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

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

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

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

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1. Ensure access to treatment for every addict

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

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

4. Ensure high treatment standards for all providers

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

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

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

Research Evidence to Support CADA's Seven-Point Plan

1. ENSURE ACCESS TO TREATMENT FOR EVERY ADDICT

CADA's Position:

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

Supporting Information:

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

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

According to estimates from the 2001 National Household Survey on Drug Abuse (now called the National Survey on Drug Use and Health), California had the highest percentage treatment gap in 2000-2001, at 2.7% of all persons age 12 or older (Wright, 2003). California also had the largest number of persons age 12 or older in the treatment gap, approximately 708,000, or 15.6% of the total for the United States (Wright, 2003).

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

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

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

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

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

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

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

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

CADA's Position:

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

Supporting Information:

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

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

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

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

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

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

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

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

CADA's Position:

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

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

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

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

Governor Schwarzenegger's FY 2006/07 budget proposes only $120 million continuation funding for Proposition 36, the Crime Prevention and Substance Abuse Prevention Act of 2000. This is the same amount that was allocated for each of the five years specified in the original initiative passed by the voters in 2000. The Governor's proposed level of funding does not adjust for inflation, increased caseloads, or for increases in costs to provide services that are mandated by new state regulations nor for the increased cost of implementing the above reforms should they be adopted.

Supporting Information:

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

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

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

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

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

Supporting Information:

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

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

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

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

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

Expanding Drug Courts

Supporting Information:

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

"Drug courts have been more successful than other forms of community supervision in closely supervising drug offenders in the community through frequent monitoring and

close supervision including mandatory frequent drug testing, placing and retaining drug offenders in treatment programs, providing treatment and related services to offenders who have not received such services in the past, generating actual and potential cost savings and substantially reducing drug use and recidivism while offenders are in the program (Belenko, 1998)."

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

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

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

"Past research has generally shown that drug courts are reaching their target offenders and that program participants are rearrested at a lower or equivalent rate than comparison offenders. Few analyses have been conducted to test the relative effects of different drug court elements, however. The current research takes a closer look at the two main components of the drug court, supervision and treatment, to determine whether one is more effective at preventing failure, or whether the combination of both is necessary to observe a decreased risk of failure. Attending treatment significantly decreased the risk of failure over a two-year follow-up period, while receiving supervision did not. Offenders who received both supervision and treatment had the longest survival times, but not significantly longer than those who received treatment only (Banks and Gottfredson, 2003)."

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

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

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

Expanding in-custody treatment

Supporting Information:

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

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

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

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

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

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

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

4. ENSURE HIGH TREATMENT STANDARDS FOR ALL PROVIDERS

CADA's Position:

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

Supporting Information:

The California Department of Alcohol and Drug Programs has finalized a set of counselor certification regulations (available at www.adp.cahwnet.gov/lcb/pdf/Final_Regulations.pdf). The counselor certification regulations specifically name ten counselor certifying organizations for the purpose of certifying and credentialing alcohol and drug counselors in California. The ten specific counselor certifying organizations are listed alphabetically below:

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

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

The California Department of Alcohol and Drug Programs recently convened a committee known as the Counselor Certification Advisory Committee (CCAC). The CCAC has been created to provide recommendations to Kathryn Jett, Director of CA ADP, during the implementation of the ADP Counselor Certification Regulations. Through members' on-going professional involvement in alcohol and other drug abuse treatment, the CCAC will provide input on maintaining quality standards, education, training, and experience for those seeking to obtain certification as an addiction counselor. In addition, the CCAC will identify current and emerging issues and propose recommendations based on input from ADP stakeholders. Thomas Freese, Ph.D., PSATTC Director is the Chair of the CCAC. The first meeting was held in January 2006, and subsequent meetings will be held on a quarterly basis.

Additional Information:
According to figures from the U.S. Bureau of Labor Statistics, an estimated 6,920 Californians were employed as substance abuse counselors in 2001. This corresponds to a state rate of

2.01 substance abuse counselors per 10,000 CA residents, which is slightly lower than the national average of 2.2 counselors per 10,000 U.S. residents (http://www.bls.gov).

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

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

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

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

CADA's Position:

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

Supporting Information:

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

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

CADA's Position:

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

Supporting Information:

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

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

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

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

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

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

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

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

Recommendation 1:

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

Recommendation 2:

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

Recommendation 3:

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

Recommendation 4:

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

Recommendation 5:

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

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