Executive Summary

Alcohol and drug abuse underlie many of our greatest concerns: Persistent poverty and homelessness. Violence in living rooms and in neighborhoods.[1] The neglect by parents and the squandering of youth. Carnage on highways. Overcrowded jails, prisons, emergency rooms, and foster care systems. In many neighborhoods, the addiction and abuse of alcohol and other drugs are nothing less than a scourge, the plague of our day that is stripping communities of potential, ambition and hope.

Recovery, however, is possible. Treatment works. Managed correctly, alcohol and drug treatment is a cost-effective response to these expensive maladies – saving $7 for every dollar spent, by two analyses.[2] As part of a larger effort to reduce drug and alcohol abuse, treatment can restore lives, revive communities and reduce the growing demand on public programs. But the enormity of the problem and the potential for change are not well understood.

No matter how the accounting is done – public dollars spent, private dollars lost, lives wasted, families destroyed – abuse and addiction exact a disastrous and unsustainable toll. The University of California at Los Angeles estimated in 2001 that some 2.3 million Californians needed treatment for drug or alcohol abuse.

The National Institute for Drug Abuse estimates the annual economic impact of substance abuse to be $373 billion.[3] This figure includes the costs of health care, social services, and criminal justice systems, as well as the losses due to crime and diminished productivity, and spending on prevention, treatment and law enforcement. California's share of the national tab is estimated to be more than $32.7 billion.[4]

Those figures fail to capture the anguish. In 2001, 31,806 people were injured and 1,308 people were killed on California roadways in collisions involving alcohol alone.[5]

No one is immune from these consequences. Abuse and addiction are frustrating our social and economic goals, compromising our personal safety, draining our resources and limiting our future. And for all of the repercussions associated with the prevalence of illegal drug use, at least half of the losses can be attributed to alcohol.[6]

If these consequences could be blamed on others, we would consider it an attack. We would recruit and train the best talent, ensure they have effective technology, and expect performance and accountability. We would build an alliance and focus public support. Above all, we would demand the kind of public leadership that it takes to protect our children and to help our neighbors when faced with such an insidious danger.

In this report the Commission focuses on reducing the consequences of abuse and addiction associated with alcohol and other drugs. The term "substances" is used occasionally to connote both alcohol and other drugs.

It's not that we haven't tried. For more than a generation we have fought a "war on drugs." We have an Office of National Drug Control Policy and a national drug control strategy. In California, law enforcement agencies have task forces. The State has a department dedicated to prevention and treatment programs. And every county administers services to help the addicted and those affected by addicts.

The most controversial aspects of this "war" have been the violent crime associated with drug trafficking, the consequences of this drug trade on impoverished neighborhoods, and the high rates of incarceration in some communities, particularly those of color.

But while we have always made more room in prisons, the treatment system is chronically under-funded. The most recent UCLA estimate indicates that some 330,000 Californians could be expected to seek or be directed to publicly-funded treatment in any given year. And of those, 130,000 would be served. The other 200,000 would be placed on waiting lists – some of them while their children sit in foster care, or while their addiction lands them on the streets, in jail, an emergency room or the morgue. In December 2001, nearly 11,000 people were on a waiting list for publicly-funded treatment.[7]

Because of its earlier work on criminal justice, mental health and child abuse, the Commission began this study with the understanding that alcohol and other drug treatment could change lives and is essential to safe, healthy and productive communities. In the course of this study, the Commission was impressed by the dedication and professionalism of the people working to help the addicted recover.

But ultimately the Commission was struck by the evidence that we could do much more to coordinate drug control efforts, target our resources, improve the quality of treatment, integrate necessary interventions to improve effectiveness, and make the most of available funding.

While our resolve should be based on the consequences of addiction, our goals should be guided by the compelling case for recovery through

effective treatment. The 7-to-1 return on treatment funding is the result of reduced crime, enhanced productivity and lower health care costs. Even in good economic times, the prison and health care systems pressure public budgets and preclude investments in education, infrastructure and the environment. In times like these, controlling those costs becomes urgent.

In recent years, the public – recognizing the limited and sometimes damaging outcomes of a jail-based policy – has decided a different approach should be taken to drug abuse. In 2000, more than 60 percent of the voters approved Proposition 36, which dedicates $120 million a year to treat, rather than incarcerate, those arrested for drug offenses. In five counties alone, some 12,000 drug abusers were diverted from jail to treatment in the first nine months of the program.[8]

Proposition 36, it turns out, is more than a shift in the popular wind. It is an enormous opportunity for local and state agencies that really do share a common goal to coordinate their efforts to change lives and improve public safety. If successful, the implementation of Proposition 36 will not only demonstrate the government's faithful response to the public will, but it will document how treatment can be an effective defense against the costly consequences we now endure.

This teamwork needs to move beyond those targeted by Proposition 36. The State needs to bring together the well-intended but disparate programs and agencies – at the state and local level, in prevention, treatment and law enforcement, in the executive, legislative and judicial branches – to surgically attack this cancer. This statewide strategy must be focused on reducing alcohol and drug abuse and must employ the most effective prevention, treatment and enforcement tools, with resources directed to where the evidence shows they will do the most good.

Particular attention must be given to the needs of our young people. As important as it is to expand alcohol and drug treatment for those who are arrested or imprisoned, the paucity of treatment for young people – who have so much to lose and who could cost us so much – is irrational.

And finally, community leaders – private and public – must help everyone understand how alcohol and drug abuse affects us, and what we can do to solve the problem. If nobody wants to be hit by a driver under the influence of alcohol or drugs, we have to be willing to have treatment facilities in our neighborhoods. If we want safe and healthy communities, we have to support treatment and demand that it be well managed.

Given the consequences – and the potential for recovery – the ultimate goal should be treatment on demand. If quality can be improved and demonstrated, the necessary public and private resources should be redirected toward treatment.

After careful review of the research and existing policies – and after consulting with researchers, administrators, providers and clients – the Commission offers the following recommendations:

Finding 1: The State's efforts to reduce alcohol and drug abuse through prevention, treatment and law enforcement programs are fragmented and not focused on cost-effectively curtailing the expense and misery of abuse and addiction in California.

California and the nation have struggled for decades to control illicit drug abuse – and respond to the violence, illness and other problems caused by drug and alcohol abuse. These policies have involved a combination of law enforcement efforts to reduce the supply of illegal drugs, and to punish those involved in the trafficking and possession of drugs and those who hurt others while under the influence of drugs or alcohol. To a lesser extent, government has tried to reduce the demand through prevention – primarily aimed at discouraging young people from trying alcohol and other drugs – and treatment for those who become addicted.

A persistent and growing controversy has emerged over the effectiveness of some parts of this approach, and of enforcement efforts in particular. Arresting drug users has overcrowded jails and prisons with little evidence that this strategy deters the demand for drugs and success has been sporadic in limiting the price, availability or purity of illicit drugs.

More importantly, there is growing consensus among prevention, treatment and law enforcement professionals that a strategic combination of all three components is essential to reducing alcohol and drug abuse and its costly consequences.

Some coordination is necessary because dozens of public agencies have a role in some aspect of drug control efforts or serve a portion of the population. Some 17 different state agencies have drug-related responsibilities, and every county has its own array of prevention, enforcement and treatment entities – from school districts and police departments, to community groups and service providers.

But coordination also is important because, from drug to drug, the most effective strategy is likely to be a different combination of prevention, enforcement and treatment. Raiding methamphetamine labs in California, for example, has been far more effective in reducing supplies

than attempts to stop international smuggling of cocaine. In turn, research shows cocaine and heroin usage can be reduced more through treatment than enforcement efforts.

California recognized the need for a strategic effort when the Legislature and the Governor in 1989 established detailed drug control goals for all counties and 13 state agencies, and authorized a master plan. The plan, published in 1991, identified specific actions for local communities and the State, guided by a coordinating council. But true partnerships were never formed and the plan was never fully implemented.

Other states have successfully developed multiple-agency responses. Florida has vested interagency authority in a drug czar reporting directly to the governor. Washington has a governor's council to recommend state and local strategies to combat substance abuse and the budgets to support them. In Oregon and Arizona, governors' councils advise on prevention and treatment matters. Among these four states, only Florida has concentrated the authority to coordinate all three components of the drug control strategy – prevention, treatment and law enforcement.

Proposition 36 required local agencies to coordinate services for diverted abusers. In turn, state agencies created an interagency committee to review implementation efforts and advise state leaders on policy or funding changes necessary for success. The administration and Legislature have been responsive – demonstrating the benefits of bottom-up partnerships. Early assessments are encouraging.

Recommendation 1: The State should establish a council to develop a unified strategy to cost-effectively reduce the expense, injury and misery of alcohol and drug abuse. The council should advise policy-makers, coordinate programs and assess the effectiveness of statewide efforts to reduce the consequences of addiction. The Council should:

- ***Involve prevention, treatment, and law enforcement leaders.*** State and local leaders need to come together to link alcohol and drug prevention, treatment and law enforcement efforts into a statewide strategy guiding a three-pronged attack on substance abuse. The council should elect a chair from among its members, hire a small staff and tap the resources of member agencies to support its analyses. The strategy should set quantifiable goals, such as those in the National Drug Control Strategy, for reducing abuse and include ways to measure progress toward those goals. (A listing of proposed members is included on page 42.)
- ***Institutionalize a planning and coordination process.*** The council should develop a statewide strategy for controlling drug and alcohol abuse that includes quantifiable goals like those in the National Drug

Control Strategy, and ways to measure progress toward those goals. The council should submit the strategy to the Governor and the Legislature for enactment. The council also should ensure that state alcohol and drug control efforts are aligned with local, regional and federal efforts.

- ***Guide the allocation of resources.*** As a guide to the budget process, the council should present an annual plan to the Legislature and Governor for reallocating resources from the least cost-effective to the most cost-effective drug control strategies. Recommendations should be based on progress toward outcome-based goals of prevention, treatment, and law enforcement efforts as they apply to individual drugs, their availability and consequences.
- ***Advance evaluation and accountability.*** The council should have access to the necessary data from state and local agencies to identify emerging trends in substance abuse, assess the performance of the drug control strategy, and report progress and problems to policy-makers and the public.
- ***Focus on youth.*** The statewide strategy should identify specific goals and objectives for reducing the alcohol and other drug abuse of youth.

The State Should Consider Eliminating OCJP

After examining the role of the Office of Criminal Justice Planning (OCJP) in this and previous studies, the Commission concludes that OCJP has consistently failed to exercise the leadership and policy-making role in criminal justice and delinquency prevention that was envisioned by the Legislature.

The number of criminal justice and juvenile delinquency-related programs the Legislature has awarded to other state departments in recent years suggests its loss of confidence in OCJP's ability to be an effective steward of public funds.

The Commission believes policy-makers should seriously consider whether this office should be eliminated and its functions distributed among existing and related entities, such as the Board of Corrections or the Department of Justice. The Commission intends to review the office and how these functions might be better performed.

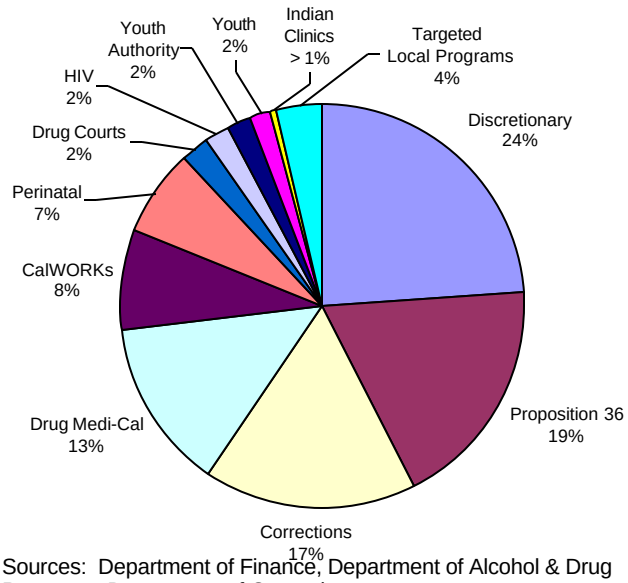
Finding 2: The State does not make the most of available resources by prioritizing treatment to serve those whose drug and alcohol abuse imposes the greatest consequences on Californians and their communities.

Communities currently do not have adequate resources to satisfy the demand for publicly-funded treatment, and so access to care has been

limited. Some of the choices have been made at the federal or state level, or directly by voters. But these choices have not been made after considering all of the needs and as a result, the allocation of scarce services is neither equitable nor rational.

Both the federal and state governments set aside funds for particular populations. In the 2001-02 budget year, for example, the federal government provided $268 million to California, of which $107 million, or 40 percent, was earmarked: $83 million for Medicaid clients, perinatal programs, HIV-infected clients, and the incarcerated. Another $24 million was allocated directly to counties and community-based organizations through one-time grants. The State then set aside another 6 percent of the federal allocation – $16 million – for youth treatment and drug testing of Proposition 36 clients.

State & Federal Funding for Treatment by Category 2001-02: Total $682 Million



Sources: Department of Finance, Department of Alcohol & Drug Programs, Department of Corrections.

Of the $414 million in State funds allocated during the same budget year, the State set aside $255 million (62 percent) for people who were arrested or incarcerated. Another $133 million (32 percent) was set aside for use by Medicaid, perinatal, CalWORKs and Indian Health Clinics. Only $26 million (6 percent) was unrestricted. Most counties use these limited unrestricted funds to provide treatment on a first come, first served basis.

While access to treatment has been greatly expanded for adults who have been arrested or incarcerated, most counties have dedicated very few resources to youth – whose addictions present a much more expensive long-term liability on public coffers. While perinatal programs are intended to protect the unborn and infants from exposure to alcohol and other drugs, foster care caseloads have swollen with children whose parents are addicted to drugs and do not have ready access to treatment.

Importantly, federal, state and local policy-makers have been putting some people in the front of the line for treatment – but those choices were not made by comprehensively examining who needs treatment, and then determining who will be served first.

Sacramento and San Francisco counties illustrate two different approaches to prioritizing caseloads. Sacramento County identified

which clients impose the greatest costs and consulted with community members about their priorities. The early benefits include improved relationships among social services agencies, a better use of existing resources, and the development of cooperative strategies.[9]

San Francisco's Treatment on Demand Planning Council identified 58 service needs, and then set priorities. The process was driven more by compromises than cost analysis, but it considered all of the needs and then the reality of limited resources.[10] Early results are promising: emergency room visits for substance abuse and deaths from heroin overdoses are declining.[11]

Limiting access to services is always difficult. The Commission believes the ultimate goal is for anyone seeking treatment to receive it. But in the near term, without periodic analyses of community and statewide needs and priorities, decision making is influenced by fleeting headlines and anecdotes rather than analyses that can maximize benefits.

Recommendation 2: Working with counties, the State should set broad goals for treatment programs and help counties to ensure that treatment is available to those whose substance abuse imposes the greatest harm on their communities. Specifically, the State should:

- ***Establish State goals.*** In setting goals, the State should assess the impact of abuse and addiction on health, social service, criminal justice and other public systems. The assessment should be designed to enable counties to assess their specific needs, document the consequences of addiction in their communities and target resources to clients posing the greatest social and financial costs. Clients that fit the criterion on harm might include:
  - ✓ Clients whose substance abuse results in physical and emotional abuse to others and increases the burden on other public programs such as foster care and corrections.
  - ✓ Youth with substance abuse problems or who are at high risk of abusing drugs or alcohol and need help breaking the generational cycle of abuse.
- ***Require counties to assess community needs and concerns.*** With State goals in mind, counties should be required as part of the annual funding process to document treatment needs and gaps and identify community resources. They should consider how available resources could be maximized to serve community members and align funding to meet local priorities and state goals. Counties should incorporate the assessment into budget and management decisions of other departments, including the siting of service providers.

- ***Shift resources to intervene earlier with substance abusers.*** State and community analyses need to consider how resources are spent on the continuum that includes prevention, treatment and enforcement to reduce abuse of alcohol and other drugs over the long term. In particular, prevention dollars need to be targeted to children with the highest risk factors for alcohol and drug use and other dangerous behaviors. County assessments should also be used by civic leaders to focus philanthropic and other private resources on effective treatment.

- ***Establish accountability for outcomes.*** The State should develop the means to measure outcomes, monitor and publicly report progress on state and community goals.

Finding 3: The State has not structured substance abuse treatment programs to provide a statewide basic level of quality or encourage continuous quality improvement.

While treatment can effectively help individuals change their lives, treatment programs are not always effective. Respected members of the medical and treatment community adamantly testified that the lack of quality controls diminished the benefits derived from available resources. One provider bluntly told the Commission that some providers were not competently administering treatment and suggested that the State needed to identify them and stop funding them. Another doctor suggested that quality needed to be systematically improved before funding is increased.

The tensions within the treatment profession over quality – and how to achieve it – are understandable. The profession has labored under a stigma held by many that addiction is nothing more than a lack of will power. Only in recent years have scientific researchers explained some of the biological aspects of addiction. And this information is helping to determine which treatment modalities are most effective with which clients, and how treatment can be more effective overall.

This growing knowledge of how to make treatment effective – and the growing consequences of addiction in California – require policy-makers, administrators and providers to agree on a strategy to ensure quality.

There are at least three opportunities to improve quality: ensuring a competent workforce, safe and supportive facilities, and the best available methodologies. But there are no qualifications required of counselors or program managers. The majority of treatment standards are included in county contracts with providers, resulting in variations in quality and effectiveness across the state. Without standards for

treatment programs, some providers employ unproven treatment practices and others do not faithfully replicate programs that have proven to be effective. Facility-related rules are limited to ensuring physical health and safety.

The Department of Alcohol and Drug Programs (ADP) oversees substance abuse treatment and prevention programs in California.[12] The Health and Safety Code charges the director with developing minimal statewide levels of quality provided by alcohol and other drug programs[13] This requirement involves setting standards for personnel, programs, and facilities providing alcohol and other drug abuse services.

But there are significant limitations on the director. The director must submit regulations to county program directors before adopting them. And the director does not have authority over treatment programs within the Department of Corrections.

Unfortunately, there is no agreed upon protocol for measuring quality. The profession relies primarily upon retention rates and length of stay in treatment to assess performance.[14] The National Institute of Medicine recommends the establishment of standard measures of quality, assessment of each care provider, and publication of comparative data to enable consumers to choose the best providers. It also recommends tying reimbursement levels to quality of treatment.[15]

As the primary purchaser of treatment services, the State has tremendous leverage to set quality standards and encourage providers to strive for continuous quality improvement by linking pay to performance.

Recommendation 3: The State should implement outcome-based quality control standards for treatment personnel, programs, and facilities and encourage continuous quality improvement. Specifically the State needs to:

- ***Define and enhance the director's authority.*** The director of ADP should be given clear authority to assess prevention and treatment efforts and advocate for high-quality treatment wherever it occurs, particularly in the Department of Corrections. Health and Safety Code Section 11835 should be revised to allow the director to establish regulations without approval from county administrators.
- ***Develop management tools.*** The State should accelerate the implementation of the California Outcomes Measurement System (CalOMS) to track the effectiveness of individual programs. ADP should establish an advisory board that includes stakeholders from all levels and areas of expertise to ensure the system will be an effective tool for consumers and providers, state and local administrators and policy-makers.

- ***Establish a strategy to develop a well-qualified workforce.*** ADP should ensure completion of an occupational analysis to establish knowledge, skills, abilities and other characteristics required of counselors and other key personnel. The department should establish a method for determining which candidates meet requirements. Requirements should be implemented gradually to allow incumbents to upgrade qualifications as necessary.

- ***Develop, promulgate and enforce treatment quality standards.*** The State should require counties to provide evidence-based treatments. The State should disseminate evidence-based best practices for each treatment modality. ADP should convene a group of providers, stakeholders, accrediting organizations and others to validate the goals of treatment, performance standards and outcome measures developed during the occupational analysis. The director should be required to report publicly on ineffective treatment programs.

- ***Tie provider reimbursement to outcomes.*** After establishing performance benchmarks and implementing CalOMS, the department should reward high-quality treatment providers with higher rates of reimbursement. Providers continually failing to meet specified outcomes should have their funding terminated.

- ***Ensure safe and suitable treatment facilities.*** The State should expand facility licensing to include outpatient facilities. An accreditation process similar to that used by the Joint Council on Accreditation of Hospital Organizations (JCAHO) or other accrediting organizations should be developed and implemented.

Improving Treatment in Prisons

Based on a pilot project that reduced recidivism, the State has expanded the use of therapeutic communities within prisons, and aftercare to those inmates when they are released. The Department of Corrections (CDC) now operates 8,500 in-prison beds at a cost of nearly $120 million a year.

But recent evaluations by UCLA show that the Department of Corrections is not faithfully replicating the pilot project. CDC's low-bid contracting rules preclude quality and prison administrators are putting inappropriate inmates in the program. The evaluators also concluded that CDC does not institutionally support the goals of treatment, frustrating the program in numerous ways. Steps can be taken:

- Restructure the contracting process to account for quality of treatment rather than lowest price.
- Specify in contracts the types of inmates who can participate in the program.
- Monitor and report return to custody rates resulting from continued addiction.
- Promote a drug-free prison system including drug testing of inmates and staff as suggested in previous Commission studies.

Finding 4: To be effective, substance abuse treatment must be coordinated and integrated with other social services to effectively reduce the social and financial costs of alcohol and drug abuse.

Treating someone's addiction without treating the contributing causes is akin to healing homeless pneumonia patients and sending them back into the winter cold. Recovery requires resolving the problems that cause or contribute to abuse.

While people from all walks of life and professional backgrounds become addicted to drugs and alcohol, those who seek help from the public system often have overlapping and related problems. According to ADP, 77 percent of public clients are unemployed and 39 percent do not have a high school education. Some 21 percent are homeless, and 8 percent also have a mental illness. Looking more broadly, UCLA researchers estimate that 75 percent of California's 360,000 homeless have substance abuse problems. And 50 percent of the mentally ill suffer from substance abuse.[16]

Recovering from addiction may require help with housing, education, job training, physical and mental health services, family counseling and legal assistance. As with treatment, eligibility rules for these programs are restrictive. And ultimately, clients may get some, but not all, of what they need to become healthy and self-reliant.

Benefits of Service Integration

- Addresses multiple needs to return clients to productive citizen status.
- Reduces or eliminates barriers to obtaining all needed services, particularly categorical funding.
- Supports families.
- Improves outcomes and reduces social service expenditures.

Two federally funded studies document the wide-ranging benefits of effective treatment in reducing drug use, medical visits, welfare dependency, homelessness, criminal activity and unemployment.[17] But to capture these benefits, the National Institute on Drug Abuse found that treatment must be linked with the other services that respond to the underlying causes of abuse.[18]

From its work on foster care, criminal justice and mental health, the Commission recognizes that integrating services is often held up as the Holy Grail of effectiveness. For more than 20 years, administrators and policy-makers have tried to weave together substance abuse, mental health, and social services.[19]

But public agencies struggle to overcome the regulatory, fiscal and cultural barriers that make it difficult to respond to a person's entanglement of needs. And incremental changes tend to add more categories for funding, more specific eligibility rules, and more complex accounting requirements. The resulting maze makes it difficult if not impossible to tailor needs to the individual, undermining the effectiveness of efforts to help children and families with a variety of challenges.

There are examples in California of public agencies or service providers overcoming the institutional obstacles. SHIELDS for Families, Inc. operates 17 programs that provide a continuum of services for families afflicted by substance abuse in south central Los Angeles. Besides help

with substance abuse, the Exodus residential treatment program offers transitional housing, on-site child care, parenting classes, mental health counseling, family counseling, prevention and early intervention for children, physical health assessments, vocational training and job placement assistance, transportation and aftercare services. To provide this one-stop shopping service for its clients, Shields will tap into 33 different public funding sources in its current fiscal year.

Because the State does not adequately coordinate its effort, the hard work of integration is either left to counties or individual providers. If counties or providers fail to take on the job, weaving together the necessary services for recovery is left to the client. If the client fails, the benefits of recovery are lost – along with the public investment in their recovery.

At a time of growing demands on the public system and declining resources, integrating already available public services to increase performance should be of the highest priority. At the very least, state agencies need to be responsive to valid suggestions from counties and providers on ways to reduce reporting and other paper-based obstacles to integration. In turn, counties can demonstrate leadership – as some already have – by mustering public and private resources in their community to meet the most crucial needs. Working together, counties – or the professional associations representing social service directors – could identify the incremental steps necessary to make it easier to integrate at the provider level and seek outside resources to develop skilled administrators and replicate proven strategies.

The teamwork demonstrated in implementing Proposition 36 shows that local and state agencies can work together to get the job done, and to systematically remove barriers to integrating services.

Los Angeles County Sheriff's Initiative

In November 2000, Los Angeles County Sheriff Leroy Baca established a Community Transition Unit to provide inmates who are military veterans with the educational, vocational, and other life skills needed to successfully reintegrate into the community. The unit has partnered with public and private community-based agencies. Before release, a discharge plan is developed for each inmate and contacts lined up in the community.

Early results are encouraging, including substantial initial reductions in recidivism rates. But the custody staff also reports a reduction of violence within the Community Transition Unit.

The unit provides a model beyond the custodial setting for making the most of available community resources to meet the multiple needs of clients.

Recommendation 4: The State should facilitate the integration of alcohol and drug treatment with other social services to effectively reduce abuse and related public costs. Ways to promote integration include:

- ***Replicate and reinforce success.*** The Health and Human Services Agency – or in its absence, the counties – needs to encourage the replication of successful integrated programs by documenting how they work, how they have navigated the system, and training other providers to do the same.
- ***Develop leaders.*** Given that most integration occurs at the hands of individual and inspired leaders, the State should work with counties, professional organizations and foundations to provide formal leadership development for agency managers and service providers.
- ***Create a process and a venue to facilitate change.*** ADP should develop a forum allowing for state and local government, treatment providers, educators and job trainers, mental health providers, and social services personnel to systematically identify and remove barriers to integration. Specifically:
  - ✓ They should identify ways to share data to understand demands on the system and to document performance.
  - ✓ They should identify which measures would most easily increase flexibility in funding, such as a waiver process or a single reporting format, and align funding for all social services with outcomes.
  - ✓ They should detail and prioritize regulatory and legislative changes necessary to streamline and integrate services.

While the State should take on this mission, the counties should do so on their own if necessary.

Finding 5: Even if the State integrated its drug control efforts and improved alcohol and drug treatment services, as presently funded, available treatment would be inadequate to respond to the costs and misery inflicted on California communities by substance abuse.

The State needs to make sure it is maximizing federal funds and can use those resources to improve outcomes and expand the availability of treatment. By providing a sufficient state match, for example, California could ensure that it draws down federal Healthy Families funds to serve those families mired in addiction. The Robert Wood Johnson Foundation has documented how other states have scrutinized their systems to make sure they were making the most of federal Medi-Cal dollars. And other states have sought waivers so that federal funds could be used more

effectively to respond to alcohol and other drug-related problems. Delaware, for example, has received a waiver to use federal foster care funds for alcohol and drug treatment of parents, potentially reducing foster care costs as well as alcohol and drug abuse.[20]

While publicly-funded providers can charge clients to pay for part of their treatment, few do – in part because of how the reimbursement system is structured and in part because there is no incentive to do so. While the goal should be to help those who need help, that goal will only be reached if services can be offered to those who want help. If clients can help pay for recovery or have insurance, those resources should be tapped.

Cost savings resulting from successful treatment also can be used to expand treatment. In Washington State, for example, the medical expenses for each welfare recipient completing substance abuse treatment declined by $900 a year. Those savings were used to increase treatment. Savings from treating rather than incarcerating Proposition 36 clients should also be transferred from the Department of Corrections to treatment. Annual savings could be as high as $20,000 per client.

As a large employer, the State could make sure the benefits it provides effectively respond to addiction – curtailing the problems within its ranks while providing a model to other large employers. Seventy-percent of all substance abusers are employed, and turnover among personnel is a major hidden cost to all employers. In 1996, the cost to employers nationally for absenteeism, lost productivity, accidents and medical claims due to drug abuse was $60 billion. Adding alcohol costs raises employers' ante to $140 billion.[21] Treatment reduces these costs to employers.[22] Demonstrating to the business community the costs of substance abuse and documenting how to effectively structure benefits to include drug and alcohol treatment has the potential to reduce abuse, help the economy and reduce the demand for public services.

Finally, at least half of the addiction problems imposed on Californians are the result of alcohol abuse.[23]

Alcohol is a particular threat to our children. One in ten youth is a binge drinker. Two-thirds of drinkers begin drinking between the ages of 12 and 17. It is not uncommon for the first drink to come before the 12th birthday. Even delaying the initial use of alcohol can reduce chemical dependency later in life.[24]

Alcohol abuse also is a common factor in violent crimes. For example, a review of people arrested for domestic violence in Sacramento County

revealed a heavy use of alcohol, and far more abuse of alcohol than illicit drugs.[25] Surveys of jail and prison inmates reveal that more violent crimes are committed under the influence of alcohol than illicit drugs.[26]

Alcohol abuse costs California close to $15 billion a year. Yet, with the exception of the penny-a-drink tax enacted by the Legislature in 1991, taxes on beer and distilled spirits have not been raised in more than three decades. New taxes are never popular. But in the same way that government imposes fees on polluters to pay for the public harm they cause, California should consider seeking reimbursement from alcohol producers to respond to the costs imposed by alcoholism, even if those costs are imposed by a minority of drinkers.

As described earlier, California should seize opportunities to reallocate money from less effective drug control efforts to treatment. Communities should set priorities to serve those imposing the greatest costs on society. The State should develop the quality controls that will ensure treatment dollars are well spent, and resources should be directed to the most effective providers. Savings yielded by improving the system should be reinvested in the system until much more of the demand for treatment can be satisfied. And when the treatment system can document it is working efficiently and effectively with all available resources, additional resources should be considered.

Recommendation 5: The State should immediately maximize available resources that can be applied to treatment. As the treatment system improves, the State also should consider new funding sources to provide more stable funding.

- ***Make the most of available federal funds.*** The State and counties should ensure that they are using all available matching funds to leverage federal dollars – including Medi-Cal, Early Periodic Screening, Detection and Treatment, State Children's Health Insurance Program, Social Security and Social Security Disability, and federal foster care funds. The State also should explore the possibility of a federal waiver on the use of Title IV-E foster care funds for alcohol and other drug treatment.
- ***Seek reimbursement from clients.*** The State should provide incentives to counties to seek reimbursement from clients based on their ability to pay for treatment.
- ***Reinvest in treatment.*** The State should reallocate cost savings from substance abuse treatment successes. Cost savings and cost avoidance figures should be used to guide transfers of funding from agencies with reduced demands to expand treatment opportunities.
- ***Expand private sector participation.*** The State should demonstrate to employers and private sector health insurers the benefits of

providing adequate coverage for alcohol and drug treatment. The State also should reform the Public Employees Retirement System treatment standard to create a model for employer-based benefits.

- ***Identify new sources of revenue.*** Once policy-makers are confident that resources devoted to treatment are being well spent, they should explore ways to generate revenue from the sale of alcoholic beverages to fund treatment, including increasing alcohol excise taxes or instituting a fee on beer and distilled spirits' producers to fund youth treatment.