

Continuum of Services System Re-Engineering Task Force



PHASE II REPORT



California Department of Alcohol & Drug Programs



TABLE OF CONTENTS

Executive Summary1

Introduction.....3

Conceptual Framework for Re-Engineering in California4

Continuum of System Re-Engineering in Four Phases6

Re-Engineering the AOD System of Services: Phase I7

Re-Engineering the AOD System of Services: Phase II8

System Improvement Model (SIM) Committee Descriptions and Objectives9

SIM Committee: Process for Implementation Planning10

SIM Committee: System of Services Design11

SIM Committee: Leadership and Administrative Support14

SIM Committee: Policies and Resources16

SIM Committee: Community Partnerships Committee17

SIM Committee: Prevention and Recovery Support18

SIM Committee: Workforce Development.....20

Next Steps: Phase III.....22

Conclusion23

APPENDIX

1. Complete Set of Committee Objectives and Major Tasks

System of Services Design26

Leadership and Administrative Support.....35

Policies and Resources38

Community Partnerships Committee40

Prevention and Recovery Support42

Workforce Development.....46

2. Roster of COSSR Phase II Task Force members.....48

3. Glossary of Commonly Used Terms.....52

Executive Summary

This report summarizes progress to date on the Department of Alcohol and Drug Programs' (ADP) Continuum of Services System Re-engineering (COSSR), a significant, multi-phase system improvement initiative to re-engineer California's continuum of services (COS) for alcohol and other drug (AOD) problems. The foundation of this initiative lies in the acknowledgement that alcoholism and drug addiction are the result of a chronic brain disease and that a new, integrated system of care is necessary in order to achieve the desired outcomes for the prevention, treatment, and recovery for those individuals and communities served by the AOD field. This new system of care would require integration and coordination from the many stakeholders in the AOD field working in prevention, treatment, and recovery support services, as well as partners in mental health, health care, law enforcement, social services, and education.

Currently, the system addresses AOD problems as acute issues. This model for serving individuals with AOD problems limits the potentiality for successful treatment outcomes because the acute care model inhibits holistic treatment and continuous care. Indeed, AOD use and dependency have been likened to chronic conditions such as diabetes, asthma and heart disease. As health experts assert and current research demonstrates, all chronic conditions share the similar need for the prevention, treatment, and recovery maintenance of that condition.

The members of the COSSR Task Force shared a common vision of a continuum of alcohol and drug services that provides effective, high quality and integrated prevention, treatment and recovery support services. The goal of Phase I was to outline the basic design of a system responsive to the chronic nature of AOD problems. In this design work, the Department of Alcohol and Drug Programs (ADP) worked with a variety of stakeholders to adopt core principles, identify service categories and develop a set of recommendations to address the gaps between the current system of an acute care model and a system fundamentally based on a chronic care model.

Phase II built on this work by using Phase I recommendations as the basis for implementation planning. The Task Force membership was broadened to include representatives who reflect the diversity of California's AOD, mental health, and medical systems of care.

The System Improvement Model (SIM), which was developed to improve the quality of care for other chronic health conditions, was adapted to the alcohol and drug continuum of care services. The Task Force was divided into committees for the six SIM areas to develop a plan for implementing the AOD chronic care model in these areas: System Design, Leadership and Administrative Support, Policy and Resources, Workforce Development, Community Partnerships and Prevention and Recovery Support.



Phase II concluded with basic conceptual agreement on the goals, objectives, and major tasks in these six areas. Several policy issues were emphasized, including cultural competency across the six SIM areas, moving from a provider centered system to a client and community centered system, the inclusion of recovery support as a critical part of the service continuum, and acceptance by a range of community partners that addiction is a chronic disease that can be successfully prevented and treated. This report details these findings.

ADP will continue to provide leadership and support for the continuing initiative to re-engineer California's AOD system of services.

Introduction

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 system based on acknowledging both the acute and chronic nature of AOD problems and addiction. Fundamental to the system change effort is the recognition that the current system is designed to address AOD problems as only acute conditions; however, addiction causes problems that are of a continuous, chronic, and relapsing nature to both individuals and communities, necessitating on-going continuous care and support.

Viewing substance dependence and addiction as a chronic disease requires a shift in thinking about current systems for addressing AOD problems. New approaches that are systematic and disciplined must be considered, and there must be a willingness to develop a new model for delivering services that includes the participation of individuals and communities within an interdependent system.

In 2006, ADP established the Continuum of Services System Re-Engineering (COSSR) Task Force to assist the department in examining the current AOD services delivery system and to develop a plan for overall system change. The primary goal of the re-engineering process is to work with the department's stakeholders to reshape and reposition ADP's operations to ensure system accountability, efficiency, and effectiveness, while delivering comprehensive, high-quality AOD services.

The charge of the Phase I Task Force was to construct a framework for a California continuum of services (COS) model and to develop a set of recommendations that would serve as the basis for re-engineering (Phase I report available at http://www.adp.ca.gov/COSSR/pdf/COSSR_Report-Sep2006.pdf). The Phase II COSSR Task Force, which began meeting in October 2006, continued the re-engineering process using the Phase I recommendations as a foundation for developing a comprehensive implementation plan.

Process

It is ADP's intention to re-engineer the COS system in California as a joint effort between ADP and stakeholders in the AOD field. Consequently, the Task Force included stakeholder groups' representatives and staff representing ADP's divisions and programs, so that joint planning could occur throughout the process.

Because of the re-engineering effort's significant impact on the current AOD system of services, it was important to invite individuals who could represent the views of a constituent body or interest group of critical stakeholders. This included county administrators, providers, academicians and researchers, and constituency groups. Additional individuals were invited to be Task Force members based on their expertise, experience, leadership, and contributions to the AOD field; consideration was given to ensure that the membership reflected the cultural and geographic diversity of California. In an effort to ensure continuity, ADP invited Task Force members who participated in Phase I to continue serving on the Phase II Task Force; sixteen individuals agreed to continue.

This report summarizes:

- the recent movement to address addiction as a chronic disease and subsequent efforts to redesign an interdependent system of care;
- a history of the re-engineering effort in California;
- the process and outcomes of Phase II; and,
- the next steps in system change.

Conceptual Framework for Re-Engineering in California

The COS model developed for California AOD systems is based on the concept that AOD addiction and dependence is a chronic illness, 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.” By this definition, AOD dependence should be addressed in a manner similar to other chronic illnesses such as depression, Hepatitis C, Human Immune-deficiency Virus (HIV), and asthma.

In 2004, the Institute for Research, Education, and Training in Addictions (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.” They established principles of care for development of new systems to treat addiction, including the overarching principle that:

the individual (family and community) receiv[es] 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, the group 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.”

The 2006 update of the Institute of Medicine’s (IOM) Quality Chasm Series, “Improving the Quality of Health Care for Mental and Substance-Use Conditions,” 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

Continuum of System Re-Engineering in Four Phases

The current re-engineering effort is built on several prior ADP initiatives, including the System of Care Redesign, the Managed Care Policy Advisory Committee, the California Treatment Outcomes Project and California Outcomes Measurement System Implementation Work Group. These initiatives are designed to enhance system improvement in a variety of ways. ADP is committed to expanding on, not duplicating these initiatives as the COS is developed and implemented.

Given the enormity of re-engineering California’s system of care, this effort was designed to occur in phases, involving ADP stakeholders in all phases of the process as described and shown as follows:

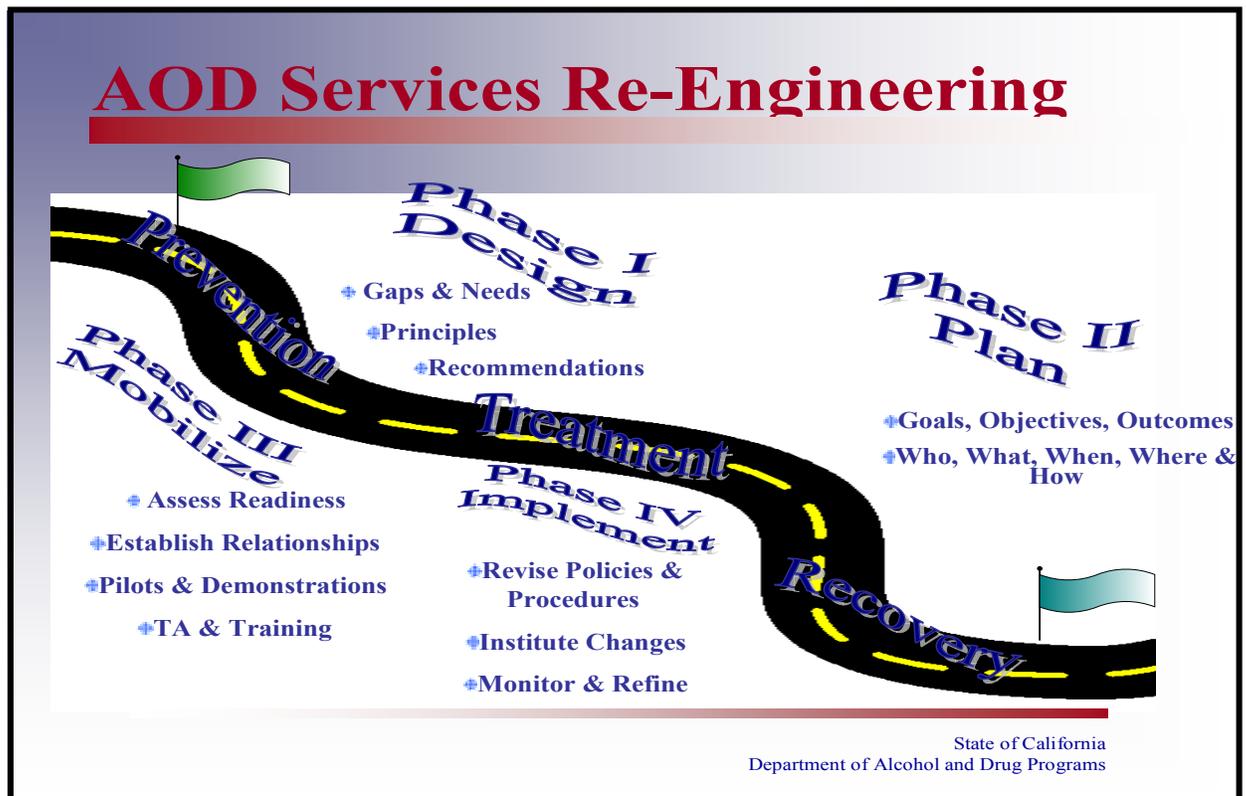
Four Phases

COSSR - Phase I: Design The Task Force identified gaps and needs, established principles, and developed a set of recommendations for incorporating the COS model in California’s system of AOD services (prevention, treatment, and recovery).

COSSR - Phase II: Plan The Task Force developed an implementation plan for re-engineering the system of AOD services in California using the Phase I recommendations as a starting base.

COSSR Phase III: Mobilize ADP will mobilize AOD stakeholders and community partners to implement the Phase II recommendations for services system re-engineering.

COSSR Phase IV: Implement ADP will continue to implement prioritized recommendations, evaluate programs, and provide training.





Re-Engineering the AOD System of Care: Phase I - Design

The primary tasks of the COSSR Task Force were to:

- Identify gaps and needs in the current system of AOD services;
- Develop core principles to guide the process of re-engineering; and
- Develop a framework for a COS model for California based on the chronic care model.

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 established the following core principles to ensure that services are effective, high quality, and sustainable and that the AOD system has the capacity and the resources to facilitate holistic health and promote wellness:

1. Services must be strength-based, comprehensive, integrated, and high quality, with demonstrated effectiveness.
2. 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.
3. Delivering quality and effective care requires outcome and data-based planning for California's prevention, treatment, and recovery systems.
4. Potential problems can be prevented by reducing risk factors and increasing protective factors for both communities and individuals.
5. Transient or non-dependent alcohol or other drug problems can be resolved through acute care, including brief intervention and brief treatment services.
6. Recovery from severe and persistent problems can be achieved through continuing and comprehensive AOD treatment and recovery maintenance services.

These principles are the basis for all phases of the re-engineering process.

Key Outcomes of Phase I

In addition to developing the core principles to guide the re-engineering process, the Phase I Task Force created California's COS model that included the major categories of prevention, treatment, and recovery support services, with intervention occurring throughout the continuum. The Task Force also determined that cultural competence must be integrated throughout the continuum and that sustainable client or community-driven services are essential.

After completing an assessment of gaps, needs, and barriers in the AOD system of services, the Task Force developed a comprehensive set of recommendations that addressed re-engineering the current system of care. The recommendations covered the three service categories and reflected the consensus of COSSR members. These recommendations were circulated to the field for comment, and presented at the ADP sponsored statewide conference in September 2006. The Phase I report is available on the COSSR webpage at the ADP website.

Re-Engineering the AOD System of Care: Phase II – Plan

The overall goal of Phase II of ADP's initiative is to develop an implementation plan to re-engineer California's AOD system of services from an acute care model to a chronic care model that addresses the prevention, treatment, and recovery service needs of individuals and communities in California.

The Phase II Task Force process for implementation planning was based on the essential elements of a health care system that are necessary for high-quality chronic disease care. The success of the model is based on community involvement, requiring a partnership between the community and the health care system.

Four essential elements contribute to the success of the chronic care model:

- 1) self-management support;
- 2) delivery system design;
- 3) decision support; and,
- 4) clinical information systems.

Productive interactions between informed consumers, clients, and participants and providers with resources and expertise also contribute to improved outcomes for individuals and communities.

System Improvement Model

In order to organize the work of the Phase II Task Force and provide a structure for implementation planning, ADP utilized a System Improvement Model (SIM). This model, made up of six areas of improvement, was adapted from a chronic care model designed to improve health care for chronic conditions. It is anticipated that the combination and cumulative result of improvements in *these six areas* will create the kinds of system changes that will enhance outcomes for clients, consumers, and participants.

- 1. System of Services Design:** A successful system of care will define roles, responsibilities, and functions; use planned interactions to support coordinated evidenced-based care; and provide services that are community and client centered, as well as culturally and linguistically appropriate.
- 2. Leadership & Administrative Support:** An effective system reflects a commitment to improvement at all levels of the organization, ensuring adequate support, incentives and information systems with ready access to key data – all fundamental to high quality, efficient and effective practice.
- 3. Resources and Policies:** Local and state AOD-related health policies, funding and other resources, including insurance benefits, and other regulations are needed to support a comprehensive and integrated system of AOD services.
- 4. Community Partnerships:** Participants in the AOD system need services from a range of other community systems; it is therefore essential to form partnerships with community organizations to fill gaps in services needed from outside the direct AOD system.
- 5. Prevention and Recovery Support Services:** A system should empower and prepare individual clients and community groups to prevent, reduce or manage their AOD risks and recovery by promoting and facilitating effective self-management support strategies at individual and community levels.
- 6. Workforce Development:** The system must ensure that the workforce is a prepared and proactive team that supports the continuum by addressing barriers and employing strategies to recruit, retain, and develop a workforce with the knowledge, skills and abilities necessary for providing an effective COS.

SIM Committee Process for Implementation Planning

Task Force members selected one of six committees to join based on their expertise and the interests of the stakeholder group they represented.

In the six SIM committees, members refined SIM area goals, and developed a set of objectives that would need to be implemented to accomplish the overall goal of that committee. The Phase I recommendations, which ADP staff assigned to the most appropriate SIM committee, became the basis for developing a set of specific objectives to meet the goal within each SIM area. During the course of the committees' work, these recommendations were expanded and additional objectives developed to complete the system re-design.

The SIM Committee members also identified barriers, estimated needed resources, and developed the major tasks needed to implement each objective. The planning work occurred in committee meetings that were part of the face-to-face sessions, so that frequent reports back to the full Task Force could occur. The six SIM committees also used conference calls to work on implementation planning.

The following section provides the goal and description of each committee's purpose and the objectives developed by the committee for that SIM area. (See Appendix 1. for a complete set of objectives with major tasks delineated.)

System of Services Design

I. **Goal: Develop a comprehensive, integrated, effective, and efficient AOD services system.**

Improving the health of people with chronic illness and reducing their impact on communities requires transforming a system that is essentially reactive – responding mainly when a person is sick – to one that is proactive and focused on keeping individuals and communities healthy while supporting on-going recovery and wellness.

The services and linkages between prevention, treatment, and recovery support must be clearly delineated; the system must provide a complete range of services necessary and sufficient to effectively prevent, reduce, and treat AOD problems and addiction. The system must have the capacity to support sustained recovery and healthy environments and use evidence-based practices and strategies to ensure high-quality and effective and efficient services and outcomes.

In a comprehensive AOD system of services, integrated services for prevention, treatment, and recovery should be a part of standard procedure. Individuals with more complex AOD-related problems may need more intensive service coordination for a period of time to optimize clinical care and self-management. Further, health literacy and cultural competency are two important concepts in AOD services. Providers must respond to the diverse cultural and linguistic needs of communities and individuals.

An effective AOD system of care depends on a network of services that share their information in order to ensure ready access to key data on the service needs of individuals, as well as populations to:

- a) facilitate efficient and effective care and services;
- b) provide timely reminders for providers and individuals;
- c) identify relevant subpopulations for proactive services;
- d) facilitate community and individual services planning;
- e) share information with communities, individuals, and providers to coordinate services; and,
- f) monitor the performance of the services system.

The ability to monitor performance and assess outcomes is critical to continuous quality improvement efforts.

The following objectives were developed by the System of Services Design Committee:

Objective 1

Position AOD System as a specialized and distinct system that collaborates, partners, and links with other service systems and the community.

- 1a. Position the AOD System as separate and distinct.
- 1b. Identify partners (including mental health and public health) with which to collaborate and create collaborations, linkages, and partnerships.
- 1c. Share and train personnel regarding effective collaboration strategies across providers, counties, and states.
- 1d. Establish standards and benchmarks for integrated services, where appropriate (e.g. substance abuse disorders and child welfare).

Objective 2

Ensure that the prevention, treatment and recovery system is community and client-centered and driven, and culturally, gender and age developmentally appropriate:

- 2a. Provide gender and culturally responsive services across the COS and life cycle.
- 2b. Provide age and developmentally appropriate services across the COS and life cycle.
- 2c. Ensure that individuals and communities are centrally involved in all decision making related to their own services.

Objective 3

Ensure both intervention and service coordination occurs throughout the continuum.

- 3a. Define COS and its components: prevention, treatment, and recovery support.
- 3b. Define and incorporate intervention and services coordination in the COS.
- 3c. Incorporate services coordination in the COS.

Objective 4

Enhance service linkages and cross-discipline coordination within the continuum for family-based prevention and treatment services. (Family is defined by the individual and may include spouses, children, godparents, partners, household members.)

Objective 5

Establish a COS that has the capacity to prevent and treat co-occurring disorders (substance abuse and mental health disorders).

Objective 6

Create processes for identifying, selecting and implementing effective approaches for preventing and treating AOD problems in a variety of populations, communities, and settings.

Objective 7

Implement on-going, comprehensive, community and client data driven, outcome-based state and local planning across the COS including prevention, treatment, and recovery support that incorporates evaluation for continuous quality enhancement.

Objective 8

Integrate Driving Under the Influence (DUI) and Drug Diversion (PC1000) programs into the overall COS.

Objective 9

Incorporate harm reduction concepts and strategies into the COS.

Leadership & Administrative Support

- II. Goal: Develop an organizational culture and infrastructure that promotes comprehensive, integrated, effective, and efficient AOD services; reduces stigma, discrimination, and negative stereotypes; and provides for active consumer participation and preferences.**

Effective and active leadership is necessary to support and sustain an AOD services system. This is accomplished by creating a culture, organization, and mechanisms that:

- a) promote safe, high quality care and visibly support improvement at all levels of the organization;
- b) promote effective improvement strategies aimed at comprehensive system change;
- c) encourage open and systematic handling of errors and quality problems to improve services;
- d) provide incentives based on quality of services; and,
- e) facilitate services coordination within and across organizations.

Improving AOD prevention, treatment, and recovery support services require leadership that recognizes and supports quality improvement as critical to system success by developing clear goals and policies, and instituting effective and ongoing improvement strategies. Supporting these goals and policies may include use of incentives that encourage comprehensive system change. Effective organizations try to prevent errors and problems by reporting and studying inefficiencies and making changes to their systems. Breakdowns in communication and services coordination can be prevented through agreements that facilitate communication and data-sharing.

In order to improve prevention, treatment, and recovery support services, it is critical to assemble scientific evidence on the efficacy and effectiveness of a variety of interventions, including their implementation and use in varied age and ethnic groups; use a well-established approach to rate and categorize the strength of these interventions; and recommend or endorse guidelines for the use of the evidence-based interventions for AOD problems.

Objective 1

Prevention, treatment, and recovery support services should be covered by insurance and reimbursed like other chronic medical conditions in both private and public insurance health care plans.

Objective 2

Reimbursement policies and funding decisions should be guided by the needs of the individuals and communities that we serve.

Objective 3

Ensure competency by promoting an AOD/COD COS that treats all people with respect and dignity and meets the needs of and is culturally appropriate for people of all ages, races, ethnicities, sexual orientations, gender identities, native tongues, religions or spiritualities, socioeconomic classes, partner statuses, and physical and mental disabilities, and requires knowledge of particular drugs, methods of use, and drug cultures.

Objective 4

Appropriately utilize evidence-based, medication-assisted treatments and recovery support services, including replacement therapy options for AOD/COD problems across the range of substances.

Objective 5

Reduce stigma against people suffering from addictions and COD in all areas of the prevention, treatment, and recovery support services system and AOD providers.

Objective 6

Establish the framework for performance management, monitoring, and improvement for the entire COS in ADP's publicly-funded licensed or certified programs.

Objective 7

Develop useful data information systems and standards for prevention, treatment, and recovery support services that include families and communities, in order to document outcomes and improve client/patient management leading to timely, safe, effective, and person-centered services.

Objective 8

Examine and amend laws, regulations, policies, and administrative procedures and practices to eliminate barriers and support the implementation of COSSR.

Objective 9

Ensure that all licit and illicit addictive substances including prescribed medications and tobacco are addressed in the AOD system.

Policies & Resources

III. Goal: Develop and implement policies and resources that support system-wide effective outcomes.

An AOD services system must be supported by federal, state, and local AOD and health-related policies, regulations, funding sources, and other resources, including insurance benefits, to support a comprehensive and integrated system of AOD services.

Policy makers and planners should examine laws, regulations, policies, and administrative procedures and practices that create barriers to comprehensive, integrated, and effective services. AOD service providers' ability to obtain information about an individual's health, health care, and service needs, and to share this information in a timely, safe, and secure manner with other providers, is essential to effective, coordinated care.

Gaps in knowledge about prevention, treatment, and recovery impact the effectiveness of services delivery, as well as mechanisms and processes for improving quality. This can lead to shortcomings in public policy for the prevention, treatment, and management of AOD problems and addiction. Improved models that support services for community and individual care require changes in the structure and delivery of services.

Funding decisions based on established and common outcomes, guided by market incentives and driven by client outcomes and performance quality measures will also serve as leverage for the needed changes. The structure of public policy will be impacted as well by efforts to address the workforce issues.

Objective 1

Develop comprehensive prevention policies and regulations regarding COS for AOD services for individuals, families, and communities.

Objective 2

Designate ADP as the single state agency for the oversight and development of funding and policy for all AOD services, and to promulgate the regulations to implement policy.

Objective 3

Examine and change laws, regulations, policies, and administrative procedures and practices to eliminate barriers and support the implementation of COSSR.

Objective 4

Develop comprehensive treatment policies and regulations regarding continuum of care for AOD services to address the specific needs of adolescents.

SIM: Community Partnerships Committee

IV. Goal: Ensure linkages between AOD and other community systems and partners to promote effective outcomes for communities and individuals.

Community partnerships are necessary to ensure coordination between AOD and other community service systems. These coordination efforts need to be established and in place to promote effective outcomes for individuals and communities. It is the role of state and local community partnerships to ensure these needed linkages so that the AOD system of care is able to support and develop interventions that fill gaps in needed services. In the AOD services continuum, prevention services apply to both individuals and to communities. Improving the quality of services, and community and individual health depends upon the effective collaboration of AOD, mental health, and other health and human service and criminal justice providers serving communities, individuals, and families. Coordination of services is essential to improved health outcomes, especially for chronic illnesses. Providers must develop and maintain strong linkages within the AOD system, as well as with other systems of care.

The array of human service providers not considered part of the direct AOD services sector necessitates additional levels of coordination, which must be effected despite the difficulties of working with multiple bureaucracies and in systems with differing priorities and practices. Organizations that are not part of the traditional health care sector, such as schools, employers, the child welfare system or the criminal justice system, often refer, arrange for, support, monitor, and deliver AOD-related services.

Objective 1

Work with partners to adopt a paradigm that acknowledges the chronic nature of alcohol and drug problems.

Objective 2

Promote collaborative models with state and community partners through both formal and informal policy.

Objective 3

Continuously identify new and potential partners based on data and information on emerging AOD issues.

Prevention and Recovery Support Services

V. Goal: Empower and prepare individuals and communities to prevent, reduce, or manage their AOD risks and recovery.

The COS model should promote and facilitate effective self-management support strategies at individual and community levels and engage those individuals in the prevention and in the recovery system as partners, integral to the COS.

Prevention reduces the probability of developing or exacerbating direct and/or indirect personal, social, health, and economic problems resulting from problematic ATOD availability, manufacture, distribution, promotion, and sales, as well as individual use. The desired result is to promote safe, healthy behaviors and environments for individuals, families, and communities.

Successful treatment outcomes depend to a significant degree on the effectiveness of self-management. Effective self-management in recovery acknowledges the communities' and individuals' central role in aftercare. The system of services must empower and prepare individuals to manage their recovery and health care by using effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up; and by organizing internal and community resources to provide ongoing self-management support to individuals.

Using a collaborative approach, providers, communities, and individuals must work together to define problems, set priorities, establish goals, create recovery plans and solve problems along the way. These "productive interactions" between providers and individuals need not be restricted to face-to-face visits, nor necessarily to one-on-one encounters. Self-management support using group visits and telephone follow-up are evidence-based examples of new methods of making communication between individuals and providers both more efficient and more useful to the individual.

Objective 1

Provide outreach services to persons and their significant others who may or may not have gone through formal treatment and/or who may benefit from recovery support services.

Objective 2

Require ADP to take leadership in creating and implementing a recovery management system.

Objective 3

Assure that prevention practices and services include community-based approaches, policies, procedures, and program approaches that are evidence-based and culturally competent.

Objective 4

Increase availability of an array of housing for sober and transitional-living communities.



Objective 5

Organize culturally appropriate community resources to provide ongoing self-management support to individuals and communities to effectively reduce their risk of AOD problems.

Objective 6

Assure that cultural competency is integrated in community-based prevention and recovery support services.

Workforce Development

VI. Goal: Ensure that the AOD workforce is prepared to deliver effective services to support the prevention, treatment, and recovery needs of communities and individuals.

The implementation of any re-engineered system will depend on the people delivering the services. Strategies are needed that address barriers to developing, recruiting, and retaining a workforce with the knowledge, skills, and abilities necessary for providing an effective COS. AOD professionals are often trained with the same content and methods that have existed for many years. When training does not keep pace with current AOD needs and best practices, problems arise such as misdistribution of the AOD workforce, lack of a representative workforce, and superficial awareness that employs short-term, ad hoc initiatives as opposed to long-term and ongoing measures to address system problems.

Addressing workforce issues should be an integral component of the delivery of prevention and care services needed in the 21st century. A successful COS depends on the development and implementation of training to ensure ongoing dissemination and application of the knowledge, skills, and abilities necessary for the AOD prevention and treatment workforce. An appropriately distributed AOD workforce with proper, contemporary, and culturally-relevant training will aid in successful recruiting and retention strategies.

State and local providers must focus on collecting better, relevant data to more accurately assess workforce trends, issues, and working conditions. Structured processes are essential for insuring the continuing competence of the workforce. Requirements for training and education should be ongoing as new ideas come into the field. Multidisciplinary approaches, modern technology, and developments in the AOD field all contribute to an effective workforce.

Regulatory and other oversight processes must be developed and coordinated to reinforce the principles of client and community-centeredness, evidence-based practice, and systems' improvement and to address those legal and regulatory constraints that inhibit changes in processes of care.

Objective 1

Adopt or establish standards for prevention and treatment certification.

Objective 2

Establish a single State license/certification entity for prevention, treatment, and recovery to certify and/or license for the COS.

Objective 3

Link salary and benefits to standards, certification, and licensure.

Objective 4

Develop incentives to attract and retain qualified people into the profession.

Objective 5

Establish AOD standards for allied fields.

Objective 6

Establish continuing professional and/or education standards to ensure those working in the prevention, treatment, and recovery field are knowledgeable in current AOD trends consistent with the COS.

Next Steps

Next Steps: Phase III

With the completion of the objectives and major tasks from each of the six COSSR Task Force SIM committees and the issuance of this report, Phase II of ADP's re-engineering effort is complete. The objectives and major tasks developed by the committees, along with the comments provided by members on behalf of the stakeholder groups they represented, will be the foundation for Phase III of the re-engineering process.

Phase III Goal

The goal of Phase III is to mobilize AOD stakeholders and community partners to implement the Phase II recommendations for services system re-engineering.

Phase III Objectives

1. Align Phase II objectives and tasks into a single cohesive plan, with sequenced actions and milestones.
2. Assess readiness for system re-engineering at the state and local level. (This will contribute to the decision making process for prioritizing the recommendations and identifying the locations where implementation can begin.)
3. Identify fiscal and programmatic resources that are needed to implement each recommendation, including potential new and existing funding sources.
4. Build capacity for system re-engineering.
5. Identify the roles and responsibilities of ADP staff, stakeholders, and community partners in re-engineering efforts.
6. Identify changes to laws, regulations, policies, and administrative procedures at the federal, state, and local level that need to be developed, revised, or amended as necessary to implement the recommendations for re-engineering.
7. Develop timelines for completing Phase II objectives.
8. Implement pilot and demonstration projects.
9. Identify technical assistance and training needs of AOD stakeholders to implement Phase II recommendations.

In Phase III, ADP will continue to work closely with AOD stakeholders in implementing key components of the re-engineering process.

Conclusion

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. It is a challenging task to re-engineer a system that will be dynamic and responsive to changes; considers the needs of all people and communities and addresses their multiple needs; anticipates new groups and new issues; is driven by data and outcomes; and provides for continuous quality improvement. In supporting ADP's COS Re-Engineering efforts, ADP's stakeholders are helping to advance California towards a comprehensive and integrated system of AOD services that addresses the prevention, treatment, and recovery support needs of all Californians.





Appendix

Services System Design

Objective 1

Position AOD System as a specialized and distinct system that collaborates, partners, and links with other service systems and the community.

1a. Position AOD System as separate and distinct.

- Build consensus, develop a white paper and disseminate findings that explains how the AOD system is a specialized and distinct system. Elements include: specialty knowledge, body of research that guides services, stigmatized population.
- Increase understanding of how much other disciplines have learned from AOD experience – obesity prevention is using AOD community prevention framework, mental health is using recovery support etc.
- Ensure we provide the highest possible quality of services with integrity.
- Build visibility and PR of the AOD system.
- Be a “good neighbor” to other service delivery systems.

1b. Identify Partners (including mental health and public health) with which to collaborate and create collaborations, linkages, and partnerships.

- Develop a collaborations matrix including service systems with which clients interact, gaps in care that could be filled with improved linkages and collaboration and types of collaborations (existing and potential) with other service systems at the federal, state, county and provider levels (e.g., CDE, DMH).
- Conduct collaborations inventory and assess levels, strengths, opportunities and resources for collaboration, encouraging interdepartmental dialogue with mental health, DOE, and CDCR, as well as others.
- Identify community institutions and informal resources with which to collaborate in order to improve access and resources to un-served populations or communities.
- Conduct a funding inventory to identify different agencies with funds for AOD populations (e.g., HIV, Education, CalWORKs, IHS, CDCR). Inventory can include where resources match, where competing, where they could work together, benefits of differing collaborative models.
- Develop quality standards for different types of collaborations (e.g., information sharing, resource sharing, decision-making, and integration) in terms of inter-system work, methods of monitoring, evaluation and cross-training, funding, etc.

- Overcome hurdles to collaboration and encourage interdepartmental dialogue (especially with DMH around co-occurring and other issues).
- 1c. Share and train personnel regarding effective collaboration strategies across provider, county, and states.
- Use technology transfer approaches to encourage adoption in the field.
- 1d. Establish standards and benchmarks for integrated services, where appropriate (e.g. substance abuse disorders and child welfare).

Objective 2

Ensure that the prevention, treatment and recovery system is community and client-centered and driven, and culturally, gender, and age developmentally appropriate. Specifically:

- 2a. Provide gender and culturally responsive services across the COS and life cycle.
- Improve access, retention and outcomes for individuals and communities by providing culturally and gender responsive services.
 - Conduct a system-wide assessment of cultural and linguistic capacity and need, utilizing effective tools (e.g., National Center for Cultural & Linguistic Competence) and ADP's existing Constituency Committees.
 - Include factors on racial/ethnic, gender, sexual orientation, and MSA in CalOMS data collection and analysis.
 - Develop and disseminate models for analyzing cultural and linguistic factors with service utilization (types, volume, and patterns) and treatment outcomes for program management, evaluation, and planning purposes.
 - Participate in state and national initiatives to develop treatment standards addressing cultural groups, i.e., women, LGBT, racial/ethnic groups, etc.
 - Develop and provide training and technical assistance to counties on quality improvement and outcome measures for underserved cultural groups.
 - Promulgate standards of care and develop tools for determining performance improvement in meeting culture-specific and linguistic needs.
- 2b. Provide age developmentally appropriate services across the COS and life cycle.

- Provide effective age/developmentally appropriate services across the COS and life cycle.
 - Identify major age groupings to be served at each level of the COS and across the lifespan.
 - Create a profile of current public AOD funding/expenditures by age group.
 - Review existing reports/recommendations regarding service needs and gaps by age group and synthesize findings.
 - Create a report summarizing the prevention and treatment service utilization by age grouping identified above.
 - Identify policy or funding barriers to prevention/treatment at each stage of the lifespan.
 - Prioritize groups to focus initial efforts on expanding participation or service utilization based on extent to which population is underrepresented in AOD services or return on investment.
- 2c. Ensure that individuals and communities are centrally involved in all decision making related to their own services.
- Identify general community members and advocacy groups who have a stake in AOD prevention and treatment with interests in AOD issues and planning.
 - Identify needs assessment tools to include needs of family and consumers for comprehensive AOD services.
 - Form a consumer and/or family's advisory group to include representatives of advocacy organizations, families, and actual consumers of AOD services representing the diversity of the State, modalities and diversity of counties.
 - Define specific consumer involvement, roles, and mechanisms throughout the COS including advisory and planning bodies (i.e. SPF, DAC).

Objective 3

Ensure both intervention and service coordination occurs throughout the COS.

- 3a. Define COS and its components: prevention, treatment, and recovery support.
- 3b. Define intervention and incorporate in the COS.
- Build consensus on terminology and key components for both individual and community level intervention.
 - Identify placement on COS.

- Identify effective interventions for a range of AOD problems, acknowledging that not all problem use is dependency.
- Discuss early intervention and referral as a component of intervention.
- Expand use of effective intervention approaches throughout COS.
- Develop effective outreach and engagement services to reach unserved populations.
- Expand training and resources in order to expand intervention.
- Use technology transfer approaches to encourage adoption in the field.
- Approach intervention from an inter-disciplinary standpoint.

3c. Incorporate services coordination in the COS.

- Determine how to articulate inclusion throughout the COS.
- Expand the use of effective service coordination approaches throughout the COS.
- Expand training and resources in order to expand services coordination.
- Establish services coordination as a reimbursable service.
- Use technology transfer approaches to encourage adoption in the field.

Objective 4

Enhance service linkages and cross-discipline coordination within the COS for family-based prevention and treatment services. (Family is defined by the individual and may include spouses, children, godparents, partners, household members.)

1. Collect and share research findings, program models, and the CSAT COS of family-based services with stakeholders across the state by including sessions at SARC and ADP Conferences; disseminating model and checklist; providing technical assistance.
2. Collaborate with family strengthening, support and intervention programs/systems to integrate AOD prevention and intervention into family services and family services into AOD COS.
3. Build consensus within AOD field on the array of family-based services in the COS. Identify components of family-centered treatment and other service system linkages.
4. Survey the availability of service delivery models and resources for interventions and services for children of substance abusers. Distribute findings.

5. Do a funding inventory to identify where there are federal, state and local funds for components of family-based prevention, intervention, treatment and recovery services.
6. Develop prevention, intervention and other services for children with a parent/caretaker in treatment and/or recovery.
7. Review licensing, certification, funding regulations and identify barriers to family-based services and possible resolutions to these barriers.
8. At a state level, encourage First 5, Safe From the Start, mental health, DSS, CDCR CDE and other related departments to further engage in efforts that address families which may be impacted by AOD use.
9. Improve knowledge and resource sharing within the AOD system (state, county, provider) regarding collaboration models and resources.
 - Learn from each other regarding collaborations with First 5, mental health (EPSDT), DDS, family resource centers and child welfare for children's services
 - Develop a mechanism to share information with AOD stakeholders about effective collaborations with Maternal, Child, and Adolescent Health (MCAH) (e.g., screening/assessment methods, brief interventions in clinics, AOD engagement at hospitals)
 - Learn from other professional organizations impacting these systems, such as, but not limited to, California Mental Health Directors Association, Probation Chief's Association, Child Welfare Directors, etc.
 - Convene a joint AOD child welfare meeting to explore collaborative approaches to service delivery and innovative models
 - Consider developing a county to county meeting of teams with substance abuse, child welfare, MCAH and children's services to share effective collaboration models (similar to early work in Prop 36).
 - Convene a cross-systems conference about welfare of COSAs and interventions.
10. Build consensus with AOD and other stakeholders on the continuum of family-based services including services for children.
11. Seek federal and other funding for collaboration development and/or service demonstrations.
12. Use technology transfer approaches to encourage adoption in the field.

Objective 5

Establish a COS that has the capacity to prevent and treat co-occurring disorders (substance abuse and mental health disorders).

1. Collect emerging best practices (EBP) for persons with COD, and review California-based and other states implementation of EBP.
2. Identify focal populations to move COD system forward with limited resources.
3. Implement training and technical assistance to support development of COD prevention and treatment system.
4. Introduce DDCAT (Dual Diagnosis Capability in Addiction Treatment Index) to providers for self-evaluation.
5. Begin training and T.A. for those prevention, treatment and recovery support providers at high levels of readiness-to-change.
6. Explore new funding streams or untapped sources of funds for COD.
7. Review licensing and certification regulations and identify barriers to COD treatment implementation.
8. Collect emerging EBP for prevention of COD (e.g. Australia work).
9. Adopt the COJAC report recommendations.
10. Encourage the involvement of ADP with DMH, while maintaining its distinct system.
 - Discuss extent to which co-licensing and other issues present barriers to collaboration.
 - Begin to address barriers identified.

Objective 6

Create processes for identifying, selecting, and implementing effective approaches for preventing and treating AOD problems in a variety of populations, communities, and settings.

1. Convene consensus panels to identify specific evidence-based approaches across the COS:
 - creating definitions, identification of resources.
 - addressing innovative approaches through a theory of change or logic model.
 - exploring specialized services such as those for women and children, services coordination, DUI, harm reduction, intervention techniques, medication assisted treatment, etc.

- articulating process for selecting and implementing effective approaches (incorporating the planning process identified in System Design Objective 7).
2. Reconvene consensus panels to:
 - clearly identify programs as prevention (universal, selective, indicated), treatment, or recovery.
 - ensure appropriate level of services for clients and communities, to ensure greatest community support and buy-in for AOD programs.
 - ensure appropriate use of 20 percent set-aside for block grant funding for prevention.
 3. Based on the consensus panel findings develop a “Collection of California Evidence Based Practices” which programs which local communities and providers can review and consider adopting. The Collection would include broad applications such as culturally responsive services and related criteria as well as specific tested curricula.
 4. Encourage local planning efforts to adopt relevant California recognized evidence based approaches that fit the needs and resources of their community.
 5. Identify a process to periodically update the California recognized evidence based practices Collection.
 - Market California recognized evidence based approaches.
 - Apply for funding to build a cadre of evidence based approaches from California.
 6. Define different types of evidence, using Substance Abuse and Mental Health Services Administration (SAMHSA) - National Registry of Evidence-Based Programs and Practices’ definitions of types of evidence as a base.
 7. Develop system capacity to collect data that meets demands of preliminary research and explore efficient use of data that is already being collected.
 8. Use technology transfer approaches to encourage adoption in the field.

Objective 7

Implement on-going comprehensive community and client data driven, outcome-based State and local planning across the COS including prevention, treatment, and recovery support that incorporates evaluation for continuous quality enhancement.

1. Establish requirement for a three year State and county planning process which includes annual updates.

- Sharing and integrating of plans
2. To guide required planning process, establish the following guides:
 - Strategic planning framework (SPF) or other valid tools
 - Policy for aligning state and local resources
 - Educational materials and/or training to facilitate planning implementation
 3. Develop plan for accountability to ensure outcomes are met and that there is continuous quality improvement.
 4. Create policy and implementation plan to ensure that:
 - Consumers (to be defined) and family are included and play key roles at all levels of planning and decision making for the AOD system.
 - Services are designed and delivered to ensure equity and appropriateness of services for the populations served.
 5. Use information/data already being collected.
 6. ADP provides timely and actionable data for AOD administrators and other stakeholders.
 7. Use technology transfer approaches to encourage adoption in the field.

Objective 8

Integrate Driving Under the Influence (DUI) and Drug Diversion (PC1000) programs into the overall COS. For both drug diversion and DUI:

1. Build consensus on terminology and key components.
2. Increase understanding of how current systems operate by regulation and legislation.
3. Determine unique components of each.
4. Assess current services, client satisfaction, and need for other services.
5. Collect ongoing data.
6. Determine where DUI/Drug Diversion fit with prevention, treatment, and recovery.
7. Develop or identify outreach and engagement strategies.

Objective 9

Incorporate harm reduction into the COS.

1. Define harm reduction.
2. Make connection to chronic care and programmatic requirements.
3. Build consensus on how harm reduction can be applied throughout the COS.
4. Identify effective harm reduction strategies throughout the COS.
5. Use technology transfer approaches to encourage adoption in the field.

LEADERSHIP AND ADMINISTRATIVE SUPPORT

Objective 1

Prevention, treatment, and recovery support services should be covered and reimbursed like other chronic medical conditions in both private and public insurance health care plans.

1. ADP should work with community leaders and stakeholders who are developing and promoting legislation that would mandate parity. Enlist community support to develop economic arguments and educate consumers on chronic illness.
2. ADP should work with community leaders and stakeholders to develop and enhance coverage and reimbursement under current health insurance systems.
3. ADP should ensure that there is equity in reimbursement policies and funding decisions across prevention, screening, treatment and recovery support services.

Objective 2

Given the complexity and chronicity of addiction and the prevalence of co-occurring disorders, reimbursement policies, and funding decisions should be guided by the needs of the individuals and communities that we serve.

1. Achieve clarity on allowable services for Medi-Cal (MC) and Drug Medi-Cal (DMC) reimbursement.
2. Modify MC regulations and rules regarding reimbursement to allow for “one-stop shopping” and multiple services per day, including psychiatric services and medications.
3. Revise DMC and MC audit procedures to allow peer supported clinical standards; provide technical support rather than punitive measures for compliance issues and findings.

Objective 3

Ensure competency by promoting an AOD/COD COS that treats all people with respect and dignity and meets the needs of and is culturally appropriate for people of all ages, races, ethnicities, sexual orientations, gender identities, native tongues, religions or spiritualities, socioeconomic classes, partner statuses, and physical and mental disabilities and requires knowledge of particular drugs, methods of use, and drug cultures.

1. Develop strategies to educate the public about AOD/COD issues to reduce stigma and increase awareness of the benefits of AOD/COD prevention, treatment, and recovery support services.
2. Educate the public about the complexity and chronicity of addiction and COD.
3. Educate the public on the value and success of prevention, treatment, and recovery support services.
4. Examine community data from multiple sources on prevalence and risk and support services that reflect these demographics in staffing and consumer characteristics.

Objective 4

Utilize evidence-based medication-assisted treatments and recovery support services, including replacement therapy options for AOD/COD problems across the range of substances.

1. Partner with the medical community to encourage physicians in the opioid field to take the needed training and to include this care as part of medical and psychiatric practice in California.
2. Expand access to care for opioid dependence by increasing treatment options with opioid pharmacotherapy in California with appropriate standards and accountability including: increased funding, office based maintenance, and reimbursement in OTPs for buprenorphine.
3. Require each county to have Medi-Cal coverage for physician visits, observed dosing, testing, counseling, and medication needed for appropriate implementation of office-based maintenance pharmacotherapy under DATA 2000.
4. Design proper Drug-Medi-Cal benefits to match the Office-Based Opiate Detoxification (OBOT) regulations. The elements may be the same or somewhat different from those listed above for DATA 2000, depending on the final form of the regulations.

Objective 5

Reduce stigma against people suffering from addictions and COD in all areas of the prevention, treatment, and recovery support services system providers.

1. Develop community, consumer, and provider educational materials to reduce stigma.
2. Identify social marketing resources and options for developing social marketing campaigns to reduce stigma.
3. Develop policies, regulations, and laws that promote reduction of stigma and prohibit discrimination.

Objective 6

Establish the framework for performance improvement for the entire COS in ADP's publicly funded licensed or certified programs.

1. Make continuous quality improvement (CQI) activities required for program licensure and certification.
2. Coordinate CQI protocols and adapt or accept CQI protocols from other accrediting and certifying bodies.
3. Ensure that CQI protocols are data and outcomes driven.

Objective 7

Develop useful data information systems and standards for prevention, treatment, and recovery support services that include families and communities, in order to document outcomes and improve client/patient management leading to timely, safe, effective, and person-centered services.

1. Identify barriers to using the CalOMS data system for continuous quality improvement in client services and outcomes.
2. Examine data systems utilized by other health care systems.
3. Provide technical assistance to set up effective systems and standards.
4. Identify statute and regulations (HIPAA, 42CFR) that inhibit sharing of data and information across the COS.

Objective 8

Examine and amend laws, regulations, policies, and administrative procedures and practices to eliminate barriers and support the implementation of COSSR.

Align current State advisory committee planning efforts with the COSSR.

Objective 9

Ensure that all licit and illicit substances including prescribed medications and tobacco are addressed in the COS system.

1. Require Narcotic Treatment Providers to report into Controlled Substance Utilization Review and Evaluation System (CURES).
2. Require addiction treatment programs to use PAR for their consumers.
3. Make it a standard of care that physicians who prescribe scheduled substances use Patient Activity Reports (PAR).
4. Include assessment in basic competencies.
5. Mandate assessment of problems with the entire range of substances.
6. Identify new trends and monitor epidemiology of substance use.
7. Develop guidelines for incorporating tobacco smoking and chewing cessation across the COS.

POLICIES AND RESOURCES

Objective 1

Develop comprehensive prevention policies and regulations for the COS system for individuals, families, and communities.

1. Establish definitive definitions of terms used in the COS relative to prevention, e.g., IOM universal, selective and indicated; practices, policies, procedures, programs; and intervention.
2. Reassess and update net negotiated amount (NNA) contract language to reflect services appropriate for strategies and services that may be paid by SAPT prevention funds.
3. Reassess Safe and Drug Free Schools and Communities (SDFSC) requirements to assure SDFSC-funded prevention services comply with the requirements.
4. Establish mechanisms (NNA contract, policies and/or regulations) that obligate counties to deliver prevention services in accordance with the COS design and objectives as well as the Strategic Prevention (Planning) Framework.
5. Use the COS construct in Technical Assistance RFPs so TA contractors deliver services that advance understanding and use of the COS.
6. Incorporate review procedures in PSD County Monitoring to assess COS applications within prevention services.
7. Draw data from PSD CalOMS Prevention reports to assess the range and quantity of services delivered by counties and their providers for universal, selective and indicated populations.

Objective 2

Designate ADP as the single state agency for the oversight and development of funding and policy for all AOD services, and to promulgate the regulations to implement policy.

1. Conduct statewide assessment to identify all federal and state funding streams for AOD services in California, including source of funding, utilization, statutory authority, responsible agencies, types of services, and target populations served.
2. Identify those areas that could be transferred to ADP for oversight by amending or developing legislation and policy.
3. Develop legislation and regulations to implement changes in program authority.
4. Determine the need for additional resources for ADP in assuming oversight role of additional programs.

Objective 3

Examine and change laws, regulations, policies, and administrative procedures and practices to eliminate barriers and support the implementation of COSSR.

1. Assure that all on-going Statewide efforts are coordinated and aligned with COSSR.
2. Develop uniform definitions and an adoption of uniform standard of care
3. Identify all statutes, regulations, and policies required to implement the objectives recommended by the COSSR Task Force.
4. Develop long-range plan, including timelines and responsible party, and agencies which ADP will need to collaborate and/or coordinate efforts to initiate changes.

Objective 4

Develop comprehensive treatment policies and regulations regarding COS for AOD services to address the specific needs of adolescents.

1. Conduct a statewide and local needs assessment to identify AOD service needs of adolescents.
2. Identify all federal and state funding streams for AOD services for adolescents in California, including source of funding, utilization, statutory authority, responsible agencies, types of services, and target populations served.
3. Develop additional requirements for special AOD counselor certification for Youth services.

COMMUNITY PARTNERSHIPS

Objective 1

Work with partners to adopt a paradigm that acknowledges the chronic nature of alcohol and drug problems.

1. While defining “chronicity paradigm for AOD problems” and how it applies across the COS delivery system, be sure to include that AOD problems are preventable and curable.
2. Increase community awareness of chronicity of AOD related problems by developing a California-specific white paper and other materials for a variety of audiences.
3. Advocate for public policy to support/promote chronic nature of AOD problems at federal, state, and local levels.
4. Devote funding for collaborative models when collaboration would produce more effective and efficient outcomes.
5. Create educational materials for a variety of potential partners on how the chronicity paradigm could be integrated into their disciplines/policies/programs.
6. Ensure that the chronicity paradigm is consistent with new and updated curriculum and standards for allied fields, community institutions, and traditional and non-traditional organizations.
7. Ensure all statewide AOD conferences include presentations about the chronic nature of AOD problems.

Objective 2

Promote collaborative models with community partners through both formal and informal policy.

1. Seek opportunities to create public funding that requires collaborative models across continuums ranging from universal prevention through recovery maintenance.
2. Select two primary focus areas to create pilot projects at the local level that demonstrate collaboration.
3. Ensure ADP participates in an advisory capacity to provide leadership in promoting collaborative models in a variety of public agencies and institutions such as but not limited to education, criminal justice, mental health, child welfare, public health, physical health, housing, Board of Equalization, Alcohol Beverage Control, etc.

Objective 3

Continuously identify new and potential partners based on data and information on emerging AOD issues.

1. Identify, obtain, and share all current statewide epidemiological efforts collecting AOD information such as crime stats, hospital admissions, school data, treatment admissions, drinking driver program admissions.
2. Identify and remove barriers for sharing the data statewide.
3. Constantly look for new ways to collect qualitative data, e.g., focus groups.
4. Disseminate the trends on an annual basis at conferences and statewide association meetings and to public policy makers, etc.
5. Identify natural partners who have access to the targeted populations identified in emerging trends.
6. Continuously document and assess engagement of new partners in continuing service work when identified in these emerging data sets.

PREVENTION AND RECOVERY SUPPORT

Objective 1

Provide services to persons and their significant others who may or may not have gone through formal treatment and/or who may benefit from recovery support services.

1. Conduct statewide and local assessments of relapse recovery support services available through formal treatment programs and analyze opportunities to expand existing recovery services.
2. Research and document specific geographic areas and populations with high rates of relapse to target prevention outreach strategies (i.e. youth, homeless, low income, women, communities of color).
3. Determine baseline of recovery support services; set objectives for reducing the number of relapsing clients to free up slots for treatment on demand.
4. Develop system-level community-friendly recovery support service directories online and cross-link to other public service agencies, i.e. DSS, DHS, CPS, EDD, Mental Health, Managed Care and EAP networks.
5. Establish multi-faceted information dissemination to reach local community level outlets, such as community clinics, hospitals, schools, community colleges, adult schools, regional transit agencies.
6. Create and market a statewide hotline number with trained relapse prevention specialists to provide online support and referrals 24/7.
7. Establish and maintain formal and informal relationships and linkages with critical support systems: housing, employment, food assistance; mentoring, coaching and support networks.
8. Seek funding for recovery support services and system enhancements.

Objective 2

Require ADP to take leadership in creating and implementing a recovery management system.

1. Conduct needs assessment to define scope of problem; include desired outcomes, target populations, including youth in public schools, transitional age youth and out of school youth.
2. Gather case management/service coordination models used in other systems, i.e. developmental services, mental health, HIV, CARE, developmental services, child protective services, and educational institutions.
3. Research other states' use of case management or services coordination models for individuals, including youth, transitioning from formal AOD treatment to recovery and other individuals in recovery.

4. Analyze existing and new AOD models of service coordination and delivery (including Student Assistance Program models, SBIRT) with consideration of: capacity, resources, payments, standards, performance measures, CQI, responsibilities.
5. Develop special component designed specifically for youth in public schools, transitional age youth, and out-of-school youth.
6. Fund pilot application in like-sized counties of population settings.
7. Evaluate results of pilot projects.
8. Modify program based on evaluation results; make policy decisions on Statewide adoption with appropriate funding.
9. Implement Statewide Services Coordination system.

Objective 3

Assure that prevention practices and services include community-based approaches, policies, procedures, and program approaches that are evidence based and culturally competent.

1. Require County SPF plans to incorporate evidence-based or “best practices” that include community-based approaches, policies, procedures and program approaches that are evidence based.
2. Monitor County SPF plans to ensure that the above requirements are being met in the implementation of the County SPF plans.
3. Provide support (technical assistance, training, etc) for Counties in their efforts to implement #1 & 2, above.
4. Reduce factors that negatively impact communities, including residential neighborhoods, mixed land-use environments, sober living environments by using best practices that may include:
 - Reducing AOD availability, marketing and consumption.
 - Reducing drug paraphernalia availability at smoke shops and other retail outlets.
 - Increasing community responses to problematic and potential alcohol outlets through clear opportunities for public review, input and nuisance abatement.
5. Using current research to assess and implement effective evidence-based approaches to reduce underage drinking in communities.

Objective 4

Increase availability of an array of housing for sober and transitional living communities.

1. Conduct statewide needs assessment of sober and transitional living and categorize and rank into groups based on similarities.
2. Research and review studies on sober living; analyze the success of clients and impact on neighborhoods.
3. Analyze and support legislation that increases availability of housing for clean and sober/ transitional living communities.
4. Establish ADP liaison to field and communities to examine “Use Permit” Process, promote public acceptance to address neighborhood concerns and issues.

Objective 5

Organize culturally appropriate resources to provide ongoing self-management support to individuals and communities to effectively reduce their risk of AOD problems.

1. Conduct needs assessment of the State and community preventive care delivery system to: identify systems and organizations providing preventive care; analyze participant flow and service delivery; and identify gaps in services for at-risk populations.
2. Assess readiness for systems change by examining barriers to implementing preventive care for individuals and communitywide.
3. Obtain agreement and ongoing commitment to address participant and community needs for self-management and support by enlisting State and community support to: involve state and local stakeholders to ensure that preventive services are a routine part of service delivery; involve stakeholders who will be impacted by the changes in the planning and implementation process; and establish clearly defined roles and responsibilities of stakeholders for the planning and problem-solving process.
4. Establish prevention protocols (i.e. SPF, evidence-based).
5. Pursue funding resources at state, local, and organizational levels.
6. Develop and conduct training in communities and organizations in service delivery, client resources, tools/materials for prevention, and, tasks and roles of health care providers in the context of supporting client’s self-management to reduce AOD risk.
7. Develop and implement an evaluation component to evaluate effectiveness of service delivery system.

Objective 6

Assure that cultural competency is integrated in community based prevention and recovery support services.

1. Research current standards.
2. Develop standards.
3. Provide training and technical assistance.
4. Dedicate staff to focus on the integration of cultural competency.
5. Monitor implementation/effectiveness of cultural competency.

WORKFORCE DEVELOPMENT

Objective 1

Adopt or establish standards for prevention and treatment certification.

1. Collect standards from existing prevention/treatment standards from other certifying organizations.
2. Identify tiers of professional competencies.

Objective 2

Establish a single State license/certification entity for prevention, treatment, and recovery support to certify and/or license for COS system workforce.

1. Develop a subcommittee to identify and implement a single State license/certification entity for prevention/treatment/recovery.
 - Research current licensure/certification bodies at the national level.
 - Develop justification for a single body such as a board, commission, private or State.
 - Identify resources and needs assessment.

Objective 3

Link salary and benefits to standards, certification, and licensure.

1. Survey and compile salary and benefits data from other like states.
2. Determine suggested salary ranges based on tiered levels/system.

Objective 4

Develop incentives to attract and retain qualified people into the profession.

1. Identify and review incentive models in other professions and like professions.
2. Research and identify grant opportunities that will provide funding for incentives.
3. Establish a mentoring program.
4. Promote profession through various means such as PSA's, multi-media, peer support, EAP, etc.

Objective 5

Establish AOD standards for allied fields.

1. Survey existing AOD Standards in the nation involving other professions providing AOD services in prevention/treatment/recovery settings.

Objective 6

Establish continuing professional and/or educational standards to ensure those working in the prevention, treatment, and recovery field are knowledgeable in current AOD trends consistent with the COS.

1. Identify the current continuing education requirements/standards of all current certifying organizations in California.
2. Identify national continuing education standards/requirements.
3. Create continuing education standards conducive to California workforce.
4. Identify resources available to agencies, counselors and support staff to implement low cost, cutting edge continuing education programs throughout the state.

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GLOSSARY OF COMMONLY USED TERMS

Abstinent: not using substances of abuse at any time.

Acute Care: short-term care provided in intensive care units, brief hospital stays, and emergency rooms for those who are severely intoxicated or dangerously ill.

Addiction: a chronic, relapsing disease of the brain with social and behavioral manifestations marked by continued AOD use despite negative consequences; a physical dependence on a substance of abuse; and the inability to cease use of a substance without experiencing withdrawal symptoms.

Addiction Counseling: professional and ethical application of specific competencies that constitute practice dimensions, including clinical evaluation; treatment planning; referral; service coordination; individual, group, and family counseling; client, family, and community education; and documentation.

Addiction Severity Index: a standardized assessment tool used to conduct a comprehensive drug evaluation and to match offenders' drug problems with treatment approaches.

Advocacy/Advocate: 1) a social or political movement working for changes in legislation, policy, and funding to reflect clients' concerns and protect their rights (i.e., advocacy for clients); 2) a philosophy of substance abuse treatment practice maintaining that clients should be involved actively in their own treatment and have rights in its planning and implementation; 3) shifting the system from the directive model to one in which the client is an empowered, involved participant in treatment decisions.

Aftercare: structured services offered to an individual who has completed treatment, typically for a set period of time (e.g., six months), to ensure successful recovery.

Alcohol and drug testing: laboratory testing to determine whether a client is using, or has used, alcohol and/or other drugs; testing methods may include, but are not limited to, urine, blood, saliva, and breath alcohol testing.

Assessment: gathering key information and engaging in a process with a client that enables the counselor to understand the client's readiness for change, problem areas, and the presence of mental illness or substance abuse disorders, disabilities, and strengths; typically involves an examination of the functioning and well-being of the client and includes a number of tests and written and oral exercises.

Brief Intervention: a discussion aimed at raising an individual's awareness of their risky behavior and motivating them to change their behavior; a single session or multiple sessions of motivational discussion focused on increasing insight and awareness regarding substance use and motivation toward behavioral change; it can be tailored for variance in population or setting and can be used as a stand-alone treatment for those at-risk as well as a vehicle for engaging those in need of more extensive levels of care.

Brief Treatment: a limited course of highly focused cognitive behavioral clinical sessions; may involve motivational discussion and client empowerment, in addition to assessment, education, problem solving, coping mechanism, and the development of a supportive social environment.

Buprenorphine: partial opioid agonist approved by FDA for use in detoxification or maintenance treatment of opioid addiction and marketed under the trade names Subutex® and Suboxone® (the latter also containing naloxone).

Case Management: a participant-centered, goal-oriented process for assessing the needs of an individual for particular services; assisting the participant in obtaining those services; and reviewing participant accomplishments, outcomes, and barriers to completing recovery goals; may be either an element of a recovery and treatment modality or a freestanding service. (See also “Service Coordination.”)

Child Care: care-taking services provided to client’s children while the client is participating in AOD services.

Chronic Care: any condition that requires ongoing adjustments by the affected person and interactions with the health care system.

Chronic care model: identifies the essential elements of a health care system that encourage high-quality chronic disease care: the community, the health system, self-management support, delivery system design, decision support and clinical information systems; evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. The model can be applied to a variety of chronic illnesses, health care settings and target populations; the goals are healthier patients, more satisfied providers, and cost savings.

Client: individual, significant other, or community agent who presents for alcohol and drug abuse education, prevention, intervention, treatment, and consultation services.

Client Empowerment Services: services based on the concept that empowerment occurs, in part when people impacted by addiction become active participants in the healing of themselves, families and communities.

Cognitive Behavioral Therapy: a therapeutic approach that seeks to modify negative or self-defeating thoughts and behavior. Cognitive Behavior Therapy combines Behavior Therapy, treatment designed to weaken connections between troublesome situations and an individual’s habitual reaction to them (by altering behavior) and Cognitive Therapy, which seeks to correct distorted thinking based on negative self-perceptions.

Community Resources: resources that the community at large provides and that clients may access, such as food banks and/or meal services, clothing, diapers, mental health, spiritual services, social services, etc.

Confidentiality: a client’s right to privacy as defined by applicable federal and state statutes.

Conflict resolution: a wide range of processes that encourage nonviolent dispute resolution. The field of conflict resolution also includes efforts in schools and communities to reduce violence and bullying and help young people develop communication and problem-solving skills.

Continuing Care: care that supports a client’s progress, monitors his or her condition, and responds to a return to substance use or a return of mental disorder symptoms; both a process of post-treatment monitoring and a form of treatment itself; sometimes it is to as aftercare.

Continuum of Care: an array of services that differ in terms of unique needs of clients throughout the course of treatment and recovery.

Co-Occurring Disorders (COD): co-occurring substance use (abuse or dependence) and mental disorders; clients with COD have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs; mental disorder may include: mood disorder, depression, mania, bipolar, anxiety disorder, personality disorder, psychotic disorder, or schizophrenia.

Counseling: a therapeutic process aimed at meeting specific identified needs of the client.

Cultural Competence: the capacity of a service provider or organization to understand and work effectively in accord with the beliefs and practices of persons from a given ethnic/racial/religious/social group or sexual orientation; includes the holding of knowledge, skills, and attitudes that allow the treatment provider and program to understand the full context of a client's current and past socio-environmental situation.

Culturally Competent Treatment: the capacity of a service provider or of an organization to understand and work effectively with the cultural beliefs and practices of persons from a given ethnic/racial group.

Cultural Diversity: the vast array of different cultural groups based on varying behaviors, attitudes, values, languages, celebrations, rituals, and histories.

Cultural Proficiency: the highest level of cultural capacity; in addition to understanding nuances of culture in even greater depth, the culturally proficient counselor also is working to advance the field through leadership, research, and outreach.

Cultural Sensitivity: the capacity and willingness of a clinician or other service provider to be open to issues of culture and diversity.

Detoxification: the medical and bio-psychosocial procedure that assists a person who is dependent on one or more substances to withdraw from dependence on all substances of abuse; acute abstinence syndrome requiring medical monitoring and management.

Diagnosis: classification of the nature and severity of the substance use, medical, mental health, or other problems present; DSM-IV-TR and ICD-10 commonly used to classify substance use and mental disorders.

Domestic Violence: the use of emotional, psychological, sexual, or physical force by one family member or intimate partner to control another; violent acts include verbal, emotional, and physical intimidation.

DSM-IV: Diagnostic and Statistical Manual, 4th edition, published by the American Psychiatric Association, a standard manual used to categorize psychological or psychiatric conditions.

Educational Services: services provided to clients such as academic tutoring and literacy training to support the client's academic goals.

Effective Assistance Strategies: a strategy that can be shown to improve outcomes; effective interventions tend to fall into one of five areas: the use of evidence-based, planned care; reorganization of practice systems and provider roles; improved patient self-management support; increased access to expertise; and greater availability of clinical information.

Emergency Services: services that are provided (crisis intervention/management, professional home visits, emergency shelters) due to a sudden and unexpected turn of events calling for immediate action.

Employment Services: services such as employment readiness, job skills development, and career exploration that support the client's employment needs and goals.

Engagement: a client's commitment to treatment and to the maintenance of recovery.

Evidenced-Based Practices: approaches to prevention or treatment that are validated by some form of documented scientific evidence; evidence is defined as findings established through scientific research, such as controlled clinical studies, but other methods of establishing evidence are considered valid as well; evidence-based practice stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.

Fully Integrated Program: a treatment program that actively combines substance abuse and mental health interventions to treat disorders, related problems, and the whole person more effectively.

Group Counseling: face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time, focusing on the needs of the individuals served.

Harmful Use: patterns of alcohol or drug use for non-medical reasons that result in negative health consequences and some degree of impairment in social, psychological, and occupational functioning for the user.

Individual Counseling: face-to-face contacts between the client and a therapist or counselor.

Individual Family Therapy: face-to-face contacts between the client and their family and a therapist or counselor.

Individualized Treatment Plan: a strategy that addresses the identified substance use disorder(s), as well as issues related to treatment progress, including relationships with family and significant others, employment, education, spirituality, health concerns, and legal needs; plans are developed in collaboration with the client and significant others and tailored to fit the client's unique biopsychosocial strengths and needs.

Intervention: the process of providing care to a patient or taking actions to modify a symptom, an effect, or a behavior; the process of interacting after assessment with a patient who is substance addicted to present a diagnosis and recommend and negotiate a treatment plan; types of intervention can include crisis intervention, brief intervention, and long-term intervention.

Intoxication: An altered physical and mental state resulting from the overuse of alcohol or drugs.

Life Skills Training: activities that include development of job, vocational, life (budgeting, leisure, etc.), anger management, general coping, communication, and social skills; literacy classes and GED preparation; parenting classes; and relationship building.

Managed Care: an approach to delivery of health and mental health services that seeks to reduce the cost of care by monitoring the access to and use of medical services and supplies, as well as outcomes of that care.

Mental Health Treatment System: a broad array of services and programs intended to treat a wide range of mental health disorders.

Mentoring: the activities of an adult who, along with parents, provides young people with support, counsel, friendship, reinforcement, and constructive examples.

Methadone: a synthetic opioid that binds to opiate receptors and produces a range of agonist effects similar to those of short-acting opioids such as morphine and heroin.

Modality/Treatment Modality: any specific treatment method or procedure used to relieve symptoms or motivate behaviors that lead to recovery.

Motivational Interviewing: direct, client-centered counseling style implemented to elicit behavior change by helping clients resolve their ambivalence to change.

Mutual Self-Help: an approach to recovery from substance use disorders that emphasizes personal responsibility, self-management, and clients' helping one another, using a broad spectrum of personal responsibility and peer support principles.

Naltrexone: the only opioid antagonist approved for use alone in long-term treatment of people with opioid addiction; used primarily after medically supervised withdrawal from opioids to prevent drug relapse in selected, well motivated patients.

Native American Healing Practices: the practices commonly used by tribes to address alcoholism and drug abuse in clients, such as sweat lodges, talking circles, roundhouse ceremonies, smudging, traditional herbal and plant gathering, traditional singing and dancing, pipe ceremonies, etc.

Opioid: a type of depressant drug that diminishes pain and central nervous system activity. Prescription opioids include morphine, meperidine (Demerol), methadone, codeine, and various opioid drugs for coughing and pain. Illicit opioids include heroin, also called "smack," "horse," and "boy."

Opioid Treatment Program (OTP): a program that engages in supervised assessment and treatment, using methadone, buprenorphine, LAAM, or naltrexone, of individuals who are addicted to opioids in a number of settings, including intensive outpatient, residential, and hospital settings; services may include medically supervised withdrawal and/or maintenance treatment, along with various levels of medical, psychiatric, psychosocial, and other types of supportive care.

Outcome Monitoring: collection and analysis of data during and following alcohol and drug treatment to determine the effects of treatment, especially in relation to improvements in client functioning.

Outpatient Treatment: Treatment/recovery or rehabilitation services provided where the client does not reside in a treatment facility. The client receives drug abuse or alcoholism treatment services with or without medication, including counseling and/or supportive services; also known as nonresidential services.

Outreach Strategies: approaches that actively seek out persons in a community who have substance use disorders and engage them in substance abuse treatment.

Peer Counselor: Individuals in recovery from substance use disorders who have been trained to work with other individuals in recovery in substance abuse treatment settings.

Placement Criteria: evidence-based way to decide what level of care a person needs for an addictive disorder; includes a methodical assessment across several domains.

Positive or "Warm" Hand-Offs: Helping the patient navigate between compartments of the health care system; activities that enhance referral adherence.

Prevention Screening: a formal process of testing to determine whether an individual warrants further attention at the current time for AOD use. The screening process does not necessarily identify what kind of problem the person might have or how serious it might be but determines whether further assessment is warranted. For Safe and Drug Free Schools' grantee's, age-appropriate screening is used to identify the AOD level of risk present for an individual to determine: 1) if the individual is appropriate for AOD prevention services, or 2) if the risk level is too high for prevention services to provide optimum benefit, in which case the person needs referral for an AOD treatment assessment of other services.

Prevention Services Strategies

Universal prevention services are targeted at everyone regardless of the level of risk and before there is an indication of an AOD problem.

Selected prevention services are targeted at persons or groups that can be identified as “at risk” for developing AOD problems.

Indicated prevention services target individuals identified as experiencing problem behavior related to alcohol and other drug use to prevent the progression of the problem. These services do not include clinical assessment or treatment for substance use dependence.

Prevention Strategies

Information Dissemination: this strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco and drug use, abuse and addiction and their effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.

Education: this strategy involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g. of media messages) and systematic judgment abilities.

Problem Identification and Referral: this strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

Alternatives: this strategy provides for the participation of target populations in activities that exclude alcohol, tobacco and other drug use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco and other drugs and would, therefore, minimize or obviate resort to the latter.

Community-based process: this strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, inter-agency collaboration, coalition building and networking.

Environmental: this strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. This strategy is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those which relate to service and action-oriented initiatives.

Psychosocial: involving a person’s psychological well-being, as well as housing, employment, family, and other social aspects of life circumstances.

Recovery: a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship; achieving and sustaining a state of health in which the individual no longer engages in problem behavior or psychoactive substance use and is able to establish a lifestyle that embraces health and positive goals; overcoming both physical and psychological dependence to a psychoactive substance while making a commitment to sobriety; the effort to link the attempt at recovery with sobriety or non-use of illicit mind- or mood-altering substances. If substance dependence is defined as a chronic illness, recovery also means avoiding the contaminant that causes or exacerbates the illness (i.e., triggers). In short, in a wellness and recovery model, recovery becomes as much a “process” as an end. As with other chronic illnesses, the absence of illness in an active phase does not mean it has forever gone away or that the individual can abandon self-care. Within this model, recovery status may be defined as abstinence-based, moderation-based (i.e., the sustained deceleration of use to a sub-clinical and abstinence level) or medication-supported (i.e., medically monitored pharmacological support leading to recovery).

Recovery Management Services: services that include engagement, stabilization, education, monitoring, support and re-intervention technologies to maximize the health, quality and level of production of persons with alcohol and other drug problems; promotes hope for recovery, exemplifies a strength-based orientation and offers a wide spectrum of services aimed at support of long-term recovery from alcohol and other drug disorders.

Re-entry Support Services: services designed to establish linkages between the public systems (jails, prisons, detention centers, foster care system, etc.) and community services; re-entry services may include discharge and transition planning activities.

Referral: a process for facilitating client/consumer access to specialized treatments and services through linkage with, or directing clients/consumers to, agencies that can meet their needs.

Relapse: the return to a pattern of substance abuse or the process during which indicators appear before the client’s resumption of substance use; a breakdown or setback in a person’s attempt to change or modify any particular behavior; an unfolding process in which the resumption of substance abuse is the last event in a series of maladaptive responses to internal or external stressors or stimuli.

Relapse Prevention: a variety of interventions designed to teach people with substance use disorders to cope more effectively and to overcome the stressors/triggers in their environments that may lead them back into drug use and dependence; interventions can be placed in five categories: assessment procedures, insight/awareness raising techniques, coping skills training, cognitive strategies, and lifestyle modification.

Remission: a state in which a mental or physical disorder has been overcome or a disease process halted.

Residential Treatment: typically over 30 days of non-acute care in a setting with recovery/treatment services for alcohol and other drug use and dependency; services are provided by program-designated personnel and include the following elements: personal recovery/treatment planning; educational sessions; social/recreational activities; individual and group sessions; detoxification services; and information about, which may include assistance in obtaining, health, social, vocational, and other community services.

Resilience: the ability of an individual to cope with or overcome the negative effects of risk factors or to “bounce back” from a problem; this capability develops and changes over time, is enhanced by protective factors, and contributes to the maintenance or enhancement of health.

Risk Factors: conditions for a group, individual, or identified geographic area that increase the likelihood of a substance use problem or substance abuse.

Screening: a quick, simple way to identify patients who need further assessment or treatment for substance use disorders; does not establish definitive information about diagnosis and possible treatment needs; a formal process of testing to determine whether a client warrants further attention at the current time for a particular disorder; the screening process does not necessarily identify what kind of problem the person might have or how serious it might be, but determines whether further assessment is warranted.

Self-Determination: the extent to which individuals control their lives.

Self-Help Group: a supportive, educational, usually change-oriented mutual-help group that addresses a single life problem or condition shared by all members.

Service Coordination: the process of prioritizing, managing, and implementing activities in an individual's treatment plan.

Service Integration: the availability and delivery of a comprehensive array of appropriate mental health and substance abuse services and interventions that are identified within a single treatment plan, coordinated by a single treatment team, and both effective and responsive to the high degree of severity of both mental illness and substance abuse experienced by the client.

Skill Building: services such as life skills training, independent living skills training, problem solving, and leadership training that support the client's needs and goals to become a productive, independent adult.

Sober Living Environments: alcohol- and drug-free houses that support treatment and recovery services in a community by helping recovering persons to maintain an AOD-free lifestyle; the house or its residents: do not and cannot provide any treatment, recovery, or detoxification services; do not have treatment or recovery plans or maintain case files; and do not have a structured, scheduled program of AOD education, group or individual counseling, or recovery support sessions. These houses have three things in common: they ensure that a person who is in recovery lives in an environment that is free from AOD use; the residents themselves reinforce their recovery through support with other recovering persons; the residents are free to voluntarily pursue activities to support their recovery, either alone or with others.

Sobriety: the quality or condition of abstinence from psychoactive substance abuse supported by personal responsibility in recovery; the quality or condition of abstinence of use or abuse is defined by a hierarchy of sobriety: "early" sobriety (one month to one year), "sustained" sobriety (one to five years), and "stable" sobriety (five years or longer).

Social Model: a model of treatment and recovery that utilizes role modeling and peer support to individuals seeking abstinence from their alcohol and/or drug use. Social Model programs emphasize the process of learning through the daily practice and experience of drug-free living where treatment and recovery patients and program staff model desirable behaviors and other appropriate activities most conducive to the recovery of its participants. Social model programs are community-based, cost and outcome effective because of their ability to build strong and lasting social support systems.

Special Populations: diverse groups of individuals sharing a particular characteristic, circumstance, or problem.

Spirituality: a belief system that acknowledges and appreciates the influence in one's life of a higher power or state of being.

Stage of Change: transtheoretical description of one of several stages through which a person passes in moving from active use to treatment and abstinence.

Stage of Readiness: an individual's awareness of need to change that can be influenced by external pressure (family, legal system, or employer) or internal pressure (physical health concerns).

Stigma: a negative association attached to some activity or condition. A cause of shame or embarrassment.

Substance Abuse: a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.

Substance Abuse Treatment Program: an organized array of services and interventions with a primary focus on treating substance use disorders, providing both acute stabilization and ongoing treatment.

Substance Abuse Treatment System: a broad array of services organized into programs intended to treat substance use disorders; includes services organized in accord with a particular treatment approach or philosophy (e.g., methadone treatment or therapeutic community).

Substance Dependence: a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by a need for increasing amounts of the substance to achieve intoxication, markedly diminished effect of the substance with continued use, the need to continue to take the substance in order to avoid withdrawal symptoms, and other serious behavioral effects, occurring at any time in the same twelve-month period.

Substance Use Disorders: a class of substance-related disorders that includes both substance abuse and substance dependence.

System: an organization of a number of different treatment programs and related services in order to implement a specific mission and common goals.

Therapeutic Community (TC): a consciously designed social environment or residential treatment setting in which the social and group process is harnessed with therapeutic intent; treatment focuses on drug abstinence, coupled with social and psychological change that requires a multidimensional effort involving intensive mutual self-help typically in a residential setting.

Transitional Housing: a facility designed to help clients maintain an alcohol and drug free lifestyle and transition back into the community; transitional housing activities are supervised within an alcohol and drug-free environment; attendance at recovery and treatment services is mandatory, although those services are typically not provided on-site.

Trauma: violent mental or physical harm to a person, damage to an organ, etc.

Treatment: an organized array of services and interventions with a primary focus on treating substance abuse disorders; includes hospital, short- and long-term residential, and outpatient; mental health treatment is an organized array of services and interventions with a primary focus on treating mental disorders, whether providing acute stabilization or ongoing treatment.

Treatment Outcomes: accepted measures that show treatment of the addictive disorder is working. In addiction treatment these include retention, reduction in drug abuse, engagement in socially productive roles, reduction in legal problems, improved adherence to medical and psychiatric care, healthy family relationships and engagement in personal growth activities.

Treatment Retention: keeping clients involved in treatment activities and receiving required services.

Unbundled: a practice that allows any type of clinical service (such as psychiatric consultation) to be delivered in any setting (such as a therapeutic community); the type and intensity of treatment are based on the client's needs and not on limitations imposed by the treatment setting; designed to maximize individualized care and to encourage the delivery of necessary treatment in any clinical setting.

Uniform Policy Provision Law (UPPL): allows insurers to refuse to pay the health costs for patients injured while under the influence.

Wellness: the movement of a client toward his or her maximum physical or mental health and recovery. Wellness may include medication and should include all aspects of physical and mental health – particularly those that might be risk factors for relapse that, if addressed, could reduce or prevent further illness.

Withdrawal: predictable constellation of signs and symptoms after abrupt discontinuation of or rapid decrease in use of a substance that has been used consistently for a period. Signs and symptoms of withdrawal are usually opposite to the direct pharmacological effects of a psychoactive substance.

Wraparound Services: aspects of a treatment program that address difficult-to-treat problems, such as finding childcare while in treatment, arranging for proper housing, and finding employment.