Workforce Development Needs in the Field of Substance Use Disorders

A Report from Department of Alcohol and Drug Programs

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Special thanks are extended to Jon T. Perez, Ph.D., Regional Administrator, Region IX, Substance Abuse and Mental Health Services Administration (SAMHSA) for his participation in task force meetings.

The Workforce Development Task Force first met on January 8, 2013. The executive sponsors were Michael Cunningham, Acting Director; Millicent Tidwell, Deputy Director; and dave neilsen, Deputy Director. A project charter was created and a report due date of June 28th was established.

At project initiation, the task force members represented the licensing, treatment, prevention, recovery support, cultural competency, performance monitoring, and executive perspectives of ADP. Resulting from the transfer of ADP programs and functions to Department of Health Care Services, some of the original task force members have since assumed new job responsibilities.

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Welcome Message

With the implementation of health reform on a national level, changes are required of programs, policies, and the workforce, to successfully and effectively meet these additional requirements and the resulting increased demand for services. Adding complexity to the difficult job of building the capacity to meet the demands for high quality SUD services is the lack of consistent and standard workforce credentials, a lack of a recognized career ladder, a decreasing number of individuals entering the field, and an increasing number of individuals leaving the field.

Even with these changes, I remain optimistic! Health reform creates the urgency and need to make changes long recognized as desired and necessary. It creates a challenge of meeting the requirements for service, but more importantly for the SUD workforce, it offers the opportunity to create standard and consistent credentials, a career ladder, and in general, make changes that recognize changes that solidify the recognition that the SUD workforce is a valid and vital part of our healthcare delivery system. Historically, the SUD workforce has consisted of highly motivated and passionate individuals who care strongly about their profession and those they serve. I expect this attitude will remain.

Until now, the SUD workforce has consisted of a fairly narrow range of practitioners in the prevention, treatment and recovery support fields. Moving forward, the functions and roles of individuals addressing SUD will likely change to meet the increased demand for services in new settings. The workforce will expand to include practitioners in managed care settings - outside the current realm of the SUD workforce.

Alcohol and Drug Program's (ADP'S) Workforce Development Task Force completed work resulting in this report: a summary of health reform related changes, an assessment of the current workforce, and recommendations for preparing the workforce to meet the changes required of health reform. This report is not an implementation plan, although it does contain an implementation strategy. This report recognizes that the development of an implementation plan as the next step requires the representation of all stakeholders as partners in creating workforce solutions.

As ADP transfers its programs and functions to Department of Health Care Services (DHCS), and as I transition to another role in life, I will enthusiastically watch from afar and continue to be a strong advocate for the SUD workforce. As each of you meets the challenge of change, I applaud the work you have accomplished, the dedication you have shown and your courage to expand your knowledge.

MICHAEL S. CUNNINGHAM
Acting Director
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Introduction: Health Reform Brings Change and Opportunity

Change is coming to California's healthcare field. For the first time, federal law requires every American to have health insurance by January 1, 2014. Health reform is the global term for the health care-related changes that came about as the result of the federal Affordable Care Act (ACA). Some of the health reforms originated at the federal level and others are mandated at the state level.

Health reform raises questions and creates complex issues because it touches or changes the very core of our healthcare system. In turn, these changes impact every segment of the Substance Use Disorders (SUD) workforce – administrators, treatment providers, prevention specialists, and recovery support specialists. To create efficiency and effectiveness, emerging directions from the federal government indicate that integration of services and collaboration between providers is critical. The federal government also places emphasis on using evidence-based practices, expanding the administrative support structure, and learning new skills such as Electronic Health Records and Electronic Billing.

The SUD field has long recognized the need to create a standardized credentialing system, grow the workforce in number, create an upward career path, and offer incentives to keep the workforce engaged, motivated, and committed to remain in the field. Even though the need for change has been recognized there has not been an urgency to make changes. A benefit of health reform is it has created the impetus for change, not only for the SUD workforce, but for the entire healthcare workforce, some of which have already recognized the need to make adjustments. For example, the mental health workforce identified core competencies that will allow them to fit into a primary care environment, and primary care has recognized the importance of adopting the use of Electronic Health Records and other uses of technology. It is now crucial for the SUD workforce to adjust and address the emerging requirements in health reform which creates a tremendous opportunity to make long-needed changes to the workforce scopes of practice, credentialing system and career ladder allowing the SUD workforce to remain competitive in the changing healthcare environment.

This report identifies the impact of health reform on the SUD workforce. It provides an overview of health reform; identifies the direction that substance abuse reduction efforts are taking; assesses the composition of the existing SUD workforce; and looks at the knowledge, skills and credentials needed to deliver services that comply with these new mandates. Regardless of the current position held or the location where services are delivered, the entire workforce needs to be informed and aware of the impending changes, and equipped with the proper tools and training to meet the service delivery requirements resulting from health reform. Expanding and enhancing one's skill set is not to be viewed as correcting a deficiency or defect, but rather as a way of keeping pace with changing times.

At the conclusion of this report are suggestions and recommendations regarding standards, training, policy and practices. Implementation of the recommendations will prepare the workforce to function efficiently in the emerging world that is recovery-oriented, uses prevention strategies at the community level, and provides individual choices for treatment. While some information remains unknown and decisions are still being made, the task force

made assumptions in order to make reasonable recommendations. The process of implementing the recommendations will be a multi-year process. To reflect this, the recommendations are presented as either short-, mid- or long-range.

In summary, health reform presents both a challenge and an opportunity to the State of California. The challenge comes in assessing the capacity of our workforce, identifying the skills required to deliver services in the changing environment, and developing the necessary infrastructure to support health reform. Several opportunities exist to strengthen the role of the SUD workforce by creating a standardized credentialing system, addressing the known shortfalls in the workforce career path, and providing training to broaden the workforce skill set. In the process, the workforce may become eligible for new employment opportunities, experience less employee turnover and greater job satisfaction. Acknowledging and addressing these issues now is critical to ensuring that our SUD workforce remains on a level playing field with the rest of the healthcare field.

A short report, such as this one, does not assume to address every possible scenario that may impact the workforce. It also does not delve into the intricacies of legislative authority and regulatory oversight. Issues such as pay scales and background checks are deemed important; however, they are not included in this report. This report has a fairly narrow scope and focuses on recommendations for tools and strategies that will allow the workforce to continue its dedicated and passionate work in the field of SUD treatment, prevention and recovery support.

The intended audience of this report includes the SUD workforce, primary care providers, county personnel, public and private agencies, and other stakeholders. As the SUD functions and programs of the Department of Alcohol and Drug Programs transfer to the Department of Health Care Services (DHCS), there is a desire to provide DHCS with specific SUD workforce related information and assistance.

Information in this report has been extracted from a large number of publicly available documents listed at the end of the report.

Chapter 1 - Emerging Directions Resulting from Health Reform

Summary of Health Reform

Healthcare in California changed in 2010 when Congress passed the Affordable Care Act (ACA) creating a minimum level of healthcare for citizens and residents using standardized programs and systems. The ACA ends the barrier of treating pre-existing conditions, expands Medicaid eligibility to those earning less than 139% of the Federal Poverty Level, establishes subsidies for individuals and small businesses needing health insurance, and requires most residents to obtain either private or public health insurance.

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA), Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues (January 24, 2013) an estimated 38 million more Americans will have an opportunity to be covered by health insurance due to changes under the ACA. Between 20 and 30 percent of these people (as many as 11 million) may have a serious mental illness or serious psychological distress, and/or a substance use disorder. Among the currently uninsured, aged 22 to 64, with a family income of less than 150 percent of the federal poverty level, 36.8 percent had illicit drug or alcohol dependence/abuse or mental illness. The lack of coverage and cost of services was cited as a significant barrier in seeking SUD services.

Based on this information and using round numbers, approximately one-third of the population who are newly eligible for health insurance will have a mental or substance use disorder. This increased need for services requires the existing workforce to expand, to become more efficient, and to broaden their skill set. The composition of the workforce will be reshaped by the ACA as we move toward a more integrated primary and behavioral health care system. Brief interventions and brief treatment will likely be delivered by staff in primary care settings as screening for depression, alcohol and substance abuse becomes a standard part of care. Staff will include health educators, nurse practitioners, care managers and physicians, as well as counselors, social workers, psychologists and addiction specialists.

Primary care settings differ from the specialty sector. As integration of primary and behavioral health services becomes the standard, a greater emphasis will be placed on evidence-based practices and outcomes, a team approach to patient care, and a focus on improving quality of care as well as administrative and clinical processes.

People with more severe and persistent mental and substance use disorders will receive longer term and more intensive treatment, either within a primary care setting or specialty setting. The use of peers to promote long-term recovery is also expanding across the country. These peer specialists, who in some states are now being certified, play a key role in the recovery process serving as role models, navigators, recovery coaches, as well as providing hope - a critical part of the recovery process. These peer specialists are an important component of the workforce and can help meet the increased need for services. The support they provide is that of a trained person who is certified but not licensed as a traditional health

or behavioral health care practitioner. New or expanded roles and types of workers are also likely to be needed to facilitate integration, including health educators, behavioral health specialists, and care managers.

The following sections detail the areas affected by health reform that must be addressed in the assessment of workforce development needs.

Types of Service Needed

The ACA established ten categories of Essential Health Benefits that new insurance plans must provide.

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- **Mental health and substance use disorder services, including behavioral health treatment**
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Each state determines the details of the services that will be included in each of the ten categories. Health plans will have to cover at least 60% of the costs for these services with the remaining 40% being paid by enrollees as copays and deductibles. California selected a benchmark plan that includes drug counseling and screening for alcohol use. In 2014, these will become mandatory benefits for all Medicaid participants and will create an increased demand for SUD services.

California's independent public entity responsible for creating standardized health plans, California's Health Insurance Exchange, has not finalized all of the details pertaining to SUD coverage. Covered services will likely include the types of services already generally provided for SUD treatment, plus alcohol screening and brief interventions. We do know there are specific locations where insurance-billable services can be delivered, and there is a staff scope of practice authorized to deliver the service. Both seem to be limited to primary care settings. This limitation of providers authorized to deliver insurance-billable services can negatively impact access to services for the newly eligible and expanded coverage populations.

Increased Demand for Service

As more individuals from a variety of socio-economic groups and population segments become eligible for coverage under the new eligibility criteria, the demand for services is

expected to increase. In addition to those who are newly eligible, individuals who are currently insured will be entitled to receive expanded benefits. Also included are the underserved populations who may be located in areas not currently well staffed with AOD professionals. Other segments of the population identified as having an increased need for service include veterans, older adults, newly released prison inmates, youth, and all cultural and ethnic groups.

Since mental health and SUD services are both included in the essential benefits package—and there is evidence that the two often are dual diagnosed—we can expect that this, too, will result in more people seeking SUD services.

Reports from SAMHSA, UCLA and others estimate that 300,000 – 700,000 Californians will become eligible for mental health, behavioral health and SUD related services. For the Medicaid Expansion population, the National Survey on Drug Use and Health (NSDUH) identifies the most common characteristics of those with a SUD as male, 18-34 years old, non-Hispanic White or Hispanic, and having less than a high school education.

Some of the expansion population may not have previously had the benefit of healthcare; therefore, it is not known if their needs will be significantly greater or different than the current population.

Service Delivery Facilities/Locations

Depending on the individual's entry point and/or the intensity of services needed, SUD treatment may currently be provided through the criminal justice system, community organizations, outpatient programs, non-medical residential facilities, opioid treatment programs, medical residential/inpatient facilities, emergency room visits, and primary care facilities. As progress continues toward integration of care, primary care facilities, hospitals, nonmedical residential or social model programs, and mental health facilities will be expected to work together to find the best way to treat the individual.

The services provided in primary care and hospitals may be limited to a screening, brief intervention or counseling; however the current workforce providing services in these settings are not well trained in screening for, or recognizing, SUD. Likewise, the SUD workforce certified to provide services in residential nonmedical facilities licensed by ADP, and outpatient facilities certified by ADP are not well trained or prepared to screen for, or recognize, physical, or mental disorders.

In rural or underserved communities, the primary care facilities, hospitals, and mental health facilities may bear the sole responsibility for recognizing the need for and providing SUD intervention or treatment. Cross training staff in these locations becomes a priority because of the limited number of healthcare staff.

SUD often carries a stigma with it, whether it is a patient being treated for SUD or someone who works in the SUD field. As integration of care progresses and SUD services are made

available in primary care, a potential benefit is that patients may have options for treatment in settings that do not inherently have an SUD treatment stigma.

Linking Mental, Physical & Pharmacologic Treatment to AOD

Health reform extends the provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) to include treatment of mental health and substance abuse disorders. Currently, the SUD workforce is segmented among mental health, substance abuse, and physical healthcare settings. Generally, one segment does not have the skill set necessary to address all three service delivery domains. Primary healthcare workers typically are not well trained to screen for or provide treatment for substance use disorders. Likewise, SUD personnel and mental health practitioners usually are not medically trained to address the full range of physical wellness.

The prevalence of co-occurring mental health and substance use disorders is documented in the 2010 National Survey of Drug Use and Health (NSDUH) which indicates that approximately 9.2 million adults with SUD have a co-occurring mental illness. And approximately 20 percent of adults with a mental illness have a co-occurring SUD. This underscores the need for the development and promotion of behavioral health competencies among both the addictions and mental health workforce. As the use of medication-assisted treatment increases and treating Co-Occurring Disorders (COD) becomes more frequent, more physicians will be needed in mental health settings. Physicians in primary care are also more likely to be treating and prescribing medications for addictions.

In California, estimates vary as to the number of people suffering from both SUD and mental health problems (not necessarily at a level considered to be "Seriously Mentally Ill" – SMI). The number of Californians with COD is presumed to be above the national average for several reasons. California has a higher-than-average veterans' population, among whom Post Traumatic Stress Disorder is prevalent and often a factor in COD. California also has a disproportionate number of homeless individuals, who have a higher rate of COD than the general population.

In raw numbers, based on SAMHSA figures nationwide (and projecting from those, based on California's percent of the national population), California could have, at least 800,000 to 1,000,000 individuals with both SUD and mental illnesses of some kind. More specifically to California's SUD population, the rate of CODs among California's SUD population is likely to range from 40 to 70 percent. Consequently, the core competencies for SUD providers should include those for COD treatment.

Evidence-Based Practices

Evidence-Based Practices (EBP) are programs or strategies that are recognized to improve client outcomes in more than one randomized clinical trial. They can be pharmacological (i.e., methadone) or psychosocial (i.e., cognitive-behavioral therapy, motivational interviewing, contingency management, and 12-step facilitation).

Screening and brief intervention, motivational interviewing, and medication-assisted treatment are all EBPs for the treatment and prevention of substance use disorders. Additionally and specifically related to the prevention of underage drinking, environmental prevention strategies are EBPs.

The United States Preventive Services Task Force (USPSTF) ranked screening and brief intervention for alcohol use as a high priority and cost effective intervention. Medications are available to assist patients to reduce drinking, avoid relapse and support abstinence. Similarly, medications are available to treat opiate addictions. Their use in primary care is feasible and cost effective.

The best methods for training the workforce in using EBPs involve a multi-dimensional training approach or blending of strategies. Distance learning appears to develop knowledge, workshops may serve as the platform for establishing basic skills, and clinical supervision that includes observation, feedback and coaching can serve to develop proficiency with real patients.

Screening and Brief Intervention

Screening and Brief Intervention (SBI) for alcohol misuse are now part of the Affordable Care Act's essential health benefits, and as noted above, the USPSTF has recognized its effectiveness in addressing alcohol misuse. SBI is an evidence-based approach that focuses upon early identification and intervention of potentially problematic substance use patterns. When correctly implemented, SBI reduces the time and resources needed to treat conditions caused or worsened by substance use, improving the health status of patients and making our health systems more cost effective. Depending on the setting, the approach may include Screening and Brief Intervention; Screening and Referral to Counseling; or Screening, Brief Intervention and Referral to Treatment (SBIRT). As health reform is implemented, screening and brief intervention will be a new service within primary care settings.

In SAMHSA's recent Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues (January 24, 2013), SBIRT is part of routine and ongoing prevention activities. More people will receive the screenings, brief interventions or brief treatment, often conducted by health educators, recovery specialists or other staff in the primary care system. Those needing more intensive treatment services will be referred to specialty treatment providers.

SAMHSA defines a comprehensive SBIRT model to include the following components:

- Universal screening of all patients regardless of an identified disorder
- One or more specific behaviors related to risky alcohol and drug use are targeted
- Brief (e.g., typically 5-10 minutes for brief interventions; 5 to 12 sessions for brief treatments)
- Services occur in a public health non-substance abuse treatment setting

- Comprehensive Services (comprised of screening, brief intervention/treatment, and referral to treatment)

No specific SBIRT definition has been articulated by the USPSTF or other authoritative/coordinating bodies. The SAMHSA definition of SBIRT is based on methodology that was developed during the implementation of a comprehensive SBIRT grant program comprised of all the integral components, and supported by research by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism.

Universal screening as part of primary care accomplishes critical health objectives: it establishes a baseline of patient behaviors, and helps identify the appropriate level of services needed based on the patient's current risk level. Patients who indicate little or no risky behavior and have a low screening score will not need an intervention. Those who have moderate risky behaviors and/or reach a moderate threshold on the screening instrument may receive a brief intervention. Patients who score high may need a brief treatment or further diagnostic assessment and more intensive, longer-term specialty treatment.

As primary care begins to implement universal screening, it becomes important to understand how screening will be accomplished and by whom. Options may include having multiple access points to gather the information. For example, an online assessment could be used for those who have internet capabilities, patients could fill out a short survey as part of their intake process or, a trained and credentialed workforce member within the health care facility could conduct the screening and make the appropriate recommendation or referral for intervention or treatment. Training the existing primary care work force in these new requirements, or successfully co-locating substance use counselors with specialty training in brief interventions will be challenge in the years ahead.

Essential Health Benefits and Federal Parity

Essential health benefits and federal parity are two federal frameworks that oversee mental health and substance use benefits. Both require inpatient, outpatient, emergency and prescription drug benefits that cannot have annual or lifetime limits, copays and deductibles, and treatment limitations that are more restrictive than medical/surgical benefits. The parity treatment issue is important because it prohibits states from instituting more rigorous management methods in behavioral health than exists in physical health.

A summary of the four categories of groups receiving benefits and their associated level of benefit is shown below.

Group	2014 Behavioral Health Benefits
Individuals and small businesses	Essential health benefits at federal parity
Medi-Cal expansion and basic health	Benchmark benefits package at federal parity
Traditional Medi-Cal, moderate to severe disorders	No change in existing mental health benefits Upgraded substance use benefits at federal parity
Traditional Medi-Cal, lower need	Upgraded mental health and substance use benefits at federal parity

The Traditional Medi-Cal enrollees with moderate to severe disorders have access to a very limited mental health benefit that includes two visits per month to mental health care provided by a physical health practitioner, to medications and to emergency care. This category of benefit may be upgraded to the same mental health benefit as that offered to the Medi-Cal expansion population at federal parity.

Insurance Billable Services

Billable services are defined differently, depending on the provider, the insurance plan, the setting in which the service is delivered, and the scope of practice authorized to deliver the service. The SUD field needs a translation of the various billable services definitions in a format that aligns with the available workforce credentials and scopes of practice.

As an example, the Kaiser Small Group HMO includes mental health and substance use benefits and is shown in Appendix F. This example demonstrates the use of terminology not consistent with that used by the SUD workforce resulting in confusion and questions about the types of services covered.

Assumptions for Future Direction

The future direction of California's SUD workforce continues to evolve as federal directions and regulations change, and as the State determines the most effective methods to incorporate the existing workforce into the developing model. More than ever, the workforce is relying on the State to determine a future direction for the field. Regardless of the uncertainties that exist at the federal and state levels, there are assumptions that can be made. These assumptions are consistent with the findings identified in several reports and include: reports commissioned by SAMHSA, written by the University of California Los Angeles (UCLA), the County Alcohol and Drug Program Administrators' Association of California (CADPAAC), the National Association of Alcoholism and Drug Abuse Counselors (NAADAC), the International Certification and Reciprocity Consortium (IC&RC), and others. These assumptions are the building blocks for the recommendations made in this report:

- In the next five years, more SUD treatment professionals will be needed who are able to care for individuals with SUDs in a variety of managed healthcare settings, recognize co-occurring disorders, and be culturally competent.
- Applicants for open positions in SUD treatment facilities need to be well qualified. The workplace will be competitive.
- The workforce needs to be diversified and able to work in integrated settings and collaborate between providers regarding a patient's care plan.
- Health reform offers California an opportunity to address the SUD workforce concerns and make forward progress for recognizing the SUD field as a standard component of healthcare.
- SUD treatment facilities must adopt and implement EHR systems to remain a part of the changing healthcare environment. The workforce must learn and adopt EHR systems and other technology that creates efficiencies.
- Now is the time to commit to an SUD professional Scopes of Practice and credentialing system.
- Specific steps must be taken to grow and sustain the workforce.
- The existing workforce must be provided tools to prepare for the future.

Required Knowledge, Skills and Credentials

The workforce needs to expand and enhance its knowledge base to meet the increased demand for SUD services; to acknowledge that SUD services will be delivered in a variety of healthcare settings and that integration into primary care will occur; to recognize that the workforce must have the appropriate education and credentials to work in multiple health care settings; and to provide tools to keep pace with emerging federal directions and guidelines for SUD services.

As the workforce prepares to provide services in the varied settings of SUD treatment, any credentials they currently have may not be recognized as sufficient for a primary care setting. The existing credentials offered by California's seven certifying organizations are valid in a setting or program certified by ADP. Although the major healthcare providers such as Kaiser Permanente and other hospitals may choose to hire the individuals certified by the seven organizations, there are no requirements to do so.

The following list serves as a starting point for identifying the areas in which the workforce can develop. Since SUD services will be delivered in multiple healthcare settings, the primary care and mental health workforces should expand and enhance their knowledge base about alcohol and other drugs.

Findings

- To prepare for integration of services into primary care, cross train between the SUD, primary care, and mental health workforces to understand the basics of

substance abuse, mental health issues, and physical ailments that mimic AOD. (Goal 15)

- All practitioners of the healing arts, including doctors, nurses, physicians assistants, LCSW's, MFT's, and others, must expand their skill set to recognize AOD and COD. (Goal 3)
- COD affect a large portion of those seeking treatment. Core competency standards and training should address this. (Goal 7)
- Sharing information among providers will be a key element to creating one problem list, one drug list, and one care plan. This collaboration between providers can be aided by the use of Electronic Health Records, Electronic Billing, care management, and the concept of individual wellness. (Goal 9)
- The workforce must be trained in the use of, and adopt evidence-based practices. (Goal 11)
- Acknowledge that some areas of the state may have very limited access to SUD workforce. (Goal 5)
- Address the influx of underserved populations. (Goal 5)
- Identify how cultural competency will be addressed. (Goal 15)
- All services delivered are not considered insurance billable services. Build a business case for reimbursement and provide input to SAMHSA. (Goal 4)
- Universal screening could pave the way for a newly designated category of SUD credential. (Goal 6)
- Ensure the workforce is trained and prepared to deliver all SUD related services identified for the expansion population and the Health Insurance Exchange. (Goal 15)
- The private healthcare workforce will also expand and enhance its skillset to stay competitive and able to meet the increased demand for service. In an effort to augment the private workforce, county level workforce may be enticed to the private healthcare market by better wages, benefits, and educational opportunities. This will further add to the public sector workforce shortage. (Goal 5)

Chapter 2 - Environmental Assessment – Overview of Existing Workforce

As it exists today, the workforce spans the realms of prevention, treatment and recovery support. Services are delivered in a wide range of SUD treatment facilities and include residential non-medical, community-based organizations, opioid treatment programs, hospital and primary care settings, mental health facilities, adolescent social service environments, prevention, and the criminal justice system. The education, licenses and skills of practitioners range from a high school education with no specialized licenses or certifications to a post graduate education with full accreditation. In addition, the workforce includes those who are in direct service plus those who have the combined responsibility of managerial and supervisory duties.

Each segment of the workforce is unique and plays a vital role in combating substance abuse. Those specializing in treatment provide services in a variety of programs and have a focus on individual outcomes. Most of the recovery support workforce consists of former substance users who provide mentoring to individuals and small groups. The prevention worker is both individual-based and community-based and has a focus of population-based change. Each segment of the workforce has a place in the emerging world of health reform. Their scope of practice may become more refined, and their knowledge base and skill set may be expanded to address new practices and technology.

The following information is a summary of the national workforce demographics taken from the report, *Vital Signs: Taking the Pulse of the Addiction Treatment Profession* (September 28, 2012). The report was written by the Addiction Technology Transfer Network and was funded by SAMHSA.

National Workforce Demographics

- Clinical directors are predominantly white, middle-aged women with no military affiliation. These clinical directors are educated professionals who began their career in the SUD treatment field and have, an average of 17 years of experience in the field. About one-third identify as being in recovery from an SUD.
- Direct care staff members supervised by the clinical director respondents are also mostly white women with no military affiliation. Direct care staff members tend to be younger, on average, than clinical directors and have less years of experience at their current places of employment. Direct care staff members are also educated professionals. The highest degree status of direct care staff that was most commonly reported was a Master's degree. Furthermore, the majority of direct care staff is currently licensed/certified or is seeking licensure/certification. Slightly less than one-third of direct care staff are in recovery from SUDs as estimated by their clinical directors.

- Almost one-third of clinical directors are only somewhat proficient in web-based technologies, and almost half of SUD facilities do not have an electronic health record system in place.

Common Strategies and Methodologies of Recruitment and Retention

- SUD treatment facilities most commonly offer professional development for staff through new employee orientation, ongoing training, and direct supervision. When facilities do not provide for staff training and continuing education, the most commonly reported reason was a lack of funds.
- Recruitment continues to be a significant issue for many SUD treatment facilities. According to survey respondents, facilities primarily use web-based classified advertisements to recruit new staff and almost half of facilities have difficulty filling open positions, mostly due to an insufficient number of applicants who meet minimum qualifications. Through interviews, clinical directors emphasized the positive effects that developing relationships with colleges and universities can have on recruiting qualified professionals.
- Retention continues to be an ongoing challenge for SUD treatment facilities. According to survey respondents, the average staff turnover rate is 18.5 percent. Some of the most successful retention strategies employed by treatment facilities include the provision of healthcare benefits, a supportive culture, and access to ongoing training.

A CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey released in 2009 reports similar workforce demographics for California. Two interesting responses are shown below and support the belief that the workforce is prepared to make changes.

- Twenty percent (20%) of respondents indicated that it was very likely (highly probable/definite) that they will be changing their place of employment within the next two years, and 13% indicated that it was very likely that they would leave the substance abuse treatment field altogether. The most frequently indicated reasons for changing place of employment (but staying in the field) include: greater pay and/or benefits (260 responses; 15%), greater responsibility/authority (137 responses; 8%), and better management/administration (124 total responses; 7%). And the most frequently indicated reasons for changing place of employment (and leaving the field) include: greater pay and/or benefits (136 responses; 8%), better management/administration (65 responses; 4%), and greater responsibility/authority.
- The top five personal training and technical assistance needs indicated by respondents include: providing trauma informed or trauma sensitive services (48%); providing services for co-occurring disorders (47%); providing clients with integrated treatment services of addiction and mental health disorders (43%); improving client problem solving skills (40%); improving behavioral management of clients OR improving client thinking skills (tied at 39%); and improving cognitive focus of clients during group counseling (38%).

Education Levels and Credentials

The majority of clinical directors are well educated, with a large number holding graduate degrees (master's, 57%; doctoral or equivalent, 8%; medical degree, 1%). Of those who do not have graduate degrees, 15% have a bachelor's degree, 7% have an associate's degree, and 7% have some college but no degree. Clinical directors reported that of the direct care staff they supervise, 24% have bachelor's degrees and 36% have master's degrees.

More than three-quarters (84%) of clinical directors are licensed/certified in substance abuse counseling, and over half are licensed/certified as clinical supervisors (55%). Of those licensed/certified as clinical supervisors, most hold licensure/certification at the state level (77%). For direct care staff, most are already licensed/certified (54%) or are currently pursuing licensure/certification (18%).

Clinical directors discussed how financial and structural resources needed for recruitment in the SUD treatment field can often act as a barrier to attracting the best job candidates. Financial barriers do not allow treatment facilities to offer competitive salaries, one of the key elements in successful recruitment. Additionally, structural barriers such as the amount of paperwork and documentation expected of clinicians affect successful recruitment.

Clinical directors also suggested that stigma and misunderstanding of SUD treatment play a role in recruitment challenges. They noted that SUDs are often not considered a legitimate healthcare issue and have not been traditionally integrated into mainstream healthcare.

Areas of Concern

In February 2012, the Technical Assistance Collaborative (TAC) and the Human Services Research Institute (HSRI) released a major report, *California Mental Health and Substance Use System Needs Assessment.* The report applauds efforts to expand and support the behavioral health workforce and identified ten areas of concern:

1. A shortage of psychiatrists and psychiatric nurse prescribers, especially those specializing in serving children and elders.
2. Shortages of behavioral health workers in many rural areas.
3. A workforce that is predominately Caucasian, English-only speaking in a state where 38% of the population is of Hispanic/Latino origin, 36% of residents are foreign born, and 57% speak a language other than English.
4. A lack of formal integration and coordination of mental health and substance use treatment and primary care and a shortage of providers skilled in co-occurring disorder treatment.

5. An absence of state certifications for peer counselors and family support specialists, as well as a lack of positions in the public mental health system for peers/family members.
6. A need for more culturally responsive and competent providers' practices to engage underserved populations.
7. Variability among the counties in the use and training of staff in state-of-the art, evidence-based, and recovery-oriented treatments.
8. A workforce with limited training in providing care that is family-centered or recovery-oriented as well as limited training opportunities in those areas.
9. An inadequate supply and mal-distribution of inpatient psychiatric beds, detoxification beds, and inpatient alternatives such as crisis residential services.
10. Variability among the counties in collaboration with Federally Qualified Health Centers and a need for more consistent collaboration and stronger partnerships with these health centers.

The report notes that several California communities have addressed some of these issues.

Another report, *Evaluation Services To Enhance The Data Management System In California (EnCAL), Final Report 2011–2012*, by University of California, Los Angeles, Integrated Substance Abuse Programs, identifies a critical need to adopt EBPs and the barriers for doing so.

Providing quality care to identify and reduce risky substance use and diagnosing, treating, and managing addiction requires a critical shift to science-based interventions and treatment by health care professionals. Significant barriers stand in the way of making this critical shift, including: (a) an addiction treatment workforce starved of resources, operating outside the medical profession, and lacking capacity to provide the full range of evidence-based practices including necessary medical care; (b) a health profession that should be responsible for providing evidence-based addiction screening, interventions, treatment, and management; and (c) inadequate oversight and quality assurance.

Treatment

A person entering the treatment workforce has an abundance of credentials from which to choose. Confusion exists as to which credential is the most valuable—there are no standards or consistency. The lack of standards creates confusion for job applicants, hiring managers, and the patients themselves. Individuals who function as supervisors or managers typically do not receive special training to operate within that role and frequently are expected to carry a treatment workload and maintain their technical expertise.

Currently there is no state agency that issues certifications or licenses for a specific "SUD workforce." Individuals licensed as LCSW, MFT and physicians all may provide AOD counseling in any SUD treatment setting. ADP has the authority to determine the skills,

knowledge and abilities of the workforce providing AOD counseling in ADP licensed and certified facilities. ADP has authorized seven certifying organizations to certify to the determined skills, knowledge and abilities regulated by ADP for individuals not otherwise licensed. These individuals are only certified to provide services in ADP licensed and/or certified facilities, not any of the other settings available for individual SUD treatment (hospitals, primary care) unless that hospital or primary care setting is also AOD certified by ADP.

Prevention

SUD prevention strategies such as screening and brief intervention, classroom education, and youth development are individual-based. Other strategies such as community outreach, strategic planning, and public policy development are population-based. The manner in which the population-based activities are conducted is based on the needs of the specific community environment. The prevention workforce needs to be knowledgeable and skilled in these strategies for SUD prevention to be effective.

Credentialing or standards are needed within the prevention field. Currently, counties each have their own minimum competencies for prevention staff, resulting in a workforce with varying levels of knowledge, skills and abilities.

At the county level, the county Alcohol and Drug Program Administrator frequently has conflicting priorities between treatment and prevention. Recently, the prevention workforce has felt the brunt of California's economic turmoil. Prevention specialists have lost jobs due to budget cuts and responsibilities are then transferred to those who have little or no prevention background or experience.

The role of prevention within communities is similar to the role of health screenings in detecting early warning signs of cancer, diabetes and other medical conditions. Data suggests that early warning signs exist as risk factors. If ignored, the risk factors tend to lead to behaviors such as underage drinking, binge and excessive drinking, illicit drug use, and prescription drug abuse.

Recovery Support

Recovery support plays a critical role for an individual with SUD. Many recovery support specialists, peer mentors and counselors come from the perspective of "been there, done that" and are able to build rapport with an individual and provide hope for recovery – a necessary element that extends beyond medical care. Recovery support staff represent all walks of life, all socio-economic levels, and all racial and ethnic groups. This diversity makes them particularly effective at relating to others.

Recovery support is not always viewed as medically necessary, so it may not be considered an essential part of a primary care setting. There is no standard credential or certification for a recovery support person.

Administration and Managerial

Individuals in administrative and managerial roles spend the majority of their day doing these types of tasks, leaving minimal time to practice their skills as counselors. The expectations for administrative and managerial staff are not standardized and little training exists to help prepare a person for these roles. There is no state recognized certification or license required to provide the administration and management function in a facility licensed or certified by the state.

Findings

- Staff need specific training to become supervisors and managers. (Goal 16)
- Licensure and certification requirements are less for substance abuse counselors in comparison to mental health counselors. A standardized certification and scopes of practice may potentially allow SUD paraprofessionals to work within primary care settings. This not only adds credibility to their credentials, but also expands their job marketability. The certification and scopes of practice should include treatment, prevention, recovery support, and supervisory positions. (Goal 11)
- There is great diversity in the demographics of the workforce and in the patient population. Therefore, the workforce must acknowledge the influence of their own pre-conceived opinions and biases on the services they provide to specific segments of the population. There is a need for more culturally responsive and competent providers to engage underserved populations. (Goal 15)
- Grow, maintain and sustain the workforce by creating a career path - recognizing the current shortfalls within the career field, actively recruiting, and creating incentives to stay in the field. Youth and young professionals need to be encouraged to enter the workforce to help offset the natural attrition that will occur as the aging workforce retires or leaves the field. (Goal 13)
- To retain staff, incentives such as increased compensation, incentives for continuing education, healthcare and other benefits, and implementation of a supportive culture are needed. (Goal 14)
- Implementation of Electronic Health Records is needed, along with the training to effectively use the system. (Goal 15)
- Formal integration and coordination of mental health and substance use treatment, prevention and recovery support into primary care is needed, along with an increase in the number of providers skilled in treating co-occurring disorders. (Goal 8)
- Create consistency among the counties in the training of staff and use of state-of-the art and evidence-based and recovery-oriented treatments. (Goal 15)
- The workforce has limited training opportunities in providing care that is family-centered or recovery-oriented. (Goal 15)

Chapter 3 - Potential Workforce Competencies, Certifications & Standards to Deliver Service in Health Reform

To meet the requirements of health reform and the emerging federal directions, all members of the workforce need to expand their knowledge, skills and abilities. In the process, it is expected that two of our State Needs Assessment and Planning (SNAP) goals will be achieved.

- Health Reform Readiness, Goal 3: Develop the AOD workforce to conform to health reform requirements for service provisions including early intervention and reimbursement strategies for health reform related activities, and
- Prevention Strategies, Goal 2: Build workforce capacity based on core competencies for Prevention practitioners.

The following sections provide examples of the types of services, certifications, and standards that are needed by the workforce.

SAMHSA's Strategic Directions

SAMHSA provides the strategic direction for substance abuse and mental health. Therefore, it is logical for the workforce to prepare to meet the eight strategic initiatives that SAMHSA has embedded in its strategic plan document, *Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014*. Examples of workforce objectives in each of the Strategic Initiatives include:

1. Prevention of Substance Abuse and Mental Illness: Educate the behavioral health field about successful interventions, such as screening, brief intervention, and referral to treatment (SBIRT); develop and implement training around suicide prevention and prescription drug abuse.
2. Trauma and Justice: Provide technical assistance and training strategies to develop practitioners skilled in trauma and trauma-related work and systems that have capacity to prevent, identify, intervene and effectively treat people in a trauma-informed approach.
3. Military Families: Develop a public health-informed model of psychological health service systems, staffed by a full range of behavioral health practitioners who are well trained in the culture of the military and the military family and the special risks and needs that impact this population, such as Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). The role of peer counselors within this model will also be important to its success.
4. Recovery Support: Build an understanding of recovery-oriented practices, including incorporating peers into the current workforce to support peer-run services. Emphasize collaborative relationships with children, youth, and families that involve shared decision-making service options.

5. Health Reform: Work with partners and stakeholders to develop a new generation of providers, promote innovation of service delivery through primary care and behavioral health care integration, and increase quality and reduce health care costs through health insurance exchanges and the essential and benchmark benefit plans.
6. Health Information Technology: Promote the adoption of electronic health records (EHRs) and the use of health information technology (HIT) through SAMHSA's discretionary program and Block Grant technical assistance efforts.
7. Data, Outcomes and Quality: Target quality improvement through workshops, intensive training and resources that promote the adoption of evidence-based practices, and activities to advance the delivery of clinical supervision to foster competency development and staff retention.
8. Public Awareness and Support: Ensure that the behavioral health workforce has access to information needed to provide successful prevention, treatment, and recovery services.

Scope of Practice, Certifications, Career Ladder

Within the SUD field, agreement exists that a scope of practice and a career ladder are needed to address the full range of responsibility from entry level to clinical supervision, and include the roles of prevention, treatment and recovery support staff. However, there is not yet agreement about the specific details to include on a scope of practice, or the positions that should be on a career ladder.

As defined by the Federation of State Medical Boards (FSMB) a Scope of Practice is the "definition of rules, regulations and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field of medicine or surgery or other specifically defined field. Such practice is also governed by requirements for continuing education and professional accountability." The benefits of having a Scope of Practice include the following.

- Protect the public by setting standards
- Put practice in line with higher education
- Allow practitioners to be reimbursed for services (to collect 3rd party payment)
- Raise awareness of the profession
- Inform workforce development activities

Regarding credentials, according to the International Certification and Reciprocity Consortium (IC & RC), the credentialing of professionals enhances services in at least three important ways:

1. Ensuring Public Safety: The most compelling reason to certify substance abuse professionals is to ensure public safety. It is reasonable for consumers of substance abuse services to expect protection from other abuses, such as misappropriation of funds, misrepresentation of credentials, conflicts of interest, and discrimination.

2. Enhancing Public Funds Accountability: Ethical practice demands accountability for public expenditures, and accountability dictates that states and their programs utilize staff who demonstrate proficiency with competency-based standards.

3. Providing Professional Benefits: Professionals gain significant benefits by achieving and maintaining a practice credential. Not only are they able to demonstrate practice competencies in their daily work, but they become part of an international cadre of advocates for quality service delivery.

Career ladders are occupational structures designed to encourage and reward competent employee performance within a field or a particular organization. Employees move up the rungs – or in the case of a career lattice, across -- by demonstrating successful performance and/or obtaining education and training that prepares them for the next level. Career ladders help employees plan for upward mobility in their careers, even if they start in an entry-level job.

Some benefits include the following.

- Employee retention—Career ladders illustrate potential for advancement, which serves as an incentive for employees to stay with organizations or within a field. Employers save on costly turnover, recruitment, and training expenses.
- Performance incentive—Opportunity for advancement motivates employees to produce and perform well on the job and to acquire new knowledge and skills.
- Career development programs—The graphic representation of career ladders provides an easily understood tool to assist career counselors and individuals in career planning and decision-making.

Used together, the scopes of practice and the career ladder create the standards for the roles and responsibilities within the field of substance use disorders. As these professional roles are more clearly articulated and these documents incorporated into the workplace culture, the SUD profession will be better able to position itself in a specialized field.

Treatment

Creating a standard scope of practice and set of credentials for the entire SUD workforce, not just counselors providing services in ADP licensed and certified facilities, is a topic that has been reviewed and endorsed by multiple entities. The State recognizes that creation of these standards, having a universal code of conduct, and training all workforce members to understand prevention based services and cultural competency are needed.

Currently, treatment can be provided in multiple settings, both licensed and not licensed by ADP. The facility licensing aspect of treatment serves to confuse the already complex

individual certification choices. Individuals may seek treatment for SUD issues from service providers; however, not all service providers are regulated by the state. ADP is the single state agency to monitor the funds from the SAPT Block grant, but ADP is not the single state provider of services for SUD issues.

Facility Licensing – Certain facilities must be licensed by the state to provide specific services to individuals. The facility license dictates the services which may be provided in the facility.

- Emergency medical services for individuals suffering from SUD issues are provided in a hospital. After the medical services are delivered, the individual will either be released or admitted for an extended period of time.
- Residential medical services for individuals with SUD can be provided only in a facility licensed to provide medical services to individuals overcoming alcohol and/or other drug issues. These services may be provided in either a hospital setting or in a chemical dependency recovery hospital licensed by Department of Public Health (DPH).
- Residential non-medical services for individuals with SUD can be provided only in a facility licensed by ADP to provide residential non-medical treatment or recovery services to adults for the treatment of alcohol and other drug issues.
- Outpatient SUD services may be provided in any outpatient facility. These facilities may provide medical services and need oversight from DPH to provide medical services. They may be provided in a facility that provides no medical care. There is no requirement for this type of facility to be licensed by any state agency. There is no license available for this type of facility.
- Narcotic treatment programs (NTP) provide replacement narcotic therapy to individuals overcoming opioid dependency. These facilities must be licensed by ADP.
- Driving under the influence (DUI) programs provide court mandated educational sessions to individuals convicted of driving under the influence.

Program Certification – any program providing SUD treatment or recovery services may seek to have their program certified by ADP to provide AOD services. By state law, this AOD certification is voluntary. ADP certifies AOD programs providing AOD treatment or recovery services in residential medical facilities licensed by DPH; residential non-medical facilities licensed by ADP; and residential non-medical facilities licensed by DSS and DHS.

Drug Medi-Cal Certification – any qualifying program that seeks reimbursement for services through the state Medi-Cal system must be certified by DHCS (previously ADP) to provide drug Medi-Cal services. Facilities eligible to apply for a drug Medi-Cal certification include perinatal, residential non-medical, NTP's and outpatient providers.

For the SUD workforce, there is currently no state issued AOD/or SUD counselor registration, certification or license in California. ADP has been given the authority to determine the appropriate skills, qualifications, education, and training of personnel

working in ADP licensed or certified recovery or treatment programs. Registration and certification of individuals providing AOD counseling in ADP licensed or certified facilities recognizes program compliance with established standards. Regulations require that to provide AOD counseling in any ADP licensed or certified program, individuals must be registered or certified with an approved certifying organization at the appropriate level of certification, or be otherwise licensed as defined as a physician, marriage family therapist, clinical social worker, or an intern registered with the Board of Behavioral Sciences. Six entities have been recognized as California's certifying organizations, each of which have established standards that meet the minimum standards identified in regulations and which vary significantly from one certification body to another.

While the examples shown in this report are from a federal perspective, the standards used within the State should reflect state-level needs. The state will need legislation to gain oversight of all individuals providing SUD counseling in California to include prevention, recovery or treatment services.

Much work has been done to define a scope of practice for the SUD treatment field. For an example, refer to Appendix F: Example - Scopes of Practice & Career Ladder for Substance Use Disorder Counseling, SAMHSA, September 2011.

Prevention

SAMHSA has a strategic initiative to develop Prevention Prepared Communities. The Institute of Medicine's (IOM's) 2009 report *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, describes evidence-based services and interventions that build emotional health by addressing risk factors and supporting protective factors and resilience to prevent many mental and substance use disorders in children and young adults. The report documents that behavior and symptoms signaling the likelihood of future disorders—such as substance abuse, adolescent depression, and conduct disorders—often manifest 2 to 4 years before a disorder is actually present. If communities and families can intervene earlier—before mental and substance use disorders are typically diagnosed, future disorders could be prevented or the symptoms mitigated. Doing so requires multiple and consistent interventions by all systems touching these children and youth (e.g., schools, health systems, faith-based organizations, families, and community programs). Most adult mental and substance use disorders manifest before age 25, and many of the same risk and protective factors affect physical health. The focus on preventing mental health and substance use disorders and related problems among children, adolescents, and young adults is critical to the nation's health now and in the future.

Mental, emotional, and behavioral health contribute to the overall psychological well-being of individuals. SAMHSA plans to promote health by placing a national priority on healthy mental, emotional, and behavioral development, especially in children, youth, and young adults.

At the State level and in a collaborative effort, ADP and CADPAAC are developing components of curricula for the prevention workforce and include training in the areas of

collaboration, community organization and outreach, youth development, screening and brief intervention, and the Strategic Prevention Framework (SPF).

At the international level, the United Nations Office of Drugs and Crime (UNODC) recently released a report, *International Standards On Drug Use Prevention*. The report contains a summary of the interventions and policies that have been found to yield positive results in preventing substance abuse. An excerpt from the report is shown in Appendix H: International Standards On Drug Use Prevention.

Recovery Support

Although non-traditional, and unrecognized currently in California, the recovery support workforce needs to be a part of data collection efforts, including those in recovery from mental and substance use conditions, community health workers, patient navigators, and health educators. Recovery support workers play a key role in the mentoring of individuals and need to be included in the career ladder, in the credentialing system, and integrated into primary care.

One of SAMHSA's strategic initiatives is to build a recovery-oriented support structure which relies upon a strong peer recovery support network.

Administrative and Managerial

As the use of electronic health records, electronic billing and other health information technology gains momentum, the workforce needs to be educated on the importance of using these systems, the value they bring to patient care, and trained in using the systems.

The changes in credentialing, scopes of practice, and available training require the creation and administration of a system to track and monitor activities such as, the level of credential held by each practitioner, credential renewal information, the training they have received, and the training they need, to name a few.

Workforce who desire to advance to managerial positions require training to understand and meet the demands of reporting, staff recruiting and retention, and create a plan to ensure their workforce is trained to meet credentialing and treatment standards.

Coordination of Care

Integration into primary care will incorporate the concept of total individual wellness. This includes physical and mental health and requires coordination of care between multiple primary care and specialty treatment providers. Managing patient care from the perspective of one problem list, one medication list and one care plan requires a category of workforce having a focus on effective coordination of care. This role is not currently defined, and is not recognized as a credentialed position or included in a career ladder.

Defining the role and identifying the training and credentials for it will help to establish it as a needed and viable part of the workforce.

Summary

In combination, the federal government, IC&RC, UCLA and CADPAAC have many goals, objectives, and initiatives that point in the direction our workforce should go for credentials and types of services. Health reform creates an immediate need for increased treatment capacity. Federal directions point toward increasing the future role of prevention by creating Prevention Prepared Communities resulting in decreasing the future workload on the treatment workforce. Likewise, family-centered and recovery-oriented objectives could reduce treatment workload burden by shifting it to the recovery support staff.

The creation of a standardized SUD credentialing system that expands the workforce core set of competencies to allow work within a primary care setting will benefit the workforce. It will create consistency within the field and will make each individual more marketable. Each member of the workforce can choose a credential that is the best fit for them, and then take the appropriate steps to achieve that specific level of credential. The credentialing system, in combination with training, recruitment, and incentives, will help stabilize the SUD field and make it an integral part of the healthcare system.

Regardless of health reform and its impact on the SUD workforce, these recommendations should be implemented as quickly as possible. Health reform plays the role of providing the impetus and the urgency to start the process now.

As summarized in a report prepared by the Annapolis Coalition *The Action Plan on Behavioral Health Workforce Development: Executive Summary*, the following items identify the current state of the SUD workforce.

- A workforce and treatment capacity insufficient to meet demand.
- A changing profile of the people in need of services, which includes increased co-occurring mental illnesses and substance use disorders, medical comorbidity, rapidly evolving patterns of licit and illicit drug use, and involvement in the criminal justice system.
- A shift to increased public financing of treatment, accompanied by declining private coverage, budgetary constraints in publicly funded systems, managed care policies and practices, and the large number of undocumented and uninsured individuals.
- Major paradigm shifts within the field, including the movement toward a recovery management (and resilience-oriented) model of care.
- A continual escalation of demands on workers to change their practices, including the adoption of best practices and evidence-based interventions.
- An increase in the use of medications in treatment, with the resultant demand that the workforce be knowledgeable and skilled in managing medications.

- A challenge to provide services more frequently in non-behavioral health settings.
- An expansion of requirements to implement performance measures and to demonstrate patient outcomes through data.
- A climate of ongoing discrimination or stigma related to people who receive and provide care.

Trends such as illness self-management, peer-support approaches, and increased access to information via the Internet are remodeling the relationships among practitioners, patients, and their families, thus posing new challenges for the workforce as well as new opportunities for genuine partnerships between consumer and provider in the decision-making process.

The recommendations that follow are categorized as related to one of the five following areas:

- Ensure the work of the task force continues beyond the time when the SUD functions and programs of ADP transfer to DHCS
- Increase the short term capacity of the workforce to meet the increased demand for SUD services
- Increase the long term capacity of the workforce by effectively using all segments of the workforce
- Develop a long term strategy to attract and retain people to the workforce
- Provide easily accessible, affordable training that will allow the workforce to increase their skill set.

The implementation timeframes are either short-, mid-, or long-range.

- Short-Range Implementation Timeframe = by December 31, 2014
- Mid-Range Implementation Timeframe = by December 31, 2016
- Long-Range Implementation Timeframe = by December 31, 2019

Findings

- Educate the SUD workforce about successful interventions, such as screening, brief intervention, and referral (SBIR); and develop and implement training around suicide prevention and prescription drug abuse. (Goal 10)
- Provide technical assistance and training strategies to develop practitioners skilled in trauma and trauma-related work and systems that have capacity to prevent, identify, intervene and effectively treat people in a trauma-informed approach. (Goal 15)
- Develop a public health-informed model of psychological health service systems, staffed by a full range of health practitioners who are well trained in the culture of the military and the military family and the special risks and needs that impact

this population, such as Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). (Goal 15)

- Build an understanding of recovery-oriented practices, including incorporating peers into the current workforce to support peer-run services. Emphasize collaborative relationships with children, youth, and families that involve shared decision-making service options. (Goal 10)
- Ensure that the workforce has access to information needed to provide successful prevention, treatment, and recovery services. (Goal 10)
- Train health care personnel to deliver patient centered care as members of an interdisciplinary team and emphasizing evidence-based practices. (Goal 10)
- Develop a career ladder for the workforce that includes prevention, treatment, recovery support, administrative and managerial, and care management staff. (Goal 14)
- Develop a standardized credentialing system that includes prevention, treatment, recovery support, administrative and managerial, and care management staff. (Goal 3)
- Continue to support the clarification of needed competencies for peers and family members; encourage creation of a peer professional career ladder, including training and supervision of peers by peers. (Goal 10)
- Collect and disseminate information on state-specific descriptions of peer services for Medicaid programs and other insurers, including: identification of peer services that are reimbursed; descriptions of coverage limitations or specific supervision or training requirements; payment mechanisms and rates; and how to encourage the greater inclusion of peers in integrated health care teams. (Goal 10)
- Encourage funding of innovations and services that include peers in accountable care and other alternative payment programs, as well as in block grant and competitive grant programs where possible. (Goal 13)
- Build bridges between peer counselors, health educators, and community health workers in primary care settings; encourage their participation in prevention and wellness issues as well as programs or activities that help people maintain their recovery. (Goal 10)
- Include peers as navigators and enrollment/eligibility assistants in state and federally facilitated health insurance marketplaces and in Medicaid expansion programs. (Goal 11)
- Work with community colleges to develop curriculum and supports for peer and other alternative practitioners to assist licensed mental health and SUD practitioners. (Goal 13)
- Develop an administration system to track and monitor credential and training information. (Goal 12)
- Moving forward, ensure the recommendations in this report transition to DHCS. (Goal 1)

Chapter 4 – Recommendations

Logic Model - Workforce Development Task Force Recommendations

Problem Statement 1: The transition of ADP to DHCS may cause the implementation of these recommendations to stall. Progress on the implementation of the SUD Workforce Development Task Force recommendations must continue beyond June 30, 2013.

To ensure the Workforce Development Task Force recommendations continue to make progress toward implementation after the June 30, 2013 transfer of the SUD functions and programs of ADP to DHCS, create a Workforce Plan Development Work Group with responsibility and authority to ensure implementation of these recommendations, to monitor the progress of the implementation, to determine the data sources used to evaluate the effectiveness of the changes, and to continually work to create relationships among and between the many disciplines of the healthcare workforce at the county, state and federal levels. The Workforce Plan Development Work Group should consist of representation from the SUD, mental health, and primary care workforces; representation from the education, judicial, and public policy systems; stakeholders representing county and federal interests; and stakeholders such as insurance carriers and other groups impacted by SUD and health reform.

Goal 1: Increase the ability to monitor progress of the recommendation implementation.

- **Objective:** Create a Workforce Plan Development Work Group that has the responsibility of implementing, monitoring, and evaluating implementation progress.
- **Objective:** Determine the data sources to be used for evaluation purposes and to monitor the changes from pre- to post-implementation.
- **Objective:** Ensure continuity by maintaining participation from the workforce development task force.
- **Objective:** Ensure a broad representation of viewpoints by requesting participation from multiple disciplines.
- **Objective:** Build communication bridges to multiple disciplines.

Goal 2: Increase the timeliness of integration of SUD into primary care and other health settings.

- **Objective:** Seek representation on the Workforce Plan Development Work Group from the California Office of Statewide Health Planning and Development (OSHPD).
- **Objective:** Seek representation of the Workforce Plan Development Work Group into OSHPD groups.
- **Objective:** Incorporate the use of OSHPD pilot program options into the implementation of scopes of practice.

Objective: Seek representation of a Workforce Plan Development Work Group member on a National level advisory group/board to provide input and guidance.
Objective: Recognize the input from the field and create a Single State Authority for credentialing.

Problem Statement 2: There will be an immediate increased need for SUD services and no corresponding increase in the number of SUD workforce to address the need.

Increase the short term capacity of the workforce to meet the increased demand for SUD services by expanding the number and types of workforce skilled and trained in delivering SUD services, expanding the number and types of services eligible for insurance reimbursement, and expanding the number and types of facilities authorized to deliver SUD services.

Goal 3: Change the licensing and credentialing structure to allow the workforce to meet the increased demand for services.

Objective: Coordinate and develop a scope of practice for SUD providers to clarify which positions are able to deliver services.

Strategy: Create a standard and uniform scope of practice for the SUD workforce.
Strategy: Establish the minimum or baseline level of credential needed to provide SUD services.
Strategy: Identify the primary care providers who have SUD diagnosis and treatment ability in their scope of practice.
Strategy: Determine the types of training necessary to allow primary care practitioners to feel comfortable working within their SUD scope of practice.
Strategy: Identify potential "new" positions that may emerge from health reform, i.e., health educator, care coordinator, universal health screener, etc.
Strategy: Identify the likely types of services to be delivered.
Strategy: Identify the minimum level of credential required to deliver SUD services, for all positions, new and existing.
Strategy: Identify the policy changes needed to implement a scope of practice.

Objective: Reduce the confusion regarding the multiple and varied SUD credentials available.
Objective: Increase or change the SUD workforce skills and competencies to work in multiple healthcare settings.
Objective: Increase or change the credentials needed to provide SUD services.
Objective: Increase the insurance reimbursement rate for providing SUD care resulting in an expansion of workforce employment opportunities

which will ultimately lead to an increased salary range to help build a sustainable workforce.

Objective: Increase the types of facilities eligible for insurance reimbursement.

Goal 4: Increase the number of counties who are certified DMC providers.

Problem Statement 3: There is not a sufficient number of SUD treatment workforce to address a sustained increased demand for service. Integration of healthcare creates a need to use resources in the most efficient manner possible.

Expand the capacity of the workforce by effectively using all members of the workforce. Create methods to correctly identify and treat SUD problems, as well as share information between providers. Increase the long term capacity of the workforce by expanding the role of prevention and recovery support. Effective use of prevention addresses community-level risk factors and reduces the need for specialty SUD care through the use of early diagnosis of community problems, implementation of evidence-based practices, and high visibility messaging. Increased use of recovery support emphasizes a recovery-oriented approach and building collaborative relationships with family members who share decision making for treatment options.

Goal 5: Increase the ability of primary care providers to recognize and treat SUD.

Objective: Incorporate SUD diagnosis information into training sessions targeting primary care providers.

Objective: Incorporate best practices and evidence-based practices for SUD treatment into primary care facilities.

Objective: Identify the regions within the state having limited access to care.

Objective: Identify the needs associated with the influx of the underserved populations.

Goal 6: Increase the use of universal screening to be used in multiple healthcare settings and facilities.

Objective: Identify the types of conditions for which universal screenings are best suited.

Objective: Determine the locations where universal screenings can be used, i.e., hospitals, emergency departments, clinics, schools, etc.

Objective: Develop creative methods of conducting the screenings, i.e., online assessments, paper assessments, in office, telephone, etc.

Goal 7: Increase the ability of the integrated workforce to recognize co-occurring disorders.

Goal 8: Develop a list of core competencies that cross between primary care, mental health and SUD.

Goal 9: Develop a universal consent form to allow for sharing of information between providers.

Goal 10: Reduce the demand on the SUD treatment workforce while continuing to provide needed services.

Objective: Increase the role of the prevention and recovery support workforce.

Strategy: Build and sustain prevention prepared communities.

Strategy: Build and sustain a recovery oriented workforce using peer counselors, input from family members, and emphasizes collaborative relationships with families who share decision making service options.

Strategy: Emphasize the use of evidence-based practices.

Objective: Increase the roles and actions that can be taken by the primary care and mental health workforces to address SUD.

Goal 11: Increase the ability of the SUD workforce to provide services in an integrated healthcare environment.

Objective: Standardize SUD treatment protocols by creating best practices and implementing evidence-based practices.

Problem Statement 4: The SUD workforce is losing members due to a lack of employment opportunity, having a low pay scale, and no career ladder.

Develop a long term strategy to attract and retain members to the SUD workforce, provide them with a standard set of credentials, the tools to attain and maintain their credentials, and a system for monitoring and controlling the credentialing system.

Goal 12: Increase the definition and role of the administration aspects of monitoring and controlling changes.

Objective: Identify the method in which the workforce will be notified of changes.

Objective: Create a method to monitor and control the issuance of new credentials.

Objective: Create a method to monitor the workforce for staying current with their credentials.

Objective: Create a method to monitor and control the training requirements for the new credentials.

Strategy: Identify the method of determining training needs.

Strategy: Identify the method of evaluating if the training meets the needs of the workforce.

Strategy: Determine multiple methods of providing training.

Strategy: Determine a method to track how training was delivered and where it was received.

Objective: Determine whether existing credentials will be grandfathered into the new structure.

Strategy: Identify the difference between existing credentials and the new credentials.

Strategy: Determine the allowable time frame to enhance existing credentials to bring up to the level of the new credentials.

Strategy: Determine the training and or experience requirements to bring existing credentials up to the standard of the new credentials.

Goal 13: Increase the size and capacity of the SUD workforce.

Objective: Identify funding opportunities to expand the workforce.

Objective: Identify and develop partnerships to expand and sustain the workforce.

Goal 14: Increase the perceived value of the SUD workforce.

Objective: Develop incentives to keep the workforce, i.e., increased compensation, continuing education opportunities, having a career ladder, providing healthcare and other benefits.

Objective: Decrease the stigma associated with SUD treatment and the workforce that delivers it.

Problem Statement 5: Sufficient training does not exist to prepare and allow all healthcare disciplines to deliver SUD services.

Develop curricula and training for all healthcare workforce members who deliver SUD services. Make the training easy to access, affordable, and broad enough to address all elements of delivering SUD services in a wide variety of healthcare settings.

Goal 15: Increase the number and types of training available to all healthcare providers who deliver SUD services.

Objective: Increase the access points for training, i.e., web-based, distance learning, on-site, intern programs, self-study exams, etc.

Objective: Create curricula to address all core competencies and credentials.

Objective: Develop training programs for universal screenings, i.e., what screening tools are available, how to administer, how to interpret results, etc.

Objective: Develop training programs for evidence-based practices, i.e., what they are, how they are used, how to administer, etc.

Objective: Develop training programs designed to address cultural competency.

Strategy: Identify the population groups to recognize, i.e., veterans, aging population, prison population, underage drinking, Medicaid expansion, and health insurance exchange, etc.

Strategy: Train the practitioner to recognize their own preconceived ideas and the impact to service delivery.

Objective: Develop training programs to address AOD and its relationship to COD and physical health.

Objective: Develop programs designed to inform the SUD, mental health and primary care workforce about each other.

Objective: Develop training for the use of Electronic Health Records, Electronic Billing, and other health information technology.

Objective: Develop training in the use of the concept, "One problem list, one drug list, and one care plan".

Objective: Develop training for community organizing, youth development, strategic planning and public policy development needed for creating prevention prepared communities.

Objective: Develop standard training curricula that can be used statewide.

Objective: Develop training strategies to develop practitioners for trauma-related work.

Goal 16: Increase the number and types of training specifically for the Clinical and Managerial staff.

Objective: Improve the counseling skills and effectiveness of the clinical supervision staff.

Objective: Emphasize the conformity with the administrative and procedural aspects of the agency's work.

Strategy: Address the high turnover rate within the workforce.

Strategy: Find ways to retain staff.

Strategy: Reduce the paperwork burden for the workforce.

Strategy: Provide leadership training.

Strategy: Build relationships between specialty SUD facilities and primary care.

The charts on the following pages show a summary of the problem statements, goals, recommended implementation time frame, groups responsible for implementation, and the link/connection to the chapter findings.

Problem Statement 1: The transition of ADP to DHCS may cause the implementation of these recommendations to stall. Progress on the implementation of the SD workforce development task force recommendations must continue beyond June 30, 2013.			
Goal	**Implementation Timeframe**	**Responsible Group**	**Link to Findings**
Goal 1: Increase the ability to monitor progress of the recommendation implementation.	Short Range	State	Chapter 3 - Moving forward, ensure the recommendations in this report transition to DHCS.
Goal 2: Increase the timeliness of integration of SUD into primary care and other health settings.	Short Range	State	All findings relate to this goal.
Problem Statement 2: There will be an immediate increased need for SUD services and no corresponding increase in the number of SUD workforce			
Goal 3: Change the licensing and credentialing structure to allow the workforce to meet the increased demand for services.	Short Range	State, County, Certifying Organizations	Chapter 1 - All practitioners of the healing arts, to include doctors, nurses, physician's assistants, LCSW's, MFT's, and others, must expand their skill set to recognize AOD and COD. - All services delivered are not considered insurance billable services. Chapter 3 - Develop a standardized credentialing system that includes prevention, treatment, recovery support, administrative and managerial, and care management staff.
Goal 4: Increase the number of counties who are certified DMC providers.	Short Range	County	Chapter 1 - All services delivered are not considered insurance billable services.

Problem Statement 3: There is not a sufficient number of SUD treatment workforce to address a sustained increased demand for service. Integration of healthcare creates a need to use resources in the most efficient manner possible.			
Goal 5: Increase the ability of primary care providers to recognize and treat SUD.	Short Range	Providers	Chapter 1 - Acknowledge that some areas of the state may have very limited access to AOD workforce. - Address the influx of underserved populations. - The private healthcare workforce will also expand and enhance its skill set to stay competitive and able to meet the increased demand for service.
Goal 6: Increase the use of universal screening to be used in multiple healthcare settings and facilities.	Short Range	Providers	Chapter 1 - Universal screening could pave the way for a newly designated category of SUD credential.
Goal 7: Increase the ability of the integrated workforce to recognize co-occurring disorders.	Short Range	Providers	Chapter 1 - COD affect a large portion of those seeking treatment. Staff core competency standards and training should address this.
Goal 8: Develop a list of core competencies that cross between primary care, mental health and SUD.	Short Range	State, County, Providers	Chapter 2 - Formal integration and coordination of mental health and substance use treatment, prevention and recovery support into primary care is needed, along with an increase in the number of providers skilled in treating co-occurring disorders.
Goal 9: Develop a universal consent form to allow for sharing of information between providers.	Short Range	State, County, Providers	Chapter 1 - Sharing of information between providers will be a key element to achieving success in creating one problem list, one drug list, and one care plan. This collaboration between providers can be aided by the use of Electronic Health Records, Electronic Billing, care management, and the concept of individual wellness.
Goal10: Reduce the demand on the SUD treatment workforce while continuing to provide needed services.	Mid Range	State, County	Chapter 3 - Educate the SUD workforce about successful interventions, such as screening, brief intervention, and referral (SBIR); and develop and implement training around suicide prevention and prescription drug abuse. - Build an understanding of recovery-oriented practices, including incorporating peers into the current workforce to support peer-run services. Emphasize collaborative relationships with children, youth, and families that involve shared decision-making service options. - Ensure that the workforce has access to information needed to provide successful prevention, treatment, and recovery services. - Train health care personnel to deliver patient centered care as members of an interdisciplinary team and emphasizing evidence-based practices. Chapter 3 - Continue to support the clarification of needed competencies for peers and family members; encourage creation of a peer professional career ladder, including training and supervision of peers by peers. - Collect and disseminate information on state-specific descriptions of peer services for Medicaid programs and other insurers, including: identification of peer services that are reimbursed; descriptions of coverage limitations or specific supervision or training requirements; payment mechanisms and rates; and how to encourage the greater inclusion of peers in integrated health care teams. - Build bridges between peer counselors, health educators, and community health workers in primary care settings; encourage their participation in prevention and wellness issues as well as programs or activities that help people maintain their recovery.
Goal 11: Increase the ability of the SUD workforce to provide services in an integrated healthcare environment.	Mid Range	State, County	Chapter 1 - Using evidence-based practices is the wave of the future. The workforce must be trained in the use of, and adopt evidence-based practices. Chapter 2 - A standardized certification and scopes of practice may potentially allow SUD paraprofessionals to work within primary care settings. Chapter 3 - Include peers as navigators and enrollment/eligibility assistants in state and federally facilitated health insurance

Problem Statement 4: The SUD workforce is losing members due to a lack of employment opportunity, having a low pay scale, and no career ladder.			
Goal 12: Increase the definition and role of the adminstration aspects of monitoring and controlling.	Short Range	State, County, Providers	Chapter 3 - Develop an administration system to track and monitor credential and training information.
Goal 13: Increase the size and capacity of the SUD workforce.	Long Range	State, County, Providers	Chapter 2 - Grow, maintain and sustain the workforce by creating a career path, recognizing the current shortfalls within the career field, actively recruiting, and creating incentives to stay in the field. - Youth and young professionals need to be encouraged to enter the workforce to help offset the natural attrition that will occur as the aging workforce retires or leaves the field. Chapter 3 - Encourage funding of innovations and services that include peers in accountable care and other alternative payment programs, as well as in block grant and competitive grant programs where possible. - Work with community colleges to develop curriculum and supports for peer and other alternative practitioners to assist licensed mental health and SUD practitioners.
Goal 14: Increase the perceived value of the SUD workforce.	Long Range	State, County, Providers	Chapter 2 - To retain staff, incentives such as increased compensation, and incentives for continuing education, providing healthcare and other benefits, and implementation of a supportive culture are needed. Chapter 3 - Develop a career ladder for the workforce that includes prevention, treatment, recovery support, administrative and managerial, and care management staff.
Problem Statement 5: Sufficient training does not exist to prepare and allow all healthcare disciplines to deliver SUD services.			
Goal 15: Increase the number and types of training available to all healthcare providers who deliver SUD services.	Short Range	State, County, Providers	Chapter 1 - To prepare for integration of services into primary care, cross train between the SUD, primary care, mental health and behavioral health workforces to understand the basics of substance use, mental health issues, behavioral health issues, and those physical ailments that mimic AOD. - Identify how cultural competency will be addressed. - Ensure the workforce is trained and prepared to deliver all SUD related services identified for the expansion population and the Health Insurance Exchange. Chapter 2 - There is great diversity in the demographics of the workforce and in the patient population. - Implementation of Electronic Health Records is needed, along with the training to effectively use the system. - There is a need for more culturally responsive and competent providers to engage underserved populations. - Create consistency among the counties in the training of staff and use of state-of-the art and evidence-based and recovery-oriented treatments. - The workforce has limited training opportunities in providing care that is family-centered or recovery-oriented. Chapter 3 - Provide technical assistance and training strategies to develop practitioners skilled in trauma and trauma-related work and systems that have capacity to prevent, identify, intervene and effectively treat people in a trauma-informed approach. - Develop a public health-informed model of psychological health service systems, staffed by a full range of health practitioners who are well trained in the culture of the military and the military family and the special risks and needs that impact this population, such as Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI).
Goal 16: Increase the number and types of training specifically for the Clinical and Managerial staff.	Short Range	State, County, Providers	Chapter 2 - Staff need specific training to become supervisors and managers.

Stakeholder Review and Comments

As it began to take form and direction, the task force chose to solicit input from the field, recognizing the value of the opinions and experience of those who currently are a part of the SUD workforce. Input and feedback was solicited and received from County Alcohol and Drug Program Administrators Association of California (CADPAAC), California Association of Addiction Recovery Resources (CAARR), California Association of Alcoholism and Drug Addiction Counselors (CAADAC), University of California Los Angeles – Integrated Substance Abuse Programs, California Association of Alcohol & Drug Education (CAADE), and California Association of Alcohol and Drug Program Executives (CAADPE).

Overall, the feedback received was encouraging. There was a stated desire to provide more specific and forceful recommendations especially regarding the creation of a Single State Agency for credentialing/certification. A summary of the comments is shown below.

- Address the need for a single state certifying agency/body for certifications and the credentialing system.
- A certifying body/system should be placed in the Department of Consumer Affairs.
- How will this report and project continue after the transition to DHCS?
- Include options and choices for a career ladder.
- Add detail about EBP for community support programs and peer supported programs.
- More clearly define who comprises the workforce.
- Focus on the skills needed to address patients with COD and the skills needed to work in medical and mental health settings.
- MAT training needs to include the knowledge of what the medications do, the kinds of services needed to promote retention and optimal treatment response, and how to work with/communicate with the medical staff (MDs and nurses) who manage the medications.
- Other training should include integration with mental health, harm reduction approaches, addiction and pain, addiction as a chronic disease, use of data to modify services.
- These content areas are important for training.
    - Providing Behavioral Health Care in a Primary Care Setting: Culture, Needs and Interdisciplinary Collaboration
    - Screening, Brief Intervention, and Referral for Substance Use, Mental Health and Medical Diseases

    - Understanding Chronic Medical Diseases, Basic Physiology, Terminology and Treatment Strategies
    - Understanding Common Mental Health Disorders—Identification and Intervention
    - Medical Interventions for Substance Use, Physiology of Drugs of Abuse and Medication Assisted Treatment
    - Care Management of Clients in a Multi-Service Setting
    - Integrated Care Competency Categories (From Annapolis Coalition Integration Report 12/12)
    - Interpersonal Communication
    - Collaboration & Teamwork
    - Screening & Assessment
    - Care Planning & Care Coordination
    - Intervention
    - Cultural Competence & Adaptation
    - Systems Oriented Practice
    - Practice Based Learning & Quality Improvement
    - Informatics
- CAADE has developed the curriculum for Goal 13 – Increase the size and capacity of the SUD workforce.
- CAADE has developed a career ladder.
- Eliminate all references to IC&RC and the 12 core functions. Reference should be SAMHSA's TAP 21.

Implementation Strategy

Successful implementation of these report recommendations requires input from external stakeholders, their support as we move forward, and their participation in the planning and implementation phases.

The recommended implementation strategy is to immediately move forward to the next step – create a Workforce Plan Development Work Group. The Workforce Plan Development Work Group will recognize that time is of the essence and immediately develop the plan to address the recommendations outlined in this report. As a first step, the Workforce Plan Development Work Group should develop the implementation plan to address the creation of a Single State Authority/Agency for credentialing and certifications. This should occur by December 18, 2013, as shown in the Implementation Plan Time Line on page 45.

Another first step of the work group is to engage with Office of Statewide Health Planning and Development (OSHPD) to discuss possible methods and strategies to create an SUD career ladder.

The need is great to coordinate and collaborate on SUD workforce issues, therefore all functional areas within Department of Health Care Services should be approached for the purpose of coordinating and collaborating on SUD workforce issues. For example, working with groups such as the Managed Care Division can provide needed input regarding the types of skills required to deliver services within managed care facilities.

The current task force recognizes the challenge of creating forward momentum and progress given the current statewide need to work with minimal resources. To make the necessary changes, all stakeholders must participate in the process of developing and implementing solutions.

Next Steps - Timeline for Implementation of Workforce Development Recommendations

Date	**Activity**
July 31, 2013	Create the Workforce Plan Development Work Group. Determine all stakeholders.
August 15, 2013	Meeting #1
August 23, 2013	Develop the objectives, indicators of progress, and method used for tracking and monitoring progress.
August 23, 2013	Determine the data sources to be used to track and monitor progress.
August 29, 2013	Meeting #2
September 13, 2013	Develop a plan to address Problem Statement #1.
September 20, 2013	Develop a plan to address Problem Statements #2, #3, and #5.
September 20, 2013	Identify a strategy to achieve quick implementation of a screening and brief intervention pilot project by targeting counties with the highest need.
September 20, 2013	Identify regions within the state with potential misalignment of the SUD workforce and develop a strategy to provide services.
Mid October, 2013	Develop a plan to address Problem Statement #4.
Oct. – Dec. 2013	Status check meeting 2 times per month. Report on progress, obstacles, risks, and successes.
December 18, 2013	Quarterly status report and progress update.
December 18, 2013	Complete the implementation plan to create a Single State Agency for certifications and credentials.
March 18, 2014	Quarterly status report and progress update.
March 18, 2014	Complete the plan to create an SUD workforce career ladder.
June 17, 2014	Quarterly status report and progress update.

September 16, 2014 Quarterly status report and progress update

December 16, 2014 Quarterly status report and progress update.

December 31, 2014 Completion of short-range implementation tasks.

January 2015 through December 2019 Continue to meet on a quarterly basis.

December 31, 2016 Completion of mid-range implementation tasks.

December 31, 2019 Completion of long-range implementation tasks.

Sources of Information and References

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CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey, Survey Analysis and Summary Report Prepared by: The Pacific Southwest Addiction Technology Transfer Center (2009)

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Final Report: February 2012

United Nations Office of Drug Control, International Standards on Drug Use Prevention

Appendix A: Overview of Federal and State AOD Healthcare Priorities

Background

When evaluating options, strategies and potential programs to meet the increased demand for AOD/SUD services within California and resulting from health reform, there must first be an understanding of the federal and state guidelines, goals, objectives and strategies for reducing alcohol and drug use, and for providing AOD/SUD treatment. Understanding the federal and state direction will provide insight for the types of services that must be developed, which in turn determines the skill set required to deliver the necessary services. The service delivery model can quickly become complex when recognizing prevention, intervention and counseling, treatment, recovery, primary care, mental health, behavioral health, SUD settings, multi disciplines and multiple domains (individual, community, family, school) where services will be delivered.

Several federal agencies have similar goals and objectives. This document presents the information in a summarized and simplistic format and includes only those goals and objectives that relate to prevention, SBIRT, treatment and recovery of AOD/SUD. In the sections which describe specific health priorities, the information was taken directly from the public documents released by the named agency or organization.

Summary of Federal Healthcare Priorities

- Prevention
- Alcohol and Other Drugs
- Underage Drinking
- Delay onset of drinking
- Reduce fatalities due to alcohol impaired driving
- Use Evidence Based Practices
- Maintain a skilled and cross trained prevention workforce
- Foster a nationwide community based prevention system
- Health Information Exchange (health information technology and Electronic Health Records)
- Enhance linkages between drug prevention, substance abuse, mental health, and juvenile and criminal justice systems
- SBIRT
- Incorporate cultural competence
- Implement prescription drug monitoring programs
- Heighten attention to driving under the influence of illicit and prescription drugs
- Healthcare Integration

Federal Overview

When looking at the national picture, there are several key players who come from both the federal and non-federal perspectives. Some of the non-federal contributors receive federal funding and/or administrative support.

These agencies, departments and organizations establish the national priorities addressing alcohol and drug use within the United States.

- Office of the President of the United States of America
  - Office of the National Drug Control Policy
    - National Drug Control Strategy
  - National Prevention Council
    - National Prevention Council Strategy
    - National Prevention Council Action Plan
  - Office of the Surgeon General – a staff office within the Office of the Assistant Secretary for Health. The Assistant Secretary is the principal advisor to the Secretary on public health and scientific issues.
    - Surgeon General's Call to Action to Reduce Underage Drinking – 2007
  - Health and Human Services
    - Substance Abuse and Mental Health Services Administration (SAMHSA) – A part of the Department of Health and Human Services
      - Leading Change: A Plan for SAMHSA's Roles & Actions, 2011-2014
    - Healthy People 2020 – Supports the National Drug Control Strategy and the National Prevention Council Strategy. HP2020 identifies the initiatives and SAMHSA provides an avenue for funding.
- Institute of Medicine (IOM) – non governmental agency although receives federal funding
- The Community Preventive Services Task Force (The Community Guide) – non federal, unpaid, independent body, appointed by the Director of the Centers for Disease Control and Prevention (CDC). Established in 1996 by the Department of Health and Human Services
- United States Preventive Services Task Force (USPSTF) – independent group of national experts in prevention and evidence based medicine. Established in 1994. AHRQ provides support. AHRQ is a part of the Department of Health and Human Services.
- Cochran Reviews – an independent international, not-for-profit organization

National Drug Control Strategy

- Goals to be attained by 2015
- Goal 1: Curtail illicit drug consumption in America
    - Decrease the 30-day prevalence of drug use among 12- to 17-year-olds by 15 percent
    - Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15 percent
    - Decrease the 30-day prevalence of drug use among young adults aged 18–25 by 10 percent
    - Reduce the number of chronic drug users by 15 percent
- Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug abuse
    - Reduce drug-induced deaths by 15 percent
    - Reduce drug-related morbidity by 15 percent
    - Reduce the prevalence of drugged driving by 10 percent

Early intervention is essential to reducing drug use and its costs to society. Screening, Brief Intervention, and Referral to Treatment (SBIRT) provides an evidence-based approach to early intervention, addressing chronic diseases in medical settings. Research shows that in some instances a brief motivational intervention appears to facilitate abstinence from heroin and cocaine use at a 6-month follow up interview, even in the absence of specialty addiction treatment. SBIRT also reduces the time and resources needed to treat conditions caused or worsened by substance use, making our health systems more cost-effective.

Expand and evaluate screening for substance use in all healthcare settings.

Increase adoption and reimbursement of SBIRT codes. To insure for SBIRT services, and to further implementation of SBIRT, efforts have been made to encourage states to adopt SBIRT as a reimbursable service with an available set of codes. HRSA has included SBIRT in the Uniform Data Systems to track activity in Federally Qualified Health Center grantees related to substance use disorder screening. SAMHSA has partnered with the Centers for Medicare and Medicaid Services to develop and disseminate the codes available for billing SBIRT services to Medicaid (if adopted by the state) and Medicare to all health care providers in the states. This will help promote the provision of these important screening services.

Integrate treatment for substance use disorders into healthcare and expand support for recovery. Integrating substance use disorder treatment into broader health care systems is a high priority for the Administration. Practitioners in mainstream health care systems historically have not screened for substance use disorders and often have limited knowledge of them. As a result, significant resources are spent treating conditions caused or worsened by undiagnosed substance use problems while the quality and cost-effectiveness of substance use disorder treatment is undermined by a failure to identify

and address co-occurring medical and mental health conditions. Nonetheless, research has documented that substance use disorder treatment is a sound public investment. For example, a 2006 study found a 7:1 cost offset, meaning that every dollar spent on treatment yielded an average of seven dollars in costs savings. The majority of these savings came from reduced criminal justice system involvement and increased employment earnings.

Addiction treatment must be an integrated, accessible part of mainstream healthcare.

National Prevention Strategy

- The National Prevention Strategy vision is**:** Working together to improve the health and quality of life for individuals, families, and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness.
- The National Prevention Strategy overarching goal is: Increase the number of Americans who are healthy at every stage of life.
- 4 strategic directions
    - Healthy and Safe Community Environments**:** Create, sustain, and recognize communities that promote health and wellness through prevention.
    - Clinical and Community Preventive Services**:** Ensure that prevention-focused health care and community prevention efforts are available, integrated, and mutually reinforcing.
    - Empowered People**:** Support people in making healthy choices.
    - Elimination of Health Disparities**:** Eliminate disparities, improving the quality of life for all Americans.
- 7 priorities
    - Tobacco Free Living
    - Preventing Drug Abuse and Excessive Alcohol Use
    - Healthy Eating
    - Active Living
    - Injury and Violence Free Living
    - Reproductive and Sexual Health
    - Mental and Emotional Well-Being
- 5 categories of strategies
    - Policy
    - Systems change
    - Environment
    - Communications and media
    - Program and service delivery
- State, Tribal, Local, and Territorial Governments can:

- Maintain and enforce the age 21 minimum legal drinking age (e.g., increasing the frequency of retailer compliance checks), limit alcohol outlet density, and prohibit the sale of alcohol to intoxicated persons.
- Require installation of ignition interlocks in the vehicles of those convicted of alcohol impaired driving.
- Implement or strengthen prescription drug monitoring programs.
- Facilitate controlled drug disposal programs, including policies allowing pharmacies to accept unwanted drugs.
- Implement strategies to prevent transmission of HIV, hepatitis and other infectious diseases associated with drug use.

Key Facts

- Excessive alcohol use is a leading cause of preventable death in the United States among all adult age groups, contributing to more than 79,000 deaths per year. The alcohol-related death rate for American Indians and Alaska Natives is six times the national average.
- Over half of the alcohol consumed by adults and 90 percent of the alcohol consumed by youth occurs while binge drinking. Most Americans who binge drink are not dependent on alcohol.
- The relative low cost and easily availability of alcohol and the fact that binge drinking is frequently not addressed in clinical settings contribute to the acceptability of excessive alcohol use.
- Every day, almost 30 people in the United States die in motor vehicle crashes that involve an alcohol impaired driver – one death every 48 minutes.
- Prescription drug abuse is our nation's fastest growing drug problem. In a typical month, approximately 5.3 million Americans use a prescription pain reliever for nonmedical reasons. Emergency department visits involving the misuse or abuse of pharmaceutical drugs have doubled over the past five years.
- Chronic drug use, crime and incarceration are inextricably connected. At least half of both state and Federal inmates were active drug users at the time of their offense. Further, nearly 1/3 of state prisoners and a 1/4 of Federal prisoners committed their crimes while under the influence of drugs.
- Six million children (9 percent) live with at least one parent who abuses alcohol or other drugs. Children of parents with substance use disorders are more likely to experience abuse (physical, sexual, or emotional) or neglect and are more likely to be placed in foster care.
- Drugs other than alcohol (i.e., illicit, prescription, or over-the-counter drugs) are detected in about 18 percent of motor vehicle driver deaths.
- Injection drug use accounts for approximately 16 percent of new HIV infections in the U.S. In addition, injection and non-injection drug use is associated with sexual transmission of HIV and other STIs.
- Rates of marijuana use by youth and young adults are on the rise and fewer youth perceive great risk from smoking marijuana once or twice a week.

Surgeon General's Call to Action to Prevent and Reduce Underage Drinking

- GOAL 1: Foster changes in American society that facilitate healthy adolescent development and that help prevent and reduce underage drinking.
- GOAL 2: Engage parents, schools, communities, all levels of government, all social systems that interface with youth, and youth themselves, in a coordinated national effort to prevent and reduce drinking and its consequences.
- GOAL 3: Promote an understanding of underage alcohol consumption in the context of human development and maturation that takes into account individual adolescent characteristics as well as environmental, ethnic, cultural, and gender differences.
- GOAL 4: Conduct additional research on adolescent alcohol use and its relationship to development.
- GOAL 5: Work to improve public health surveillance on underage drinking and on population-based risk factors for this behavior.
- GOAL 6: Work to ensure that policies at all levels are consistent with the national goal of preventing and reducing underage alcohol consumption.

Institute of Medicine (IOM)

Several decades of research have shown that the promise and potential lifetime benefits of preventing mental, emotional, and behavioral (MEB) disorders are greatest by focusing on young people and that early interventions can be effective in delaying or preventing the onset of such disorders. National priorities that build on this evidence base should include (1) assurance that individuals who are at risk receive the best available evidence-based interventions prior to the onset of a disorder and (2) the promotion of positive MEB development for all children, youth, and young adults.

Interventions classified as:

- Universal
- Selective
- Indicated

Key Areas of Progress Since 1994

- Evidence that MEB disorders are common and begin early in life.
- Evidence that the greatest prevention opportunity is among young people.
- Evidence of multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.

- Evidence that the incidence of depression among pregnant women and adolescents can be reduced.
- Evidence that school-based violence prevention can reduce the base rate of aggressive problems in an average school by one-quarter to one-third.
- Promising evidence regarding potential indicated preventive interventions targeting schizophrenia.
- Evidence that improving family functioning and positive parenting serves as a mediator of positive outcomes and can moderate poverty-related risk.
- Emerging evidence that school-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Evidence that interventions that target families dealing with such adversities as parental depression and divorce demonstrate efficacy in reducing risk for depression among children and increasing effective parenting.
- Evidence from some preventive interventions that benefits exceed costs, with the available evidence strongest for early childhood interventions.
- Evidence of interactions between modifiable environmental factors and the expression of genes linked to behavior.
- Greater understanding of the biological processes that underlie both normal brain function and the patho-physiology of MEB disorders.
- Emerging opportunities for the integration of genetics and neuroscience research with prevention research.
- Advances in implementation science, including recognition of implementation complexity and the importance of relevance to the community.
- Determinants of mental illnesses are on the horizon. It is now recognized that most disorders are not caused by a small number of genes and that this area of research is highly complex. An emerging area of research involves the influence of the environment on the expression of a specific gene or set of genes, the importance of epigenetic modification of gene expression by experience, and direct injury to neural systems that give rise to illness.

Healthy People 2020 (HP)

HP2020 provides science-based, 10-year national objectives for promoting health and preventing disease. Since 1979, Healthy People has set and monitored national health objectives to meet a broad range of health needs, encourage collaborations across sectors, guide individuals toward making informed health decisions, and measure the impact of our prevention activity. The development process strives to maximize transparency, public input, and stakeholder dialogue to ensure that Healthy People 2020 is relevant to diverse public health needs and seizes opportunities to achieve its goals. Since its inception, Healthy People has become a broad-based, public engagement initiative with thousands of citizens helping to shape it at every step along the way. Drawing on the expertise of a Secretary's Advisory Committee on National Health Promotion and

Disease Prevention Objectives for 2020, public input and a Federal Interagency Workgroup, Healthy People provides a framework to address risk factors and determinants of health and the diseases and disorders that affect our communities.

The following are identified problem areas.

Topic Area: Educational and Community-Based Programs

ECBP–2: Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity.
ECBP-7: Increase the proportion of college and university students who receive information from their institution on each of the priority health risk behavior areas (all priority areas; unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity).
ECBP–10: Increase the number of community-based organizations (including local health departments, tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services.

Topic Area: Maternal, Infant, and Child Health

MICH–11: Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.
MICH–16: Increase the proportion of women delivering a live birth who received preconception care services and practiced key recommended preconception health behaviors.
MICH–16.4 Did not drink alcohol prior to pregnancy.

Topic Area: Mental Health and Mental Disorders

MHMD–10: Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.

Topic Area: Substance Abuse - Policy and Prevention

SA–1: Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol.
SA–2: Increase the proportion of adolescents never using substances.
SA–3: Increase the proportion of adolescents who disapprove of substance abuse.
SA–4: Increase the proportion of adolescents who perceive great risk associated with substance abuse.

Topic Area: Screening and Treatment

SA–7: Increase the number of admissions to substance abuse treatment for injection drug use.
SA–8: Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year.
SA–9: (Developmental) Increase the proportion of persons who are referred for follow-up care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department.
Potential data source: National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.
SA–10: Increase the number of Level I and Level II trauma centers and primary care settings that implement evidence-based alcohol Screening and Brief Intervention (SBI).

Topic Area: Epidemiology and Surveillance

SA–11: Reduce cirrhosis deaths.
SA–12: Reduce drug-induced deaths.
SA–13: Reduce past-month use of illicit substances.
SA–14: Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.
SA–15: Reduce the proportion of adults who drank excessively in the previous 30 days.
SA–16: Reduce average annual alcohol consumption.
SA–18: Reduce steroid use among adolescents.
SA–19: Reduce the past-year nonmedical use of prescription drugs.
SA–20: Decrease the number of deaths attributable to alcohol.
SA–21: Reduce the proportion of adolescents who use inhalants.

Substance Abuse and Mental Health Services Administration (SAMHSA)

The following eight Initiatives will guide SAMHSA's work from 2011 through 2014:

1. **Prevention of Substance Abuse and Mental Illness**—Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This Initiative will include a focus on the Nation's high-risk youth, youth in Tribal communities, and military families.
2. **Trauma and Justice**—Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health,

behavioral health, and related systems and addressing the behavioral health needs of people involved in or at risk of involvement in the criminal and juvenile justice systems.

3. **Military Families**—Supporting America's service men and women—active duty, National Guard, Reserve, and veteran—together with their families and communities by leading efforts to ensure that needed behavioral health services are accessible and that outcomes are positive.
4. **Recovery Support**—Partnering with people in recovery from mental and substance use disorders and family members to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers.
5. **Health Reform**—Increasing access to appropriate high quality prevention, treatment, and recovery services; reducing disparities that currently exist between the availability of services for mental and substance use disorders compared with the availability of services for other medical conditions; and supporting integrated, coordinated care, especially for people with behavioral health and other co-occurring health conditions such as HIV/AIDS.
6. **Health Information Technology**—Ensuring that the behavioral health system, including States, community providers, and peer and prevention specialists, fully participates with the general health care delivery system in the adoption of health information technology (HIT) and interoperable electronic health records (EHRs).
7. **Data, Outcomes, and Quality**—Realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities.
8. **Public Awareness and Support**—Increasing the understanding of mental and substance use disorders and the many pathways to recovery to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.

The impact on America's children, adults, and communities is enormous:

- The annual total estimated societal cost of substance abuse in the United States is $510.8 billion.
- By 2020, behavioral health disorders will surpass all physical diseases as a major cause of disability worldwide.
- In 2008, an estimated 9.8 million adults aged 18 and older in the United States had a serious mental illness. Two million youth aged 12 to 17 had a major depressive episode during the past year.
- In 2009, an estimated 23.5 million Americans aged 12 and older needed treatment for substance use.

- Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24.

In 2011 and beyond, SAMHSA will work to improve understanding about mental and substance use disorders, promote emotional health and the prevention of substance abuse and mental illness, increase access to effective treatment, and support recovery.

SAMHSA's Strategic Initiatives will address trauma; support military families; improve access to culturally competent, high-quality care; develop community, peer, and family support; build information systems; and promote important messages about behavioral health while adjusting to changing conditions. By working across health, justice, social services, education, and other systems and with State, Territorial, Tribal, and other partners, SAMHSA will lead the way to improving the Nation's behavioral health.

Key Facts

- By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.
- Each year, approximately 5,000 youth under the age of 21 die as a result of underage drinking.
- Annually, tobacco use results in more deaths (443,000 per year) than AIDS, unintentional injuries, suicide, homicide, and alcohol and drug abuse combined. Almost half of these deaths occur among people with mental and substance use disorders.
- In 2008, an estimated 2.9 million persons aged 12 and older used an illicit drug for the first time within the past 12 months, an average of 8,000 initiates per day.
- Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24.
- Adults who began drinking alcohol before age 21 are more likely to be later classified with alcohol dependence or abuse than those who had their first drink at or after age 21.
- More than 34,000 Americans die every year as a result of suicide, approximately one every 15 minutes.
- One estimate puts the total economic costs of mental, emotional, and behavioral disorders among youth in the United States at approximately $247 billion.
- The annual total estimated societal cost of substance abuse in the Unites States is $510.8 billion.
- In 2009, an estimated 23.5 million Americans aged 12 and older needed treatment for substance use.
- Among persons aged 12 and older who used prescription pain relievers nonmedically in the past 12 months, 55.9 percent got them from a friend or relative for free.

- In 2009, the percentage of female youth aged 12 to 17 (14.3 percent) who were current drinkers was similar to the rate for male youth aged 12 to 17 (15.1 percent).
- In 2009, transition age youth aged 18 to 25 had the highest rates of binge drinking (41.7 percent) and heavy alcohol use (13.7 percent) of any age group.
- Trauma is strongly associated with mental and substance use disorders.
- Adverse childhood experiences (e.g., physical, emotional, and sexual abuse; and family dysfunction) are associated with mental illness, suicidality, and substance abuse.
- More than half of all prison and jail inmates (people in State and Federal prisons and local jails) meet criteria for having mental health problems, 6 in 10 meet criteria for a substance use problem, and more than a third meet criteria for having both a substance abuse and mental health problem.
- The use of seclusion and restraint on persons with mental and substance use disorders has resulted in deaths and serious physical injury and psychological trauma. In 1998, the Harvard Center for Risk Analysis estimated deaths due to such practices at 150 per year across the Nation.
- In 2007, 8 percent of soldiers in Afghanistan reported using alcohol during deployment, and 1.4 percent reported using illegal drugs/substances.
- Between 2004 and 2006, 7.1 percent of U.S. veterans met the criteria for a substance use disorder.
- Mental and substance use disorders caused more hospitalizations among U.S. troops in 2009 than any other cause.

Mental and substance use disorders have a powerful effect on the health of individuals and on the Nation's social, economic, and health-related problems. Mental and substance use disorders are among the top conditions for disability, burden of disease, and cost to families, employers, and publicly funded health systems. Excessive alcohol use and illicit drug use are linked directly to increased burden from chronic disease, diabetes, and cardiovascular problems.

Trauma is a widespread, harmful, and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people receiving treatment for mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.

Increasing the understanding of mental and substance use disorders and the many pathways to recovery to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.

Summary of California Healthcare Priorities

Similar to the national healthcare priorities, California's healthcare priorities cover a lot of ground and include areas such as electronic health records, improvements in oral health, reductions in violence, improvements in environmental health and other areas. Only the AOD priorities and those that contain an element of AOD are listed below.

- Engage patients and families as partners in care.
- Reduce firearm-related deaths and injuries.
- Reduce homicides especially in those 25 years old and younger.
- Reduce pedestrian and bicyclist injuries and deaths.
- Reduce nonfatal motor vehicle crash-related injuries.
- Reduce motor vehicle crash-related deaths.
- Placeholder – positive youth development/resilience objective.
- Reduce violence by current or former intimate partners.
- Reduce sexual violence.
- Reduce child maltreatment.
- Reduce child maltreatment (physical and psychological) deaths.
- Reduce older adult falls.
- Add an alcohol indicator linked to injury and violence.
- Increase the age and proportion of adolescents who remain alcohol and drug free.
- Reduce per capita consumption of alcohol.
- Increase the proportion of children with mental health problems who receive treatment.
- Increase the proportion of adults with mental disorders who receive treatment.
- Reduce the suicide rate.
- Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.
- Decrease the annual prevalence of Major Depressive Disorders (MDO).
- Increase the diversity of the health workforce.

California's No Wrong Door

The "No Wrong Door" element of the federally mandated Affordable Care Act is the driving force behind California's implementation for its "No Wrong Door" strategy. This ensures that at whatever point an individual enters the realm of health care, they will be routed to the appropriate entity for treatment. For example, if a person enters the system seeking health insurance, they will be provided with health care options based on their personal information and status. If a person enters the system for substance abuse and is found to have a mental disorder, they will be routed appropriately.

California's Costs of Substance Abuse

Substance abuse is costing California billions of dollars. A recent report by Dr. Ted Miller, estimates costs to California to be $52.6 billion dollars. Using 2010 data, the tangible costs associated with this estimate includes medical care, public services, property damage and other costs. After recognizing the intangible quality of life costs such as lost wages, loss of life, and the contribution of substance abuse to violent crimes and car crashes, California's annual cost of substance abuse and misuse skyrockets to $172.6 billion dollars.

Appendix B: Spreadsheet of California's Certifying Organizations

The certifications shown on the following pages are the approved certifications available from the six certifying organizations approved by ADP. Other certifying organizations that are not approved by ADP offer additional certificates/credentials in California, but only individuals with the certifications provided by the approved organizations, and identified in the spreadsheet, may provide services in ADP licensed or certified AOD programs.

Addiction Counselor Certification Board of California **Affiliated with the California Association for Alcohol/Drug Educators (CAADE)**				
	Title 9 requirements for certification/Certification must meet or exceed			Education from WASC, or regional accrediting agency by US Dept of Education or BPPE approved
	Formal Classroom (155)	**Supervised Training (160)**	**Additional Work Experience (2080)**	
CATC Certified Addictions Treatment Counselor	550-660 hours Alcohol/Drug Studies	2240 supervised clinical hours at a State Licensed AOD facility (which include the hours completed in your field experience/practicum/fieldwork class at college and any supervised/verifiable work at a State Licensed AOD facility)		YES
CATC II	Associates Degree and completed an alcohol and drug studies program or equivalent	2240 supervised clinical hours at a State Licensed AOD facility (which include the hours completed in your field experience/practicum/fieldwork class at college and any supervised/verifiable work at a State Licensed AOD facility)		YES
CATC III	Bachelor's degree in AOD studies or a related field, has completed at least 15 units of CAADE-approved	2240 supervised clinical hours at a State Licensed AOD facility (which include the hours completed in your field experience/practicum/fieldwork class at college and any supervised/verifiable work at a State Licensed AOD facility)		YES

	addiction studies or equivalent (including a minimum of two internship courses)		
CATC IV	Master's degree in AOD studies or a related field , has completed at least 15 units of CAADE-approved addiction studies or equivalent (including a minimum of two internship courses)	2240 supervised clinical hours at a State Licensed AOD facility (which include the hours completed in your field experience/practicum/fieldwork class at college and any supervised/verifiable work at a State Licensed AOD facility)	YES
CATC V	Doctorate in a related field (psychology, counseling, social work, human services, addiction studies, has completed at least 15 units of CAADE-approved addiction studies or equivalent (including a minimum of two internship courses))	2240 supervised clinical hours at a State Licensed AOD facility (which include the hours completed in your field experience/practicum/fieldwork class at college and any supervised/verifiable work at a State Licensed AOD facility)	YES

CATC N (I, II, III, IV, V) The individual will have the CATC tier that correlates with their degree level, followed by the letter N.	Has a nursing degree in a related field, has completed at least 15 units of CAADE-approved addiction studies or equivalent (including a minimum of two internship courses)	2240 supervised clinical hours at a State Licensed AOD facility (which include the hours completed in your field experience/practicum/fieldwork class at college and any supervised/verifiable work at a State Licensed AOD facility)		YES
American Academy of Health Care Providers in the Addictive Disorders (AAHCPAD)				
	Title 9 requirements for certification/Certification must meet or exceed			Education from WASC, or regional accrediting agency by US Dept of Education or BPPE approved
	Formal Classroom (155)	**Supervised Training (160)**	**Additional Work Experience (2080)**	
Certified Addictions Specialist With Master's Degree or Doctorate in Mental Health	270 hours of education	6,000 hours or 3 years supervised experience providing direct health care services to those identified with an addictive disorder.		
Certified Addictions Specialist With any other degree or without a degree	270 hours of education	10,000 hours or 5 years of full-time supervised experience providing direct health care services to those identified with an addictive disorder		

Board for Certification of Addiction Specialists **Affiliated with the California Association of Addiction Recovery Resources (CAARR)**				
	Title 9 requirements for certification/Certification must meet or exceed			Education from WASC, or regional accrediting agency by US Dept of Education or BPPE approved
	Formal Classroom (155)	**Supervised Training (160)**	**Additional Work Experience (2080)**	
CAS Certified Alcohol and Other Drug Addiction Recovery Specialist	155 hours	160 hours	2,080 hours work experience within three years in an alcohol and or other drug recovery program	Yes
CAS II Certified Alcohol and Other Drug Addiction Recovery Specialist II	270 hours	160 hours	6,240 work hours in substance abuse services in an alcohol and or other drug recovery program	Yes
CAS III Certified Alcohol and Other Drug Addiction Recovery Specialist III	1800 hours	160	8,360 hours work experience in substance abuse services in an alcohol and or other drug recovery program	Yes

Breining				
	Title 9 requirements for certification/Certification must meet or exceed			Education from WASC, or regional accrediting agency by US Dept of Education or BPPE approved
	Formal Classroom (155)	**Supervised Training (160)**	**Additional Work Experience (2080)**	
RAS <u>Registered Addiction Specialist</u>	155 hours	160 hours	2080 hours	YES
RAS II <u>Advanced Level Registered Addiction Specialist</u>	450 hours 295 additional to the 155 required for RAS	10,000 hours (about 5 years) clinical experience (includes 160 hours supervised training in AOD counseling) 7920 Additional to the 2080 required for RAS		YES
M-RAS <u>Masters Level RAS Credential</u> - Option 1	Associate or Bachelors Degree* **and** 450 hours formal education in AOD abuse studies	10,000 hours (about 5 years) clinical experience (includes 160 hours supervised training in AOD counseling) 7920 Additional to the 2080 required for RAS		YES
M-RAS <u>Masters Level RAS Credential</u> - Option 2	Masters degree or Doctorate degree and 450 hours education in AOD abuse studies	6,000 hours (about 3 years) clinical experience (includes 160 hours supervised training in AOD counseling) 3920 additional to the 2080 required for RAS		YES

California Association of Drinking Driver Treatment Programs (CADDTP)				
	Title 9 requirements for certification/Certification must meet or exceed			Education from WASC, or regional accrediting agency by US Dept of Education or BPPE approved
	Formal Classroom (155)	**Supervised Training (160)**	**Additional Work Experience (2080)**	
CAODC Certified Alcohol and Other Drug Counselor	155 hours	160 hours	2,080 hours work experience	
CAODC-A Certified Alcohol and Other Drug Counselor Advanced	320 hours	5 years or 10,000 hours of work experience		

California Certification Board of Alcohol and Drug Counselors **Affiliated with the California Association of Alcoholism and Drug Abuse Counselors (CAADAC)**				
	Title 9 requirements for certification/Certification must meet or exceed			Education from WASC, or regional accrediting agency by US Dept of Education or BPPE approved
	Formal Classroom (155)	**Supervised Training (160)**	**Additional Work Experience (2080)**	
CADCA Certified Alcohol and Drug Counselor Associate	315 hours	255 hours	(was approved if individual has 2080 of experience.)	Most Schools are WASC or BPPE, not all of the schools. Some schools have waivers
CADC I Certified Alcohol and Drug Counselor	315 hours or no additional if have CADCA	255 hours or no additional if have CADCA	4000 hours full time supervised work experience	Most Schools are WASC or BPPE, not all of the schools. Some schools have waivers
CADC II Certified Alcohol and Drug Counselor	315 hours or no additional if have CADCA or CADCA I	255 hours or no additional if have CADCA or CADC I	6000 hours full time supervised work experience or 2000 additional hours if have CADCA I	Most Schools are WASC or BPPE, not all of the schools. Some schools have waivers

Appendix C: IC&RC Core Competencies

IC & RC Credentials

IC&RC provides the minimum standards for each reciprocal credential, but Member Boards may set higher standards for their credentials.

TAP 21 Competencies & the 12 Core Functions are contained within the domains.

IC&RC Credentials Offered

- Alcohol and Drug Counselor (ADC)
- Advanced Alcohol and Drug Counselor (AADC)
- Clinical Supervisor (CS)
- Prevention Specialist (PS)
- Certified Criminal Justice Addictions Professional (CCJP)
- Certified Co-occurring Disorders Professional (CCDP)

To receive the credential, applicants must pass an IC&RC examination and sign a code of ethics or affirmation statement.

Recertification must occur every two years.

IC&RC is currently developing a Peer Mentor (PM) credential.

Translating the IC&RC credentials to the CAADAC equivalents:
ADC Acronym for CAADAC credential CADC II
AADC Acronym for CAADAC credential CAADC
CS Acronym for CAADAC credential CCS
PS Acronym for CAADAC credential CCPS
CCJP Acronym for CAADAC credential CCJP

The following table summarizes the qualifications for each IC&RC credential.

	ADC	AADC	CS	PS	CCJP	CCDP	PM
Experience - hours	6000	2000	10,000	2000	6000	6000	500
Education – hours or degree	270	MS + 180	MS + 30	100	Varies based on degree	BA/BS + 200	HS + 46
Supervision – hours	300	300		120	200	200	25
Must hold current credentials			x				
Domains							
Clinical Evaluation	x	x					
Treatment Planning	x	x			x	x	
Referral	x	x					
Service Coordination	x	x					
Counseling	x	x			x	x	
Client, Family & Comm. Ed.	x	x					
Documentation	x	x			x		
Prof. & Ethical Resp.	x	x	x			x	
Research Design, Analysis & Utilization		x					
Clinical Supervision		x	x				
Counselor Development			x				
Program Development & QA			x				
Performance Evaluation			x				
Administration			x				
Treatment Knowledge			x				
Planning & Evaluation				x			
Education & Skill Development				x			
Community Organizing				x			
Public Policy & Env. Change				x			
Prof. Growth & Responsibility				x			
Dynamics of Addiction & Criminal Behavior					x		
Legal, Ethical & Prof. Responsibility					x		
Criminal Justice System & Processes					x		
Clinical Eval: Screening & Assessment					x	x	
Case Mgmt, Monitoring & Participant Supervision					x		
Crisis Prevention & Mgmt						x	
Recovery Planning						x	
Mgmt. & Coord. Of Care						x	
Education of Person, Their Support System & the Community						x	
Advocacy							x
Mentoring/Education							x
Recovery/Wellness Support							x
Ethical Responsibility							x

Appendix D: Example of Scopes of Practice for Substance Use Disorder Counseling, SAMHSA, September 2011

DEVELOPING MODEL SCOPES OF PRACTICE FOR SUBSTANCE USE DISORDER COUNSELING

Background

With the advent of parity legislation and health care reform, the need to develop a template or model Scopes of Practice and career ladder for the substance use disorders field increased in urgency. The other professions working in the behavioral health care field are all licensed and already have scopes of practice for their respective disciplines. For those who are specializing in the area of substance use disorders consistent set of scopes of practice are needed to level the playing field.

Realizing that this was a pressing concern, the Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Treatment (CSAT) convened a 15 member Expert Panel to craft model Scopes of Practice and a Career Ladder in March 2010. The intent of the meeting was to develop a model or template which could be used by the appropriate entities and which would provide some consistency across the field, while at the same time allowing for state/local variability. The group included representatives from the following organizations or categories of organizations (see Attachment 1 for specific individuals):

- Single State Authorities
- National Association of State Alcohol & Drug Abuse Directors
- State Director of Workforce Development & Fiscal Evaluation
- State Certification Board
- Association of Social Work Board
- International Certification & Reciprocity Consortium
- Higher Education
- State Association of Addiction Services
- NAADAC, The Association for Addiction Professionals
- The Applied Technology Transfer Network

The group worked together to draft elements of the Scopes of Practice and Career Ladder, and then provided comments after reviewing two drafts.

Scopes of Practice

Unlike other behavioral health disciplines, Scopes of Practice for substance use disorder (SUD) counseling have not been fully articulated. Until now, stakeholders had not agreed upon the levels of practice to be included or the requirements for each level. The Expert Panel was charged with developing scopes of practice that included a full range of responsibility and practice, from entry level to clinical supervision and beyond.

The Expert Panel based much of their discussion on the definition of Scope of Practice developed by the Federation of State Medical Boards (FSMB); it defines a Scope of Practice as the "definition of rules, regulations and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field of medicine or surgery or other specifically defined field. Such practice is also governed by requirements for continuing education and professional accountability." The Expert Panel attempted to develop Scopes of Practice that would allow the profession to regulate itself and to assure the public of appropriate self-regulation.

This model Scopes of Practice is based on CSAT's Technical Assistance Publication, Addiction Counseling Competencies: The knowledge, skills, and attitudes of professional practice, known in the field as "TAP 21".[1] The TAP 21 has been crossed-walked with the domains and functions required by the major certification and credentialing organizations and has been endorsed by these groups.

How the Scopes of Practice can be used

The Expert Panel identified the ways in which a model Scope of Practice could be used by States and their constituencies, including the Single State Authorities (SSAs), current leaders in the field, providers, professional associations, credentialing bodies, State consumer groups and institutions of higher education. Panelists noted that these constituencies might use a model Scope of Practice to:

- Protect the public by setting standards;
- Put practice in line with higher education;
- Allow practitioners to be reimbursed for services (to collect 3rd party payment);
- Raise awareness of the profession; and
- Inform workforce development activities.

Many States already have a Scope(s) of Practice for SUD counselors, along with licensing and credentialing requirements, while others do not. For those States without a Scope of Practice, this may provide a model upon which to build or adapt a particular State's needs for policy and regulation. For those States with an existing Scope of Practice, it may be a useful framework to assess whether the current Scope is in keeping with the most up-to-date thinking in the field of SUD counseling.

Career Ladders

Career ladders are occupational structures designed to encourage and reward competent employee performance within a field or a particular organization. Employees move up the rungs – or in the case of a career lattice, across – by demonstrating successful

[1] Center for Substance Abuse Treatment. Technical Assistance Publication (TAP) Series 21, Addiction Counseling Competencies: The knowledge, skills, and attitudes of professional practice. Rockville, MD: Substance Abuse and Mental Health Services Administration (DHHS Publication No. SMA 064171), 2006.

performance and/or obtaining education and training that prepares them for the next level. Career ladders help employees plan for upward mobility in their careers, even if they start in an entry-level job. A career lattice recognizes that opportunities include career paths that move a job seeker or employee laterally or upward between industries or positions. A career lattice path requires varied amounts of continuing education and/or training in order to transfer into a related job in a different type of setting in the same or related industry or in another industry.

The attached career ladder for counselors treating substance use disorders (SUDs) provides a framework for understanding the education, training, and supervised work experience necessary to enter and move up in the field to positions of increased responsibility. Some staff without degrees may start in an entry-level category and decide to pursue additional education and training to increase their level of responsibility, while others may decide to remain in such a position because it continues to be fulfilling and meaningful to them.

Individuals, employers, and industries can use this career ladder. Some benefits are:

- **Employee retention**—Career ladders illustrate potential for advancement, which serves as an incentive for employees to stay with organizations or within a field. Employers save on costly turnover, recruitment, and training expenses. Using this career ladder as an example, an organization hiring a peer support specialist in an entry-level position could encourage employee professional development by encouraging additional education and training to move into a position requiring a degree.

- **Performance incentive**—The opportunity for advancement motivates employees to produce and perform well on the job and to acquire new knowledge and skills. Using this career ladder as an example, an organization hiring someone with a Bachelor's degree could encourage employee professional development to obtain a Master's degree and supervised work experience to move into a clinical supervision position.

- **Career development programs**—The graphic representation of career ladders (such as the attached chart) provides an easily understood tool to assist career counselors and individuals in career planning and decision-making. Individual programs may add additional positions to the chart, such as program manager.

These two documents together, the Scopes of Practice and the Career Ladder, serve to support States, organizations, individuals and the greater public in setting the standards for the roles and responsibilities within the field of Substance Use Disorders. As these professional roles are more clearly articulated and these documents incorporated into the workplace culture profession will be better able to articulate its' standing as a specialized field.

Substance Use Disorder (SUD) professionals work in a broad variety of disciplines but share an understanding of the addiction process that goes beyond the narrow confines of any specialty. Professional counseling of people with SUDs consists of the application of general counseling theories and treatment methods adopted with the express purpose of treating alcohol and drug problems. Effective treatment can lead to a life of recovery and enhanced social, psychosocial or bio-psychosocial functioning of individuals, couples, families, groups, organizations, and communities. The activities of a counselor within this field are based on the practice dimensions outlined in TAP 21 and include the following:

1. Clinical Evaluation
2. Treatment Planning
3. Referral
4. Service Coordination
5. Counseling
6. Client, Family, and Community Education
7. Documentation
8. Professional and Ethical Responsibilities

CATEGORY 3: CLINICAL SUBSTANCE USE DISORDER COUNSELOR

Practice of Clinical Substance Use Disorder Counselor – The scope of practice for a Clinical Substance Use Disorder Treatment Counselor can include:

1. Clinical evaluation, including screening, assessment, and diagnosis of Substance Use Disorders and Co-Occurring Disorders (CODs)

2. Treatment Planning for SUDs and CODs, including initial, ongoing, continuity of care, discharge, and planning for relapse prevention.

3. Referral

4. Service Coordination case management in the areas of SUDs and CODs

5. Counseling -Therapy and psycho-education with individuals, families, and groups in the areas of SUDs and CODs

6. Client, Family, and Community Education

7. Documentation

8. Professional and Ethical Responsibilities

9. Clinical supervisory responsibilities for all categories of SUD Counselors

The Clinical Substance Use Disorder Counselor can practice under the auspice of a licensed facility or as an independent private practitioner. It is the responsibility of the Clinical Substance Use Disorder Counselor to seek out clinical supervision and peer support.

CATEGORY 2: SUBSTANCE USE DISORDER COUNSELOR

Practice of Substance Use Disorder Counselor – The Scope of Practice for the category of those with a Bachelor's degree includes the following activities with clinical supervision of a Clinical Substance Use Disorder Counselor or other state approved supervisor:

1. Clinical evaluation including, diagnostic impression, screening and assessment of SUD

2. Treatment Planning for SUDs and CODs, including initial, ongoing, continuity of care, discharge, and planning for relapse prevention.

3. Referral

4. Service Coordination case management for SUDs and CODs

5. Counseling -Therapy and psycho-education with individuals, families, and groups Client, Family, and Community Education

6. Documentation

7. Professional and Ethical Responsibilities

8. Clinical supervisory responsibilities for all categories of SUD Counselors

The Substance Use Disorder Counselor 2 can only practice under the auspice of a licensed facility and under the clinical supervision of Clinical Substance Use Disorder Counselor.

CATEGORY 1: ASSOCIATE SUBSTANCE USE DISORDER COUNSELOR

Practice of Associate Substance Use Disorder Counselor – The Scope of Practice for the category of those with an Associate's degree include the following activities with clinical supervision from a Clinical Substance Abuse Counselor or state approved supervisor and/or the administrative supervision of a Substance Abuse Counselor:

1. Diagnostic impression, screening of SUD

2. Monitor treatment plan/compliance

3. Referral

4. Service Coordination, case management for SUD

5. Psycho-educational counseling of individuals and groups
6. Client, Family, and Community Education

7. Documentation

8. Professional and Ethical Responsibilities

The Associate Substance Use Disorder Treatment Counselor can only practice under the auspice of a licensed facility and under the clinical and or administrative supervision of Clinical Substance Use Disorder Counselor or the administrative oversight of the Substance Use Disorder Counselor.

Appendix E: Example Career Ladder for Substance Use Disorder Counseling

Example: SAMHSA Career Ladder

CAREER LADDER FOR THE FIELD OF SUBSTANCE USE DISORDERS (SUDs)*								
	What may be required to be licensed or credentialed in this category, which varies by state*					Possible job responsibilities, which varies by state and employer*		
	Title	Education	Licensure & Credentialing	Training & Advanced Course Word	Supervised Work Experience	Activities	Setting	Supervisory responsibilities
CATEGORY 3	Clinical Substance Use Disorder Counselor	Master's degree in SUD counseling or other allied mental health professional (e.g. MA in social work, mental health counseling, marriage & family counseling, etc.) including at least 300 hours of SUD related topics – if not received with degree can be obtained as advanced coursework outside the school setting.	Most states require some kind of license and/or credential at this level. Licensing is separate from credentialing in some states while some states link licensing to credentials. Appropriate license and/or credential & written exam from a nationally-recognized credentialing body based on state regulators.	Assumed that foundational & advanced courses have been taken on substance use disorders & counseling, as well as supervised practicum and/or internships if not at least 300 hours of specific SUD training must be obtained. OFTEN NEEDED FOR THIS LEVEL: Additional course work on clinical supervision.	Prior to taking the exam for this particular credential must complete 4,000 hours of POST Master's level supervised work experience in SUDs consistent with the laws & regulations of each state, with a minimum of 2,000 hours of direct client hours.	1. Clinical evaluation, including screening, assessment & diagnosis of Substance Use Disorders & Co-Occurring Disorders (CODs) 2. Treatment Planning for SUDs & CODs, including initial, ongoing, continuity of care, discharge, & planning for relapse prevention, 3. Referral 4. Client, Family and Community Education 5. Documentation 6. Service Coordination, case management in the areas of SUDs & CODs 7. Therapy & psycho-education with individuals, families & groups in the areas of SUDs & CODs 8. Professional & Ethical Responsibilities	All confidential setting including private independent practice	Clinical supervisory responsibilities for all categories of SUD Counselors

	Title	Education	Licensure & Credentialing	Training & Advanced Course Word	Supervised Work Experience	Activities	Setting	Supervisory responsibilities
CATEGORY 2	Substance Use Disorder Counselor	Bachelor's degree in SUD counseling or other allied mental health professional (social work, mental health counseling) including at least 200 hours of SUD related topics – if not received with degree can be obtained as advanced coursework outside the school setting.	Most states require some kind of license at this level. Licensing is separate from credentialing in some states while some states link licensing to credentials. Appropriate license and/or credential & written exam from a nationally-recognized credentialing body based on state regulations.	Assumed that foundational & higher level undergraduate courses have been taken on substance use disorders & counseling, as well as supervised practicum and/or internships if not at least 200 hours of specific SUD training must be obtained.	Prior to taking the exam for this particular credential must complete a minimum of 2,000 hours of Bachelor's level supervised work experience in SUDs consistent with the laws & regulations of each state, with a minimum of 600 hours of direct client work.	1. Clinical evaluation including, diagnostic impression, screening & assessment of SUD 2. Treatment planning for SUDs including initial, ongoing, continuity of care, discharge & planning for relapse prevention. 3. Referrals 4. Client, Family, & Community Education 5. Documentation 6. Service Coordination, case management for SUD & COD 7. Psycho-educational counseling of individuals, families, & groups, therapy with individuals & groups. 8. Professional & Ethical Responsibilities The Substance Use Disorder Treatment Counselor can only practice under the auspice of a licensed facility & under the clinical supervision of Category 4 Clinical or Category 3 Master's Substance Use Disorder Counselor.	All confidential settings, except private practice, with supervision provided	Provide administrative supervision of Category 1 Substance Use Counselor, Entry Level & Peer Recovery Staff

	Title	Education	Licensure & Credentialing	Training & Advanced Course Word	Supervised Work Experience	Activities	Setting	Supervisory responsibilities
CATEGORY 1	Associate Substance Use Disorder Counselor	Associate's degree in a behavioral science field with a clinical application including at least 100 hours of SUD related topics – if not received with degree can be obtained as advanced coursework outside the school setting.	Most states require some kind of license and/or credential at this level. Licensing is separate from credentialing in some states while some states link licensing to credentials. Appropriate license and/or credential & written exam from a nationally-recognized credentialing body based on state regulations.	Assumed that foundational courses have been taken on substance use disorders & counseling, as well as supervised practicum and/or internships. Advanced course work & training are usually not required at this level unless SUD specific training was not obtained through course work, 100 hours of specific SUD course work is then required.	Prior to taking the exam for this particular credential must complete a minimum of 2,000 hours of Associate level supervised work experience in SUDs consistent with the laws & regulations of each state, with a minimum of 600 hours of direct client work.	1. Diagnostic impression, screening of SUD 2. Monitor treatment plan/compliance 3. Referrals 4. Client, Family, & Community Education 5. Documentation 6. Service Coordination, case management for SUD 7. Psycho-educational counseling of individuals & groups 8. Professional & Ethical Responsibilities. The Associate Substance Use Disorder Treatment Counselor can only practice under the auspice of a licensed facility & under the clinical and/or administrative supervision of Category 4 Independent, Clinical or Category 3 Master's or the administrative oversight of the Substance Use Disorder Counselor.	All confidential settings, except private practice, with supervision provided	Cannot provide clinical or administrative supervision of staff but can supervise community and social activities
ENTRY LEVEL	Substance Use Disorder Technician	GED/High School Diploma	Many states require some kind of license and/or credential for entry level staff. Licensing is separate from credentialing in some state while some state link licensing to credentials. Appropriate license and/or credential & written exam from a nationally-recognized credentialing body based on state regulations.	150 clock hours from a jurisdiction approved education provider (related to KSA's or TAP 21) & minimum of 6 clock hours of ethics training. This must be completed before beginning supervised experience.	Prior to taking the exam for this particular credential must complete a minimum of 1,500 hours of Entry level supervised work experience in SUDs consistent with the laws & regulations of each state.	Often able to implement independently: Screening of SUD & COD Monitor Tx Plan Compliance Under Supervision: Psycho-educational counseling independently & with groups for clients & families Tx Planning Documentation The Substance Use Disorder technician can only practice under the auspice of a licensed facility & under the clinical and/or administrative supervision of Category 3 Master's or the administrative oversight of the Substance Use Disorder Counselor.	All confidential settings, except private practice, with supervision provided.	Cannot provide clinical or administrative supervision of staff but can supervise community & social activities.

Those who are interested in entering or advancing in the field of Substance Use Disorder counseling are encouraged to review the specific titles, education, training and licensing and redentialing requirement of their State. This Career Ladder is intended to show how employees might enter and advance in the field and what general job duties and requirements might be. ducation and training requirements vary from State to State.

Appendix F: Insurance Billable Services – Example: Kaiser Small Group HMO

Kaiser Small Group

Chemical Dependency Services

- Inpatient detoxification
  - Hospitalization in a plan hospital for medical management of withdrawal symptoms
  - Room and board
  - Plan physician services
  - Drugs
  - Dependency recovery services
  - Education
  - Counseling
- Outpatient chemical dependency care
  - Day-treatment programs
  - Intensive outpatient programs
  - Individual and group chemical dependency counseling
  - Medical treatment for withdrawal symptoms
  - Methadone maintenance treatment for pregnant members during pregnancy and for two months after delivery at a licensed treatment center approved by the medical group. Methadone maintenance treatment is not covered under any other circumstances.
- Transitional residential recovery services
  - Chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by the medical group. These settings provide counseling and support services in a structured environment.
- Exclusion
  - Services in a specialized facility for alcoholism, drug abuse, or drug addiction except as otherwise described in this "Chemical dependency services" section.

Appendix G: CMS List of Authorized Credentials and Service Locations

Medicare defines SBIRT as alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention. SBIRT is an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. Medicare will pay for SBIRT services when they are medically reasonable and necessary, and when they are delivered in a physicians' office or outpatient hospital. In order to bill for these services, the mental health professional must be working within their State Scope of Practice Act, and licensed (or certified) to perform mental health services by the state in which the services are performed.

The following list of professionals is recognized by Medicare to deliver these services.

- Physician
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Clinical Nurse Specialist (CNS)
- Clinical Psychologist (CP)
- Clinical Social Worker (CSW)

Two Healthcare Common Procedure Coding System (HCPCS) G codes exist for the structured assessment and brief intervention. One code covers an intervention lasting from 15-30 minutes. The second code covers an intervention lasting greater than 30 minutes.

SBIRT services must be reasonable and meet the requirements of diagnosis or treatment of illness or injury. Documentation of the intervention must be included in the patient's medical record.

Medicare covers an annual alcohol misuse screening, and for those who screen positive, up to four brief face-to-face behavioral counseling interventions in a 12-month period. In primary care, this screening covered by Medicare, is a stand-alone billable service and is separate from the Initial Preventive Physical Examination (IPPE) and the Annual Wellness Visit (AWV).

The definition for screening is shown below.

- Those who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet the criteria for alcohol dependence. Alcohol dependence is defined as having as least three of the following:
    - Tolerance
    - Withdrawal symptoms
    - Impaired control
    - Preoccupations with acquisition and/or use
    - Persistent desire or unsuccessful efforts to quit
    - Sustains social, occupational, or recreational disability
    - Use continues despite adverse consequences, and
- Are competent and alert at the time that counseling is provided, and

- Whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting.

Primary care settings are defined as one in which there is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The following are not considered as primary care settings:

- Ambulatory surgical centers
- Emergency departments
- Hospices
- Independent diagnostic testing facilities
- Inpatient hospital settings
- Inpatient rehabilitation facilities, and
- Skilled nursing facilities.

Medicare covers screening and behavioral counseling interventions provided in the following types of primary care settings.

- An independent clinic
- An outpatient hospital
- A physician's office
- A state or local public health clinic

A primary care physician is one who has a primary specialty designation of:

- Family practice
- General practice
- Geriatric medicine
- Internal medicine
- OG/GYN
- Pediatric medicine

A qualified non-physician practitioner is a:

- Certified clinical nurse specialist
- Certified nurse-midwife
- Nurse practitioner
- Physician assistant

Appendix H: International Standards on Drug Use Prevention

International Standards on Drug Use Prevention

	Prenatal & Infancy	**Early Childhood**	**Middle Childhood**	**Early Adolescence**	**Adolescence**	**Adulthood**
Family	Selective Prenatal & infancy visitation ** Selective Interventions targeting pregnant women with substance abuse disorders *		Universal & Selective Parenting Skills ****			
School		Selective Early childhood education ****	Universal Personal & social skills *** Universal Classroom Management *** Selective Policies to keep children in school **	Universal & Selective Prevention education based on personal & social skills & social influences ***		
				Universal School policies & culture **		
			Indicated Addressing individual vulnerabilities **			

The table is continued on the next page.

<table>
<tr><th></th><th>Prenatal
& Infancy</th><th>Early
Childhood</th><th>Middle
Childhood</th><th>Early
Adolescence</th><th>Adolescence</th><th>Adulthood</th></tr>
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Alcohol & tobacco policies
*****

Universal & Selective
Media campaigns
*</td></tr>
<tr><td></td><td colspan="6">Universal & Selective
Community-based multi-component initiatives
***</td></tr>
<tr><td></td><td></td><td></td><td></td><td colspan="2">Selective
Mentoring
*</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td colspan="2">Universal
Entertainment venues
**</td></tr>
<tr><td>Workplace</td><td></td><td></td><td></td><td></td><td colspan="2">Universal, Selective &
Indicated
Workplace prevention
***</td></tr>
<tr><td>Health
Sector</td><td></td><td></td><td></td><td colspan="3">Indicated
Brief intervention
****</td></tr>
</table>

Notes: Strategy with an indication of (* limited/ ** adequate/ *** good/ **** very good/ ***** excellent) efficacy.

Universal = strategy appropriate for the population at large
Selective = strategy appropriate for groups that are particularly at risk
Indicated = strategy appropriate for individuals that are particularly at risk