

Blueprints for the States: Policies to Improve the Way States Organize and Deliver Alcohol and Drug Prevention and Treatment

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Financing

States could create “superfunds”, comprised of multiple funding streams for substance abuse treatment, early intervention and prevention and have this fund administered by a single state agency. Multi-year strategic funding plans should inform fund distributions. A single state agency could distribute funds to other state agencies with congruent missions, to regional behavioral health authorities, and to direct service providers with the capacity to programmatically support strategic plan objectives. This would allow for overall improved allocation processes, program coordination and leveraging of funding, and ultimately provide cost/benefit information, i.e., how much did it actually cost each state to generate treatment and prevention results.

Positive treatment outcomes should be tied to incentives, for both providers and clients, since providers have limited control over treatment outcomes. Vouchers appear to empower potential consumers of services. It is unclear how vouchers could be blended with public and private insurance, since many individuals are reluctant to inform their private insurers of their substance abuse treatment needs. Arizona data suggests that privately insured individuals in need of treatment do not enter treatment, and those that do, pay for their own treatment to mitigate the risk of having their insurance terminated when they switch jobs.

Essential support services should be based on each state’s criteria for eligibility for services.

Workforce Development

States need to collaborate with statewide economic councils, labor unions, state universities, colleges and for-profit technical schools to address labor pool

shortages in a coherent planning and implementation context. Ongoing workforce development programs need to be informed by national and statewide trends. Where dire labor pool shortages exist, individuals need to be offered incentives for entering certification programs, such as reduced tuition, equitable salaries, sign-on bonuses, etc.

Most states already have local and regional, if not statewide taxpayer-funded Information and Referral agencies that collect data on licensed providers and assist with referrals. In short, states are already playing a role by funding these efforts. If it were to the advantage of a state to refer clients to a list of its own preferred providers, a general rating system could be established by states, based on each provider's breadth and depth of services offered and consumer satisfaction findings. Client intake assessment data could then be matched with providers that best meet the cultural criteria and needs of a client. This matching approach could easily be achieved by any state-funded, local intake facility and would clearly support the voucher system instituted by some states.

Leadership

Recruitment from the treatment, prevention and advocacy sector appears to be a sound strategy, since provider systems serve as conduits between state funding agencies and consumers. Seasoned providers know how to leverage funds and also understand the cost burdens generated by excessive reporting and accountability requirements. Unlike career bureaucrats enmeshed in interdepartmental turf wars, leaders from the provider field are more likely to support reduction in paperwork burdens and dismantling inefficient bureaucratic obstructions that get in the way of improved service integration. Retention of dynamic and effective leadership could be achieved by providing flexibility, state-of-the-art leadership training, appropriate salary levels and performance incentives.

Governors have the responsibility to help develop, implement and monitor all statewide public health initiatives and programs, especially those programs funded with Federal block grant monies and state tax revenues. The appointment of 'czars' reporting to governors may be too narrow of a strategy, given that these positions wield too much centralized and discretionary power. Instead, independent, county-based commissions, representative of multiple, non-political sectors might engender a more fair deployment of resources to local communities. In Arizona, specifically in Tucson and Pima County, a city/county Commission on Addiction Treatment and Prevention informs elected officials on substance abuse treatment and prevention needs and trends.

Prevention

The current Substance Abuse and Mental Health Services Administration's (SAMHSA) State Prevention Framework State Incentive Grants (SPF SIG) funding across the Nation appears promising. It is encouraging states to establish a baseline of prevailing needs and trends related to prevention. Further, it guides states in a review process of statewide strategies that lend themselves to adaptation and implementation - to ultimately mitigate risk factors among targeted groups. In October 2004, the Arizona Governor's Office for Substance Abuse Policy received a SPF SIG from SAMHSA's Center for Substance Abuse Prevention (CSAP). The Arizona SPF SIG project formed an Advisory Council made up of representatives from agencies and organizations that comprise the main elements of Arizona's substance abuse prevention infrastructure. The Advisory Council has met on four occasions to advise the project. Under the project, a State Epidemiological Workgroup (SEW) was formed that included epidemiologists, researchers, and agency representatives. The SEW conducted an epidemiological study of substance abuse indicators in order to determine the worst substance abuse problems in terms of consumption and consequences, which populations are most affected by the problems, and geographic areas most affected. The study was issued as an *Epidemiological Profile and Problem Areas* for 2005. The project used findings from the State Epidemiological Profile to develop a draft State Strategic Plan to improve the state's substance abuse prevention infrastructure at the state and community level, and to prevent and reduce substance abuse. This plan is currently under review by CSAP. The Arizona SPF SIG includes the Underage Drinking Prevention Task Force, which is beginning to implement a statewide initiative for the prevention of underage drinking. In late March of 2006, the initiative will begin with teen town halls to hold inclusive dialogues with adolescent stakeholders.

Second, the Synar Amendment has been a sound strategy to hold states like Arizona responsible for consistent decreases in tobacco sales to minors. Since the implementation of Synar, Arizona's tobacco sales to minors have fallen below the allowable margin of 20 percent to 8.3 percent, according to confirmed test-buy data collected by our organization on behalf of the Arizona Department of Health Services. This is especially significant for Arizona, which reported a 56 percent sales rate to minors in 1997. Since alcohol sales to minors in Arizona are estimated to account for 10 percent of all sales by the Arizona beverage industry, a similar amendment for holding states responsible for decreased alcohol sales to minors would likely generate similar, favorable outcomes.

Third, in terms of financing alcohol prevention and treatment activities statewide, costs could be borne entirely by all consumers of alcohol through substantial "sin tax" levies. The current taxing of alcohol production and sales has been static for 30-40 years, while treatment costs have accelerated each decade. Given that 90 percent of all alcohol is consumed by 10 percent of the entire drinking public, heavy drinkers could thus financially support their eventual treatment.

Specifically, tax initiatives like “a dime a drink” puts the cost burden for prevention and treatment on all drinkers and doesn’t penalize non-drinkers, who will never enter alcohol treatment. In Arizona, the Legislature has pre-empted municipalities and counties from levying a sin tax on alcohol although it is well known that alcohol availability and discount pricing are two variables that promote youth use. In Pima County, Arizona, onset of use among children is estimated @ 12.2 years versus 13 years nationally and elsewhere in the State. Accelerated test-buying by teens, monitored by designated agencies contracted with state departments of health services, coupled with significant price increases for alcohol in the form of taxation, would likely generate similar outcomes to those achieved by the aggressive tobacco control strategies in Arizona.

Fourth, the allocation of taxpayer dollars for substance abuse prevention activities to state agencies like the National Guard and faith-based organizations should be discontinued. Specifically, taxpayer revenues to the National Guard appear incongruent with the Guard’s mission and intent, although it may be arguable that the Guard should be more involved in drug interdiction activities particularly in border states like Arizona. Prevention funds should be solely disbursed among local and statewide substance abuse prevention coalitions and providers. Since faith-based organizations already receive 1/3rd of all philanthropic dollars generated on a per state basis, their proliferation in state and Federal funding arenas has increased field competition for funding and further minimized collaboration between agencies with congruent missions. Also, it is unclear whether or not the awarding of taxpayer funds to faith-based organizations is constitutional, since operating funds are used by faith-based organizations to pursue their non-secular missions.

Fifth, substantial reductions in statewide DUIs could be accomplished by suspending the driver’s licenses of all licensed drivers in a vehicle, in which a driver was stopped and convicted for DUI. Penalizing each person in the vehicle was successfully instituted in Germany decades ago and has modified the norm of drinking and driving to drinking and hailing a cab.

Finally, developing and retaining dynamic leadership in the prevention arena on the state level appears politically challenging, if prevention leadership is to help surmount the ancillary problems generated by current Federal and state drug policies. For example, current policies related to drug-related incarceration in Arizona has not only stretched the capacity of local prisons (the Phoenix/Maricopa County Jail was running @ 176 percent capacity in 2004) it has also helped spawn a new culture of children of prisoners in Arizona. The 59,000 children of current prisoners in Arizona are seven times more likely to end up in prison themselves than children of non-incarcerated parents. Additional difficulties exist for prevention leaders, regardless of the communities of interest they represent. As evidenced in Arizona, voter-driven change in statewide drug policies not aligned with Federal drug policies is subject to Federal pre-emption. The medical marijuana use proposition, passed by a voter referendum in

Arizona, was nullified by the Federal government, shortly after its passage. Based on this example, it appears that state prevention leaders are challenged to mediate voter preference in the face of contrary Federal policies. Unless enough stakeholder involvement can generate the political will to challenge Federal drug policies at the Supreme Court level, state voter preference exercised in a democratic political context will remain moot.

Measurement issues

Treatment Services: The current approach for measuring treatment outcomes is limited and focused on “fixing one person at a time”, without taking family and community contexts into consideration. Levels of family functioning and community conditions that help sustain sobriety of the treated individual should play a role in measuring treatment outcomes. Without including these indicators in a treatment context, treated individuals return to dysfunctional families and disorganized neighborhoods with a lessened chance of maintaining sobriety.

Prevention Services: In prevention, the use of the individual as the unit of analysis appears limiting, since universal prevention seeks to maintain and promote non-use among groups and communities. Unfortunately, Federal and state applications of prescriptive, evidence-based practice models has resulted in a deluge of early intervention programs that have little to do with prevention. The unit of analysis for prevention is best achieved by measuring changing community conditions within cultural contexts. Many communities, including Tucson, Arizona, issue annual Community Report Cards that review a change in community-wide indicators. The extent to which these community indicators play a role in informing statewide policy decisions related to the re-alignment of funding streams, the development of new strategic programs and the elimination of ineffectual programs on state levels will likely bear out with the implementation of the SAMHSA SPF SIG on a per state basis.

The culture of the current research and evaluation community has not provided sufficient leadership in the prevention arena to shift the unit of analysis from the individual to community conditions. This may be due to the fact that most of the current evidence-based programs were designed and are marketed nationally by the prevention research community. This community of researchers has an obvious financial interest in the sale its “best practices” models to providers. Further, this research community has in fact dominated and cornered the prevention research and evaluation arena to such an extent that state and Federal funding agencies now disallow any community-driven approaches not considered evidence-based, promising or best practice. These constrictions have forced taxpayer-funded providers to adapt “canned” curriculums from Federally or state-approved lists. It is obvious that these current measures have greatly diminished innovation and flexibility in the field of prevention and community development.