attorney General's Office, the Office of Criminal Justice Planning, the departments of health services, social services and drug and alcohol programs. Each funding stream has its own complex rules on who can receive assistance, how the money can be spent, how services must be provided, where services can be provided, and how the money must be tracked.

Toward Service Integration

The complex and fractured nature of social programs evolved over time and incrementally. Unraveling complex rules, exchanging regulation with accountability for outcomes, and building trust also will take time. Still, there are several opportunities for remodeling these programs to better focus on the needs of clients.

- ✓ ***Create a waiver process for counties.*** Allowing counties to integrate service operations and report outcomes in a single reporting format would eliminate the need for counties to operate an integrated services system, then report to multiple state agencies on the use of each separate funding stream.

- ✓ ***Facilitate data sharing among State agencies.*** Most barriers to data sharing are technical or involve privacy concerns. In many cases, these barriers can be overcome so that data can help state agencies, counties and providers make better use of existing resources and tailor services to clients. ADP is working to resolve these problems and deserves the political support necessary to lower these barriers.

LA County Sheriff's Initiative: County Level Service Integration

In November 2000, Los Angeles County Sheriff Leroy Baca established a Community Transition Unit to provide inmates who are military veterans with the educational, vocational, and other life skills to successfully reintegrate into the community. The correctional staff partners with public and private community-based organizations and programs. A discharge plan ensures that inmates connect with community resources upon release.

Substantial reductions in recidivism rates were achieved after the first two years. Custody staff reported a reduction in violent incidents among inmates in the program. There have been no assaults by inmates on staff and correctional staff has not had to use force to secure compliance from an inmate.

Funding comes primarily from inmate welfare funds, mainly profits from inmate long distance phone calls and canteen sales. This funding is threatened, however, by proposed legislation that would transfer these funds to counties for use in planning expanded treatment services for probationers. Funding for these efforts also comes from inmates enrolled in educational programs provided by the local school district. Because ADA for inmate programs is limited to 80 percent of the ordinary reimbursement, the program has difficulty maintaining and equipping classrooms.

Source: Lieutenant McCarty, supervisor, Community Transition Unit, Los Angeles County Century Regional Detention Center. November 7, 2002.

✓ ***Work with federal authorities to increase flexibility.*** Federal agencies responsible for drug treatment funding are moving toward greater flexibility in exchange for performance-based accountability. The State can support and encourage these efforts, and apply lessons learned to other social service programs.

Local Advocacy for Those in Recovery

Tom Aswad began using drugs at age 13. By the time he reached 31, he had developed a $250-a-day heroin habit. Mr. Aswad participated in a successful 28-day treatment program. Unlike many addicts, Mr. Aswad had a supportive wife, a place to live and a successful real estate business to return to after the treatment program. He has been in recovery for 11 years. In addition to his real estate career, Mr. Aswad participates in the Contra Costa County Alcohol and Other Drugs Advisory Board, an organization providing advocacy and leadership at the county level for people in recovery.

The Contra Costa County Alcohol and Other Drugs Advisory Board has successfully:

- ✓ Advocated for the expansion of youth and adult residential treatment services.
- ✓ Educated the Board of Supervisors regarding Proposition 36, resulting in a neutral rather than negative position on the initiative.
- ✓ Facilitated funding for Partners in Recovery Alliance, a consumer group.
- ✓ Reintroduced Narcotics Anonymous meetings in county jails.
- ✓ Educated the public and the Board of Supervisors on the benefits of needle exchanges.
- ✓ Advocated for the progressive use of Proposition 10 funding.

Prior to 1991, this type of county advocacy boards was required by the State. Today, the Contra Costa County Alcohol and Other Drug Advisory Board is an example of what local governments can and should do to improve alcohol and drug treatment in local communities.

Source: Tom Aswad, Testimony to the Little Hoover Commission, May 23, 2002.

✓ ***Align funding with outcomes.*** State funds often allocated based on population density, perceived needs, and other inputs. Allocations seldom describe the desired outcome and future funding is not linked with performance. As a result, the State misses an opportunity to encourage performance and accountability. A focus on outcomes also encourages public agencies, at the state and local levels, to develop whatever partnerships are necessary to achieve goals.

✓ ***Disseminating best practices.*** Some counties and providers have figured out how to best link services to make the most of resources or best serve clients. In many cases, these successes have tapped into private funds or made better use of existing programs. Some of these lessons are informally shared among the counties and providers, but a concerted effort could improve outcomes without additional investment of public funds.

Counties Must Lead

The State can play a critical role in encouraging the integration of services by developing shared goals and focusing on outcomes, thereby enabling local organizations to work together. It is at the county level, however, that the consequences of uncoordinated treatment availability are felt and must be resolved.

Given that counties administer many of the programs that service Californians with addictions and other problems, they can be the nexus for integrating services and identifying for the State what needs to change so that clients can be better served. Counties can:

✓ ***Identify and track desired outcomes.*** Encourage all health, mental health, and social service agencies to identify client-based treatment outcomes that they expect their service providers to accomplish. Those outcomes can be included in contracts with providers and in assessing how to allocate resources. Focusing on outcomes will encourage treatment providers to partner with other service providers to improve the chances that clients will succeed.

✓ ***Identify what data to collect and how to do it.*** Counties can work closely with ADP to ensure that its CALOMS (California Outcome Measuring System) tracking project will collect the information that will allow categorical funding and other restrictions to be replaced with performance-based outcomes. Making CALOMS accessible to all counties will foster accountability by enabling counties to track their own performance and engage in continuous quality improvement.

✓ ***Make future funding dependent upon outcomes.*** Counties could make future funding contingent upon successful outcomes for clients. This approach would reinforce success.

Successful Integration

In addition to providing treatment for drug offenders, Proposition 36 provides unrestricted funding for the supportive services that drug offenders need to achieve and sustain recovery. As described earlier, the initiative has required local agencies, including the courts and law enforcement, to coordinate their efforts to make sure clients receive needed services. By focusing on a high-cost population, the program has the

Building Services Around Clients

SHIELDS For Families began serving families in South Central Los Angeles in 1987 and has grown to include 17 programs serving 900 families. The success of the program is a testament to the determination of Director Kathryn Icenhower to ensure that the families she serves have access to a continuum of comprehensive services that address their multiple needs.

Despite bureaucratic barriers, she has successfully integrated more than 30 public funding sources to provide housing; substance abuse treatment; mental health services; individual, group and family counseling; vocational and educational training; life skills and parenting training; child care; transportation and other services vital to struggling families.

She doesn't hesitate to point out that fragmentation among programs at the state level and categorical funding make difficult the task of pulling together the services necessary to effectively serve her clients. But her program is proof that with leadership and will at the local level, integration of services can be accomplished, even without state reforms.

An independent evaluation of the Shields Exodus Program for addicted parenting and pregnant women showed that 65 percent of clients successfully completed core treatment services. Six-month follow-ups showed that the clients remained drug free, with improvements in family relationships, and no further involvement with Child Protective Services or the criminal justice system. Sixty-six percent of clients were enrolled in school or job training.

Other Shields programs show completion rates between 60 and 83 percent. Outpatient completion rates normally hover around 30 percent.

potential to reduce demands on expensive public services – such as courts and jails – even as it requires the expansion of drug treatment. During its first year, more than 12,000 offenders qualified for SACPA services, and entered treatment at an average cost of about $4,500 each.[169] The program has the potential of saving the costs of incarceration that can run as high as $27,000 per inmate per year. Researchers at UCLA's Integrated Substance Abuse Programs are tracking participants as part of their evaluation of Proposition 36.

In addition to changing the drug control paradigm from enforcement toward treatment, the program could document the benefits of coordinating efforts and tailoring services to the needs of clients.

Ultimately, the job of integrating services will fall to the counties working with providers. The State needs to take a leadership role to encourage counties and lower barriers within its control.

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. Ways to promote integration include:

- ***Replicate and reinforce success.*** The Health and Human Services Agency – or in its absence, the counties – needs to encourage the replication of successful integrated programs by documenting how they work, how they have navigated the system, and training other providers to do the same.
- ***Develop leaders.*** Given that most integration occurs at the hands of individual and inspired leaders, the State should work with counties, professional organizations and foundations to provide formal leadership development for agency managers and service providers.
- ***Create a process and a venue to facilitate change.*** ADP should develop a forum allowing for state and local government, treatment providers, educators and job trainers, mental health providers, and social services personnel to systematically identify and remove barriers to integration. Specifically:
  - ✓ They should identify ways to share data to understand demands on the system and to document performance.
  - ✓ They should identify which measures would most easily increase flexibility in funding, such as a waiver process or a single reporting format, and align funding for all social services with outcomes.
  - ✓ They should detail and prioritize regulatory and legislative changes necessary to streamline and integrate services.

While the State should take on this mission, the counties should do so on their own if necessary.

Expanding Resources for Treatment

Finding 5: Even if the State integrated its drug control efforts and improved alcohol and drug treatment services, as presently funded, available treatment would be inadequate to respond to the costs and misery inflicted on California communities by substance abuse.

Throughout this report the Commission has suggested ways to ensure California is making the best use of available resources to reduce alcohol and drug abuse and addiction.

Finding 1 suggested a mechanism for allocating prevention, treatment and law enforcement funds to the most effective programs within each of these three components of the State's drug control effort, as well as to the most effective approaches among the three components.

Finding 2 identified the need to make the most of available resources by prioritizing treatment for those whose alcohol and drug abuse imposes the greatest social and financial costs on their communities and suggested the State shift resources to intervene earlier with substance abusers.

Finding 3 designated ways to ensure a basic level of quality in treatment programs and advocated that the State define and focus on outcomes to gauge success so that resources can be redirected to the most effective providers.

Finding 4 urged the State to facilitate the integration of treatment services among a variety of social service, health, and mental health agencies and offered ways to promote integration so that clients do not relapse because needed services are not accessible.

The Commission identified three remaining opportunities for the State to enhance resources for alcohol and drug treatment, including:

1. Maximizing all available funds that could support alcohol and drug treatment.
2. Increasing private sector funding for alcohol and drug treatment services.
3. Considering increasing alcohol taxes when treatment providers document that existing resources are well spent.

Within the voluntary treatment system, high demand for services, limited funding and categorical funding limit the availability of treatment for

many who need and want it. Shifting Legislative priorities make treatment funding unpredictable from year to year.

Maximizing All Available Resources

The State does not currently leverage all available federal funds by ensuring that it spends state dollars first to capture every available matching federal dollar that can support alcohol and drug treatment. MediCal, Early Periodic Screening, Detection and Treatment, State Children's Health Insurance Program, Social Security, Social Security Disability and federal foster care funds can all be used for alcohol and drug treatment. Healthy Families funding, for example, requires only a 35 percent state match; Drug MediCal requires 49 percent in state matching funds.

Additional Benefits From Maximizing State Matching Dollars

A study by the advocacy group Families USA, using a US Department of Commerce economic model, concluded that state matching of federal Medicaid dollars provides a powerful stimulus to state economies. Using fiscal year 2001 data for California, for example, the model attributed to MediCal spending $31.5 billion in increased business activity, the creation of 291,439 jobs, and an added $11.4 billion in wages. The model predicts that for every one million dollars California cuts from its current MediCal spending it will forego $2.3 billion in new business activity, 20.75 jobs and $870,000 in lost wages.

Source: *Medicaid: Good Medicine for State Economies.* Families USA Publication No. 03-101. Washington, D.C., January 2003.

The State could coordinate the SAPT Block Grant with Medi-Cal funds to increase and integrate drug treatment and related support services. Iowa pooled funds from these two federal sources to increase access to substance abuse treatment. Results included an increase in treatment provided and corresponding decreases in other social services expenditures.[170] Other states have obtained waivers in order to tap Title IV-E foster care funds for treatment.

Diverting clients from high-cost, acute care settings to more cost-effective out patient settings also can produce significant savings. Massachusetts discovered that they were spending $700 to $800 per day for six-day hospital detoxification treatments for 900 patients each month. Realizing that 85 percent of these clients could receive the same treatment safely in less medically-intensive settings, the state diverted substance abusers from emergency rooms to specialized detoxification centers costing $104 per day. The annual savings of $20 million were used to engage these clients in outpatient care after detoxification, improving outcomes and reducing health care expenditures for this group.[171]

Sometimes services are available, rather than funding. For example, providers of youth treatment services have enlisted school districts to provide teachers at treatment sites. Some substance abuse clinics have obtained county-employed psychiatrists and psychologists to work part

time at their sites, thereby increasing the level of services provided and reimbursement possible.[172] Facilities also may be available. San Francisco has made buildings at the recently closed Treasure Island Naval Base available to several treatment providers.[173]

Reinvest in Treatment

As substance abuse treatment improves, the State could reallocate cost savings from substance abuse treatment successes. Cost savings and cost avoidance figures can justify transfers of funding from agencies reaping these benefits to provide and enhance treatment. The State of Washington has done this using a data system implemented in 1994. It documented that a successful substance abuse client saved the state over $900 dollars per year in reduced health treatment costs. The alcohol and drug program manager secured a portion of these savings from the health department manager to enhance substance abuse treatment programs. California could do the same, with the right data system.

Increasing Private Sector Participation

Few treatment providers pursue payment from clients who could pay for all or a portion of their treatment. This is due in part to a widely-held belief among providers that if a person seeks treatment it should be provided, and the ability to pay is of little consequence. Also, because many counties will deduct client payments from the agreed upon reimbursement to providers, few providers are willing to invest in pursuing payment from clients.

Providing treatment to substance-abusing employees reduces absenteeism, raises productivity and improves workplace safety. A Price-Waterhouse-Coopers study estimated the cost at 50 cents per insured person.[174] The State could shift part of the burden of treatment to employers who would see improved attendance, productivity, and safety.

Employers Acting In Their Own Best Interest

The majority of substance abusers are employed. Employers know that employee substance abuse reduces productivity and raises costs from damaged and stolen property, employee turnover, and worker compensation claims. Some have also realized that they have tremendous leverage with employees to motivate them to accept treatment in order to retain their jobs. Many companies and governmental organizations have established employee assistance plans to help employees deal with substance abuse issues. Employer sponsored health plans are the major source of funding for this group, but many employees are afraid to access them for fear of losing their jobs. Employers need to convince their substance-abusing employees that it is to their benefit, not detriment, to avail themselves of the help available through these programs. They also need to ensure that the substance abuse treatment benefits offered are sufficient to provide quality care.

Unfortunately, the trend in substance abuse benefits is downward. Between 1988 and 1998, the value of employer provided health care benefits declined 14.2 percent as a result of the shift towards managed care. The value of addiction treatment benefits during this period declined 74.5 percent.

Sources: National Drug Control Strategy. The White House. February 2002. *Employer Health Care Dollars Spent on Addiction*, The Hay Group, Press Release May 2002. *Hazelden Survey Reveals U.S. Employees Fear Loss of Job if They Seek Drug Treatment.* Hazelden Foundation, Minneapolis, Minnesota. Press Release October 15, 2002.

Health plans in the Public Employees Retirement System (PERS) allow 20 outpatient visits per year for substance abuse treatment. But the research shows that clients on average need at least two to three sessions over 12 weeks to achieve sobriety. Few clients benefit from the currently allowed 20 outpatient visits. MediCal substance abuse treatment benefits and those of many employers are based on the PERS standard. The State could modify the PERS standard to increase client success and encourage other providers to follow suit.

Kaiser-Permanente has implemented a managed care model for substance abuse treatment that includes a complete continuum of services. It found that this approach contains costs by identifying and treating substance abuse early when clients are easier to treat and more likely to sustain recovery.[175]

New Sources of Revenue

Nationally, the human and economic costs of alcohol abuse are estimated at more than $166 billion a year, exceeding the costs of drug abuse and smoking.[176] The Trauma Foundation estimates the economic costs annually to California from alcohol abuse and alcoholism at $14.8 billion. Alcohol-related trauma is a leading cause of death and serious injury, with more than 100,000 deaths attributed to alcohol consumption each year. More than one-third of Americans reported that alcohol has caused problems in their immediate family.[177]

A study sponsored by the Office of Juvenile Justice and Delinquency Prevention estimated the economic costs of alcohol use by young people at $52.8 billion in 1996 – mostly due to traffic crashes and violent crime.[178]

A relatively small percentage of heavy drinkers account for the majority of alcohol sales. Among youth, most abstain from drinking, but about 8 percent of 15- to 17-year-olds report frequent binge drinking – accounting for 62 percent of the alcohol consumed by their age group and the majority of the $10 billion national youth alcohol market.[179] These young people are future adult alcohol consumers, bearing and exacting the human and economic consequences of abuse and addiction.

Research by the Center for Science in the Public Interest shows that increasing the price of alcohol is the most effective strategy for reducing youthful consumption and related problems, including violence and crime. Alcohol taxes increase the price and can provide revenue to expand the availability of alcohol and drug prevention and treatment.

Linking Responsibility to Treatment

Advocates for increasing alcohol taxes assert that the alcohol industry should be required to pay its fair share of the societal costs of alcohol consumption and that alcohol taxes have not kept pace with inflation over the last three decades.

California last raised alcohol taxes in 1991 for the first time in two decades. The increase was enacted following the failure in 1990 of Proposition 134, an initiative to raise alcohol taxes, commonly known as the "Nickel-a-Drink" initiative. Faced with fierce opposition from the alcohol industry and competing ballot measures, the initiative was defeated 69 percent to 31 percent. Despite the loss at the polls, the campaign gave the issue new visibility and public support. Six months after the defeat of the measure, poll results published in the Los Angeles Times showed that 83 percent of respondents supported alcohol tax increases, higher than before the campaign. The following year policy-makers raised taxes by approximately a penny a drink – the amount advocated by the alcohol industry in a ballot measure it proposed as an alternative to Proposition 134.

Analysts note that the revenue from California alcohol excise taxes falls far short of the economic costs of alcohol addiction. For every alcohol excise tax dollar collected by California there are $51 in costs. For every excise tax dollar collected as a result of a youth alcohol sale there are approximately $230 in costs.[180]

It is estimated that California young people spend $1 billion per year on alcohol, with beer producers the major beneficiaries of those expenditures.[181] Young people overwhelmingly identify beer and coolers, which are mostly produced by beer companies, as their beverages of choice and beer companies aggressively target their advertising to the youth market. Increasingly, distilled spirits' manufacturers are developing and marketing products that appeal to the youth market.

Recent Efforts to Tax Alcohol

Polls show that voters support increasing alcohol taxes if the revenue is dedicated to addressing alcohol problems. Advocates in California have proposed legislation to impose a fee on beer and distilled spirits' makers, a strategy designed to overcome the opposition of the alcohol industry and two-thirds vote requirement in the Legislature to approve a tax increase. Legislation to impose a fee would require only a majority vote. As the proposal is currently crafted, the fees would be based on each company's share of the youth alcohol market and be dedicated to youth alcohol prevention and treatment programs. California law imposed a

similar fee on paint producers and was upheld by the Supreme Court because the revenues were dedicated to addressing the harm caused by lead in the paint.

Alcohol Taxes Reduce Problems

The link between alcohol taxes and reduced alcohol problems – particularly among youth – is well established in the literature. Among the findings:

- If the federal excise tax on beer had been increased by 84 cents per six pack (the amount necessary to offset inflation between 1951 and 1990), heavy drinking among high school seniors would have dropped by 19 percent and binge drinking by 6.5 percent.
- A similar increase would have reduced alcohol-related motor vehicle crashes and saved more than 2,000 lives each year.
- Higher beer taxes are linked to reductions in the rates of youth violence and violence by adults against children.
- A 10 percent increase in the federal beer excise tax would reduce severe domestic violence by 2.3 percent.

Source: James F. Mosher and Andrew McGuire, written testimony to the Little Hoover Commission, September 26, 2002.

Alaska and Puerto Rico recently enacted substantial increases in alcohol excise taxes. Legislation has been proposed in eight other states including California where lawmakers are considering a proposal to impose a nickel per drink fee on wholesalers of alcoholic beverages. The revenue would be dedicated to emergency and trauma centers. In most other states considering excise tax increases, the revenues would be dedicated to addressing large budget deficits, not treatment programs. According to the Anheuser-Busch Company, it helped defeat legislation to raise taxes on beer in 11 states.[182]

While tax increases are generally unpopular, polls suggest that the public would support increases in alcohol taxes if they were dedicated to addressing alcohol-related problems.[183] Alcohol taxes have not been raised substantially in California in three decades and the cost of alcohol is low. But the human and economic costs of underage drinking and its related problems are high, including traffic crashes, violent crime, traumatic injury, suicide, and alcohol dependence and abuse.

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.

- ***Make the most of available federal funds.*** The State and counties should ensure that they are using all available matching funds to leverage federal dollars – including Medi-Cal, Early Periodic Screening, Detection and Treatment, State Children's Health Insurance Program, Social Security and Social Security Disability, and federal foster care funds. The State also should explore the possibility of a federal waiver on the use of Title IV-E foster care funds for alcohol and other drug treatment.

- ***Seek reimbursement from clients.*** The State should provide incentives to counties to seek reimbursement from clients based on their ability to pay for treatment.
- ***Reinvest in treatment.*** The State should reallocate cost savings from substance abuse treatment successes. Cost savings and cost avoidance figures should be used to guide transfers of funding from agencies with reduced demands to expand treatment opportunities.
- ***Expand private sector participation.*** The State should demonstrate to employers and private sector health insurers the benefits of providing adequate coverage for alcohol and drug treatment. The State also should reform the Public Employees Retirement System treatment standard to create a model for employer-based benefits.
- ***Identify new sources of revenue.*** Once policy-makers are confident that resources devoted to treatment are being well spent, they should explore ways to generate revenue from the sale of alcoholic beverages to fund treatment, including increasing alcohol excise taxes or instituting a fee on beer and distilled spirits' producers to fund youth treatment.

Conclusion

In reviewing the State's response to drug and alcohol abuse and addiction, the Commission reached two conclusions. First, California needs to develop a strategy for refocusing all resources spent on drug and alcohol control – whether by prevention, treatment or law enforcement programs – on those efforts that are most effective at reducing the costs and misery of abuse and addiction. Second, California needs to improve and expand substance abuse treatment programs to competently serve those who need treatment.

Substance abuse compounds most of our social ills, and imposes tremendous burdens on public programs, private ventures and personal lives. These problems cannot be efficiently addressed by isolated efforts that persist based on tradition or belief rather than actual performance. Prevention, treatment and law enforcement must all play a role, but the allocation of resources and the specific activities of each must be guided by the documented ability to reduce their consequences of addiction. The Commission believes that a council – comprised of state and local leaders dedicated to the common purpose of reducing the consequences of addiction – could bring greater discipline to the policies that are established and the programs that are implemented to pursue this overarching goal.

The public's support for treatment as an alternative to incarceration for drug offenders demonstrates that Californians want to solve this problem by the most cost-effective means, and in ways that heal individuals and protect communities. Proposition 36 by itself, however, cannot effect this change. While ambitious, the initiative is limited in scope. Policy-makers should not wait for another initiative to align other state resources and programs to the publicly endorsed policy of treating individuals whose addiction is the basis for their troubles.

The evidence is overwhelming that treatment – which has long been under-funded and undervalued in the fight against drug and alcohol abuse – can be a cost-effective tool for reducing abuse and addiction. The knowledge and technology are now available to sharpen this tool: to tailor services to individual needs using proven treatment methods, to ensure skilled staff, and to measure progress. As the quality of treatment improves and lives are changed, the savings accrued in prison and other budgets should be reinvested in successful treatment programs.

If the State truly wants to address this scourge, leaders will have to change the way they do business. Community leaders must understand

how addiction is hurting their communities, accept and support treatment providers, and rally public and private resources to support those who offer healing and hope to substance abusers and their families. Treatment providers and administrators must seize every opportunity to improve quality and achieve desired outcomes. State leaders must work together to best use all available resources for the common goal. And policy-makers must challenge both government and the private sector to overcome stigma and address addiction.

These recommendations presage a new role for the State. The State will have to set clear goals and develop evidence-based standards. It will have to provide flexible funding to counties and hold counties accountable for outcomes. This approach will require the State to continuously assess the effectiveness of each aspect of its strategy, and be willing to realign resources to where they will do the most good.

Appendices & Notes

- ✓ *Public Hearing Witnesses*
- ✓ *Advisory Committee*
- ✓ *Workgroup Participants*
- ✓ *Subcommittee Meetings with Treatment Providers*
- ✓ *Notes*

Appendix A

Little Hoover Commission Public Hearing Witnesses

Witnesses Appearing at Little Hoover Commission Alcohol & Drug Abuse Treatment Hearing On April 25, 2002

Timothy P. Condon, Ph.D.
Associate Director
National Institute on Drug Abuse
National Institutes of Health

Alice Gleghorn, Ph.D., Director of Research, Epidemiology and Grants
Community Substance Abuse Services
San Francisco Department of Public Health

Amalia Gonzalez del Valle
Project Director
Contra Costa Substance Abuse Services Division

Dellena Hoyer-Johnson
The Effort

C. Kathryn Icenhower, Ph.D.
Executive Director
SHIELDS for Families Project, Inc.

A. Thomas McLellan, Ph.D., Director
Treatment Research Institute
University of Pennsylvania

Toni J. Moore
Director, Alcohol and Drug Programs
Sacramento County Department of Health & Human Services

Verdia Nix

David W. Rinaldo, Ph.D., Partner
SGR Health, Ltd. And The Avisa Group

Witnesses Appearing at Little Hoover Commission Alcohol & Drug Abuse Treatment Hearing On May 23, 2002

Richard Browne
Director of Program Development & Technical Assistance
Los Angeles County Department of Health Services

Karen S. Dalton, DrPH, CJM
Director, Correctional Services Division
Los Angeles County Sheriff's Department

Suzanne Gelber, Ph.D., President
SGR Health, Ltd. And The Avisa Group

Gary Jaeger, M.D., President
California Society of Addiction Medicine

Kathryn Jett, Director
Department of Alcohol & Drug Programs

John D. Larson, Deputy Director
Department of Alcohol & Drug Programs
Santa Clara County

Douglas Longshore, Ph.D.
Research Sociologist
Integrated Substance Abuse Programs
UCLA Department of Psychiatry and Biobehavioral Sciences

Stephen V. Manley, Judge
Superior Court
County of Santa Clara

Tina Nunes Ober
Deputy District Attorney
Santa Clara County District Attorney's Office

Michael Prendergast, Ph.D.
UCLA Integrated Substance Abuse Programs
Criminal Justice Research Group

Richard A. Rawson, Ph.D.
Associate Director
UCLA Integrated Substance Abuse Programs

Gary Sanchez
Deputy Probation Officer
Santa Clara County Probation Department

Witnesses Appearing at Little Hoover Commission Alcohol & Drug Abuse Treatment Hearing On September 26, 2002

Victor Capoccia, Ph.D., Program Officer
Substance Abuse Policy Research Program
Robert Wood Johnson Foundation

George J. Doane, Deputy Director
Division of Law Enforcement
California Department of Justice

Michael Falasco, Legislative Liaison
Wine Institute

James P. Gray, Judge
Orange County Superior Court

Melody Heaps, President
Treatment Alternatives for Safe Communities

Martin Iguchi, Ph.D., Director
Drug Policy Research Center, RAND

Bill Kelly, Commander
Sacramento County Sheriff's Department
Narcotics Unit

Patrick N. Lunney, Director
Division of Law Enforcement
California Department of Justice

Andrew McGuire, Executive Director
Trauma Foundation

Joseph D. McNamara, Ph.D.,
Research Fellow
Hoover Institution, Stanford University

James Mosher, J.D.
Senior Program Director
Division of Legal Policy Analysis
Pacific Institute for Research and Evaluation

Rosalie Pacula, Ph.D., Economist
Drug Policy Research Center, RAND

Allen Sawyer, Interim Executive Director
Governor's Office of Criminal Justice Planning

Appendix B

Little Hoover Commission Alcohol & Drug Abuse Treatment Advisory Committee

The following people served on the Alcohol & Drug Abuse Treatment Advisory Committee. Under the Little Hoover Commission's process, advisory committee members provide expertise and information but do not vote or comment on the final product. The list below reflects the titles and positions of committee members at the time of the advisory committee meetings in 2002.

Daniel N. Abrahamson
Director of Legal Affairs
Drug Policy Alliance

Sarah Angel, Assembly Fellow
Assemby Budget Committee
Assembly Member Jenny Oropeza

Gayl M. Anglin, Ph.D.
UCLA Integrated Substance Abuse Programs

Judy Appel
Deputy Director of Legal Affairs
Drug Policy Alliance

Tom Aswad, Member
Contra Costa Alcohol and Other Drugs Advisory Board

Susan Blacksher, Executive Director
California Association of Addiction Recovery Resources

Verda Bradley, Ph.D, LCSW
Dual Diagnosis Services
Department of Mental Health
Los Angeles County

Michael K. Brady, Consultant to Senator John Burton

Ed Carlson
Substance Abuse Program Officer
Charles and Helen Schwab Foundation

Alexandra Cox
Drug Policy Alliance

Sherry Daley, Public Policy Coordinator
California Association of Alcoholism and Drug Abuse Counselors

Karen S. Dalton, DrPH, CJM, Director
Correctional Services Division
Los Angeles County Sheriff's Department

David Deitch, Ph.D.
Clinical Professor of Psychiatry/Director
Addiction Training Center
University of California, San Diego

Carmen Delgado
Assistant Deputy Director
Program Operations Division
Department of Alcohol and Drug Programs

Steve De Ross
Assistant Chief Probation Officer
Sacramento County

Chuck Deutschman, Director
Contra Costa County Substance Abuse Services Division

David Farabee, Ph.D.
UCLA Integrated Substance Abuse Programs

David Feinberg, Manager
Residential & Outpatient Programs
Compliance Branch
Department of Alcohol and Drug Programs

Thomas Freese, Ph.D., Co-director
Pacific Southwest Addiction Technology Transfer Center
Integrated Substance Abuse Programs, UCLA

Venus L. Garth, Chief
Work Services Branch, Welfare to Work Division
Department of Social Services

Suzanne Gelber, Ph.D., President
SGR Health, Ltd. And The Avisa Group

Brian Greenberg, Ph.D.
Vice President & Director of Development
Walden House

Christine Grella, Ph.D.
Associate Research Psychologist
UCLA Drug Abuse Research Center

Frederick Heacock, Deputy Director
Alcohol, Drug & Mental Health Services, Yolo County

Sharon Jackson, Deputy Director
Parole and Community Services Division
Department of Corrections

Gary Jaeger, M.D., President
California Society of Addiction Medicine

Ross Jamison, Research Consultant
Center on Juvenile and Criminal Justice

Guy Howard Klopp
Policy, Planning, Evaluation Training Manager
Sacramento County Alcohol & Drug Services Division

Victor Kogler, Consultant
Former Director Alcohol and Drug Programs
Santa Barbara County

Jim L'Etoile, Assistant Director
Office of Substance Abuse
Department of Corrections

Daniel Macallair, Vice President
Center for Juvenile & Criminal Justice

Al Medina, Administrator
Alcohol and Drug Programs
San Diego County

Helyne Meshar, Executive Director
CAADPE

Toni J. Moore, Director
Alcohol and Drug Programs
Sacramento County Department of Health & Human Services

Charles Moore, M.D., Medical Director
Chemical Dependency Recovery Program
Kaiser Permanente Medical Group Inc.

Rod Mullen, President & CEO
Amity Foundation

Marcus Nieto
California Research Bureau

Sue North, Chief of Staff
Senator John Vasconcellos

Patrick Ogawa, Director
Los Angeles County Alcohol and Drug Program Administration
Department of Health Services

Joseph Ossmann
Manager, Proposition 36 Unit
Board of Prison Terms

Gary E. Ransom, Judge
Sacramento County Superior Court

Richard A. Rawson, Ph.D.
Associate Director
UCLA Integrated Substance Abuse Programs

Henry Richards, Ph.D.
PBSI/The Washington Institute for Mental Illness Research and Training

David W. Rinaldo, Ph.D., Partner
SGR Health, Ltd. And The Avisa Group

Terry Robinson, Program Director
Children & Family Futures

Al Rodriguez, Manager, Alcohol, Drug & Mental Health Services, Santa Barbara County

Louis Romero
Supervising Assistant Public Defender
Sacramento County Public Defender's Office

Jim Rowland, Chief Probation Officer
Napa County

Suzanne Salazar, Deputy District Attorney
Sacramento County District Attorney's Office

Prentice E. Sanders, Chief of Police
San Francisco Police Department

Del Sayles-Owen
Department of Alcohol and Drug Programs

David Smith, Founder
Haight Ashbury Free Clinics

Elizabeth Stanley-Salazar, MPH
Vice President
Director of Public Policy
Phoenix Houses of California, Inc.

Sushma Taylor, Ph.D., Co-Chair
California Perinatal Treatment Network
Center Point, Inc.

Don Troutman
CSTL, Inc.

Joan Ellen Zweben, Ph.D.,
Executive Director
The 14th Street Clinic & EBCRP
Department of Psychiatry, UCSF

Appendix C

Little Hoover Commission Workgroup Meetings

The following people participated in one or more of the Commission's seven workgroup meetings during the alcohol and drug abuse treatment study. The meetings focused on funding, integration and coordination, capacity, standards and accountability, leadership and public awareness, Proposition 36 and youth.

Funding Workgroup Meeting On June 11, 2002

Venus L. Garth, Chief
Work Services Branch, Welfare to Work Division
Department of Social Services

Frederick Heacock, Deputy Director,
Alcohol, Drug & Mental Health Services
Yolo County

Victor Kogler, Consultant and Former Director Alcohol and Drug Programs
Santa Barbara County

Integration & Coordination Workgroup Meeting On June 20, 2002

Jennifer Cassulo
Executive Assistant
CAADPE

Carmen Delgado
Assistant Deputy Director
Program Operations Division
California Department of Alcohol and Drug Programs

Gary Jaeger, M.D.,President
California Society of Addiction Medicine

Guy Howard Klopp
Policy, Planning, Evaluation Training Manager
Sacramento County Alcohol & Drug Services Division

Al Medina
Administrator
Alcohol and Drug Programs
San Diego County

Charles Moore, M.D.
Medical Director
Chemical Dependency Recovery Program
Kaiser Permanente Medical Group Inc.

Maria Morfin
Program Manager
Sacramento County Alcohol & Drug Services Division

Antonia Taylor
Work Support Services
Department of Social Services

Capacity Workgroup Meeting On July 11, 2002

Susan Blacksher
Executive Director
California Association of Addiction Recovery Resources

Ed Carlson
Substance Abuse Program Officer
Charles and Helen Schwab Foundation

Sherry Daley
Public Policy Coordinator
California Association of Alcoholism and Drug Abuse Counselors

Warren Daniels, CADC Chairman
CCBADC

Carmen Delgado, Assistant Deputy Director
Program Operations Division
Department of Alcohol and Drug Programs

Gary Dunlap,CADC Executive Director
CAADAC

David Feinberg, Manager
Residential & Outpatient Programs
Compliance Branch
Department of Alcohol and Drug Programs

Thomas Freese, Ph.D., Co-director
Pacific Southwest Addiction Technology Transfer Center
Integrated Substance Abuse Programs, UCLA

Guy Howard Klopp
Policy, Planning, Evaluation Training Manager
Sacramento County Alcohol & Drug Services Division

Rebecca Lira
Deputy Director of Licensing & Certification
Department of Alcohol and Drug Programs

David W. Rinaldo, Ph.D., Partner
SGR Health, Ltd. And The Avisa Group

Al Rodriguez, Manager
Alcohol, Drug & Mental Health Services
Santa Barbara County

Trisha Stanionis, Execuitve Director
The Effort

Elizabeth Stanley-Salazar, MPH
Vice President
Director of Public Policy
Phoenix Houses of California, Inc.

Standards & Accountability Workgroup Meeting On July 18, 2002

Daniel N. Abrahamson
Director of Legal Affairs
Drug Policy Alliance

Verda Bradley, Ph.D, LCSW
Dual Diagnosis Services
Department of Mental Health
Los Angeles County

Jennifer Cassulo
Executive Assistant
CAADPE

Carmen Delgado
Assistant Deputy Director
Program Operations Division
Department of Alcohol and Drug Programs

David Feinberg, Manager
Residential & Outpatient Programs
Compliance Branch
Department of Alcohol and Drug Programs

Beth Finnerty, MPH
UCLA Integrated Substance Abuse Programs

Frederick Heacock, Deputy Director
Alcohol, Drug & Mental Health Services, Yolo County

Victor Kogler, Consultant
Former Director Alcohol and Drug Programs
Santa Barbara County

Christopher Lewis
Licensing & Certification Division
Department of Alcohol & Drug Programs

Charles Moore, M.D.
Medical Director
Chemical Dependency Recovery Program
Kaiser Permanente Medical Group Inc.

Public Awareness & LeadershipWorkgroup Meeting On July 31, 2002

Tom Aswad, Member
Contra Costa Alcohol and Other Drugs
Advisory Board

Ed Carlson
Substance Abuse Program Officer
Charles and Helen Schwab Foundation

Michael Cunningham
Department of Alcohol and Drug Programs

Carmen Delgado, Assistant Deputy Director
Program Operations Division
Department of Alcohol and Drug Programs

Venus L. Garth, Chief
Work Services Branch, Welfare to Work
Division
Department of Social Services

Gary Jaeger, M.D., President
California Society of Addiction Medicine

Les Johnson
Department of Alcohol and Drug Programs

Guy Howard Klopp
Policy, Planning, Evaluation Training
Manager
Sacramento County Alcohol & Drug
Services Division

Patrick Ogawa, Director
Los Angeles County Alcohol and Drug
Program Administration
Department of Health Services

Richard A. Rawson, Ph.D.
Associate Director
UCLA Integrated Substance Abuse
Programs

Terry Robinson, Program Director
Children & Family Futures

Del Sayles-Owen
Department of Alcohol & Drug Programs

Sushma Taylor, Ph.D., Co-Chair
California Perinatal Treatment Network
Center Point, Inc.

Don Troutman
CSTL, Inc.

Proposition 36 Workgroup Meeting On July 31, 2002

Daniel N. Abrahamson
Director of Legal Affairs
Drug Policy Alliance

Gayl M. Anglin, Ph.D.
UCLA Integrated Substance Abuse
Programs

Judy Appel
Deputy Director of Legal Affairs
Drug Policy Alliance

Ed Carlson
Substance Abuse Program Officer
Charles and Helen Schwab Foundation

Alexandra Cox
Drug Policy Alliance

Carmen Delgado, Assistant Deputy Director
Program Operations Division
Department of Alcohol and Drug Programs

Sharon Jackson, Deputy Director
Parole and Community Services Division
Department of Corrections

Jim L'Etoile, Assistant Director
Office of Substance Abuse
Department of Corrections

Rod Mullen, President & CEO
Amity Foundation

Patrick Ogawa, Director
Los Angeles County Alcohol and Drug Program Administration
Department of Health Services

Joseph Ossmann
Manager, Proposition 36 Unit
Board of Prison Terms

Gary E. Ransom, Judge
Sacrmento County Superior Court

Richard A. Rawson, Ph.D.
Associate Director
UCLA Integrated Substance Abuse Programs

Terry Robinson
Program Director
Children & Family Futures

Louis Romero
Supervising Assistant Public Defender
Sacramento County Public Defender's Office

Suzanne Salazar
Deputy District Attorney
Sacramento County District Attorney's Office

Del Sayles-Owen
Department of Alcohol and Drug Programs

Craig Toni, Parole Agent III
Parole and Community Services Division
Department of Corrections

Youth Workgroup Meeting On August 20, 2002

Verda Bradley, Ph.D, LCSW
Dual Diagnosis Services
Department of Mental Health
Los Angeles County

Ed Carlson
Substance Abuse Program Officer
Charles and Helen Schwab Foundation

Carmen Delgado
Assistant Deputy Director
Program Operations Division
California Department of Alcohol and Drug Programs

David Farabee, Ph.D.
UCLA Integrated Substance Abuse Programs

Venus L. Garth, Chief
Work Services Branch, Welfare to Work Division
Department of Social Services

Brian Greenberg, Ph.D.
Vice President & Director of Development
Walden House

Sue Heavens
Youth Treatment Analyst
OPSA
Department of Alcohol & Drug Programs

Guy Howard Klopp
Policy, Planning, Evaluation Training Manager
Sacramento County Alcohol & Drug Services Division

Martin Prisco
Department of Alcohol & Drug Programs

Ruth Range
League of Women Voter's
Children's Lobby

Terry Robinson
Program Director
Children & Family Futures

Elizabeth Stanley-Salazar, MPH
Vice President
Director of Public Policy
Phoenix Houses of California, Inc.

Appendix D

Little Hoover Commission Subcommittee Meetings with Alcohol and Drug Abuse Treatment Providers

On October 15, 2002, the Commission's alcohol and drug abuse treatment subcommittee met in San Francisco to tour facilities and meet with treatment providers. The subcommittee also met with leaders from Community Substance Abuse Services, San Francisco Department of Public Health. On November 7, 2002, the Commission met with officials from the Los Angeles County Sheriff's Department, toured the Century Regional and Twin Towers Correctional Facilities and met with offenders in various programs at the facilities. Commissioners also toured a transitional housing facility and met with representatives from a treatment provider in Compton, California. Participants included:

Walden House, Project Sister Kin, San Francisco, October 15, 2002

Erica Chambre, Manager, Adolescent Mental Health Services, Walden House

Jackie Chambers, Manager, Project Sister Kin, Walden House

Carol Chapman, Program Analyst, San Francisco Department of Public Health, Community Substance Abuse Services

Brian Greenberg, Ph.D., Vice President and Director of Development, Walden House

Jack Malan, Director, Adolescent Services, Walden House

The Young Women of Project Sister Kin

Community Substance Abuse Services, San Francisco Department of Public Health October 15, 2002

Darryl Burton, Director of Operations and Community Services, San Francisco Department of Public Health, Community Substance Abuse Services

Alice Gleghorn, PhD., Director of Research, Epidemiology and Grants, San Francisco Department of Public Health, Community Substance Abuse Services

Jorge Partida, M.D., Director, San Francisco Department of Public Health, Community Substance Abuse Services

Haight Ashbury Free Clinics, San Franciso, October 15, 2002

Rudy Aguilar, Program Analyst, San Francisco Department of Public Health, Community Substance Abuse Services

John DeDomenico, Clinical Supervisor, Detox Programs, Haight Ashbury Free Clinics, Inc.

Benjamin M. Eiland, MA, CEAP, CATS, Director, Substance Abuse Treatment Services, Haight Ashbury Free Clinics, Inc.

Frank Staggers, M.D., Medical Director, Substance Abuse Treatment Services, Haight Ashbury Free Clinics, Inc.

Matt Rowe, Center Manager, Youth Outreach Team, Haight Ashbury Free Clinics, Inc.

Century Regional Detention Facility, Lynwood, California, November 7, 2002

Karen S. Dalton, DrPH., Director, Correctional Services Division, Los Angeles County Sheriff's Department

Angel Gonzalez

Dale M. Gulley, Sergeant, Community Transition Unit, Los Angeles County Sheriff's Department

Robert K. Hudson, Lieutenant, Inmate Services Unit, Los Angeles County Sheriff's Department

Terence L. McCarty, Lieutenant, Century Regional Detention Facility, Los Angeles County Sheriff's Department

Arthur Torres

Steve Worthen

Monica Yonthers, U.S. Veteran's Administration

The men participating in the Veteran's Module Program at the Century Regional Detention Facility

Twin Towers Correctional Facility, Los Angeles, November 7, 2003

Leroy D. Baca, Sheriff, Los Angeles County

Karen S. Dalton, DrPH., Director, Correctional Services Division, Los Angeles County Sheriff's Department

Dale M. Gulley, Sergeant, Community Transition Unit, Los Angeles County Sheriff's Department

Robert K. Hudson, Lieutenant, Inmate Services Unit, Los Angeles County Sheriff's Department

Terence L. McCarty, Lieutenant, Los Angeles County Sheriff's Department

Al A. Scaduto, Chief, Correctional Services Division, Los Angeles County Sheriff's Department

Addelle Hutak, Site Administrator, Hacienda La Puente Unified School District, Correctional Education Division

The women participating in the Correctional Education Program at the Twin Towers Correctional Facility

Exodus, SHIELDS for Families Project, Inc., Compton, California , November 7, 2002

The following representatives from SHIELDS for Families Project, Inc. met with the Commission at the Exodus facility in Compton, California:

Robert Alvarado, After Care Counselor, Proposition 36 Program

Darnell Bell, Director of Youth Services

Candace Benton-Lawson, Program Manager, Intake and Assessment

Bree Davis, Program Manager, Eden

Kathryn Icenhower, Ph.D., Executive Director

Louis Jacinto, Contracts Administrator/Housing Coordinator

Jane Lamothe, Director of Quality Assurance

Charlotte Mims, Intake and Assessment Specialist

Corliss Perry, Program Manager, Exodus

Alison Quals, Program Manager, Genesis

Lenora Robinson, After Care Coordinator

Charlene Smith, Program Manager, Healthy Start

Teresa Stevenson, Clinical Coordinator

Sara Tienda, Director of Mental Health

Also attending: Sarah Angel, Assembly Fellow, Assemblymember Jenny Oropeza's Office

Notes

1. Jacqueline Carrigan, Ph.D., Institute for Social Research, California State University, Sacramento. November 21, 2002. "Violent Crime Linked to Drug and Alcohol Abstinence for Sacramento Arrestees."

2. Dean R. Gerstein, Robert A. Johnson, Natalie Suter and Kathryn Malloy, National Opinion Research Center, University of Chicago and Henrick J. Harwood and Douglas Fountain, Lewin-VHI, Inc. April 1994. "Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA)". National Opinion Research Center, University of Chicago. Pages i-v. RAND. Spring 1995. Treatment Effective (But Unpopular) Weapon Against Drugs. Page 1.

3. The White House Office of National Drug Control Policy. September 2001. "Economic Costs of Substance Abuse in the United States 1992-1998." Drug Strategies. 2002. "Denver: On the Horizon, Reducing Substance Abuse and Addiction." The $373 billion figure is based on an update of the 1992 Economic Costs of Drug and Alcohol Abuse in the United States, published by the National Institute on Drug Abuse (NIDA) & National Institute on Alcohol Abuse and Alcoholism (NIAAA). In September 2001, the Office of National Drug Control Policy published an update to the NIDA study on the costs of illicit drug abuse and addiction, estimating the annual costs at $160.6 billion in 2000. The corresponding data on alcohol abuse and addiction was not updated. Researchers at Drug Strategies, using population and inflation figures, estimated the economic impact of alcohol in 2000 to be $212.6 billion.

4. Kathryn P. Jett, Director, Department of Alcohol & Drug Programs. May 23, 2002. Written testimony to the Commission.

5. Office of the Governor. November 19, 2002. "Governor Davis Announces State to Increase Driver Safety Enforcement During the Holidays." California Highway Patrol. October 19, 2001. "2000 Annual Report of Fatal and Injury Motor Vehicle Traffic Collisions."

6. The White House Office of National Drug Control Policy. September 2001. "Economic Costs of Substance Abuse in the United States 1992-1998." Drug Strategies. 2002. "Denver: On the Horizon, Reducing Substance Abuse and Addiction." The $373 billion figure is based on an update of the 1992 Economic Costs of Drug and Alcohol Abuse in the United States, published by the National Institute on Drug Abuse (NIDA) & National Institute on Alcohol Abuse and Alcoholism (NIAAA). In September 2001, the Office of National Drug Control Policy published an update to the NIDA study on the costs of illicit drug abuse and addiction, estimating the annual costs at $160.6 billion in 2000. The corresponding data on alcohol abuse and addiction was not updated. Researchers at Drug Strategies, using population and inflation figures

7. Carmen Delgado, Assistant Deputy Director, Alcohol & Drug Programs. February 6, 2003. Personal communication.

8. Drug Policy Alliance. July 1, 2002. "Proposition 36 One-Year Progress Report."

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