

Little Hoover Commission

Alcohol and Drug Review

Thursday, August 23, 2007

**TESTIMONY OF ELIZABETH STANLEY-SALAZAR, M.P.H., VICE-PRESIDENT AND
DIRECTOR OF PUBLIC POLICY AND ADOLESCENT SERVICES OF PHOENIX HOUSES
LOS ANGELES**

Thank you for the opportunity to present a provider perspective on the challenges facing those agencies, leaders, clinicians, volunteers and advocates committed to the reduction of alcohol and drug problems and impact of these on our communities and the wellbeing of families and children in California. I have been privileged to work for Phoenix Houses of California for the past 12 years, supporting the Phoenix House mission to reclaim disordered lives, provide innovative leadership to the behavioral health field, and to engage families, strengthen communities, and safeguard public health. Phoenix House achieves its mission through the delivery of a range of treatment interventions, embracing new science, pursuing research and adapting promising and best practices in the prevention of substance abuse, and the treatment of addiction and co-occurring disorders. This year Phoenix House celebrates its 40th Anniversary – operating more than 100 programs in nine states – and we proudly provide services for more than 6,000 men, women, and adolescents each day at outpatient and residential centers, in community and correctional settings.

Phoenix House, along with many committed community-based non-profit organizations in California, is faced with growing challenges to sustain our mission, goals and service delivery. We exist and work in an under-funded, under-resourced, volatile and annually unpredictable public business environment. We must respond to workforce shortages; rising costs of employee benefits; rising property, utility and gasoline costs; zoning challenges and local hostility toward the location of our services; antiquated and poorly constructed government requests for proposal and contracts with little or no shared risk or incentives; fragmented regulations; and increasing accountability for data collection and documented outcomes with no additional resources. Of particular concern is the lack of vision and policy direction for our field experienced in the repeated failure to formulate a coordinate a meaningful multi-system state plan – complete an analysis – make recommendations – enact and chapter legislation as requested not only by the Little Hoover Commission, but also year-in and year-out by the Legislative

Analyst Office since 1999 when it published its report *Substance Abuse Treatment in California: Services Are Cost Effective to Society*, outlining the cost effectiveness of substance abuse treatment and the gaps in service.

Phoenix House

In California Phoenix House operates a continuum of prevention, education, information and referral, screening and assessment, outpatient and residential services in San Diego, Los Angeles, and Orange Counties for more than 2,200 adults, women and children and adolescents each day. These programs include: two adult residential programs with a capacity to serve 139 clients (Venice and Santa Ana); two women's and children's programs serving 91 (Sante Fe Springs and Monrovia); three adolescent treatment centers with capacity to serve 235 clients (Descanso, Lake View Terrace and Santa Ana); and three community-based sober living centers for men and women (Venice, Monrovia, and Anaheim). In San Diego we provide in custody treatment services for 100 youth at the Juvenile Ranch Detention Facility in Campo and re-entry services for 60 youth probationers in the community. Additionally, Phoenix House provides in custody programs in three prisons in the Central Valley serving 950 inmates daily, and a jail-based treatment program at Orange County Theo Lacy Jail for 64 inmates. All of our programs provide aftercare and/or referrals for continuing care. Within each county, we work closely with probation, substance abuse and mental health, and child welfare departments, schools, and many other local organizations to meet the diverse and complex needs of individuals, families and communities served by our organization. Our most recent grant is a partnership with the Department of Juvenile Justice for Re-Entry Services in Orange and Los Angeles Counties.

Phoenix House has been one of the few providers of residential substance abuse treatment services for adolescents licensed by the Department of Social Services and certified by the California Department of Alcohol and Drug Programs. For over 20 years we have developed a range of adolescent programs with the support of the most up-to-date literature and research integrating mental health services into a unique program for co-occurring disorders at our Los Angeles Academy, certified by the State Department of Mental Health and under contract with the Los Angeles Department of Mental Health. Our Academies are recognized by Office of Juvenile Justice and Delinquency Prevention as a Model Residential Program for juvenile delinquents. Additionally, Phoenix Academy of Los Angeles was included in *Bridging the Gap: a Guide to Drug Treatment in the Juvenile Justice System* by Drug Strategies in 2005. Based on our success and program design in California we have opened programs in

Texas and Florida. Successful outcome data from our San Diego ACCESS program has been reported at the annual Center for Substance Abuse Treatment Adolescent Conferences. The RAND Corporation is currently tabulating and reporting results of data collected over the past four years on the components and dimensions of behavioral change in our residential programs.

California System of Alcohol and Drug Programs

On any given day there are over 150,000 individuals in publicly funded substance abuse treatment services under the auspices of the Department of Alcohol and Drug Programs. Countless others are impacted by the prevention, education, intervention and recovery support services provided throughout the local continuum of care. This is no small accomplishment given the nature and pervasiveness of the problems associated with alcohol and drug use and abuse in our communities and the limited funding available to the Department of Alcohol & Drug Programs and its county partners. The good news is that treatment access and capacity was significantly increased for adult offenders with the passage of the Substance Abuse and Crime Prevention Act of 2000 - Proposition 36 (SACPA). The state has expanded adult drug courts statewide albeit without sufficient funds for adequate treatment services. The Mental Health Services Act of 2004 – Proposition 63 created new and sustainable funding for individuals with mental illness with a commitment to address co-occurring disorders.

The bad news - today our leaders are engaged in a budget stalemate that not only further reduces the proposed \$4.7 million net decrease (compared to the 2006-07 budget) in the DADP budget, the plan under discussion further reduces funding for the combined SACPA and Offender Treatment Program (OTP) by \$50 million. By the time of the Commission's August Hearing the debate may be over and funds restored; however, the volatility of these debates dramatically impact the system of care, essentially placing the counties and providers in limbo, undercutting system and organizational stability, and workforce, program and system development. The alcohol and drug field and the Legislature stand \$125 million apart in the amount needed to address treatment and supervision mandates. A survey on unmet needs conducted. Earlier this year by County Alcohol & Drug Program Administrators Association of California identified the SACPA/OTP funding needed for the fiscal year beginning July 1, 2007 at \$265 million. The projected shortfall for the 2007-08 fiscal year is approximately \$95 million for treatment only and an additional and projected \$25 million needed for

supervision by Probation, as well as the \$25 million for OTP. The sheer madness of this debate is that it occurs while more and more funds are diverted to address the prison overcrowding crisis and demand for rehabilitative services for inmates and parolees. The SACPA/OTP alternative to incarceration option for non-violent drug offenders reduces the need for space in California's chronically overcrowded prison system, particularly if delivered to those appropriately screened and assessed for appropriate levels of care. Furthermore, treatment reduces costs to other public systems reunifying families and reducing costs foster care.

In addition to reviewing the implementation of Proposition 36, the Little Hoover Commission developed a set of five recommendations for how the State could improve access to treatment, system accountability, service quality and the measurement of outcomes in its 2003 report, *For Our Health & Safety: Joining Forces to Defeat Addiction*. The findings and recommendations of the report clearly articulated that expensive and disturbing social problems can be traced directly to alcohol and drug dependence and that if managed and supported correctly alcohol and drug treatment is a cost-effective response to reducing the burden of these problems on the multiple safety net systems, as well as improving individual, family and community safety, health and well-being. The report brought attention to the need for leadership, planning, investment, quality improvements to the infrastructure, and cross-system responses and coordination. The Commission recognized the critical importance of investment in services for youth, particularly high risk youth in foster care, juvenile and mental health systems. Most importantly the Commission found that *as presently funding the available treatment was inadequate to meet the needs and demands for intervention*. The Commission called for a strategic review and plan that would identify opportunities to maximize and leverage all available funds and increase private sector funding for alcohol and drug treatment, as well as consider appropriate tax increases or diversions.

In 2003, the Department of Alcohol and Drug Programs was in the second full year of the implementation and operation of the Substance Abuse Crime Prevention Act of 2000, creating an environment of energy and excitement. The annual investment of \$120 million starting in 2001, had allowed counties to establish coordinated partnerships and linkages with the courts, probation and law enforcement, as well as expand the quantity and quality of treatment services and network capacity. Data management systems were designed and implemented locally supported by first year funding.

As we examine the impact of the 2003 report four years later, significant barriers to the successful implementation of the Commission's five recommendations remain. The environment has become significantly more challenging for government agencies charged with the responsibility for impacting alcohol and drug problems, as well as for those non-profit and private agencies providing services to our communities. While progress has been made in several areas considered by the Commission, infrastructure changes have been slow and limited. All of the changes have occurred within the same regulatory and funding constraints that existed in 2002 reported during the hearings and committees that were held to develop the Commission's 2003 report. Structural and legislative changes that are necessary for a coordinated strategic response by the State Department of Alcohol and Drug Programs have not occurred. New outcome data requirements, system upgrades, regulations for certification of the workforce, and demand for new clinical technologies and evidenced-based practices have not been financially supported. Each year it becomes more difficult to sustain and maintain the quality and infrastructure of services at all levels of the network of services – the safety net of voluntary services has been eroded by a shift to mandated treatment.

Leadership and Coordinated Strategic Planning

While DADP convenes several councils (Director's Advisory Council) and dedicated advisory boards (Governors Prevention Council, Co-Occurring Joint Action Committee), these councils do not meet the thresholds of purpose, scope or authority recommended by the Commission for a *California Coordinating Council on Alcohol and Drug Control Strategy*. At the time of the Commission's report, the Statewide Advisory Group (SAG) had been established to meet the requirements of the SACPA. The SAG brought together treatment, probation, the judiciary, and law enforcement leaders in a collaborative effort to guide the implementation of treatment and supervision services for the offenders eligible for treatment in lieu of incarceration under SACPA. A critical responsibility of the SAG was to guide the mandated evaluation of the effectiveness of these programs and to advise the DADP on policy and procedural issues related to implementation. For five years, programs funded under proposition 36 have been subject to regular and rigorous evaluation. This advisory group did meet many of the strategy and coordinating goals recommended by the Commission, creating system linkage and joint efforts that coordinated services, funding and data management across multiple systems, albeit narrowly focused on services delivered to the eligible population vs. the system of care.

Unfortunately, the ballot initiative allowed for the sunset of the mandated funding and the rest is history. We are now in the second year of creation of a second parallel initiative with the same target population but different approaches and sanctions with the cloud of a legal battle hanging over both initiatives. Parallel initiatives not only raises the question of how much to fund each; but also, divert administrative resources, create discord amongst partners, prevent collaboration, create an unstable service environment and ultimately undermine the treatment goals of the original ballot initiative. In this highly charged political and fiscally challenged environment, we are now engaged in an annual debate not only of the effectiveness of the program but also continuation of these treatment services. Proposition 36 has changed the sentencing laws in California increasing treatment capacity and workforce thus increasing access to treatment. The grave jeopardy is that in expanding service capacity, these funds are now calculated in the federally mandated maintenance of effort required to secure and maintain Substance Abuse Prevention and Treatment Block Grant funds. While this may be an appropriate leveraging of federal funds, each year for the past five the budget has teetered on the margin of the maintenance of effort requirements.

Accountability and Outcomes

The State Department of Alcohol and Drug Programs effectively tracks its expenditures which are primarily administered through the counties. The Department and counties are closer to tracking and monitoring the results of its services and activities and making these reports available system wide. DADP implemented a statewide reporting system in January 2006 to collect treatment admission and discharge data from counties and providers that receive funding from the Department. The data includes the National Outcome Measures (NOMs) created by the Substance Abuse and Mental Health Services Administration (SAMSHA), as well as additional indicators chosen by the Department to measure and improve treatment outcomes. Today you can find CalOMS reports posted on the DADP web page which contains prevention client and provider outputs from all counties. While there has been progress made in the design and data input for the treatment system, reports are not yet available. These changes have been made to meet federal requirements and counties have had to design, implement and sustain these changes with no increase resources at the county level.

Delivery of Youth Treatment

Despite the Commission's recommendation prioritizing the development of a strategy for addiction treatment for youth, this area which affects health, mental health and education and ultimately juvenile and adult corrections as youth age out of the juvenile system untreated, is still virtually ignored by our state agencies and leaders. There is not an adequate network of services for youth involved with alcohol or other drug abuse throughout the state and that only 1 in 13 youth who need treatment receive services. In the past year the Administration has declined several opportunities to begin to address this treatment gap - its own 2007-08 budget proposal, the Medi-Cal State Plan, Senate Bill 1299, nor continuation or expansion of funding for the California Access to Recovery Effort (CARE). CARE, the federal Access to Recovery pilot project, provided access to services for 4,670 youth in Sacramento and Los Angeles over a two year period. The Legislative Budget Committees have also not seen fit to include this issue on their agendas despite the efforts of many provider groups and agencies.

Drug abuse has increasingly come to be recognized as a defining characteristic of society's most troubled and troublesome teens. These are boys and girls who rarely have much family support, who lives at or below the poverty level, who often drop out of school, and for whom available social services traditionally provide no safety net. Often they end up in foster care or the juvenile justice system, neither of which is equipped to alter the downward spiral of their lives.

The majority of these indigent youth face barriers to services, lack adequate access to substance abuse treatment and community mental health resources, and the present waiting list for available slots in residential treatment is long. Most adolescents do not receive services until their conduct disorder and life style graduate to the juvenile justice system.

In its 2006 Annual Scorecard, the Los Angeles Children's Planning Council reported there are 1,269,009 youth ages 10-17 living in Los Angeles – all trends predict continued population growth. During the same period the Los Angeles Juvenile Court reported that over 60,000 of these youth cycled through the world's largest juvenile court and probation system. The link between juvenile crime and substance abuse and the cost effectiveness of treatment is well documented. In fact, The RAND Corporation conducted an outcome evaluation of Phoenix Academy residents over a three year

period and found that outcomes improved significantly for those adolescents who received treatment at the Phoenix Academy as compared to those who did not. Sadly, because of a lack of funding, a small percentage of the youth in LA who would benefit from long-term residential treatment have an opportunity to receive such treatment.

In 2006, the Senate Select Committee on Methamphetamine Abuse brought to light the impact of the production, distribution and abuse of methamphetamine on public health and the juvenile and criminal justice systems. Methamphetamine, followed by the growing abuse of internet ordered prescription psychotropic medications are now considered the most significant drug threats in the state and the availability and use among adolescents has increased significantly. Among adolescents admitted to Phoenix Academy of Los Angeles, self-reported use of methamphetamines has increased from 22% two years ago to over 60% in the past six months. Funds have not been identified, leveraged, redirected nor prioritized to address the prevention and treatment gaps for adolescents in Los Angeles or statewide. The work of this committee initiated a commitment of funds to a methamphetamine public service campaign in 2006 which resulted in recent publication and distribution of more than 5,000 copies of *Methamphetamine Treatment: A Practitioner's Reference*. The 74-page guide is the most comprehensive collection of research and best practices, to date, on the issue of methamphetamine treatment.

Continuous Quality Improvement

The existing system of care was built for a fraction of the current clients at a fraction of the acuity. Contributing to providers' inability to keep pace with the need and demand for service is the extremely limited authority of the State's Department of Alcohol and Drug Programs (DADP). An agency that was created primarily for oversight of the Federal Substance Abuse Prevention and Treatment Block Grant to our Counties, DADP has not been in the position to develop the infrastructure (particularly in terms of capacity expansion and workforce development), conduct the strategic planning, or drive the legislation and regulation necessary to create a modern and comprehensive treatment system throughout the state. The system is additionally challenged by the need and demand to rapidly create community-based alternatives and re-entry services for offenders and parolees in response to the prison overcrowding crisis.

The current regulations governing the standards for licensing and certification are outdated and do not reflect the state of the art in knowledge and best practices in the alcohol and drug field, nor corrections re-entry services. Although many attempts have been made to convene workgroups and achieve consensus related to these issues, overall the Department of Alcohol and Drug Programs has been unable to develop or implement innovations, program designs, competencies, approaches or standards. We have yet to achieve a statewide threshold of quality nor encourage or establish continuous quality improvement. Decisions for appropriate uniform screening, assessment and client service matching are decentralized to counties and funding support does not exist. Certification for outpatient services is voluntary and there are no set standards for outpatient programs, which make up 70 percent of the treatment opportunities. While there are limited standards for residential programs, with the greatest emphasis on health and safety, not treatment best practices or recovery management

The State Department of Alcohol and Drug Programs (ADP) has taken a major step toward improving the delivery of AOD prevention and treatment services by establishing the Continuum of Services System Re-engineering Taskforce (COSSR). The goal of the COSSR is the development of an effective continuum of services, based on the defining principle that AOD problems are transient, severe and persistent, similar to other chronic diseases that need to be managed.; however, there are no funds available to support the recommended system modifications. The treatment industry would be well served by the State Department of Alcohol and Drug Programs setting *uniform, relevant and specific* treatment standards to reduce the dissonance between these mainly voluntary and somewhat arbitrarily applied systems; and creating a common data system that eliminates the fragmentation, duplication, and gaps within the current system.

Workforce Development

Efforts to regulate or even set minimum standards for treatment personnel are complicated by the history of treatment. While some counselors have advanced degrees and are licensed in related fields, others start as peer counselors who are in recovery themselves and use their experience to support others. In order to work as a counselor in an alcohol and other drug (AOD) treatment program, individuals are currently required to be certified by one of ten certifying organizations. The regulations require all certifying organizations to become accredited by the National Commission for Certifying

Agencies (NCCA) by April 1, 2007 in order to continue certifying AOD counselors. This regulatory action will amend Section 13035(b) and (c) by extending the date by which certifying organizations must be accredited by NCCA to September 30, 2007. The department in developing these regulations has been forced to find consensus and compromise between competing associations representing different approaches, interests and staff competencies. Without single state agency administration and management the process-based certification for counselors is complicated and burdensome. The approach to date has not squarely identified the key issue: the knowledge, skills, and competencies required of counselors to maximize recovery and outcomes for clients. Compounded by the fact that DADP has not yet defined the standards and outcomes to be achieved by treatment programs, and the methods of achieving these outcomes, it would be difficult to identify the attributes that staff should have or determine the best way to ensure that staff have those attributes.

For every two counselors that leave the field, only one is hired back to fill the vacancy. A contributing factor is the state's wage scale based on current public funding levels. Agencies and employers are unable to pay the wages necessary to deliver these services. In addition, human service programs and corrections programs as well as any government or private agency have more resources attract employees by offering greater salaries and benefits, thus depleting the ranks of AOD counselors.

Insufficient funding for public programs leads to inadequate wage levels at many agencies. Counselors earn approximately \$20,000 to \$23,000 annually which is well below current labor market rates for professionals with similar qualifications. At these wage levels, employers are unable to retain qualified workers. Many providers are unable to increase wages because public funding has been kept at a static level for the past fifteen years. Additionally, the field's workforce is aging much like what is seen in other areas. The difference is the replacement is slow or not at all because of low wages. Retirement of experienced employees leads to loss of historical knowledge and ability to train new employees adequately.

In the past, publicly funded alcohol and drug abuse programs largely relied on a highly motivated, paraprofessional, and often voluntary, workforce to deliver services. This workforce often consisted of people in recovery who were motivated to enter the field in the tradition of "giving back" and whose counseling skills were based on their own experiences in recovery. Recent advances in our

understanding of addictions and its effective treatment now have placed a greater demand for advanced training on staff entering the field. Staff in the addictions field at any level must now obtain substantial formal education prior to entering the field and they must stay abreast of recent advances through continuing education. For individuals to obtain this level of preparation and to maintain it requires a substantial personal and financial commitment. Unfortunately, public funding levels for alcohol and drug abuse programs were largely established when a non-professional workforce was the norm; these funding levels with their associated levels of workforce compensation have remained static for decades. As a result those motivated to work in the helping professions who have invested their time and financial resources to develop their knowledge and counseling skills do not perceive the addictions field as offering rewarding careers. The field is not only failing to attract skilled, career minded, human service professionals, it is also losing its current workforce to other health and human service fields where overall compensation and avenues for advancement are higher.

Driving up overall payroll, the cost of doing business continues to rise every year. Wages however small, as well as costs for health benefits, general and professional liability coverage have all gone up. Substance abuse treatment is a form of healthcare with significant rising costs like other forms of healthcare. Quality care does require a commitment of sufficient funds to cover these basic costs. Substance abuse treatment is the integral part of health care delivery and the delivery of chronic care model system. Substance abuse has not been incorporated in health care delivery costs or in employee compensation package, and health care packages. The new state certification standards have raised the bar in terms of counselor qualifications but funding levels have not risen to match the higher level of skill and training thus, the gap between professional preparation and salary levels discourages individuals from pursuing substance abuse counseling as a career choice and creates an ever expanding workforce gap.

A single certifying agency, such as ADP, with the objectivity and authority to oversee certification is necessary at this time in order to properly manage the current state regulations. The organizations which now act as certifying bodies are actually education organizations and should stay focused on their primary purpose as an educational resource for the field of substance abuse. Unfortunately, the current system of multiple certifying bodies is riddled with fragmentation, inefficiencies, and mismanagement so as to lack public and provider confidence.

In order to address these workforce issues, an occupational analysis specifying how people can attain the required knowledge, skills, abilities, and other characteristics, is needed to establish a career ladder that will counteract high turnover rates, low wages, and low public recognition for the field. An analysis and strategic plan would address client to counselor ratios, compensation levels, and turnover rates of over fifty percent statewide. Occupational fields with undetermined qualifications, low wages, and high turnover generally are not regarded highly by the public. This factor exacerbates already high turnover. The fact that many counselors and some program managers are persons in recovery adds to the public's low esteem for the field, whether warranted or not the lack of standards for key treatment program personnel means that program quality is a function of chance. Those programs that manage to find and keep good leadership excel.

Recommendations

Untreated substance abuse imposes significant human and financial costs on the community and state government. It impacts health costs, overuse of emergency services, auto and workplace accidents, jail and prison overcrowding, increased public safety and foster care costs. In fact, untreated substance abuse increases the burden on an overburdened state and local police, court, correctional, health and social systems across the board. In contrast, it has been demonstrated time after time that substance abuse treatment reduces these costs significantly. For adolescents untreated substance abuse erodes educational productivity which then requires vocational rehabilitation; it degrades workforce productivity and safety; and it complicates mental health and medical treatment. Our field is supported by an ever growing body of evidence of the cost effectiveness of prevention and treatment, and a greater scientific understanding of the causes, underlying factors and appropriate interventions and approaches for specific populations and settings. There are also a growing number of promising and evidenced based practices available with the capacity for technology transfer and adaptation and implementation. Many states are employing innovative practice to address the causes and consequences of substance abuse and the National Institutes as well as the National Governor's Association tracks trends and practices providing technical assistance to states, local governments and agencies. California needs a blueprint to respond to what is a public health problem impacting multiple public systems. Gaps in treatment services can be addressed, access increased and barriers removed statewide. This will require

vision, leadership and investment services and infrastructure. Positions the Little Hoover Commission might take that would address a majority of the barriers facing treatment providers include:

- Recommending support for policies and program development that recognize the chronic nature of substance abuse and addiction.
- Recommending the creation of a cabinet-level position for Alcohol and Other Drug Issues in the Governor's Office and reconvening of the Governor's Interagency Council on Substance Abuse.
- Proposing expanding the mandate of the State Department of Alcohol and Drug Programs to a significantly more active role, allowing for policy leadership and such changes as the setting of uniform, relevant, and specific treatment standards to which all publicly funded providers would be required to adhere and the authority to provide direct and meaningful oversight, along with the data collection required to evaluate and maintain continuous quality improvement efforts and review the existing regulations
- Urging revision to the Health and Safety Code that would eliminate its outdated and conflicting language; support empirically based, effective treatment services; and create an infrastructure that will support capacity growth.
- Recommending increased funding for treatment services beyond the Federal Block Grant and limited corrections-based initiatives – particularly funding that will help maximize targeted federal funds, promote the “no wrong door” concept of treatment¹, and assist with providers' efforts for workforce development.
- Supporting efforts to make sure that the treatment Californians receive ensures their likelihood of success. Funding for all treatment initiatives must ensure that the treatment provided follows research-driven, “best practices” methodology. Examples include mandating continuing care in the community for parolees who have received treatment in prison, ensuring that funding for continuing care – from all programs – includes monitoring and support for relapse prevention and recovery management, and fighting the managed-care-driven reductions in lengths of stay.
- Promoting the building of a system of care for adolescent treatment in the State that would ensure the elimination of the policies that have created the counterproductive operating conditions for youth treatment described above. Examples include working with the state foster care system to increase their recognition of substance abuse practitioners in the rate classification structure to ensure appropriate reimbursement for the expert services they provide.
- Obtaining and analyzing employment and wage data for the substance abuse field when considering future funding proposals for public substance abuse programs in order to ensure that the public investment, along with expectations for positive

outcomes, can be realized. An occupational analysis could define the outcomes to be achieved and the methods of achieving these outcomes. Using this information, ADP could identify the knowledge, skills, abilities, and other characteristics personnel should have and a performance-oriented test to measure these attributes.

- Recommending the creation of a single certifying agency with the objectivity and authority to oversee certification is necessary at this time in order to properly manage the current state regulations.

Despite many obstacles and challenges, the amount that has been accomplished by the treatment community in the past decade is remarkable – reducing substance abuse, crime, recidivism, and a number of other societal ills. More can be done. With leadership, funding, and a commitment equal to the magnitude and impact of the problem, treatment agencies will have the tools they need to meet our societal mandates and significantly reduce substance abuse and its effects throughout the State.

Elizabeth Stanley-Salazar, M.P.H.
Vice President, Director of Public Policy and
Adolescent Treatment Services in Los Angeles
Phoenix Houses of California
11600 Eldridge Avenue
Lake View Terrace, CA 91342
818.686-3015
818.896.4859 fax
lsalazar@phoenixhouse.org