Continuum of Services System Re-Engineering Task Force

PHASE I REPORT
September 2006

California Department of Alcohol & Drug Programs

Contents

Introduction.....1

Conceptual Framework for Re-Engineering.....3

Goal of Re-Engineering the California Continuum of Services Systems.....5

Methodology: Designing the Continuum.....6

Core Principles.....6

Gaps and Needs
Overall, Prevention, Treatment, Recovery.....7

Recommendations.....12

Summary.....16

References.....17

List of Task Force Members.....18

Introduction : a re-engineered california continuum of aod services system

The Department of Alcohol and Drug Programs (ADP) is committed to the development, maintenance, and continuous improvement of a comprehensive and integrated continuum of alcohol and other drug (AOD) services.

Towards that end, in May 2006, ADP established the Continuum of Services System Re-Engineering (COSSR) Task Force to provide recommendations to the department on re-engineering the system of AOD prevention, treatment, and recovery services in California. This is the first step in a process that will guide ADP, working with our stakeholders, in reshaping and repositioning the AOD field in California to insure system accountability, efficiency, and effectiveness, while delivering comprehensive, high quality AOD services.

ADP invited individuals to participate based on their expertise, experience, leadership, and contributions to the AOD field, and reflecting the cultural and geographic diversity of California. The COSSR Task Force included AOD administrators; prevention, treatment, and mental health specialists; Narcotic Treatment Program (NTP) providers; Director's Advisory Committee (DAC) members; policy professionals; and educators. There were representatives from the County Alcohol and Drug Program Administrators Association of California (CADPAAC), the California Association of Alcohol and Drug Program Executives (CAADPE), the California Association of Addiction Recovery Resources (CAARR), the California Association of Alcoholism and Drug Abuse Counselors (CAADAC), and the Friday Night Live Partnership.

The primary tasks of the COSSR Task Force were to: identify gaps and needs in the current system of services; develop core principles to guide the process of re-engineering; and develop a framework for a continuum of services (COS) model for California. Once this was accomplished, the Task Force developed a set of recommendations on re-engineering the AOD system of services in California to ensure that services are effective, high quality, client and community centered, sustainable and culturally competent, and that the AOD system has the capacity and the resources to facilitate holistic health and promote wellness.

The COSSR Task Force is committed to expanding upon and not duplicating prior ADP initiatives to improve system outcomes for clients, their families, and California communities. The recommendations ultimately produced by the COSSR Task Force build upon the work done in previous efforts (System of Care Redesign, Managed Care Policy Advisory Committee, California Treatment Outcomes Project, and California Outcomes Measurement System).

Based on the gaps and needs identified by the Task Force and the adoption of the IOM chronic care model, ADP developed the California Continuum of AOD Services system model. The continuum model reflects the Task Force members' recommendation that intervention must occur at all levels in the continuum and that coordination of services. Coordination of services within the AOD services model and with other service providers is a critical component. Finally, the model acknowledges that recovery services are a necessary and critical component of the AOD system of services in California.

Conceptual framework for re-engineering

Re-engineering a system is defined as a radical transformation of business processes to achieve significant levels of improvement in one or more performance measures through examination, rethinking, redesigning, and implementation. It requires a close examination of assumptions and a willingness to consider new approaches that are systematic and disciplined.

The COS model in California AOD systems is based on the concept that AOD dependence is a chronic illness, which has been defined by the Improving Chronic Illness Care Program as "any condition that requires ongoing adjustments by the affected person and interactions with the health care system." Consistent with that definition AOD dependence should be addressed in a manner similar to other chronic illnesses such as depression, hepatitis C, Human Immuno-deficiency Virus (HIV), and asthma. This is consistent with the 2006 update of the Institute of Medicine's (IOM) Quality Chasm Series which recommends that "substance use disorder treatment move toward building its standards of care, performance measurement and quality, information and cost measures upon a chronic illness model rather than the current, acute illness-based, fragmented and deficient system of health care." The IOM report also noted that substance abuse problems and illnesses are not separate from or unrelated to overall health care and wellness.

Viewing substance dependence as a chronic illness requires a shift in thinking about current systems for addressing these problems and a willingness to examine a new model for delivering services.

Viewing substance dependence as a chronic illness requires a shift in thinking about current systems for addressing these problems and a willingness to examine a new model for delivering services. In 2004, the Institute for Research, Education, and Training (IRETA) facilitated a leadership group to examine the assertion that substance abuse is a chronic illness and to develop "a common vision for the prevention and treatment of substance use disorders." In addition to concurring with the IOM's findings, they established principles of care for development of new systems to treat addiction, including an overarching principle that:

> *the individual (family and community) receiving the right prevention, intervention, and/or treatment and support, at the right level, for the right period of time by the right practitioner, agency or sponsor, every time. . . In this principle will be the assurance of quality, efficiency and accountability to all stakeholders and the assurance that every individual has the best opportunity to achieve wellness and recovery.*

Further, they concluded that “to build a continuum model all parts of the system, including self-care, prevention, intervention and recovery support and management strategies, are complimentary and necessary; and that “wherever the entry point occurs, the continuity of care must be prioritized and supported.”

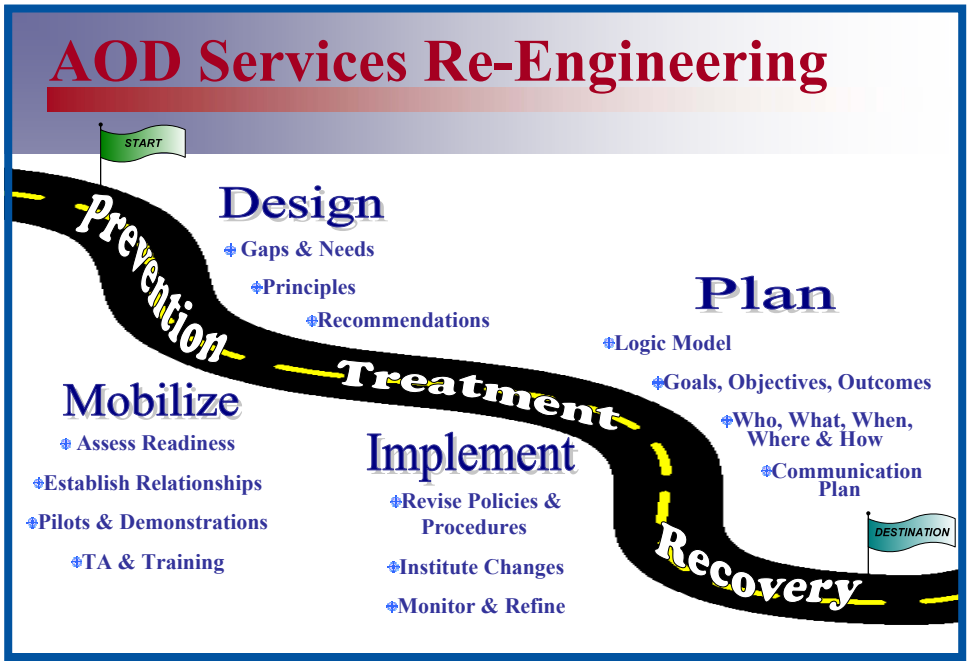
It is ADP’s intention to re-engineer the COS system in California to reflect these principles, as well as others that are identified in this report as critical to providing effective, high quality, and integrated prevention, treatment, and recovery services in California.

Goal of re-engineering the california continuum of services system

The overarching goal of re-engineering the AOD services system is to develop and to maintain a comprehensive statewide prevention, treatment, and recovery system that will prevent, treat, and reduce AOD addictions and related problems and improve the health and safety of the citizens of California.

To accomplish this goal, ADP has established a Continuum of AOD Services Re-Engineering Roadmap to guide the process of services system re-engineering. The system re-engineering goal and road map directly support two of ADP's strategic plan goals, which are to:

- Develop and maintain a comprehensive, integrated statewide prevention, treatment and recovery system.
- Improve quality, capacity and effectiveness of AOD prevention, treatment and recovery services through better use of data, including epidemiological research, and the application of continuous quality improvement practices.



Methodology: designing the continuum

The COSSR Task Force met four times over a six week period. Activities were designed to advance the process of developing recommendations for re-engineering the California AOD system of care. Task Force members were encouraged to develop recommendations that could be easily implemented, as well as those that may require more complex and long-term implementation plans.

The COSSR Task Force members self-selected to participate in a prevention, treatment, or recovery subcommittee; members also worked, at times, in multi-disciplinary groups. Work developed by the small groups was presented and discussed in the Task Force as a whole to allow for continuing input and discussion. Once a set of recommendations based on the work of the subcommittees and multi-disciplinary groups was completed, they were approved by consensus.

Core Principles

The COSSR Task Force established core principles to guide ADP and stakeholders during all phases of the process to re-engineer the COS system in California.

The COSSR Task Force members agreed that an effective COS recognizes that AOD problems are both acute and transient, as well as severe and persistent, and are similar to other chronic conditions. Further, problems can be successfully prevented, treated and/or managed through comprehensive and integrated prevention, treatment, and recovery services. Thus, important principles for an effective continuum of AOD services include:

AOD problems are both acute and transient, as well as severe and persistent, and are similar to other chronic conditions.

AOD problems can be successfully prevented, treated and/or managed through comprehensive and integrated prevention, treatment, and recovery services.

- Services must be strength-based, comprehensive, integrated, and high quality, with demonstrated effectiveness.
- Services must share the following characteristics: accessible, affordable, individual and community-centered, culturally and gender appropriate, and responsive to individual and family needs and differences.
- Delivering quality and effective care requires outcome and data-based planning for California's prevention, treatment, and recovery systems.

- Potential problems can be prevented by reducing risk factors and increasing protective factors in both communities and individuals.
- Transient or non-dependent alcohol or other drug problems can be resolved through acute care, including brief intervention and brief treatment services.
- Recovery from severe and persistent problems can be achieved through continuing and comprehensive AOD treatment and recovery maintenance services.

The Task Force utilized these core principles to develop the recommendations to re-engineer the AOD system of services, and will continue to utilize them in Phase II of the process to develop a plan to implement the recommendations for a COS model in California.

Gaps and needs

In order to develop recommendations for re-engineering the California AOD system of services, the Task Force identified and discussed gaps, needs, and barriers in the current AOD system overall, as well as for prevention, treatment, and recovery. This was not intended as a formal gap analysis nor a needs assessment, but rather the identification of items that, if addressed properly, would enhance or improve the COS in California.

Overall

Numerous barriers interfere with providing the most appropriate services for communities and individual clients, and providing access to a comprehensive array of available services.

Of primary concern to the COSSR Task Force members are the barriers that interfere with providing the most appropriate services for communities and individual clients, and providing access to a comprehensive array of available services. Treatment and recovery client needs, as determined by a qualified AOD professional using a standardized assessment in collaboration with the client, should dictate placement in services and treatment and recovery planning. Instead, services are often determined by available funding and capacity. This also contributes to a severe lack of appropriate and efficient services for family members, including children of individuals in treatment or recovery.

Exacerbating this problem is the lack of coordination, cooperation, and linkages between AOD providers and other state and local systems, particularly criminal justice, primary healthcare, and mental health, that contributes to clients being

under-served. Further, funding is structured in a way that forces compartmentalization or "siloing" of services, adding to the difficulty of prevention participants, treatment clients, and persons in recovery receiving needed services that are outside the AOD system of services.

Finally, stigma continues to undermine effectiveness at all service levels, discouraging individuals from seeking and obtaining services. This, in the long run, can result in a significant increase in costs to the AOD and health care systems, as an individual delays seeking assistance for an AOD problem.

Prevention

Youth face two primary service gaps in the current system: a) there are few options for those whose use and AOD-related behavior problems require indicated prevention services; and, b) there is little youth treatment available for those who are diagnosable by DSM IV as abusers or dependent users. Ideally, to create a seamless transition between prevention and treatment services for adolescents, prevention providers can increase screening and early intervention activities while treatment providers can increase the availability of adolescent brief treatment services.

The COSSR Task Force also noted the lack of consistency in how evidence-based model programs are defined among funding sources, causing difficulties in adopting programs on a large-scale level when working with multiple funders. The requirement for selection of science-based programs creates an artificial gap in services, as customization or adaptation of programs to be culturally appropriate for California results in additional resources and costs. There is a lack of flexibility for innovation due to funding limitations within a given community. Indicated services are more resource intensive and need precise understanding since they blur more readily with treatment. Further, providers may not be experienced in all three categories of prevention services (universal, selective, and indicated).

Finally, special populations and/or communities, such as foster or homeless youth, the elderly, and out-of-school youth tend to be underserved.

Intervention

COSSR Task Force members agreed that, for a variety of reasons, intervention has not been formally identified or funded as a service modality, yet is a vital component of the AOD system.

Intervention should be a bridge from one category of services to another and belongs in all phases of the COS – prevention, treatment, and recovery.

Intervention should be a bridge from one category of services to another and belongs in all phases of the COS – prevention, treatment, and recovery. However, there is a lack of consistency in how intervention is defined in prevention, treatment, and recovery settings. Funding barriers and lack of definitions and service responsibilities often preclude opportunities to intervene with a client with AOD issues or problems.

Treatment

The COSSR Task Force examined the AOD treatment system and identified gaps in current services and for specific populations. In general, there's a need to build capacity to provide client-centered, effective, and comprehensive services and on the system changes that may necessary to insure that client's treatment needs are met. Too often, income and geographic location often dictate what treatment services a client receives. The Task Force identified a number of services that can be critical to the success of individuals while they are in treatment and as they move from treatment to the recovery in the COS. These include: options for post-treatment (sober) housing; financial management and basic living skills; primary health care services; employment services; and integrated co-occurring treatment (mental health and substance abuse).

The Task Force recognized the critical need for treatment services and linkages to services in the criminal justice system. Correctional facilities often lack staff who are trained and professionally certified to identify or properly address individuals with substance abuse problems. There is a gap in services for parolees seeking AOD treatment services or seeking services that will support their sobriety, such as sober living and employment training. Lack of funding limits the number of individuals who can participate in drug court programs.

Capacity is a major issue, and as a result many programs have waiting lists for those wishing to enter treatment. Residential treatment services are unavailable for many who need them, particularly those living in less affluent or rural communities. In some areas, individuals may have to travel long distances to receive services and may be precluded from doing so by lack of transportation options. In addition, there's a significant lack of availability of culturally appropriate treatment services for women, families, and special populations (the elderly, Lesbian-Gay-Bisexual-Transgender, African-Americans, Latinos). There is also an especially acute need for a range of age appropriate adolescent treatment services.

> The continuing decrease in funding and the growing demand for services and improved service effectiveness and accountability is a critical issue.

A critical issue raised by a member of the California Association of Alcohol and Drug Program Executives (CAADPE) and discussed by the COSSR Task Force as a whole is the continuing decrease in funding and the growing demand for services and improved service effectiveness and accountability. The options for addressing the funding shortfalls are problematic; providers can serve more people by reducing the duration of treatment, reducing the frequency of client contact, or reducing care to a level lower than indicated by clinical assessment. Another option is to shift funds from other programs; however, this results in decreased services to another segment of the population whose needs may be perceived as less critical. These attempts to artificially increase program capacity by reducing standards of care are inconsistent with research findings on what constitutes "best practices" for treating addiction. Task Force members agreed that the best option is to maintain current treatment standards with existing funding priorities and to accept first-come-first-served waiting lists where the demand for services exceeds the currently funded capacity, while providing interim treatment services to individuals on waiting lists.

Efficient data and quality assurance systems that ensure accountability across the continuum of AOD services would assist providers in developing evidence-based practices.

There is another issue with incorporating evidence-based practices in treatment services and activities. The complexity of an individual's treatment and recovery needs, as well as the variation of treatment methods and philosophies of AOD providers make evidence-based practices difficult to apply consistently to all programs. However, members note that having efficient data and quality assurance systems that ensure accountability across the continuum of AOD services would assist providers in developing evidence-based practices to meet the specific needs of identified target groups.

The COSSR Task Force identified a comprehensive services coordination system as an important need in insuring that clients succeed while in treatment and also post-treatment. A case manager can help insure that a client is receiving services that are necessary and appropriate and can coordinate and link clients to a range of necessary services is critical. This would help to reduce service fragmentation and prevent loss of clients.

There are numerous issues surrounding the lack of integration of diagnosis and treatment of co-occurring disorders; clients with both a substance abuse and mental health problem are often misdiagnosed and, consequently, receive inappropriate treatment. Another barrier to clients receiving appropriate AOD treatment is the availability of narcotic replacement treatment (NRT) in residential recovery settings; this, in part, is due to a lack of agreement in the treatment

community of how and when NRT should be used. This limits the availability of residential and other treatment services for clients who need NRT.

The laws and regulations governing Drug Medi-Cal (DMC) can be barriers to providing effective AOD treatment services. Having staff person-certified as opposed to site-certified DMC would improve access to persons who do not have access to facilities due to rural area residence, disability, or age. Some changes in eligibility requirements would benefit DMC clients in need of AOD services. For example, once children are removed from a parent's custody, that parent may no longer be eligible for DMC.

Recovery

Recovery should be client centered, based on an individual's needs, preferences, experiences, and cultural backgrounds; clients have the right to choose from a range of options and participate in decisions that will effect their lives.

While prevention and treatment have formal and established AOD systems, there is not a similar system in place for clients who have completed treatment and are in the maintenance phase of recovery. There is a lack of consensus in the AOD community of when treatment ends and recovery begins. Recovery is a term that has varied meanings; for example, people may refer to themselves as being in recovery while they are still in a formal treatment program or years after treatment and sobriety. While there is recognition of the strong link between treatment and recovery, there is no such link between recovery and prevention. However, there was consensus that:

1. Recovery is the business of an AOD System and belongs firmly in the continuum;
2. Self-help is an integral part of recovery, along with other culturally-supportive peer help systems, such as 12 Step, Talking Circles and faith-based activities;
3. These services should be available in the recovery part of the COS system: services coordination, relapse prevention, continuing involvement, continuing comprehensive assessments, motivational counseling, recovery maintenance planning, community services linkages, exit planning, family preservation and reunification, child care, housing (sober living, safe housing, permanent housing), drop in services, transportation, peer support and mentoring, education/ life skills training;
4. Recovery should be client centered, based on an individual's needs, preferences, experiences, and cultural backgrounds; clients have the right to choose from a range of options and participate in decisions that will effect their lives; and
5. There is a significant lack of funding for recovery services, especially services that address the needs of families.

Recommendations

The COSSR Task Force developed the following recommendations to begin the process of re-engineering the COS system of AOD Services in California.

Overall System

Policy

- Hold harmless the current service system by insuring that financial and other resources are identified or developed for recommended system changes and improvements that may require additional funding to implement.
- Advocate for parity in insurance and medical plans for AOD services for individuals with AOD problems.
- Advocate for the repeal of the Uniform Policy Provision Law (UPPL) law to allow for identification and documentation of an AOD problem in health care settings, including emergency rooms.
- Identify resources to expand Screening, Brief Intervention, Referral, and Treatment (SBIRT) in all medical settings.

Fiscal

- Reduce the funding restrictions between systems that are barriers to providing individual and community-centered services.
- ADP should identify resources for technical assistance and training needed to implement COSSR Task Force recommendations.
- Provide resources for pilot or demonstration projects for recommended service approaches.
- Advocate for new resources and useful data information systems that document demonstrated outcomes and lead to improved services.

Linkages

- Foster and promote key partnerships, and use a multi-disciplinary approach at the federal, state, and local levels to facilitate effective service linkages and cross-referrals, as well as collaboration to identify and develop resources, while respecting philosophical and bias differences between systems.

- Develop linkages and improve service coordination between Employee Assistance (EAP) programs and AOD service providers.

- Enhance service linkages and cross-discipline coordination within the continuum for family-based services, including services to children with a parent/caretaker in treatment and/or recovery.

- Insure cultural competency in prevention, treatment, and recovery services to address barriers to service, including language barriers.

- Increase consumer input into ADP's process for re-engineering the COS.

- Develop a plan to address the specific services needs of adolescents in prevention, treatment, and recovery.

- Include DUI in the COS as part of treatment; through screening assessment and treatment referral services, DUI services should be a portal to the appropriate services in the continuum.

- Intervention should occur in all phases of the COS system; individuals representing a broad array of systems, disciplines, and settings should be trained to provide AOD prevention screening and referral for AOD treatment assessments (DSM IV criteria) as warranted.

Specific Recommendations

Prevention

- Enhance workforce development opportunities for prevention providers by developing core competencies for prevention and early intervention specialists (e.g., EAP, SAP, SBIRT).

- Encourage participation of parents/caretakers in prevention parenting classes; eliminate current barriers to providing incentives.

- Develop and clarify the definitions of selected and indicated prevention in order to plan for and insure service delivery in compliance with the Block Grant; services delivered through indicated prevention need to be clearly distinguishable from treatment assessments (DSM IV diagnosis) and services.

- Enhance the opportunities for individuals in recovery to participate in local planning and implementation efforts that advance prevention, treatment, and recovery objectives.

- Partner with the medical community to develop strategies to address prescription drug abuse, including continuing education and availability of computer based information.

Treatment

- Expand the availability and affordability of health services, including primary care, dental care, and mental health services, through coordination and linkages for all individuals in treatment and recovery.

- Explore the option of services for opioid-related treatment in residential settings.

- Provide reimbursement for narcotic replacement therapy in medical settings, such as primary care or community care clinics, who are served by physicians, pharmacists, registered nurses, physicians' assistants, and nurse practitioners.

- Use AOD specialists in pre-release planning programs.

- Increase workforce development for criminal justice staff regarding AOD issues through continuing education requirements and as part of peace officer/correctional staff training.

- Ensure jail based AOD treatment, including narcotic replacement therapy.

- Provide AOD specialists to courts and judges to help inform their decisions.

- Work with the Judicial Council and the Administrative Office of the Courts to expand judicial education regarding AOD problems, including addictions.

- Expand the number of dependency drug courts for interaction and linkages between AOD services and the child welfare system.

Recovery

- Advocate for recognition of the importance of recovery in the continuum of services at the Federal, State, and local level.
- Identify available resources and advocate for flexibility in spending public dollars in order to provide sufficient resources for recovery services.
- Insure that Recovery Support Services occur in demonstrated ways in both the treatment and recovery areas of the continuum.
- Eliminate arbitrary and absolute timeframes that limit how and when services can be provided.
- Promote outreach to recovering persons who may benefit from recovery services even if they have no formal treatment program experience.
- Develop recovery-supportive services for youth in schools.
- Insure that clients have the right to choose from a range of options and participate in decisions that will affect their lives to insure that recovery services are client centered and based on an individual's needs, preferences, experiences, and cultural background.
- Recovery planning for individuals in treatment and recovery should be comprehensive and include housing, employment, education, mental health, addiction treatment, spirituality, social networks, family supports and more; this should be provided for, when appropriate, through services and/or coordination and linkage with other systems.
- Develop and implement a model of statewide services coordination for clients in treatment and/or recovery.

Summary

In supporting ADP's Continuum of AOD Services Re-Engineering Roadmap, the COSSR Task Force is advancing California towards a more comprehensive and integrated system reflects and addresses the specific needs of Californians, with an emphasis and focus on integration - linkages between and within modalities.

Re-Engineering the COS system in California is a challenging task that will require the development of a system that: is dynamic and responsive to changes; considers the needs of all people and communities served by the system and addresses their multiple needs; anticipates new groups and new issues; is driven by data and outcomes; and provides for continuous quality improvement. In taking this step, Phase I of the roadmap, California is leading the nation in addressing the need to improve AOD systems through a comprehensive and integrated continuum of AOD services based on chronicity and the need for the availability of continuous care.

ADP will be convening a COSSR Task Force for Phase Two: Implementation Planning, which will review the recommendations and plan the steps for implementation.

References

- Improving Chronic Illness Care Program. MacColl Institute for Healthcare Innovation, Group health Cooperative Center fro Health Studies.

- Institute of Medicine. (2006a). Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington, D.C.; National Academy Press.

- Institute for Research, Education, and Training in Addictions. (2006). Special Report: A Unified Vision for the Prevention and Management of Substance Use Disorders: Building Resiliency, Wellness and Recovery – A Shift from an Acute Care to a Sustained Care Recovery Management Model. Institute for Research, Education and Training in Addictions (IRETA).

List of Task Force Members

ADP would like to acknowledge the following individuals, who participated in the Continuum of Services System Re-Engineering Task Force and contributed their time and expertise in developing the recommendations to re-engineer California's AOD system of services.

Lily Alvarez, Administrator
Kern County Mental Health AOD Programs

Tom Avey, Executive Director
Progress House

Paul Brower, Manager
Department of Alcohol and Drug Programs
Program Services Division - Prevention

Ron Bevers, Analyst
Department of Alcohol and Drug Programs
Program Services Division

Susan Blacksher, LCSW, Director
California Association of Addiction
Recovery Resources

Adrienne Buckle, AOD Prevention
Coordinator
Kern County Mental Health AOD Programs

Michael Cunningham, Deputy Director
Department of Alcohol and Drug Programs
Program Services Division

Carmen Delgado, Assistant Deputy Director
Department of Alcohol and Drug Programs
Program Services Division - Treatment

Haven Fearn, Director
Contra Costa County Health Services
Substance Abuse Services

Lisa Fisher, Public Information Officer
Department of Alcohol and Drug Programs
Legislation and Public Affairs

Tom Freese, PhD, Director
Pacific Southwest Addiction Technology
Transfer Center

Angela Goldberg, Consultant
Prevention by Design
Regional Trainer for Orange, Riverside and
San Bernardino Counties

Jonathan Graham, Drug Court
Data Coordinator
Department of Alcohol and Drug Programs
Office of Applied Research and Analysis

Mary Hale, Division Manager
Orange County Health Care Agency
AOD Services

Bob Hulsey, Manager
Paar Center

Joy Jarfors, Branch Manager
Department of Alcohol and Drug Programs
Licensing and Certification Division

Marty A. Jessup, PhD, RN, CNS
UCSF School of Medicine
Department of Family Health Care Nursing
Institute for Health and Aging

Ellen M. Johnson, MA, Behavioral Health
Director Sacramento Native American
Health Center

Linda Jue
Stanislaus County AOD Services
Education and Prevention Services

Bosseba Kong, MSW, LCSW
Stanislaus County Behavioral Health &
Recovery Services

Diana LaMotta, Deputy Director
Department of Alcohol and Drug Programs
Office of Criminal Justice Planning

Susan Lussier, Deputy Director
Department of Alcohol and Drug Programs
Administrative Services

Judith Martin, MD, Medical Director
14th Street Clinic

George Lembi, Data Programming
Manager II
Department of Alcohol and Drug Programs
Information Management Services Division

Rhonda Messamore, CADC II,
Executive Director
California Association of Alcoholism and Drug
Abuse Counselors

Thomas Metcalf, LCSW, Program Manager
Sutter-Yuba Mental Health Services

David Mineta, Associate Director
Asian American Recovery Services

David Monti, Assistant Deputy Director
Department of Alcohol and Drug Programs
Program Services Division - Prevention

Carol Nottley, Chair
Director's Advisory Council
Aging Constituent Committee

Terry O'Brien, Chief
Kaiser Permanente Chemical Dependency
Recovery Program

Patrick Ogawa, Director
Los Angeles County Alcohol and Drug
Program Administration

Lori Phelps, Psy.D, CATC
California Association for AOD Educators

Roger Riott, Sober Living Consultant
California Association of Addition
Recovery Resources

Terry Robinson, Executive Director
Alcohol and Drug Policy Institute

Kerrilyn Scott-Nakai
Center for Applied Research Solutions

Albert Senella, Director
Tarzana Treatment Center

Naomi Smith, Director
Ujima Family Recovery Services, East

Laura Solis, Program Administrator
Lake County Mental Health Department
Division of AOD Services

Morgan Staines, Chief Counsel
Department of Alcohol and Drug Programs
Legal Services

Shirin Vakharia, Acting Administrator
Napa County HHS Agency AOD Programs

Barbara Weiss, Analyst
Department of Alcohol and Drug Programs
Program Services Division

Joan Zweben PhD, Program Director
14th Street Clinic
East Bay Community Recovery Project