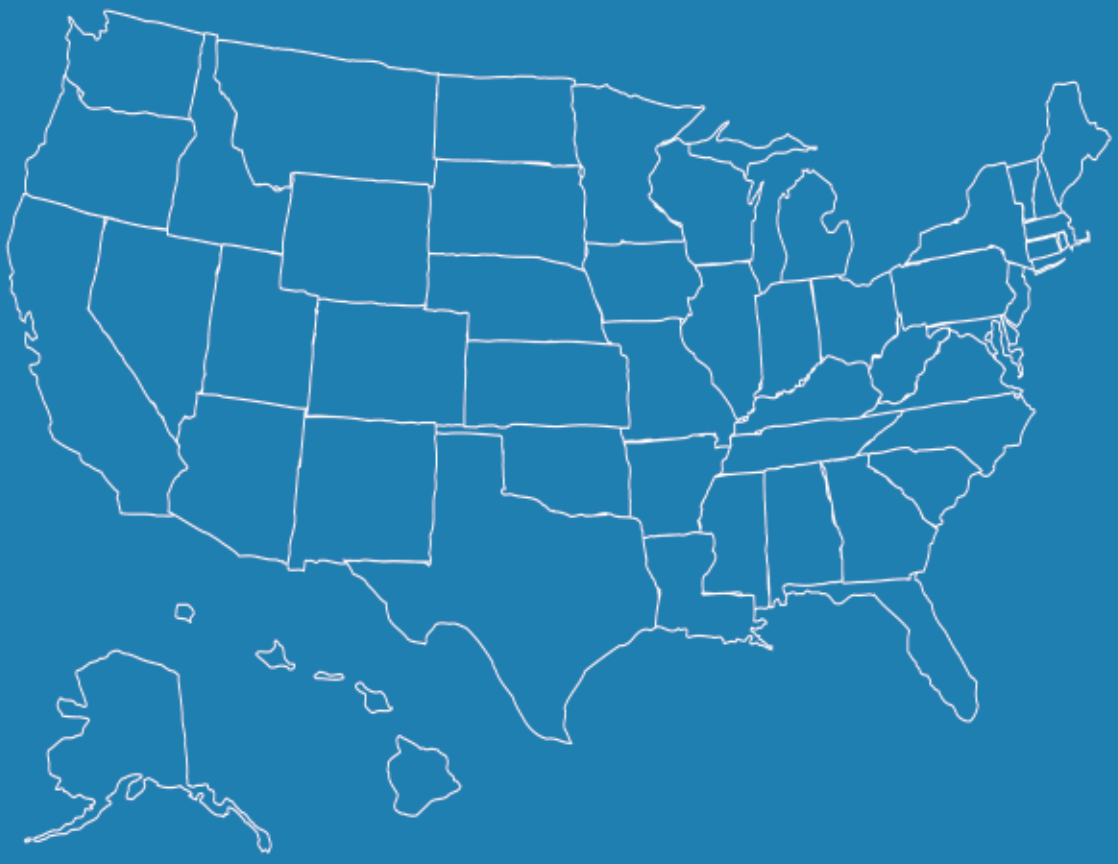
BLUEPRINT FOR THE STATES

Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment



Findings and Recommendations of a National Policy Panel

2006

JOIN TOGETHER

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ACKNOWLEDGEMENTS:

The authors would like to give special thanks to the following individuals for advising and providing background information and administrative support: Dennis McCarty, Oregon Health and Science University; Jenn O'Connor, National Governors Association Center for Best Practices; Robert Morrison, National Association of State Alcohol and Drug Abuse Directors; Tami L. Mark, Associate Director, Thomson/Medstat; General Arthur T. Dean and Jane Callahan, Community Anti-Drug Coalitions of America; Drs. Theresa B. Moyers and William R. Miller, Department of Psychology and Center on Alcoholism, Substance Abuse and Addiction (CASAA) at the University of New Mexico; Conveners of the eleventh annual International Conference on Treatment of Addictive Behavior (ICTAB) and Community Anti-Drug Coalitions of America (CADCA) for hosting the panel's hearings; and the following Join Together staff: Shelley Barnes, Susan Aromaa, Pamela Anderson, Sarah Guckenburg, Carol Girard, Rachel Hassinger, and Norman Scotch.

Published 2006 by Join Together
with support from the Robert Wood Johnson Foundation

Book Design by Velir Studios

For more information about the Blueprint for the States Policy Panel and a PDF version of this publication, visit www.jointogether.org.

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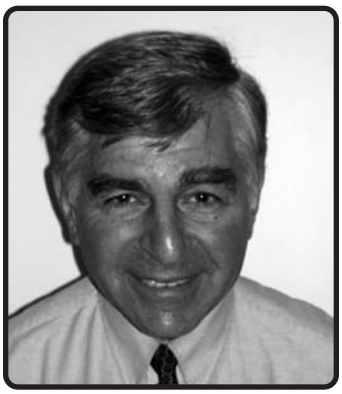
FOREWORD



When I was the governor of Massachusetts in the 1980s, we had an epidemic of drug and alcohol use on our hands. Something had to be done, and it was the state governments that were on the front lines in this often difficult and frustrating battle.

Working closely with the governors, Congress passed legislation and appropriated resources. We began introducing sweeping programs to educate our youngsters about the problem at an early age. We attempted to expand and deepen our treatment programs, and we reached out to our legislators, civic leaders and popular role models to get them and our communities actively involved.

In 1984 I established the Governor's Alliance Against Drugs and Alcohol which included the active participation of educators, community coalitions, media, and the police. Drug and alcohol use among young people in the state dropped dramatically. Unfortunately, the Alliance was disbanded in 2003.

The initial enthusiasm for tackling the problem seems to have faded in other states as well even though the damage to people's lives and the huge financial costs of drug and alcohol use continue to plague us.

That is why Join Together asked a group of us to come together to take a searching look at the problem from a state standpoint. I can say personally that it has been an honor and a privilege to work with this extraordinary group, each of whom brings his or her own special expertise and experience to the panel.

I know of no task that is more important than the one we address here. The toll that drug and alcohol addiction is taking in this country is almost incalculable in personal as well as financial terms. And this time, it cannot be a one-time effort. Tenacity and consistency are critically important if we are going to win this battle.

We look forward to working with you on a broad, bipartisan basis to embrace these recommendations and ensure that they have a real impact on millions of Americans and their families who are struggling with substance use problems and their consequences.

We hope our recommendations make sense to those of you at the state level who are on the front lines, as well as to our colleagues in Washington and at the local level, and we intend to do everything we can to help you carry them through.

Michael S. Dukakis

SUMMARY OF THE RECOMMENDATIONS

Join Together convened this panel to address two realities: state governments pay dearly for the nation's failure to effectively prevent and treat alcohol and drug problems. They also have enormous potential because state governments are the primary funders of prevention and treatment services. These recommendations were unanimously adopted by the panel:

Leadership

Governors, legislative leaders and chief judges need to provide personal, continuous leadership for a statewide strategy to prevent and address alcohol and drug problems. When prevention and treatment are delegated to mid-level state agencies, states can not successfully prevent or treat drug problems at the population level.

Structure

Every state should have a strategy that encompasses all the agencies affected by alcohol and drug problems. Responsibility for state and federal prevention and treatment funds should be held by an entity that reports directly to the governor and has direct access to the state legislature.

Resources

States can generate two key resources needed to improve alcohol and drug services: money and skilled practitioners. An annual public report should detail alcohol and drug related spending in all state agencies. If additional funds are needed, states should consider raising alcohol taxes. States should also use their licensing and educational resources to improve and retain the prevention and treatment workforce.

Measurement and Accountability

States should hold agencies and contracted providers accountable for meeting identified outcome measures. They should reward those that meet or exceed outcome targets and penalize those that consistently fail.

Legislation

States should review and update the legislation that controls their alcohol and drug policies including authorization for prevention and treatment agencies and alcohol control boards. Laws and regulations that prevent recovering individuals from getting jobs, education and other services needed for successful reintegration should also be reviewed and repealed.

Sustain State Focus and Attention

State advisory councils should be created or revived with enough staff and authority to hold elected officials accountable for providing needed leadership. States should support community coalitions and recovery organizations to build a lasting constituency for continuing effective state action.

INTRODUCTION

State governments bear the financial burden of the consequences of drugs and alcohol in our nation, spending over thirteen percent of their budgets on problems related to drug and alcohol use. Less than four percent of this is spent on prevention and treatment, while more than 96 percent pays for the avoidable social and physical consequences that result from our failure to apply what we know about how to prevent and treat substance use problems.[1] These consequences are seen across state systems:

- Between forty and eighty percent of families in the child welfare system have alcohol or other drug problems, and a majority of children in foster care come from families with drug or alcohol problems.[2,3]
- More than half of all state prison inmates were under the influence of alcohol or drugs when they were arrested.[4]
- Nearly one in six state inmates committed their crimes to support a drug addiction.[5]
- Drunk driving is a major expense to the police, courts and emergency medical systems.[6]
- About 20 percent of acute Medicaid expenditures pay for alcohol or drug related medical costs.[7]

Today, very few states have a strategy for effective action that is led by the governor and legislative leadership and crosses agency lines. To make matters worse, treatment and prevention agencies have been moved like checkerboard pieces in administrative reorganizations that have buried them far from the state's senior leadership. We found these reorganizations often miss the mark, focusing on organizational efficiency at the cost of effective prevention and treatment.

State governments hold the keys to their own recovery from the financial and human waste caused by excessive alcohol and illicit drug use. State policy, financing and regulatory authority can be effective tools. We were struck by the consensus that emerged in our hearings about the many strategies that can be pursued at surprisingly low cost. We also found what is missing: leadership at the top and strategies that use the range of tools that states already have.

This report is a blueprint for governors, legislative leaders and chief judges to adapt and use to gain control of the biggest single financial drain they face. Most of us have had significant experience in state government. We have been there. We understand the challenges faced by senior leaders and the many calls on them for time and attention. Our message to state leaders in this report is straightforward: pay attention to alcohol and drugs because they are the root of the most expensive and serious problems in all your human service and criminal justice agencies.

THE POLICY PANEL

Join Together convened this national panel to examine how state governments could be most effective in preventing and treating substance use disorders and problems. Chaired by former Massachusetts Gov. Michael S. Dukakis, the panel met four times, held hearings in Santa Fe, N.M., and Washington, D.C., received written testimony, and reviewed research and existing models. The panel heard from experts, clients, providers, government officials and community leaders. We also reflected on our own experience in state government. This is the report of our findings and recommendations.

Members of the Blueprint for the States Panel:

- **Michael Dukakis (Chair),** former Governor of Massachusetts
- **Diana Bontá,** Vice President of Public Affairs for Kaiser Permanente's Southern (California) Region
- **Barbara Cimaglio,** Deputy Commissioner for Alcohol and Drug Abuse Programs, Vermont Department of Health
- **Judge Karen Freeman-Wilson (ret.),** CEO of the National Association of Drug Court Professionals and Chair of the Governor's Commission for a Drug-Free Indiana
- **Sidney L. Gardner,** President of Children and Family Futures
- **Hon. Pat George,** Member, Kansas House of Representatives
- **Patricia Kempthorne,** First Lady of Idaho
- **Tom McHale,** former Work and Family Representative for the United Auto Workers-General Motors Commercial Truck Center and Board Member of Faces and Voices of Recovery
- **Katie McQueen,** Assistant Professor at the Baylor College of Medicine and University of Texas Health Science Center in Houston and Medical Director of the Harris County Hospital District's Screening, Brief Intervention, Referral and Treatment Program
- **Paul Roman,** Distinguished Research Professor at the University of Georgia and Director of the Center for Research on Behavioral Health and Human Services Delivery's Institute for Behavioral Health Research
- **Ken Stark,** Director of the Mental Health Transformation Project and former Director of the Washington Division of Alcohol and Substance Abuse

CONSENSUS THAT GUIDES OUR RECOMMENDATIONS

State alcohol and drug policy is often ineffective because different agencies and leaders have varying ideas about the nature of the problem and focus on only one piece of the puzzle. Our panel quickly reached a consensus that guided our work. As state leaders review our recommendations and move to develop their own strategies, we believe an important early step for them will be to discuss and articulate a consensus that will guide their work.

"No other single issue impacts more areas of government than alcohol and other drug problems, and none is more destructive to state budgets."

Luceille Fleming, former Director, Ohio Department of Alcohol and Drug Addiction Services

Testimony to the Panel

- Alcohol and drug problems occur within the context of families and communities. Children often suffer because of untreated adult alcohol and drug problems in their families and neighborhoods. Their exposure to alcohol and drug use places them at high risk for developing their own substance use problems.[8] Children growing up in these circumstances should receive special attention from health, education, social services and juvenile justice agencies.

- Alcoholism and drug addiction are treatable and preventable diseases. We believe states should address them through a public health strategy with the goal of long-term recovery.

- Health care for general, mental and substance use problems can be delivered with an understanding of their interconnections. Payment streams and policies that create or reinforce institutional barriers to a patient-centered focus should be identified and changed.[9]

- We find that criminal behavior under the influence of alcohol or drugs cannot be excused, but punishment alone – without equal attention to treatment and reintegration – is expensive and ineffective. We believe every person entering or under the control of the criminal justice system should be assessed for alcohol and drug problems; provided with high-quality physical health, substance use and mental illness treatment; and be connected with community-based treatment and recovery services to help reintegrate them with family, work and the community when released.

- We find that there is an economic imperative for governors and legislators to provide leadership on substance use issues. Unless they do, governors may not have the resources they need to meet many of their other objectives. Here are the facts of how the costs of substance use are spread throughout state government. Consider the following table:

The Cost to States

The most recent state spending figures available are from 1998.[10] This lack of current data illustrates the importance of the need for stronger systems of measurement and accountability.*

State Agency	*Percent of State Agency Budgets Spent on Alcohol and Drug Related Problems	Positive Impact of Prevention and Treatment
Child Welfare	70%[10]	Children whose families receive appropriate drug and alcohol treatment are less likely to remain in foster care.[11]
Criminal Justice	77%[10]	Re-arrest rates dropped from 75% to 27% when inmates received addiction treatment.[12]
Juvenile Justice	66%[10]	Adolescent re-arrest rates decrease from 64.5% to 35.5% after one year of residential treatment.[13]
Health	25%[10]	Families receiving addiction treatment spent $363 less a month on regular medical care than untreated families.[14]
Mental Health	51%[10]	When mental health and drug and alcohol disorders are treated collaboratively, patients have better outcomes.[15]
Welfare	16% - 37%[16]	After completing treatment, there is a 19% increase in employment and an 11% decrease in the number of clients who receive welfare.[17]
Developmental Disabilities	9%[10]	Fetal Alcohol Syndrome affects an estimated 40,000 infants each year.[18]

LEADERSHIP

Governors, legislative leaders and chief judges must provide personal, continuous leadership to prevent and address alcohol and drug problems. We conclude that when prevention and treatment are delegated to inconspicuous, mid-level state agencies, states will not be able to successfully prevent or treat alcohol or drug problems at the population level.

We recommend that the following leadership principles be adopted:

- The governor, legislative leaders and chief judges in each state should develop, implement and monitor a statewide strategy that includes all state agencies affected by drug and alcohol problems.
- Each governor should establish a process through which all state agencies that work on issues related to substance use will be held accountable for delivering appropriate policies and services required by the state strategy.
- State legislative leaders should ensure that lawmakers understand the true costs and consequences of alcohol and drug problems; participate in the development of standards for treatment and prevention; and support and hold accountable the agencies that their committees oversee.
- Chief judges should exercise leadership by ensuring that all other judges and judicial personnel are adequately trained to identify and act on the substance use problems that affect the majority of people who enter the courts. They should establish partnerships with the alcohol and drug agency as well as other agencies working on these issues. Chief judges need to ensure that each person released into the community is connected with the treatment and recovery services needed to maintain abstinence.
- States should create or strengthen a state alcohol and drug advisory board that reports to the governor and legislative leadership. This board should be led by civic leaders who reflect the cultural diversity of the state's demographics and who have the personal strength and stature to develop public understanding and support for a state strategy. Its membership should include representatives of the organized recovery community. To sustain leadership, we recommend that this board should be responsible for collecting and reporting key outcome and trend data. (See Recommendation 6 on sustaining state focus and attention.)

DISCUSSION

"Governors, legislative leaders and chief judges are in perfect positions to lead and crystallize change. Leaders must understand adaptive pressures and dynamics, and use those insights to successfully lead change and build support networks at the grassroots level."

~ Ron Heifetz, co-author, Leadership on the Line: Staying Alive through the Dangers of Leading[19]

If the recommendations of this report had to be reduced to one word, it would be "leadership." The research we reviewed, the testimony we heard and the interviews we conducted were unanimous in pointing to leadership as the linchpin in creating and maintaining effective state substance use policies and programs. Equally clear is that leadership must come from the highest tiers of state government – the governor, legislative leaders and top judges.

Governor

The leadership role of the governor is essential because of the governor's capacity to create and drive strategies that cross agency boundaries. The governor is the one person who can provide the linkage and oversight required for agencies to collaborate effectively to create a client-centered state strategy. A powerful way for a governor to exercise this leadership is to create a governor's-level office of alcohol and drug policy to coordinate treatment and prevention programs, social services, law enforcement and alcohol control.

A governor can also use his/her authority to:

- Engage the media and support marketing and advertising campaigns to raise public understanding about substance use disorders;
- Recruit and retain leaders to direct drug and alcohol agencies – professionals prepared to exercise broad responsibility – and provide them appropriate compensation, training and support as well as the authority and discretion to be effective; and
- Provide leadership training and development for agency directors and staff, both to support existing management and to develop future leaders.

"The governor, state legislature and other elected and appointed officials must publicly recognize the devastating costs to lives, families and a state's infrastructure from alcohol and other drug abuse and addiction."

Hope Taft,
First Lady of Ohio

Testimony to the Panel

Legislative Leaders

We believe legislative leaders should educate other legislators about the causes and consequences of alcohol and drug use and the importance of supporting recovery. They should:

- Allocate funding to programs that support the state strategy to prevent, reduce and treat alcohol and drug problems;
- Provide the state alcohol and drug director with direct access to appropriate legislative committees;
- Establish substance use specific committees or caucuses to track performance, provide accountability and oversight; and
- Work with legislators who are in recovery or whose families are affected by alcohol and drug problems to demonstrate that recovery is real.

These recommendations parallel those of the National Governors Association Center for Best Practices, which in a 2002 policy brief set out six actions state leaders could take to promote substance use prevention and treatment.[20]

Judicial Leaders

People with alcohol and drug problems show up in the state courts, but few judges have training in the nature and treatment of substance use disorders. Even when they do, they are often restricted by the lack of resources available to them and a lack of discretion in sentencing. Some states have developed effective training. For example, in Massachusetts all judges attend a one-day conference to learn more about alcohol and drug issues.

Judicial leaders should encourage the development and expansion of drug courts and implement procedures for screening, brief intervention and referral to treatment wherever appropriate within the court system. Screening asks questions about patterns of drug or alcohol use and a brief intervention is a conversation between a professional and client designed to reduce use.

"The most effective state systems with which we have worked have featured an understanding of the importance of combating substance abuse at the highest levels of state government and an energetic and dynamic leader heading up the effort."

Amy E. Singer,
Senior Vice President,
Phoenix House

Testimony to the Panel

State Directors of Alcohol and Drug Services

We believe that sustained leadership is important for the success of a state alcohol and drug agency. Currently agencies are hampered by high turnover rates among directors, often caused by frequent and disruptive reorganizations.[21]

- In 2002, 23 state directors were new to the position.
- In 2003, 19 were new to the position.
- Of the 60 state agencies (including U.S. territories and possessions), 38 had at least one change in leadership from 2002 to 2004.[22]

A Job Description for Tomorrow's Leaders[23]

Future leaders will require skills that go beyond direct program experience, so every state director's job description should require:

- The ability to frame key policy questions and follow through to see them realized.
- Familiarity with new health care technology and a commitment to preparing state systems and workers in advance of its arrival.
- The understanding that outcomes will determine funding and measure the state director's performance.
- The capacity to design and implement new outcome measures.
- The ability to understand the organization and financing of systems of care and to make a compelling, data-driven business case for their return on investment.
- The ability to collaborate with other agencies and seek new partnerships.

STRUCTURE

We recommend that each state structure its alcohol and drug efforts in the following way, adapted to its unique circumstances:

- Responsibility for a statewide, authoritative strategy to address substance use and related problems, incorporating all appropriate agencies, should be held at the highest possible level in state government and report directly to the governor. (See Recommendation 1 on leadership.)

- Responsibility for administering state and federal treatment, prevention and recovery funds and regulating service providers should be held by an entity that reports directly to the governor and has accountability to the state legislature. The agency needs adequate infrastructure and authority to collect, analyze and disseminate regular public reports on trends and outcomes (See Recommendation 4 on measurement and accountability); and sufficient authority to convene and collaborate with agencies such as child welfare, protective services, Medicaid, housing, employment and criminal justice.

- States should not place their substance use agencies within larger entities that would impede their ability to develop and coordinate a single set of statewide standards for substance use disorder treatment. If a state places a treatment and prevention agency within a larger state entity, it should be guided by whether the placement will further the state's strategy and ensure the treatment system's movement toward supporting a patient-centered focus.[24]

- States should require formal mechanisms to review and change prevention and treatment programs and contractors that do not meet minimum standards of effectiveness.

- State prevention systems should coordinate programs and resources to promote evidence-based environmental strategies, community-wide mobilization and interventions.

- States should create structures that provide prevention, screening, brief intervention, and referral to quality treatment in child welfare and criminal justice agencies.

DISCUSSION

"Based on my experience serving as state director and my subsequent experience working with multiple state authorities, a best model for organizing state authorities does not exist. Each state is idiosyncratic and the model that works most effectively in one state may not be appropriate in another state."

~ Dennis McCarty, PhD, former Director, Massachusetts Bureau of Substance Abuse Services; Professor of Public Health and Preventive Medicine, Oregon Health & Science University.

Testimony to the Panel

We believe that state structures must focus on the client and family to assure they receive services appropriate to their individual situations, without regard to where or how they came into the state system. We understand that this calls for an unprecedented degree of collaboration and cooperation among all appropriate agencies and entities, but what goes on now does not work.

We did not find a state structure that has all the characteristics needed to improve prevention, treatment and recovery services at the scale that will achieve sustained reduction in alcohol and drug problems. Testimony and studies we reviewed indicated that most state alcohol and drug structures today lack:

- Direct access to the governor and top leadership;
- Authority to drive meaningful coordination and collaboration across agency and department lines; and
- High visibility and strong operational management, including a strong data management and accountability system.

As of 2005, 26 alcohol and drug programs were integrated with a mental health agency, 10 were housed in behavioral health agencies responsible for substance use and mental health, and 8 were within a public health agency. In 40 states, the substance use agency was nested within a large superagency such as the Dept. of Health or the Dept. of Human Services.[25]

We realize that states structure their substance use authorities along many different models to meet unique needs, but they are not all equally effective. Only Connecticut, New York, Ohio and South Carolina have a cabinet-level agency. In most other states, the substance use authority is now housed under the umbrella of mental health, public health or social services agencies.

We understand that pressure to increase efficiency often leads states to merge systems and agencies. However we found that consolidation can weaken or bury a substance use agency, causing a loss of leadership and program effectiveness.

Through interviews and testimony, substance use agency staff reported to us that they face increasing pressure to do more with less. This has led to a rise in attrition among senior and mid-level staff. This environment makes it difficult for directors to maintain or begin innovative programs.[26]

In contrast, we found that substance use agencies have greater success when they enjoy autonomy because they are housed at cabinet level or are led by gubernatorial appointees.

Luceille Fleming, former director of the Ohio Department of Alcohol and Drug Addiction Services, testified that cabinet-level status for a state's alcohol and drug-services organization "is crucial for effective services across systems." Independent research corroborates that the location of a substance use agency within the government affects its funding in comparison to mental health and developmental disability agencies. Substance use agencies that were frequently reorganized and merged into other organizations faired less well in the funding process than agencies that had a stable location within state government.[27]

Making Clients and Families the Focus of Interagency Collaboration

States still segregate health care, substance use, behavioral health and social services into separate agencies. For clients, however, these problems overlap. We believe agencies must collaborate with a focus on the clients' multiple needs. To accomplish this, state agencies will need:

- A common language to define services, outcomes and measures;
- A unified data system to track activity and outcomes for individuals across agencies (See Recommendation 4 on measurement and accountability.); and
- Cross training and other opportunities to actually know and work with colleagues in other departments.

We found that cross agency collaboration can be fostered by statute. For example, in Ohio, a statute authorizing the Department of Alcohol and Drug Addiction Services specifies that it "coordinates the alcohol and other drug services of state departments, the criminal justice system, law enforcement, the legislature, local programs and treatment/prevention professionals."[28] With this grant of legislative authority, the department is better able to coordinate services among diverse groups.

"Unless you are at the center of state government working with the governor, you cannot hope to have the clout and the timing to effectively lead the drug control effort."

James McDonough
former Director, Florida Office of Drug Control; Interim Secretary, Florida Department of Corrections

Testimony to the Panel

Coordination with Criminal Justice

As many as 75 percent of people involved in the criminal justice system are addicted to or misuse alcohol and drugs.[29] Strong evidence shows that quality treatment and aftercare substantially reduce rearrest rates.[30]

We believe the criminal justice system should tap the expertise of the state alcohol and drug agency to ensure it provides the full continuum of care that people with alcohol and drug dependence need to achieve recovery. The state agency should take the lead to ensure that criminal justice treatment programs are licensed and accountable and that their staffs are trained and qualified.

Drug courts are a good example of how the criminal justice system can collaborate successfully to provide a continuum of care. We believe that drug courts can help transform the way substance use issues are addressed within the criminal justice system. Drug courts have proven effective in reducing recidivism. Last year alone, 20,000 individuals graduated from drug courts and more than 840 children were born drug-free to drug court clients.[31] We understand that these numbers are still small when compared to the national problem but the results are strong enough to warrant continuing expansion.

Coordination with Juvenile Offender Programs

The need for collaboration among state agencies is particularly evident when it comes to teenagers caught in the cycle of drugs, alcohol and crime. These troubled teens and their families often need a broad range of health, education and social services to turn their lives around. Too often, they receive only slices of services that fail to break the cycle.

Reclaiming Futures, an initiative of the Robert Wood Johnson Foundation, sponsors pilot projects in ten communities that combine system reform, treatment improvement, and community engagement to help teens overcome drugs, alcohol and crime. According to the Urban Institute, twelve out of thirteen indicators of success have shown significant improvements since 2003. [32]

In New York City, the Administration for Children's Services (ACS) has an extensive protocol, in partnership with the state's alcohol and drug agency, to enable a smooth transition into drug and alcohol treatment for parents who have children in the foster care system.[35]

Coordination with Child Welfare Services

Alcohol and drug problems cause or exacerbate seven out of ten child-abuse and neglect cases. These problems contribute to the inability of the parents to care for their children and often result in children being removed from their home.[33] Once a parent is identified as having a substance use problem, it is critical that they be referred to treatment, that their status be monitored, and that treatment providers inform child welfare officials of any progress.[34]

Encouraging Collaboration

We know that it is a lot easier to talk about collaboration than to achieve it. We recommend the following steps that states can take to encourage collaboration:

- Provide incentives to agencies to increase collaboration among providers of primary care, mental health and substance use services;
- Revise laws, regulations and administrative practices that create inappropriate barriers to the communication of information between providers, for example, agency-specific confidentiality requirements that do not really protect client interests;
- Encourage the adoption of uniform electronic state health records, computer-based clinical decision-support systems, computerized provider order entry, and other forms of information technology;
- Enter into memoranda of understanding (MOU) that describe joint statements of purpose and commitments to specific roles and responsibilities;
- Develop cross training programs; and
- Encourage cooperation among agencies on budget and funding requests.[36]

RESOURCES

States can generate two key resources needed to improve prevention and treatment: money and skilled practitioners. We recommend that states, as part of their strategies, identify these resources in each of the agencies affected by issues related to substance use. States should comprehensively plan and coordinate the use of these resources to maximize their overall effectiveness.

Money

States can use existing funding or raise additional funds to accomplish the goals of the state strategy. We recommend that states:

- Identify the separate streams of state and federal money for prevention, treatment and recovery that flow through multiple agencies. These findings should be reported to the governor and legislature and each agency head should be held accountable to use these funds in a manner consistent with the overall state strategy.
- Pool treatment funds and case management support from multiple agencies into joint purchasing arrangements or memoranda of understanding to ensure use of a standard of treatment for all clients using current best practices.
- Expand Medicaid coverage to provide a range of alcohol and drug treatment services for all beneficiaries, and preventive services for high risk children. We believe this is the fastest and most cost effective way to get critically needed services to low income parents and their children.
- Require all public and private health insurance programs to offer the same coverage and access for alcohol and drug treatment as they provide for other diseases.
- Consider raising alcohol excise taxes, especially on beer, earmarking the revenues for prevention, treatment and recovery programs if they need additional money.

Skilled Practitioners

We recommend states use the resources and institutions they control to improve the skills of people who provide prevention and treatment services and to retain them in the field. We believe states should:

- Use their certification and licensing powers to:
  - Set standards of skills and training for counselors and managers.
  - Require all treatment agencies to have the clinical capacity to use medication assisted treatment when appropriate for their clients.

- Set state-controlled salaries and payment rates at levels that will attract and retain qualified providers.

- Create loan forgiveness and tuition-assistance programs to encourage individuals to choose careers in prevention and treatment.

- Establish programs and curricula at state colleges and universities to prepare counselors to make full use of new and emerging behavioral and pharmaceutical treatments.

- Recruit and train more minorities to work in the fields of prevention and treatment.

- Set standards to ensure that those in the recovery community without formal education or certification are able to contribute their unique and valuable understanding of the treatment and recovery process by serving in roles such as coaches, advocates and case managers.

- Require physicians and health care professionals, as a condition of licensure, to participate in continuing education and training, at least annually, on issues related to alcohol and drugs.

- Require lawyers, judges, court personnel, social workers and youth-services workers to participate in continuing education and training on issues related to alcohol and drugs.

DISCUSSION

"Incentives are the cornerstone of modern life.... Economics is, at the root, the study of incentives."

~ Steven Levitt and Stephen Dubner, Freakonomics[37]

Money

The reality of large expenditures with poor results drives the panel's recommendations about money. States should get better value for the significant amount of money now being spent. Those adopting these recommendations might actually save money. More likely, they will stop wasting it and start getting results. Mechanisms are available for states to generate more money using political leadership and a sound strategy.

States now spend about thirteen percent of their annual budgets on alcohol and drug related problems but less than four percent of this goes to prevention and treatment.[38] The rest is spent cleaning up the mess from unattended alcohol and drug problems, including the cost of a majority of jail and prison inmates, a majority of foster care and other child protective placements, police response to drunk drivers, alcohol-infused domestic violence, rowdy teens and unreimbursed emergency medical services provided to people in drug and alcohol related crashes.

Funding Streams

In a typical state, more than a half dozen agencies independently spend significant amounts of money on alcohol and drug related problems. The agency with direct responsibility for publicly funded prevention and treatment programs is often not the biggest spender. In some states, the Medicaid agency spends more on treatment for its beneficiaries. In others, drug courts and probation departments have become large purchasers of care. In virtually every state, the prison and jail systems spend more money housing alcoholics and drug addicts yet do little to treat or prepare them to return to society. In many states, the Temporary Assistance for Needy Families (TANF) program must spend significant amounts purchasing treatment and other services for women whose addiction prevents them from being in the workforce. State youth agencies are also buying treatment for adolescents in their care.

There is evidence that pooling funds, or other formal collaboration, improves results and access to care in the states where it is being tried.[39] We found scattered instances of collaboration among some state agencies, but we found no state in which all the relevant agencies were systematically working together to ensure that the state, and the people it serves, are getting the best value and treatment for their money. We are convinced that continuing the current pattern of uncoordinated spending will perpetuate poor results and increase public frustration with ineffective government programs.

Iowa: Managed Treatment of Medicaid and Other Enrollees[40]

Iowa Plan for Behavioral Health has provided managed substance use treatment for all programs since 1999. Using a single contract, Magellan Health Services administers all programs using Medicaid funding, state mental health and substance use money, and block grant treatment funds. Results include:

- Annual Medicaid savings of $2 million.
- Increased access to substance use treatment by 187% over the prior fee-for-service system.

Expand Medicaid Coverage for Treatment and Prevention

Research has repeatedly shown that a family's medical expenses decline after an addicted member of the family receives alcohol or drug treatment.[41] Washington State, for example, found that it saved more on reduced Medicaid spending for regular medical care than it spent for alcohol or drug treatment in the population studied.[42]

Federal Medicaid guidelines allow states discretion over whether, and to what extent, to cover substance use treatment programs. As a result, coverage for substance use treatment varies substantially from state to state:

Medicaid Coverage of State Substance Use Services[43]

Substance Use Service	Number of States Providing Coverage
Inpatient hospitalization	40
Inpatient detoxification only	6
Opioid treatment	28
Extensive Outpatient Rehabilitation	25
Residential Rehabilitation	15
Case Management	13

For the past decade, private insurance spending for substance use treatment has been declining. As a result, states now pay for 60 percent of all alcohol and drug treatment with a combination of state and federal dollars even though they insure only about 25 percent of their populations.[44]

We urge states to require private insurers to cover substance use treatment to protect themselves from this shift to the public sector. Only nine states currently require insurance parity for the treatment of alcohol and other substance use disorders.[45] However, these states often have managed care restrictions that limit access to effective care.

We know that many state legislatures and governors are reluctant to mandate insurance parity because business owners and insurers complain about the possible added costs of any new requirement. However, research demonstrates that adding or expanding this benefit does not drive up costs. The federal government started covering mental illness and substance use disorder care for all federal employees in 2001. Research has shown that the cost of insurance did not increase when parity for behavioral healthcare was implemented.[46]

Alcohol Excise Taxes

We believe that raising alcohol excise taxes is a sound approach to raise additional funding for prevention and treatment. This shifts more of the burden of paying for state alcohol programs to those who consume excessive amounts of alcohol. Further, raising the price of alcohol through a sales tax reduces drinking and binge drinking among youth. Increasing the price also decreases drinking and driving among all ages.[47]

The Effects of Beer Tax on Underage Drinking[48]

	5 states with the highest beer tax	5 states with the lowest beer tax
Average tax	70 cents	6 cents
Percent of 18-20 year olds who binge drink	17.3	31.8

We focus on beer taxes because they are dramatically lower than other alcohol taxes in almost every state, and because cheap beer is the drink of choice for underage drinkers. We believe it is important for states to review their alcohol taxes. Their revenue and deterrent value has declined dramatically because they are rarely adjusted for inflation. For example, the beer tax in Massachusetts was set at 11 cents a gallon in 1976. In 2006, this is the equivalent of 3 cents a gallon, not enough to buy much treatment or deter many teens.

Securing and Retaining a Skilled Workforce

"Workforce development is one of the greatest challenges staring down the field of addiction recovery today. To ensure the furtherance of this profession, we must take several steps to recruit, retain, and reward our current and future workforce."

~ Cynthia Moreno Tuohy, Executive Director, NAADAC, The Association for Addiction Professionals

Testimony to the Panel

Workforce instability is a major obstacle to effective prevention and treatment programs. Turnover rates among workers in many substance use treatment programs rival the fast-food industry, averaging 50 to 60 percent a year.[49] Research suggests that about half the treatment program directors have been in their job for less than one year and that few of them have specialized training for their position.[50]

Fewer than half of the treatment programs in the country have even a part-time physician working with them. We believe this is a major problem because it means that a high percentage of clients may not be able to get medication supported treatment that can help them recover. In the last five years, for example, three new medications have been approved as effective treatments for alcohol or opiate addiction. Therefore we recommend that licensing and contracting standards for treatment programs include the active participation of physicians in planning and providing treatment for all clients.

Substance use counselors are asked to treat some of the most complex patients, but they are among the least-trained and lowest paid health care providers. We believe the level of success they achieve with clients is remarkable given the lack of training and formal supervision that they receive. No credentials of any kind are required for substance use counselors in eleven states.[51] We believe that all states should use credentialing and continuing

education requirements to ensure that providers are equipped to deliver treatment with evidence of its effectiveness.

We heard testimony that states need to pay enough for treatment to enable providers to attract and keep qualified workers and to provide them with supervision and continuing education. We believe trying to spread limited public dollars by paying unrealistically low reimbursement rates is self-defeating, especially when there are no higher paying private entities to take up the slack, as in the rest of the health care system.

States license and employ most of the front-line social service, health care and criminal justice workers who come in contact with clients who have serious alcohol and drug problems. Often, these workers cannot recognize the problem or refer their clients to help because they have not been trained or they have been told that it is "not in their job description." We believe states can use their regulatory and licensing rules to enable and empower these workers to identify and refer individuals and families they serve.

MEASUREMENT AND ACCOUNTABILITY

We recommend that states develop and publish prevention, treatment and outcome measures for all state agencies serving individuals and families affected by substance use.

States should hold agencies and contractors accountable for meeting their objectives. They should reward those that meet or exceed outcome targets, and penalize those that fail to meet targets. We also believe states should measure and document client centered collaboration among relevant state agencies to ensure that it, in fact, is happening.

Specifically, we recommend that states:

- Create a unified data system to track who is receiving services from multiple sources; the costs of those services; and outcomes related to social functioning, engagement with family and work and involvement with the criminal justice system.
- Provide training and reinforcement for officials in all agencies to make appropriate use of the unified data system.
- Publish annual reports that track the costs and consequences of alcohol and drug use, as well as the outcomes of prevention and treatment programs.
- Pay more to providers that consistently achieve better results and less—or nothing—to providers that cannot achieve reasonable expectations.[52]

DISCUSSION

"With declining federal resources, low-cost strategies are vital to the public health and safety of states and cities. The key to make this happen is to move to a statewide public-health model of promoting these strategies, which includes carefully constructed monitoring to show results."

~ Dennis D. Embry, President/CEO, PAXIS Institute

Testimony to the Panel

Defining and Achieving Results

When state leaders decide and articulate the goals they are seeking, they can direct development of appropriate measures and start to hold agency heads and contractors accountable for meeting them.

We find that since state agencies have different goals for their substance using clients, states sometimes fail to make progress against alcohol and drug problems. Therefore, a critical first step for the governor and senior leaders is to decide which prevention and treatment goals are most important. For example, we heard that improved family functioning is often overlooked when a

Oklahoma: Drug Courts Show that They Make a Difference[53]

Drug courts in Oklahoma have received increases in funding because they have measured and reported on their success. Drug court graduates are two times less likely to return to prison than probation offenders and four times less likely than released prison inmates. The annual per-person cost of drug court is $5,000, while the annual cost of keeping that person in prison would be $16,000.

treatment goal is set for an individual, despite the strong evidence that children in substance use affected families are at extraordinary risk for developing problems themselves. Similarly, in our own experience, we have seen tension between a treatment agency whose primary focus is on maintaining abstinence and a public agency whose primary concern is that the clients function well enough to stay out of trouble.

We know that state treatment and prevention agencies have been negotiating over a set of national outcome measures with their federal funding source, the Center for Substance Abuse Treatment (CSAT), for almost a decade. We believe the result will be a compromise that is, at best, a starting point. For example, we are concerned that the outcome data will be based only on the time of the clients' last contact with the treatment provider, yielding no information about what happens to the client and his/her family after that. We recommend that states move ahead on their own to develop outcome measures that will provide benchmarks they can use for quality improvement.

A prior Join Together policy panel report on improving treatment quality, *Rewarding Results,* recommended that payers use financial incentives to recognize treatment providers with consistent superior performance and penalize poor performance.[55] We endorse that idea because we heard testimony that a program like this has been implemented in Delaware and achieved the desired goals of retaining clients in treatment for longer periods—a key measure of treatment effectiveness.

We place high importance on public reporting because we have seen evidence that this helps build support for treatment quality and policy improvement. For example, we heard testimony that the Pima County, Arizona, Commission on Addiction Treatment and Prevention has used trend data in its annual report to generate public support for policy changes to reduce underage drinking.

SAMHSA's National Outcome Measures[54]

SAMHSA has identified 10 broad areas that reflect real-life outcomes for people trying to attain and sustain recovery: abstinence; employment/education; crime and criminal justice; stability in housing; access/capacity; retention; social connectedness; perception of care; cost effectiveness; and use of evidence-based practices.

LEGISLATION

We recommend that states review and update the core legislation authorizing state prevention, treatment and recovery services. We also urge them to review state legislation that regulates the distribution of alcohol, and the number and location of alcohol beverage outlets.

For states to accomplish this, we recommend that they:

- Create a formal review process in the legislature that includes treatment, prevention and recovery experts to ensure that laws governing prevention and treatment funding and programs reflect current understanding of the diseases. States should also review laws governing the operations of all state agencies to ensure that they have mandates to coordinate their services around the needs of individuals and families with alcohol and drug problems.

- Identify and repeal legislation and regulations that inhibit recovery and reentry for individuals with alcohol and drug disorders and drug or alcohol convictions. For instance, states should carefully review regulations that prevent individuals with nonviolent, drug related criminal records from getting licenses to hold jobs.

- Review mandatory minimum sentencing laws to ensure that convicted individuals get the treatment they need prior to and after release.

- Create a process in the legislature to review and act on the recommendations of the 2003 Institute of Medicine report, *Reducing Underage Drinking: A Collective Responsibility.*[56]

- Commission a comprehensive analysis of the state alcohol control and licensing system to fully understand how current practices address the state's interest in balancing the availability of alcoholic beverages with the need for public safety and health.

DISCUSSION

"States should be encouraged to revisit and update their controlling legislation to assure that the state authority can continue to respond to contemporary needs."

~ Dennis McCarty, PhD, former Director, Massachusetts Bureau of Substance Abuse Services; Professor of Public Health and Preventive Medicine, Oregon Health & Science University

Testimony to the Panel

Outdated Legislation

Treatment and Prevention. Many states used model language from the Uniform Alcoholism and Intoxication Treatment Act of 1971 to guide decrimi-

nalization of public intoxication and to establish a publicly funded treatment and prevention system.[57] However, our understanding of how to recognize and treat alcohol and drug problems has advanced so dramatically that many of the practices mandated by current law need updating. For example, many state laws put heavy emphasis on initial detoxification, especially for chronic alcoholics. That service is essential for many alcoholics and drug addicts but research has shown that detoxification that is not immediately followed by intensive treatment is usually ineffective in helping an individual maintain sobriety.

Accident Insurance Coverage. The Uniform Accident and Sickness Policy Provision Law (UPPL) is another example of a state policy that needs careful review and change because it has become an impediment to identifying and referring individuals with alcohol problems to treatment. In fact, the National Association of State Insurance Commissioners has called for its repeal. The law entitles health insurers to deny accident or injury claims if there is evidence that the claimant was affected by alcohol or narcotics (unless administered on the advice of a physician) at the time of the injury.[58] Emergency physicians are often reluctant to screen patients or test for alcohol because, if detected, the patient's health plan may not reimburse the hospital or the patient for services.[59]

Discrimination. We found that state laws often have the unintended consequences of inhibiting successful reintegration for people recovering from alcohol or drug problems. For example, we found that discriminatory polices are particularly pronounced after release from the criminal justice system. Individuals with substance use convictions continue to be punished by legal and regulatory barriers to housing, employment, education and parenting, as well as basic state rights like voting. Bans enforced without considering individual circumstances often have unintended, counterproductive consequences. We believe an individual's current behavior, not his/her past, should govern access to needed state services.[60] State policies that do not deter future drug use, but do place impediments in the way of recovery and reintegration, should be repealed.

Alcohol Control Regulations. When national prohibition was repealed in 1933, states were given primary responsibility for controlling the availability and price of alcohol to protect public health and safety. We found that the effectiveness of these laws has eroded due to agency budget cuts, lax enforcement and major changes in the markets the laws are supposed to regulate. We believe states are the appropriate level of government to balance the availability of alcoholic beverages and public health and safety. However, they need to act.

When state laws were initially passed, beer and wine were treated and taxed differently from distilled spirits, in part because the beer available then had very low alcohol content and regulators thought it was not likely to be misused. These historic regulatory and tax differences remain in place in almost every state, despite the fact that beer now has significantly higher alcohol content and has become the principal alcoholic beverage abused by young drinkers. Wine, now available for delivery from the internet, has also emerged as a significant segment of the market.

Major changes in industry composition and retailing are also challenging the assumptions of state regulatory systems. A major national retailer took Washington State to court claiming there was no proof that its distribution and pricing system promoted the state's public health intentions. In 2006 a federal court concurred, overturning many of the key elements of that state's system.[61]

Updating Policies for Prevention

We heard testimony about many opportunities for states to prevent and reduce underage drinking by creating policies that change the environment of alcohol availability and use. We encourage governors and state legislators to pay close attention to the recommendations in the 2003 Institute of Medicine report, *Reducing Underage Drinking: A Collective Responsibility,* which summarizes the research supporting these new approaches to prevention. We endorse and include a number of the IOM recommendations and findings as a way of demonstrating the choices states can make:

- Pass and enforce social host laws. Laws that make homeowners, parents and others liable if they provide alcohol to minors have been shown to reduce binge drinking and drinking and driving among all drinkers.[62]
- Require registration and notification of beer keg purchases. This practice deters inappropriate keg parties and puts local authorities on notice of potential problems.[63]
- Issue restrictions on "happy hour" alcohol drink discounts because they significantly increase alcohol consumption by both casual and heavy drinkers. Eliminating these discounts returns consumption to normal.[64]
- Limit alcohol promotion at sports and community events to reduce opportunities for youth drinking.[65]
- Increase compliance checks to deter unlawful sales.[66]
- Promote responsible beverage service training programs to hold merchants accountable for serving to intoxicated patrons and minors.[67]
- Pass graduated drivers license laws to reduce the risk of motor vehicle accidents involving youth ages 15 to 20.[68]
- Place restrictions on alcohol advertising and marketing to youth because long-term exposure to alcohol advertising and marketing increases the likelihood that children will drink early.[69]
- Raise alcohol taxes to reduce youth drinking and drunk driving among all ages.[70]

SUSTAIN STATE FOCUS AND ATTENTION

We have called on governors, state legislators and chief judges to take the lead in addressing alcohol and drug problems and we have warned them of the consequences of failing to do so. We have seen leadership on this issue rise and fall as administrations come and go. In 2006 alone, between 10 and 38 new governors will be elected.We recommend that community leaders and people in recovery work together with elected officials so they can educate state leaders and provide them with support to sustain effective action.

We recommend that the following building blocks be put in place in every state:

- A permanent, highly visible state alcohol and drug advisory board, led by civic leaders and individuals in recovery. The advisory board should have the resources and responsibility to issue regular public reports on state strategies and results. The board should also conduct social marketing campaigns to develop public support for alcohol and drug prevention and treatment programs.

- A network of community coalitions and recovery organizations that have the resources and responsibility to monitor and report local problems and progress. The network should also have the ability to mobilize local public and private groups to support an alcohol and drug strategy. These groups should work closely with local police and school authorities to develop collaborative prevention and enforcement strategies.

- A network of health services and treatment providers that can work constructively with state agencies to ensure that new clinical developments are incorporated into state standards.

DISCUSSION

"States should listen to communities. And when states support and value coalitions, they hear a groundswell of support echoed back at them."

~ Gen. Arthur T. Dean, Major General, U.S. Army, Retired; Chairman and CEO, Community Anti-Drug Coalitions of America

Testimony to the Panel

State Advisory Boards

We recommend the creation or strengthening of state advisory boards to prevent the issue from becoming buried below public notice and also as a mechanism that governors can use to help generate public support for policy innovation. We believe the chairs and members should be appointed by the governor for staggered terms to ensure both continuity and refreshment. Key public agency directors and provider groups should be present on the boards,

but should not become the dominant members because a critical role of the advisory board is to expand civic support. The goal of the boards should be to provide broad strategic oversight to the whole system of prevention, treatment and recovery and relate these programs to the social and economic future of the entire state.

Community Coalitions

We believe that community coalitions can play important roles in developing long term public support for sound policies. They can also mobilize local collaborative action to implement strategies. The federal government has provided direct financial support to more than 900 community anti-drug coalitions.[71] For the most part, state and local governments have not been involved in these grants and so have not been committed to their long term survival when the federal grants go away—as they always do. A significant percentage of these coalitions disappear at the end of the federal grant. Therefore, we believe the federal government should involve state and local governments in this program to give them a stake in the long term viability of community coalitions.

Here are some examples of how states play a role in sustaining community coalitions:

- In Florida, Gov. Jeb Bush worked to ensure that there is an active community coalition in each of Florida's 67 counties. Through investment in training and technical assistance for coalitions, Florida has exceeded that goal with close to 200 active community coalitions.

- In Vermont, the State Health Department is involving local coalitions in a 30 community program aimed at preventing young people from starting to use alcohol and drugs.

Recovery Organizations

Because of discrimination against people who have had alcohol and drug problems, those in recovery have been largely silent about their experience. However, in recent years an increasing number of people in recovery have become actively and publicly involved in a growing recovery movement. The groups, now active in many states and communities, work with advocacy groups and public officials to improve policy and reduce discrimination against people with alcohol and drug problems. We applaud this development. We believe that an active and effective recovery group will provide exactly the kind of long term commitment and involvement that is now missing in many states, and will sustain public support for the recommendations in our report. We urge states to actively support recovery groups.

The organized recovery communities in several states have built and maintained momentum and are changing policy and systems. These include:

Association of Persons Affected by Addiction, Dallas, TX

Connecticut Community for Addiction Recovery

Faces and Voices of Recovery

Massachusetts Organization of Addiction Recovery

New England Alliance for Addiction Recovery

People Advocating for Recovery, KY

Project Vox, Flint, MI

Recovery Association Project, Portland, OR

Vermont Friends of Recovery

CONCLUSION

We end where we started. The consequences of alcohol misuse and illicit drugs are the single greatest drain on state budgets. Their negative impact on children, families and communities is beyond measure. State governments have the power to change all of this through leadership, optimal structure and better use of fiscal and human resources. Strong systems of measurement and accountability will be needed to show voters the results. We believe that the public will respond to this progress with added support for further improvements.

We issued this report as a blueprint for states to use as a foundation. The shape each state gives to these recommendations will depend on many factors, but overall success will be driven by leadership. Here are the plans. Now let us all get to work in achieving success.

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WITNESSES

The following individuals presented the panel with oral or written testimony:

Uma Ahluwalia, MSW, Interim Director, D.C. Children and Family Services Agency

Johnny Allem, President, Johnson Institute

Mary Pat Behler, Director, Youth Substance Abuse Treatment Collaborative

Nicholas Bakas, Albuquerque Chief Public Safety Officer; former Cabinet Secretary of Public Safety, New Mexico

John Coppola, Executive Director, Alcoholism and Substance Abuse Providers of New York; former President, State Associations of Addiction Services

Kenneth Corvo, PhD., School of Social Work, Syracuse University

Todd Crawford, Oklahoma Department of Mental Health and Substance Abuse Services

John Daigle, Executive Director, Florida Alcohol and Drug Abuse Association; Consultant, Legal Action Center

Beverly Watts Davis, Senior Advisor to the Administrator for Substance Abuse, SAMHSA

General Arthur T. Dean, Major General, U.S. Army, Retired; Chairman and CEO, CADCA

Thomas J. Delaney, MSW, MPA, Executive Director of Boston Alcohol & Substance Abuse Programs, Inc., Massachusetts

Michele Denk, Executive Director, Pennsylvania Association of County Drug and Alcohol Administrators

Polly M. Dickerson, Pewaukee, Wisconsin

Christina Dye, Chief, Bureau of Substance Abuse Treatment and Prevention, Division of Behavioral Health Services, Arizona Department of Health Services

Deacon D. Dzierzawski, MOL, LICDC, CEO, The Community Partnership, Ohio

Dennis D. Embry, PhD, President and CEO, PAXIS Institute, Arizona

Luceille Fleming, former Director, Department of Alcohol and Drug Addiction Services, Ohio

Diane Galloway, PhD, CDM group, Inc.; former Administrator, Department of Health, Substance Abuse Division, Wyoming

Suzanne Gelber, MSW, PhD, Managing Partner, The AVISA Group, Berkeley, CA

Carolyn Givens, Director, Ohio Department of Alcohol and Drug Addiction Services

Arturo Gonzales, PhD, Executive Director, Sangre de Cristo Community Health Partnership, New Mexico

Nicholas Hoag, Massachusetts

Pamela Hyde, JD, Secretary, New Mexico Human Services Department

Dan Iser, Regional Coordinator, Federal Safe and Drug-Free Schools and Communities Program, Pennsylvania

Kathy Jett, Director, California Department of Alcohol and Drug Programs

Jack Kemp, MS, Director of Substance Abuse Services, Division of Substance Abuse and Mental Health, Delaware Health and Social Services

Harry Kressler, Director, Pima Prevention Partnership, Arizona

Larry Langdon, Prevention Coordinator, Multnomah County Mental Health and Addiction Services, Oregon

Donald Maestas, Chief of Prevention Services, Prevention Services Bureau, New Mexico Department of Health

Dennis McCarty, PhD, former Director, Massachusetts Bureau of Substance Abuse Services; Professor, Oregon Health and Sciences University

James McDonough, former Director, Florida Department of Drug Control; Interim Secretary, Florida Department of Corrections

Tom McLellan, PhD, Director, University of Pennsylvania Treatment Research Institute

William R. Miller, PhD, Distinguished Professor of Psychology and Psychiatry, University of New Mexico

Lisa Mojer-Torres, Esq, Civil Rights Attorney, Board of Directors, Faces and Voices of Recovery

Harry Montoya, Santa Fe County Commissioner; President and CEO, Hands Across Cultures Corporation

Roger Morgan, Californians for Drug-Free Schools

Jon Morgenstern, PhD, Vice President and Director of Health and Treatment Research, National Center on Addiction and Substance Abuse, Columbia University

Jim Neal, former Deputy Director, South Carolina Department of Alcohol and Other Drug Abuse Services

Jurriaan Plesman, Post Grad DIP Clinical Nutrition; Hon. Editor, Hypoglycemic Health Association of Australia

Caley I. Powell, BSN, RN, Kentucky

Mac Pritchard, Communications Director, Reclaiming Futures

Richard Rawson, PhD, Associate Director, Integrated Substance Abuse Program, UCLA

Bill Richardson, Governor, New Mexico

Julia Ross, Administrative Director, Recovery Systems, California

Jim Russell, Oklahoma Faces & Voices of Recovery

Paul Samuels, Esq, Director and President, Legal Action Center

Amy E. Singer, Senior Vice President and Director of Program Planning and Operations, Phoenix House

Maia Szalavitz, co-author, *Recovery Options: The Complete Guide: How You and Your Loved Ones Can Understand and Treat Alcohol and Other Drug Problems*

Hope Taft, First Lady, Ohio

Dave Wanser, PhD, President, NASADAD; Deputy Commissioner, Texas Department of State Health Services

Hon. Jamey Weitzman, Associate Judge, District Court of Maryland, District 1, Baltimore City

Allan Wheeler, Santa Fe County DWI Planning Council; Representative, Impact DWI

Joe Wiese, MS, LPC, CPS, Director, Southwest Center for the Application of Prevention Technologies

Mark Wirschem, King County Reclaiming Futures

Janet Zwick, Deputy Director and Division Director, Behavioral Health and Professional Licensure, Iowa Department of Public Health

ABOUT JOIN TOGETHER

Join Together is a program of the Boston University School of Public Health. Since 1991 it has been the nation's leading provider of information, strategic planning assistance, and leadership development for community-based efforts to advance effective alcohol and drug policy, prevention, and treatment. We believe problems associated with alcohol and drugs can be best addressed at the community level.

Our mission is expressed in our name. Join Together helps community leaders understand and use the most current scientifically valid prevention and treatment approaches. Our surveys have shown that communities with written strategies that are broadly supported by key leaders and institutions are the most likely to be successful in reducing and preventing alcohol and drug problems.

Public and private policies are often major impediments to progress in preventing or reducing alcohol and drug problems. Join Together creates panels of distinguished national and local leaders to study the research on particularly important issues, hold hearings to get input from people throughout the country, and recommend new policies that will be more effective.

Join Together is funded by individual donors and foundations, with major support from The Robert Wood Johnson Foundation.

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