



Connecticut Association of Addiction Professionals

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340308
Hartford, CT 06134
Phone: (860)509-7590
Fax: (860)707-1983
e-mail: Karen.Wilson@ct.gov
c/Chris Andresen, Section Chief of the DPH Licensing Division

8/12/17

**RE: Scope of Practice Review information for proposed legislation regarding change in language contained in CT Statutes-
*Alcohol and Drug Counselors, Chapter 376, Section 20-745 (4).***

Note: The proposed language changes **does not affect the new scope of practice** contained in Governor Malloy's 2016 Omnibus Legislation on Opioid Abuse:

Sec. 6. Subdivision (4) of subsection (a) of section 20-745 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2016):(4) "Practice of alcohol and drug counseling"..., and may include, as appropriate, (A) conducting a substance use disorder screening or psychosocial history evaluation of an individual to document the individual's use of drugs prescribed for pain, other prescribed drugs, illegal drugs and alcohol to determine the individual's risk for substance abuse, (B) developing a preliminary diagnosis for the individual based on such screening or evaluation, (C) determining the individual's risk for abuse of drugs prescribed for pain, other prescribed drugs, illegal drugs and alcohol, (D) developing a treatment plan and referral options for the individual to ensure the individual's recovery support needs are met, and (E) developing and submitting an opioid use consultation report to an individual's primary care provider to be reviewed by the primary care provider and included in the individual's medical record;

Dear Ms. Wilson:

I am requesting, as President of the CT Association of Addiction Professionals, a "scope of practice "committee review regarding a change of language in the statute governing the LADC 's current scope of practice. The CT Association of Addiction Professionals represents over 850 credentialed addiction specialists. It is the State Affiliate for the National Association of Alcohol and Drug Abuse Counselors (NAADAC). The Association is led and served by an all-volunteer Board of Directors, who advocate for public policy that empowers the State's workforce of addiction specialists, and most importantly, the substance abusing consumers whom the workforce serves.

Introduction

The intent of the proposed changes is to appropriately clarify the current activities of the licensed independent practitioner, LADC, as prescribed by the professional license.

The clarification of the LADC's language in the Scope of Practice does not add or subtract to the current application, by individuals trained in the treatment of Substance Abuse Disorder, best practice principles and methodologies. The requested language amendment simply **clarifies** the existing Scope with explicit details of services provided by the LADC, which are

sanctioned and authorized by the CT DPH's educational, training, supervision, and professional work credentials that are needed to attain licensure. The proposed language appropriately reflects and mirrors the standards of education, competency, and professional level that the State of Connecticut statute requires for its workforce of addiction specialists, holding the LADC.

The necessity for the proposed language was also driven by a 2017 crisis that threatened the viability of CT's LADCs to offer SA TX services. A violation identified by the Department of Public Health during a regulatory visit to a behavioral health provider cited that a client with active mental health symptoms, other than alcohol and drug dependency, was seen only by a LADC and best practice standards dictate that the client needed to be referred to an appropriate mental health provider for further mental health assessment. This violation led to confusion about whether or not an LADC could treat individuals with co-occurring disorders. This event triggered a cascading series of unintended consequences, as previously stated, negatively impacted the state's workforce.

The crisis was resolved by CAAP's advocacy for a legislative remedy. CAAP collaborated with Senator Terry Gerratana, Co-Chair of the Public Health Committee, Senator Martin Looney, President of the Senate, and Chris Andresen, Section Chief of the DPH Licensing Division to resolve the dire situation.

On June 3, 2017, the CT General Assembly passed the following legislation that included new language for the LADC License's Statute, Scope of Practice Section under the Department of Public Health's 2017 Revisor Legislation. The following information contains the new language and the legislative citation.

Nothing in this section shall prohibit or limit the ability of a licensed alcohol and drug counselor from practicing alcohol and drug counseling with an individual diagnosed with a co-occurring mental health disorder other than alcohol and drug dependency provided the licensed alcohol and drug counselor works within the scope of practice outlined in GS 20-745(a)(4)

Section 22,

<https://www.cga.ct.gov/2017/BA/2017HB-07222-R01-BA.htm>

By requesting a change of language in the LADC licensure's scope of practice, CAAP will add an assurance that will help sustain the state's workforce of LADCs' professional future.

New Language with Accompanying Narrative

CAAP presents the new language for the Scope of Practice by adhering to the national standards created by SAMSHA, as presented in its **2011 Scope of Practice in the Field of Substance Use Disorders, Propose and Approved by the Substance Abuse and Mental Health Services (SAMSHA)**. In preparation for the submission of an improvement of the current Scope of Practices, the author consulted with Dr. Kirk Bowden, who was the Chair of the Committee for SAMSHA Workforce Development- Scopes of Practice. Mr. Bowden is also a recent past President of NAADAC. These practice activities are considered to be "the national gold standards" for states that have licensure statutes governing the practice of alcohol and drug counseling for the Independent Practitioner, who possesses the required educational credentials, training modules, and supervised work or internship experience. The SAMSHA scope of services standards are based upon a tiered-system of workforce professional development, similar to professional models used in the behavioral health fields of Social Work, Marriage and Family Therapy, and Nursing. Connecticut's LADC statutory regulations and requirements meet the highest professional SAMSHA Tier -Tier IV, **the Independent Clinical Substance Use Disorder Treatment Practitioner**.

New Language:

"Independent Licensed Alcohol and Drug Counselors" means the application, by persons trained in Substance Abuse Disorders Counseling of established principles of psycho-social development, psychopathology, behavioral science, and the development and progression, and best practice treatment standards of substance abuse disorders, for;
1. Clinical evaluation, including screening, assessment, and diagnosis of Substance Use Disorders (SUDs) and Co-Occurring Disorders (COD). 2 Treatment of SUDs and CODs, including ongoing individual and/or group therapies, support for involvement in appropriate 12-Step Program, continuity of care with other service providers, discharge, and planning for relapse prevention and recovery maintenance. 3. Referral to appropriate allied behavioral health and medical providers 4. Service coordination in the areas of SUDs and CODs. 5. Assessment on interpersonal dysfunction, assessment of trauma, and psycho-education with individuals, families, and groups in the areas of SUDs and CODs. 6.. Client, family, and community education. 7. Documentation of required clinical services. 8. Adherence to professional and ethical responsibilities. 9. Clinical supervisory responsibilities for all categories of SUD Counselors. 10. Substance abuse disorders counseling includes but is not limited to, substance abuse counseling, psychotherapy, relapse prevention and behavior modification, crisis intervention, and consultation with mental health and healthcare providers. The Independent Clinical Substance Use Disorder Counselor/Supervisor can practice under the auspice of a licensed facility, within a primary care setting, or as an independent private practitioner. It is the responsibility of the Independent Clinical Substance Use Disorder Counselor/Supervisor to seek out clinical supervision and peer support.

The Qualifications of LADCs to Treat individuals with Co-Occurring Disorders

The SAMSHA Scope of Services Model is informed by and based upon an individual's attaining the educational credentials required by the state's statutory regulations and required standards. As previously stated, the LADC workforce crisis was ignited confusion surrounding the current LADC Scope of Practice contained in the current "alcohol and drug counseling" scope. The CAAP Board of Directors agreed that there was a need for an improved description of the LADCs clinical functions that correctly described the LADC's best practice diagnosis, specialized therapies, and conjoint treatment with mental health providers, providing the appropriate mental health services including psychopharmacology, specific therapeutic interventions to support medication compliance, family sessions to stabilize the patient's interpersonal relationships etc. The incidence of co-occurring disorders is staggering in our nation. **A best practice principle for the LADC, as a specialist in the field of SUDs,**

the LADC treats the SUD as the primary diagnosis and provides referral, consultation and collaboration with the mental health provider and/or the medical provider to ensure continuity of care, adherence to best practice treatment standards for the individual's Co-occurring Diagnosis, and achieve through the treatment of SUDs & CODs, optimal treatment outcomes.

According to SAMHSA's [2014 National Survey on Drug Use and Health \(NSDUH\) \(PDF | 3.4 MB\)](#) an estimated 43.6 million (18.1%) Americans ages 18 and up experienced some form of mental illness. In the past year, 20.2 million adults (8.4%) had a substance use disorder. It is estimated that **80% of these individuals have co-occurring disorders**. SAMSHA released a report that presented the following data: The incidence in opioid dependent population is estimated to be greater than the national average.

These statistics emphasize the requirement for persons entering the field of addictions possess the most rigorous educational credentials, specialized training, and supervision/ employment experience. Ethical and best practice standards clearly advocate that behavioral health professionals adhere to their scope of practice **and not provide services that are outside of their educational and training experience.**

****Comments Upon the Inclusion of Gambling Disorder in the Language of the Scope of Practice**

In my conversations regarding the LADC Scope of Practice, Mr. Andresen mentioned gambling as a possible inclusion for the new Scope. He and I had been contacted by the same behavioral health agency on this Disorder.

I undertook a fact- gathering effort to gain the information from a number of the Affiliate Presidents across the country and a review of a sampling state licensure statutes to discern if the disorder of Gambling is included in the state's statutes regulating the practice license of Alcohol and Drug Counseling. I also reached out to Dr. Bowden, previously mentioned earlier in the proposal. I received similar perspectives from the NAADAC leadership regarding the appropriateness of gambling disorder being included in the language of the Scope. The findings were clear and emphatic. **The Non-Substance Related-Disorder is not included in the Scope of Practice Language in state statutes.**

Gambling Disorder will not be included as a "stand alone" disorder in the new "scope" language for the following reason. LADCs follow the DSM V diagnostic criteria in their application of screening, assessment, evaluation, and diagnosis. Although gambling has many similar symptoms of dependency, **the DSM V does not classify Gambling as a Substance Use Disorder, but as a "Non-Substance-Related Disorder". Therefore, it falls under the category of CODs.** It is a hybrid diagnostic disorder. Dr. Bowden reported that in the creation of the SAMSHA Scopes of Practice, the inclusion of gambling addiction was a reviewed and deemed to be a co-occurring disorder.

Concluding Points

The depth and breadth of knowledge in the treatment of the disease of addiction includes; the physiology of the disease, psycho-social developmental indices, diagnosis, referral, evidence-based treatment modalities, psychopharmacology in the treatment of SUD & COD, cultural competency, posttraumatic stress disorder, ethical practice, standards for clinical records, relapse prevention, education on the value of 12- Step programs, methodologies for long-term recovery management. These fundamentals form the foundation of the educational, training, and supervision requirements of the state's Licensed Alcohol and Drug Counselor. The new language will reflect and reinforce the LADC's professional competency to offer best practice treatment to a client suffering with active SUD and contending with a COD.

Public Health and Safety Benefits of Clarified Scope of Services to Connecticut Residents

The request for accurate and clear language in the LADC Scope of Practice will sustain the current valuable contributions offered by the state's workforce of credentialed addiction specialists to the public health and safety of state residents. In 2017, LADCs are contributing their specialized skill sets and fund of knowledge in a broad array of behavioral health and health service venues. A sampling of these work settings include- in inpatient and outpatient substance abuse programs, hospital programs & ERs, community health centers, youth service bureaus, prisons and community re-entry programs for ex-offenders, DUI mandated educational programs, school-based health clinics, local and regional state SUD prevention programs, Independent Practices, and primary medical practices.

The primary element to successful SA TX is the highly skilled, educated, and compassionate qualified provider, the LADC. The provider needs to be prepared and ready to meet the intrinsic complexities and challenges inherent in the treatment of active addictions. There are those in the helping profession who believe that LADC'S are not qualified to diagnose and treat individuals with co-occurring disorder. These behavioral health professionals are not specialists, they are generalists. They do not have more education or training than LADCs. LADCs are trained to identify psychiatric symptoms as well as Substance use Disorder symptoms. If an individual requires medication management to help with co-occurring mental health disorders, the LADCs are trained to refer such an individual to the appropriate Provider and on-going case consultation is exercised. In addition to identifying the symptoms and establishing a diagnosis, LADCs are trained to treat such symptoms with individuals in individual and group psychotherapy. When specific substance use problems are the primary issue, a specialized family therapy may be an additional and necessary modality of treatment. LADCs are Substance Use Disorder Specialists who are trained in and continue to learn and apply best practice treatment standards to address the disease of addiction.

In Connecticut, we are fortunate to have a workforce of highly screened and qualified LADC's who have met uniform state-specific standards. These rigorous standards for credentialing prepares them to sort through complex mental health symptoms, health issues, and social factors to discern how active Substance Use Disorder (SUD) may be affecting the whole picture, hence to deal with patients having co-occurring disorders (dual diagnosis and medical conditions.). LADCs have the knowledge and professional skill sets to identify and deal with the manipulation that comes with this primary disease, as well as to evaluate the stage of progression of the disease and determine the type of treatment needed. In addition, they have the skills to provide consultation to other providers (MDs, APRNs, RNs, and Masters Level Behavioral Health Providers) who may be frustrated, fearful, and bewildered in their treatment of clients, who present with active addictive behaviors.

The value of a highly qualified workforce of addiction specialists was affirmed by the evidence in a **2004 report from SAMSHA**. The Report offered compelling evidence of the lack of education and experience in the treatment of addiction by PCPs and ancillary providers in a medical practice:

"A significant problem is the lack of education and training on substance use disorders for primary health care and other health and human services professionals. The National Center on Addictions and Substance Abuse (CASA) at Columbia University reported that 94 percent of primary care physicians and 40 percent of pediatricians, when presented with a person with a substance use disorder, failed to diagnose the problem properly (CASA, 2000). If similar studies were available for other health professionals (e.g., nurses, psychologists, pharmacists, social workers, dentists), the results would likely be similar."

"Curricula in most health education programs and professional schools either inadequately address substance use disorders or exclude discussion of them altogether." 2004, US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Report to Congress: Addictions Treatment Workforce Development [Section D, Education and Accreditation Priorities].

These studies triggered a national movement to acknowledge the critical need for addiction specialists to participate in an integrated health delivery system for primary medical services. In 2017, the inclusion of credentialed addiction specialists is a primary goal, as the country moves towards the establishment of the primary medical, patient-centered home. The medical costs of untreated addiction, as it impacts a patient's medical conditions has been researched in numerous studies.

In May 2013, a SAMHSA-HRSA released the report; ***Innovations in Addictions Treatment-Addiction Treatment Providers Working in Integrated Primary Care Services (SAMHSA-HRSA Center for Integrated Health Solutions)***. The report underscored the importance of this complement of services-

“Alcohol and drug addiction cost American society \$193 billion annually, according to a 2011 White House Office of Drug Control Policy report.¹ In addition to the crime, violence, and loss of productivity associated with drug use, individuals living with a substance abuse disorder often have one or more physical health problems such as lung disease, hepatitis, HIV/AIDS, cardiovascular disease, and cancer and mental disorders such as depression, anxiety, bipolar disorder, and schizophrenia.² In fact, research³ has indicated that persons with substance abuse disorders have:

8 Nine times greater risk of congestive heart failure.

8 12 times greater risk of liver cirrhosis.

8 12 times the risk of developing pneumonia.

When persons with addictions have co-occurring physical illnesses, they may require medical care that is not traditionally available in, or linked to, specialty substance abuse care. The high quality treatment needed by individuals with addictions requires a team of different professionals that includes both specialty substance abuse providers and primary care providers. The integration of primary and addiction care can help address these often nterrelated physical illnesses by ensuring higher quality care. In fact, clinical trials have demonstrated that when someone has a substance abuse problem and one or more non related disorders, integrated care can be more effective than traditional treatment delivery (i.e., separate, siloed primary care and substance abuse programs) in terms of clinical outcome and cost.⁴ It results in better health outcomes for individuals, in contrast to back-and-forth referrals between behavioral health and primary care offices that result in up to 80% of individuals not receiving care.⁵ Substance abuse disorders can also complicated the management of other chronic disorders. For example, a number of researchers found that people with HIV /AIDS who reported alcohol and drug use were more likely to be non-adherent to antiretroviral treatment.⁶ Other researchers reported that substance abuse disorders, depression, and medical co-morbidities relate to poor adherence to medications to treat type 2 diabetes.⁹ Yet, many individuals served in specialty substance abuse settings do not have a primary care provider”.¹⁰¹¹. 2011 The Economic Impact of Illicit Drug Use on American Society. Washington D.C: U.S. Department of Justice.”

With Connecticut’s opioid/heroin epidemic raging, an increase in deaths attributed to overdoses has increased to over 1,000 deaths in 2017. The Connecticut Association of Addiction Professionals sponsored legislation in 2016, which became law, to promote professional collaboration between the primary medical provider and the LADC in halting the progression of dependency upon prescription opioids. The new Scope of Practice was referred in an early section of this document. The LADC is now statutorily authorized to offer a patient referred by his or her PCP specialized prevention and early intervention services around opioid abuse. This new public policy is gaining momentum across the state, as PCPs are informed about the benefits and resources of consultation and referral to an addiction specialist. This enlightened integrated service is a model of the benefits of a primary medical home service system.

Connecticut’s policy to intervene in the early stages of opioid abuse reflects the call to action by *Nora D. Volkow, M.D., and A. Thomas McLellan, Ph.D.* in their joint article on “Opioid Abuse and Chronic Pain” in *N Engl J Med* 2016; 374:1253-1263 [March 31, 2016 DOI: 10.1056/NEJMra1507771](#).

“Clinical efforts to prevent the emergence of addiction can be initiated in primary care settings. Assessment of addiction risks before opiates are prescribed is recommended as a mitigation strategy (Table 3). Emerging signs of addiction can be identified and managed through regular monitoring, including urine drug testing before every prescription is written, to assess for the presence of other opioids or drugs of abuse. **Responsible physicians should be prepared to make a referral for specialty addiction treatment when indicated.** Although addiction is a serious chronic condition, recovery is a predictable result of comprehensive, continuing care and monitoring.¹⁰⁴ In particular, the use of medication-assisted therapy in managing opioid addiction among patients with co-occurring pain significantly improves outcomes.¹⁰⁵”.

Comments Upon Potential Harm If the Language is not Implemented:

In 2017, Connecticut residents experienced a preview of potential harm to their health, safety, and mental health caused by the unintended consequences of the DPH regulatory site visit that raised important questions as to whether or not LADCs could treat individuals with co-occurring disorders. It is important to also view this perspective considering the state’s budget crisis that has severely harmed the state’s delivery of SUD treatment.

Several of the more egregious effects were:

- *Many agencies across the state ceased hiring LADCs, even for the treatment of SA. Although the DSS Commissioner rescinded his December 2016 Bulletin that restricted LADCs' delivery of services to Medicaid clients, CAAP continued to receive complaints that DSS was not reimbursing LADCs for services rendered to the Medicaid consumer.*
- **Update-** *CAAP and its supporters' advocacy to DSS finally resulted in the correction of DSS reimbursements. LADCs are receiving payment for their services to Medicaid clients, effective April 17th.*
- *Alcohol and Drug educational programs in state community colleges experienced serious difficulties in placing interns at agencies, which had previously accepted interns, because of the "professional cloud surrounding LADCs.*
- *The unintended consequences that occurred from the findings of the DPH regulatory site visit and the miscommunication about the visit, which was spread by uninformed individuals, who did not fully understand the DPH regulatory findings unfortunately exacerbated the LADC matter. The result was a severe fracture of necessary, seamless behavioral treatment for residents with co-occurring disorders. Residents faced with seeking two providers- one for SUD & one for mental health disorders. Thus, the state was time-traveling backwards-returning to the old days of the 1950s- the unconnected treatment separation of addiction disorders and mental health disorders*
- ***CT residents with SUDs lost the assurance that they will be treated by the statutorily identified licensed provider, LADC, who is the specialist in best practice and evidence-based treatment for addictions.***

*A CAAP Board of Directors' member related the following case anecdote prior to DSS lifting its restrictions on payments for all Medicaid initial interviews and certain services that were provided by an LADC. Her client was re-entering the community from a CT DOC prison. The individual, who requested services from the CAAP Board member, was informed by Medicaid that he needed to be also seen by a licensed behavioral professional for his "mental health disorder". The client was very disturbed, but followed the CAAP Director's, who is an LADC, referral to a mental health service provider. The client returned the following week and reported that he would not seek services from the licensed mental health provider because the provider had stated in the initial evaluation- "Don't worry if you have a little relapse with alcohol, it won't be a problem." This statement was made to an individual who had parole sanctions against any substance use, diagnosis of depression, and a 15 year history of alcoholism.

Unfortunately, this clinical anecdote is not the exception. Well intentioned medical and behavioral health providers, who do not possess the necessary education, training, and professional experience in the treatment of addiction contribute to serious escalation of the client's presenting SUD diagnosis. In Connecticut, the media has reported countless stories involving medical and psychiatric physicians' errors in misdiagnosing a patient's active substance abuse. This clinical oversight jeopardized the client's health and in rare cases, life. In Connecticut as in states across the country, clear and documented evidence has indicated that PCPs offering an intervention for the pain, many MDS routinely prescribe a prescription for an opiate- with the unintended consequences of initiating a deadly relationship between the prescription pill and the vulnerable patient.

The proposed language clarification to the Scope of Practice will provide the assurance that the public good as it relates to best practice standards in the treatment of SUD and addiction, will be maintained.

Access to Care

The preceding section commented on many of the relevant issues connected to access to care for SUD. The intention of the clarification of the language in the proposed Scope of Practice is to facilitate a solid foundation for the screening, assessment/evaluation, and diagnosis of clients presenting with SUDs & CODs. With these tools, CT residents will seek and gain access to the appropriate behavioral health provider, who will offer best practice treatment to hopefully resolve their current bio-psycho-social issues.

In Connecticut's current economic climate, it is clearly known **that private and public insurance reimbursement is the primary factor in gaining access to behavioral health services.** The proposed Scope of Services combined with the LADC's educational credentials, training, and supervisory experience in the field of addictions will hopefully provide the consumer with the crucial knowledge to discern if the licensed behavioral health provider is the most qualified practitioner to help her or him work through the presenting problems.

Past and current research has provided well-documented studies demonstrating the obstructions to access to healthcare due to the stigma associated with active substance users by providers from both the medical and behavioral health professions. This research has been one of the chief drivers of SAMSHA's recent initiatives in motivating medical and behavioral health providers to acquire more education in Addiction. The complexity of the disease of addiction poses multiple barriers to an effective and honest relationship between the provider and the substance user. The inadvertent consequences of a client's undisclosed SUD triggers these dynamics, the worsening of the patient's health status through impact of substances of choice

on the pre-existing health and psychiatric co-morbidities, the patient's required medications, increased cessation of SUD treatment, and most importantly, a skewed provider-patient relationship plagued by mutual mistrust and frustration.

State Laws Governing the Profession:

The state of Connecticut regulates the profession of Licensed Alcohol and Drug Counselors, as described in the CT Statute, Chapter 376 6

Sec. 20-74s. Licensure and certification of alcohol and drug counselors.

The statute puts forth all the professional terms, limitations, renewals, exemptions, educational credentials, training, and supervisory/employment requirements to attain licensure in Connecticut. The statute describes the standards for a Scope of Practice under the Licensed Alcohol and Drug Counselor License as enabled by the state statute. The statute contains conditions of other professionals' practice of alcohol and drug counseling.

The statute states the Continuing Education professional requirements to maintain an active license. The annual fee for an Active License is also named in the Statute.

The quality control and adherence mechanisms to state regulations governing the LADC is under the direction of Connecticut's Department of Public Health. The Department of Public Health is the Executive Authority for oversight of all of Connecticut's health-related professions, either thru a license or certification.

New policies or standards of practice regulations for the LADC go through the CT General Assembly for review, approval, and culminating in a new or amended statutory law.

Current Education, Training, and Examination Requirements and any Relevant Certification Requirements Applicable to the Profession

The Connecticut Department of Public Health's current description of professional requirements for licensure as an LADC, as displayed on the CT Department of Public Health Website.

CT Department of Public Health

Alcohol and Drug Counselor Licensure Requirements

Before applying for licensure, please familiarize yourself with the general licensing [policies](#) .

An applicant for licensure shall arrange for the following documents to be submitted directly to this office:

A completed, notarized [application](#) with photograph and fee in the amount of \$190.00 in the form of a bank check or money order payable to, "Treasurer, State of Connecticut";

Verification of a master's degree from an accredited institution of higher education in social work, marriage and family therapy, counseling, psychology or a related field that included a minimum of eighteen graduate semester hours in counseling or counseling-related subjects.

Applicants holding certified clinical supervisor status by the Connecticut Certification Board, Inc. as of October 1, 1998, may substitute such certification in lieu of the master's degree requirement and graduate coursework requirement.

Official verification of all professional licenses, certificates or registrations, current or expired, held as an alcohol and drug counselor issued by any state licensing authority, sent directly from the appropriate authority to this office. Most jurisdictions charge a fee for completion of the verification [form](#). Please contact the jurisdiction for fee information (**note that this documentation requirement does not include certification issued by professional certifying bodies such as the Connecticut Certification Board**);

If not currently certified as an alcohol and drug abuse counselor by the Department of Public Health, please arrange for the submission of the following documents directly from the source to this office:

[Verification form](#) documenting completion of three hundred hours of supervised practical training in alcohol and drug counseling;

[Verification form](#) documenting completion of three years of supervised paid work experience or unpaid internship, as defined in Sec. [20-74s-1](#) of the Regulations of Connecticut State Agencies that entailed working directly with alcohol and drug clients. Please note that a master's degree may be substituted for one year of such experience;*

[Verification form](#) documenting completion of three hundred sixty hours of approved education, at least two hundred forty hours of which related to the knowledge and skill base associated with the practice of alcohol and drug abuse counseling*;

[Verification](#) of successful completion of the International Certification Examination for Alcohol and other Drug Abuse Counselors of the International Certification & Reciprocity Consortium/Alcohol & Other Drug Abuse, Inc. ([IC&RC/AODA](#));

Individuals who are not certified by the [CCB](#) as a substance abuse counselor on or before July 1, 2000, may seek admission to the IC&RC/AODA examination administered by the CCB. Please note that the results of such examination are for the purpose of state certification/licensure, and will not necessarily qualify the examinee for CCB certification.

Once an applicant has been determined eligible for examination, the Department will notify CCB of the candidate's approval and CCB will schedule the applicant to sit for the next available examination. The examination is administered four times per year. Please do not contact the CCB directly to check on the status of your application; however, any questions regarding the examination process may be addressed to CCB.

*Individuals who are certified by a board that is a member of the [IC&RC/AODA](#) shall be deemed to have met these requirements. Applicants to whom this applies need only arrange for verification of certification by an [IC&RC/AODA](#) member board. Please note that this office will obtain verification of CCB certification directly from the CCB website.

Summary of Known Scope of Practice Changes to Enacted Concerning the Profession in the Five Proceeding Years:

I. 2017- CT DPH Revisor Bill passed into law on June 3, 2017. This change was briefly discussed at the beginning of the document. To ensure the Review Committee gains a thorough understanding, the "CAAP 2017 White Paper: LADC Workforce Crisis" & Mr. Andresen's formal correspondence will be included in the Appendix Section of this document. At the time of this document's creation, the author is unsure of where the new language will be placed in the statute.

Nothing in this section shall prohibit or limit the ability of a licensed alcohol and drug counselor from practicing alcohol and drug counseling with an individual diagnosed with a co-occurring mental health disorder other than alcohol and drug dependency provided the licensed alcohol and drug counselor works within the scope of practice outlined in GS 20-745(a)(4).

II. 2016: CAAP's 2016 Legislative Initiative to Address CT's Opioid Epidemic

AN ACT CONCERNING OPIOIDS AND ACCESS TO OVERDOSE REVERSAL DRUGS. 2016 HB 5053Sec. 6.

Subdivision (4) of subsection (a) of section 20-745 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(4) "Practice of alcohol and drug counseling" means the professional application of methods that assist an individual or group to develop an understanding of alcohol and drug dependency problems, define goals, and plan action reflecting the individual's or group's interest, abilities and needs as affected by alcohol and drug dependency problems, and may include, as appropriate, (A) conducting a substance use disorder screening or psychosocial history evaluation of an individual to document the individual's use of drugs prescribed for pain, other prescribed drugs, illegal drugs and alcohol to determine the individual's risk for substance abuse, (B) developing a preliminary diagnosis for the individual based on such screening or evaluation, (C) determining the individual's risk for abuse of drugs prescribed for pain, other prescribed drugs, illegal drugs and alcohol, (D) developing a treatment plan and referral options for the individual to ensure the individual's recovery support needs are met, and (E) developing and submitting an opioid use consultation report to an individual's primary care provider to be reviewed by the primary care provider and included in the individual's medical record;

The creation, development, and advocacy to pass this ground-breaking public policy began in 2015, the Connecticut Association of Addiction Professionals conducted an informal statewide survey of addiction specialists, primary care providers, licensed behavioral health providers, and consumers. Respondents described a bleak picture for consumers with an opiate addiction. In Connecticut and across the nation, clients, who seek treatment, have two treatment options- medication assisted therapy or abstinence.

In multiple national research studies there is universal consensus that the origin of opioid addiction begins in the office of the primary care provider- 80% of individuals addicted to opioids/heroin report that their addiction began with a prescription of pain meds from their MDs. . It is important to re-emphasize that these specialized services can only be provided by an LADC.

The new Scope of Practice goals are the described:

The law provides the statutory authority for Licensed Alcohol and Drug Counselors (LADCs), within their scope of practice, to offer state residents evidence-based, early prevention and intervention services to halt the development of dependence on pain meds. As the law states, primary medical providers will be able to refer their patients, who exhibit early warning signs of opioid abuse, to addiction specialists for evaluation and treatment recommendations in the management of pain meds. It is important to note that in these fiscally challenging times for Connecticut the new legislation comes at no cost to the state, as services are reimbursable by public and private insurers.

The law moves beyond the state's enforcement statutes such as prescription monitoring, 7-day caps on opioid prescriptions, and expansion of the use of NARCAN. The services offered, in the context of a medical visit, acknowledges that addiction is a disease and needs to be treated as such. CAAP and its supporters strongly believe that the profound barrier of stigma associated with addiction will be ameliorated by the partnering of primary medical services and specialized addiction

treatment in patient care. It reflects the former US Surgeon General's rallying call to physicians across the country to treat opioid addiction as a disease (November 2016 Report on Addiction as a Disease). This blended service system contained in the new law has also been strongly endorsed by both NAADAC and SAMSHA as an evidence-based model that enhances both medical and addiction treatment outcomes.

How the Request Directly Affects Existing Relationship Within the Healthcare Delivery System

Connecticut's Licensed Alcohol and Drug Counselor has been the statutorily acknowledged provider of the spectrum of specialized services in the treatment of SUDs and addiction since 1998 (**Section 20-74a.**) The new language proposed for the practice license's Scope of Practice will clearly and simply define the guidelines and boundaries of in the treatment of addiction for the profession's colleagues in the state's behavioral health and healthcare delivery system.

Practitioners in the state's healthcare and behavioral healthcare have a solid history of referral, consultation, and collaboration, as well as uniting to advocate for legislation that impacts the behavioral health care delivery system in our state. It is important to note that LCSWs, LMFTs, LPCs, and LADCs, pursued a higher level of professionalism with the pursuit of a practice license during the 1990s to participate in the implementation of Managed Care, HMOs for private and public insurance payers. This process nurtured strong communication and understanding of each workforce's client base and what services the licensed behavioral health provider could or could not provide. In Connecticut, the majority of state-funded behavioral healthcare employ a diversity of licensed practitioners- LCSWs, LMFTs, LPCs, APRNs, and LADCs thus ensuring a "one stop shopping model" for state residents seeking mental health and addiction services. Since the mid-nineties, the professional relationships have grown even stronger due to Connecticut's worsening economy and the growing demand by state residents for behavioral health services.

Collaboration amongst behavioral and healthcare providers has never been more important due to Connecticut's severe fiscal crisis. At the time of this writing, the state is facing a 2 Billion dollar deficit and has no operating budget passed by the General Assembly. The crisis has resulted in devastating consequences for the state's healthcare delivery system due to recent crippling cuts in public-funded agencies, out-patient behavioral health programs, CHCs, hospitals, psychiatric facilities, prison re-entry programs, and a host of other programs that provide behavioral health services. Agency administrators from across the state report that they are running their agencies like private practices- ensuring that their staff's services are reimbursable by private or public insurance payors. The LADC license provides the credentialed addiction specialist, like his or her peers- LCSWs, LMFTS, and LPCs, to be reimbursed by private and public (Medicaid) insurance payors.

The 2017 Scope of Practice crisis had the unintended consequence of losing reimbursement from the Department of Social Services for approximately four months. As previously discussed, this process had a dire impact on access to care for the most needy members of CT's towns and cities. It caused clients' presenting with SUDs & Co-Occurring Disorders to experience fractured treatment. As reported to the CAAP Board of Directors, clients were compelled to go to Agency A for SA TX and Agency B for mental health treatment. The proposed clarification of the LADC Scope of Practice will ensure that provider is appropriately reimbursed for his or her services, and client will gain access to SA TX, as supported by her or his insurance carrier.

The proposed scope of practice will clearly identify the LADC's vital role in Connecticut's healthcare delivery system. A strong workforce of credentialed addiction specialists pose no threat of competition to their licensed behavioral health colleagues. The LADC's involvement in the healthcare delivery system has taken on an even more important function due to the opioid epidemic. LADCs are the primary provider of clinical services to opioid addicted state residents and their families and partners. At this point in time, the demand for services greatly exceeds the availability of treatment slots across the spectrum of care necessary to manage the complexity of opioid/heroin addiction. With the new scope of practice for LADCs in providing prevention and early intervention services in collaboration with a patient's primary care provider, the LADC may intervene in the progression of the opioid dependency thus hopefully alleviating enormous economic, social, and public safety burdens created by the epidemic.

With the state's healthcare delivery system in jeopardy, the LADC will continue to be an essential professional in the delivery of best practice and evidence-based treatment for state residents' SUDs and Addiction.

The Anticipated Economic Impact of the Request on the Healthcare Delivery System

With the strong Scope of Practice proposed, the economic benefits to the state's healthcare system is truly incalculable. It is important to always remember that one substance abusing individual's recovery positively impacts a constellation of other people in her or his family, place of employment, medical facilities, and saving the circle of affected individuals the cost of family members' specific healthcare costs. A recovering individual cuts the costs for long-term behavioral health services, loss of business productivity, cost of health-care related services provided by primary care providers, ER visits, hospitalizations, and the almost inevitable cost of encounters with the criminal justice system or actual incarceration.

The Connecticut Clearinghouse recent report states:

"The cost of untreated drug and alcohol addiction in the U.S. in a given year is estimated at \$276 billion in lost productivity, law enforcement, health care, justice, welfare, and other programs and services. That's an annual cost of \$1,050 for every man, woman, and child in America. In contrast, it would cost about \$45 per year per each American to provide the full continuum of services needed to effectively treat addictive disorders. Of course, the return on investment in terms of restored lives is incalculable. —According to several conservative estimates, every \$1 invested in addiction treatment programs yields a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1.

There are countless studies on the misdiagnosis or "missed" diagnosis of SUD by experienced and credentialed licensed behavioral health providers. Having access to a highly qualified LADC in an agency, hospital, or private practice is both a compassionate and pragmatic resource in providing best practice and cost effective SUD treatment. The costs of failed treatment, professional liability, and risk of injury to others in the circle of addiction, if a client with an underlying SUD is not addressed is an all too familiar clinical anecdote in the state's stressed health care delivery system.

The proposed language clarification in the LADC Scope of Practice will yield continuing financial support to state agencies, re-entry services, and other venues for clients with SUD as a primary diagnosis and CODs as secondary diagnosis. The administrators will have the assurance that the services provided are first and foremost, evidence-based, and secondly, the services qualify for third party payments. It is not the purview of this document to address the significant obstacles to access to SA TX due to private insurers policies on service utilization that has become a chronic problem for the behavioral healthcare delivery system over the past several years. It is therefore incumbent that LADCs possess indisputable professional credentials and standards of care, as defined by the Scope of Practice.

At a time when SA TX & MH TX agencies are fighting to survive, the state's healthcare delivery system demands an "All hands on Deck" to meet the needs of their clients, who present with complex clinical needs. The erosion of the workforce of LADCs would strike a blow not only to the quality of life of its residents but also to the state's already deteriorating economy due to untreated addiction.

Regional and National Trends in the Licensing of the Health Profession with Information on Scope of Practice Provisions In Other States

The obstacles to a national license for Masters level or above credentialed Addiction professionals continues to be a challenge for the workforce across the country. When this author became President of the CT Association of Addiction Professionals and Affiliate President Board Member of the National Association of Addiction Professionals (NAADAC) in 2013, it was stunning to learn that the same number of states **25 had state regulated practice licenses**. This was the same number, that existed when CT' Association gained licensure in 1998! Fortunately, since becoming a NAADAC Board member the number has increased to 37 with 3 states pending. It is not a secret within the membership of NAADAC that the recent leadership has taken a rigid stance as a means to protect the hundreds of Certified Alcohol and Drug Counselors across the country. Fortunately, in the past several years, NAADAC Board Members have challenged its leadership to move from obstruction to advocacy for state credentialed addiction specialists', who pursue licensure in their states.

In 2014, there was a major challenge by State Presidents to the leadership of NAADAC. The group of Board Presidents, including this author, presented evidence-based documents that clearly described the demise of the addiction professional due Managed Care shaping the delivery of behavioral health services over several decades. In the early 2000s, managed care's standard for reimbursement of masters level degrees in behavioral health with standards of educational, training, supervisory, and professional experience. Many states with certified alcohol and drug counselors, although possessing hundreds of hours of course specific training did not possess the required academic standards. With the advent of the

Affordable Care Act, its licensure and academic requirements for the Masters degree have become the best practice standards for the nation's licensed behavioral health providers. Connecticut instituted these requirements, when the 2013 General Assembly voted to restore and strengthen these requirements and standards for the LADC licensure, after the license was legislatively gutted on the last day of the 2012 General Assembly in an Implementer Bill.

Dr. Don Osborne is one of NAADAC's leading authorities on the growth and development of the credentialed addiction professional. Dr. Osborne is a former past President of NAADAC and current Chair of NAADAC's Professional Practices and Standards Committee. He has consulted with SAMSHA, as well as, several states on the need and process for implementation of licensure for the addiction professional.

In his highly received article in "Licensing the Addiction Professional in All Fifty States", *Advances in Addiction & Recovery*, Spring 2015. Dr. Osborne presents the evidence for licensure, the required standards, and state models for a Practice License. Dr. Osborne cites Connecticut as one of the top 5 state licenses in the nation. ") **In recent years, a handful of states, including Arizona, Indiana, Connecticut, Kansas, and South Dakota have set the standard and successful precedent in licensure of addiction counselors due to needs of the addiction profession.**".(20). With the proposed clarification of the licensure's Scope, CT will continue to be a leader in the empowerment of professionals in the field of addiction.

It is important to note in this section of the document that there are two major types of licensure "general counseling" and "license by profession" (D. Osborne Ph.d, "Licensure...", p.21). Connecticut's LADC follows the license by profession model. Dr. Osborne has guided states in pursuing a practice license of revising an existing license to adopt the license by profession. He stated:

*"In license by the profession legislation, each profession has a role in creating the language and criteria for licensure requirements for the specific profession. In this manner, [academic & training] courses, scope of practice, post graduate hours, and licensure exams are **specific to the profession**. This is the licensure that NAADAC now endorses, as state legislators and other state officials will seek input from the profession to develop the license to ensure that it contains the necessary specificity in language and requirements."* (D. Osborne PH.d., p.22)."

The license by practice affords professional protection thru a legislated licensure statute. CT consumers of service gain the statutory protection of knowing that the SA TX provider cannot present himself or herself as an addiction professional unless the provider holds the practice license. **NB.** This information does not exclude members of certain professions that are exempted in the LADC statute.

For comments upon Scope of Practice provisions in other states, an array of states from across the nation were reviewed- Indiana, Arizona, Massachusetts, South Dakota, Vermont, New Hampshire, and Maryland. Because the author sits on the National Association of Addiction Professionals and is also a Member of the NAADAC Northeast Regional Oversight Committee, I have followed the trends of licensure in the US. Since becoming a NAADAC Board member. The author has provided consultation to state addiction Affiliate groups in attaining Licensure. In 2017, consultation was provided to Affiliate Presidents from Michigan and New York. A point of interest, New York state has been attempting to gain licensure for Masters' Level addiction professionals, who currently possess the ACA standards for 8 years! Thankfully, with the Connecticut's budget crisis, the state workforce of credentialed addiction does not have that enormous burden to overcome.

In the above sampling of states alcohol and drug licensing regulations, the states reviewed are very similar to Connecticut's requirements as defined by **Section 20-74s**. Each state has a tiered system for professional development, reflective of the SAMSHA recommendations for professional development. In CT, alcohol and drug counseling by statute are provided by a Certified Alcohol and Drug Counselor CAC and the Licensed Alcohol and Drug Counselor (LADC). Many states have 4 tiers of professional development like Maryland & Arizona. The educational credentials are the same- language and formatting in the state regulation are slightly different to concur with the state government's regulatory systems. The majority of the states follow the guidelines of the SAMSHA's *Scopes of Practice in the Field of Substance Use Disorder*. The highest tier is the **Licensed Independent Alcohol and Drug Counselor**. This practitioner's Scope is the model that this proposal contains. **From reviewing the language, which is tweaked, that conform with each state's professional licenses' statute and regulations- the required educational credentials, professional training, and supervised experience clearly support the addiction professional's core competencies to treat individuals with Co-Occurring Disorders.**

The acceptance of the proposed Scope language to clarify and tie the LADC's professional qualifications with the practice of alcohol and drug counseling will bring the LADC license in line with the states that have already or in the process of adopting the SAMSHA "gold standard".

Identification of Any Health Care Professions that May Be Impacted by the CAAP Request

This document has presented the strong bonds of collaboration, communication, and consultation among the LADCs' licensed behavioral health peers. The state's 2 billion dollar deficit will continue to threaten the survival of state-funded behavioral health agencies, DOC addiction services, re-entry services, hospitals with mental health and substance abuse programs, etc.

The workforce of credentialed addiction professionals will benefit from the clarity of the language, so, that a similar unintended crisis like the one occurring this year, will not threaten the vital services provided by CT LADCs.

The proposed language clarification in the Scope of Practice **does not change- expand or eliminate the services that have been historically** offered in tandem with the services of the LCSWs, LMFTs, and LPCs. To support the state's behavioral health care delivery system, residents will need access to all licensed behavioral health professionals. The Connecticut Association of Addiction Professionals plans to notify each of our colleague's respective professional organization in order to inform them of the submission for the proposed clarification of the LADC Scope of Practice language contained in the licensure statute.

The worsening of the opioid epidemic in 2017 places even greater demands on the specialty services offered by LADCs. The challenges to access to preventative, early intervention, and treatment services has become even more difficult to address in 2017. It needs to be emphasized, that in conjunction with the work on the opioid epidemic, the CT Association of Addiction Professionals' goal with the submission of this document is not to compete with the state's licensed behavioral health providers but to stand and serve with them on the front lines of quality mental health and addiction services to preserve and protect them for the good people of Connecticut.

Description of the Request's Ability to Practice to the Full Extent of the Health Care Profession's Education and Training

Throughout this proposal, commentary and supportive evidence described the benefits of recommending the "gold standard" of Scope of Practices, the SAMSHA "*Scopes of Practice in the Field of Substance Use Disorders*". The following information highlights the value of adopting the new language that will support the state workforce in the delivery of best practice SUD treatment.

- ✓ **Unite the chosen SAMSHA Scope of Practice: Professional Level Tier IV, Practice of the Independent Clinical Substance Use Disorder Counselor/Supervisor's educational, training, and supervised work experience credentials with CT LADC's credentials contained in the Alcohol and Drug Counselor state statute, thus supporting the range of services provided.**
- ✓ **Establish consistency with national standards for this specific SUD professional's credentials and parameters for alcohol and drug counseling services thru the proposed language clarification for the LADC Scope of Practice.**
- ✓ **Strengthen and empower the state's workforce of credentialed SUD, so that a crisis in the profession (like the 2017 LADC matter), will be avoided.**
- ✓ **Widen and increase the health care delivery system in provision of SUD & COD best practice services. Administrators of non-profit, private, SA TX providers and primary medical providers will have a clear understanding of the qualifications for applicants, who seek to provide specialized services for SUDs and prevention and early intervention for dependence upon prescription opioids.**
- ✓ **Support Connecticut's enlightened public policies [2016 Opioid Abuse Laws] that seek to remove barriers of shame and stigma by following the former Surgeon General's November 2016 Call to Action- Treat Addiction as a Disease. Quoting a section of the Report,**
 - *"Supported scientific evidence indicates that closer integration of substance use-related services in mainstream health care systems will have value to both systems. Substance use disorders are medical conditions and their treatment has impacts on and is impacted by other mental and physical health conditions. Integration can help address health disparities, reduce health care costs for both patients and family members, and improve general health outcomes."*
- ✓ **Promote CT consumer protection and education by providing clear guidelines (contained in the state statute) to recognize LADCs, the SUD independent practitioners, who possess the required standards of education and training, that qualifies the professional to provide best practice treatment as covered under the proposed Scope of Practice language.**

In advance of your attention and consideration of the CAAP submission for clarification in the existing Scope of Practice language contained in LADC licensure statute, great thanks for your time and effort! I encourage you to contact me if you require further information.

Submitted by,
Susan Campion LADC, LMFT
President
Connecticut Association of Addiction Professionals
New Haven, CT 06512
p. 203/494/8148, e-mail. suzccampion@aol.com

APPENDIX

I. SAMSHA SCOPE OF PRACTICE in the Field of Substance Abuse Disorders
2010

II. WHITE PAPER-The Connecticut Association of Addiction Professionals' 2017 Legislative Advocacy to Resolve the Scope of Practice Crisis for the Workforce of LADCs

III. THE FUTURE--- EXTRACT from Surgeon General's Report-
"Facing Addiction" November 16, 2016

I. Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS).

Scopes of Practice & Career Ladder for Substance Use Disorder Counseling

This document reports on a meeting, Expert Panel on Scopes of Practice In the Field of Substance of Use Disorders, held March 12, 2010, supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, opinions, and content of this publication do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS. The Scopes were formally adopted at the end of 2010

Scopes of Practice & Career Ladder for Substance Use Disorder Counseling

This document reports on a meeting, Expert Panel on Scopes of Practice In the Field of Substance of Use Disorders, held March 12, 2010, supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, opinions, and content of this publication do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS. PEP11-SCOPES September 2011 MODEL SCOPES OF PRACTICE AND CAREER LADDER FOR SUBSTANCE USE DISORDER COUNSELORS

Background and Introduction Treatment of substance use disorders (SUD) is recognized as a multidisciplinary practice supported by theoretical and scientific literature. Research has demonstrated that evidence-based treatment of substance use disorders can lead to significant reductions in drinking and drug taking as well as major improvements in physical and mental health and social functioning. However, the provision of culturally relevant evidence-based practices and the demonstration of significant treatment outcomes depend on an effectively trained and supported workforce.¹ The Patient Protection and Affordable Care Act as well as the Mental Health Parity and Addiction Equity Act requires health plans, self-insured employers, and union-funded group health plans that offer mental health and substance use disorder benefits to establish the same financial requirements and benefit limitations that apply to general medical and surgical care. Behavioral health providers are preparing for changes in business practices along with developing the workforce needed to respond to changes in payment for services and anticipated increase in the demand for services. The substance use disorder treatment field will be held to the same standards and requirements as the primary health field. Therefore, the substance use disorder treatment profession needs to be ready to document and codify its services and service delivery systems. To prepare for the coming changes and increased demand for services, the Substance Abuse and Mental Health Services Administration (SAMHSA) convened key stakeholders in March 2010 to develop a Model Scope of Practice and Career Ladder for substance use disorders treatment workers. These stakeholders included representatives from the higher education, the National Association of State Alcohol/Drug Abuse Directors (NASADAD), the State Association of

Addiction Services (SAAS), the International Certification and Reciprocity Consortium (IC&RC), NADAAC, the National Association of Addiction Professionals, and the Addiction Technology Transfer Center (ATTC) network.

The draft Model Scope of Practice and Career Ladder were then sent out for field review and comments. This document provides a framework and a guide for States to develop their own Substance Use Disorder Scopes of Practice and Career Ladders to meet the needs of their specific jurisdiction.

MODEL SCOPES OF PRACTICE AND CAREER LADDER FOR SUBSTANCE USE DISORDER COUNSELORS CATEGORY 4: INDEPENDENT CLINICAL SUBSTANCE USE DISORDER COUNSELOR/SUPERVISOR

Practice of Independent Clinical Substance Use Disorder Counselor/Supervisor –An Independent Clinical Substance Use Disorder Treatment Counselor/Supervisor. Professional is Licensed to Practice Independently.

The scope of practice for Independent Clinical Substance Use Disorder Counselor/Supervisor can include: 1. Clinical evaluation, including screening, assessment, and diagnosis of Substance Use Disorders (SUDs) and Co-Occurring Disorders (CODs) 2. Treatment for SUDs and CODs, including initial, ongoing individual and/or group therapy, continuity of care, discharge, and planning for relapse prevention and recovery maintenance 3. Referral 4. Service Coordination and case management in the areas of SUDs and CODs 5. Individual and/or group therapies in best practice clinical modalities. 6. Trauma informed care, and psycho-education with individuals, families, and groups in the areas of SUDs and CODs . 7. Client, Family, and Community Education 8. Documentation of Clinical Services. Adherence to professional ethical standards. 9. Clinical supervisory responsibilities for all categories of SUD Counselors. The Independent Clinical Substance Use Disorder Counselor/Supervisor can practice under the auspice of a licensed facility, within a primary care setting, or as an independent private practitioner. It is the responsibility of the Independent Clinical Substance Use Disorder Counselor/Supervisor to seek out clinical supervision and peer support.

II. White Paper - 2017



CONNECTICUT ASSOCIATION

for

ADDICTION PROFESSIONALS

"A Strong Workforce of Addiction Professionals = Best Standards of Addiction Treatment for Connecticut Residents."

WHITE PAPER

The Connecticut Association of Addiction Professionals' 2017 Legislative Advocacy to Resolve the Scope of Practice Crisis for the Workforce of LADCs

Submitted by:

Susan Campion LADC, LMFT

President

Connecticut Association of Addiction Professionals, New Haven, CT 06512

www.ctaddictionprofessionals.org

June 2017

To: CAAP Members and Supporters,

On behalf of the Connecticut Association of Addiction Professionals Board of Directors, I am submitting a "2017 *White Paper*". The Paper presents a synopsis of CAAP's investigation, action steps, and legislative remedy for the LADC matter, which contributed to resolving the crisis affecting the workforce of the state's LADCs

Legislative Remedy

On June 3, 2017, the CT General Assembly passed the following legislation that included new language for the LADC License's Statute, Scope of Practice Section under the Department of Public Health's 2017 Reviser Legislation. The following information contains the new language and the legislative citation.

Nothing in this section shall prohibit or limit the ability of a licensed alcohol and drug counselor from practicing alcohol and drug counseling with an individual diagnosed with a co-occurring mental health disorder other than alcohol and drug dependency provided the licensed alcohol and drug counselor works within the scope of practice outlined in CGS 20-74s(a)(4)

Section 22,

<https://www.cga.ct.gov/2017/BA/2017HB-07222-R01-BA.htm>

The CAAP Board of Directors gained many valuable lessons during this very difficult process. Because of the complexity of the matter and the severity of impact on our state's addiction specialists' workforce. CAAP wanted to formally submit and post key information on its website with its membership, supporters, professional colleagues, and state residents.

CAAP's 2017 Advocacy to Support the Workforce of the State's LADCs Background and History

At the beginning of the 2017 General Assembly, CAAP was approached by the Alliance of Non-Profits regarding the licensed addiction counselor's (LADCs) scope of practice.

The Alliance representatives provided information to CAAP that a violation identified by the Department of Public Health during a regulatory visit to a behavioral health provider cited that a client with active mental health symptoms, other than alcohol and drug dependency, was seen only by a LADC and best practice standards dictate that the client needed to be referred to an appropriate mental health provider for further mental health assessment. This regulatory violation an agency happened agency several months earlier. This confusion around the LADC Scope of Practice ignited a series of severe unintended consequences, which involved many agencies and the Department of Social Services and most importantly, put the state's addiction specialists' professional future in jeopardy.

It is CAAP's practice to thoroughly investigate matters, which seriously impact the state's workforce of addiction professionals' capacity (as stated in the CT Practice License Statute) to deliver best practice treatment to state residents, who are struggling with Substance Use Disorder, and their families, partners, etc.

The information gathering's range was broad and detailed with fact-finding, beginning in the last days of December 2016 throughout the first six months of 2017. CAAP Board Members received reports from LADCs across the state. These treatment providers were representative of the diversity of our state's workforce of LADCs. Affected LADCs in an out-patient behavioral health & even SA agencies, criminal justice & DOC programs, IOPs in various venues, state colleges' addiction training programs, and independent practitioners reached out to the Association for help and guidance.

Impact

LADCs reported harmful professional consequences regarding their current employment and ability to provide treatment for substance use disorders due to the DPH "interpretation" of LADCs' Scope of Practice. CAAP identified activities and actions that harmed the LADCs' professional integrity and employability. The following are the chief issues which negatively impacted the workforce of addiction professionals during a six month period.

- *Many agencies across the state ceased hiring LADCs, even for the treatment of SA.*
- *Although the DSS Commissioner rescinded his December 2016 Bulletin that restricted LADCs' delivery of services to Medicaid clients, CAAP continued to receive complaints that DSS was not reimbursing LADCs for services rendered to the Medicaid consumer.*
- **Update-** *CAAP and its supporters' advocacy to DSS finally resulted in the correction of DSS reimbursements. LADCs are receiving payment for their services to Medicaid clients, effective April 17th.*
- *Alcohol and Drug educational programs in state community colleges experienced serious difficulties in placing interns at agencies, which had previously accepted interns, because of the "professional cloud surrounding LADCs.*
- *The unintended consequences that occurred from the findings of the DPH regulatory site visit and the miscommunication about the visit. The result was a severe fracture of necessary, seamless behavioral treatment for residents with co-occurring disorders. Residents faced with seeking two providers- one for SUD & one for mental health disorders. Thus, the state was time-traveling backwards-returning to the old days of the 1950s- the unconnected treatment separation of addiction disorders and mental health disorders*
- **CT residents with SUDs lost the assurance that they will be treated by the statutorily identified licensed provider, LADC, who is the specialist in best practice and evidence- based treatment for addictions.**

In a key evidence and information sharing activity, during this period, I had a meeting with Chris Andresen, Section Chief of the DPH Licensing Division to review the salient points of the Scope of Services' issue. We had a comprehensive and productive conversation regarding the unintended consequences of the interpretation and potential remedies. Mr. Andresen was both very empathetic and helpful to the process.

ACTION

At the beginning of May, the CAAP Board of Directors held an emergency meeting. The Board examined all the evidence relative to the matter. The Board perceived that the crisis was escalating. The Board also considered that with the state's budget crisis, the destructive impact on LADCs would likely intensify. The CAAP Board voted to take immediate action on the worsening situation and charged me with implementing the Board's Plan of Action.

Following the CAAP Board of Director's vote and recommendation, I reached out to Senator Terry Gerratana, Chair of the Public Health Committee, whom I had kept apprised of the LADC matter. I also wrote to the leadership of the Public Health Committee to ensure transparency in all communication. In my electronic reports,

I presented the **facts**---history, evidence, and severe unintended consequences that necessitated finding a timely solution to the problem.

At this time, I also contacted Senator Martin Looney, President of the Senate. I had a lengthy conversation with Sen. Looney that covered the background of the issue and serious impact on the state's addiction specialists. I emphasized the severe problems that it caused for LADCs to provide best practice treatment to individuals with SUD and their families and partners during these challenging times. Senator Looney was most concerned and offered his support in finding a remedy.

RESOLUTION

Senator Gerratana and Senator Looney went to DPH the following week to meet with Chris Andresen and other DPH staff. The afternoon of the meeting, Mr. Andresen contacted me with proposed language that presented a reset on LADCs' authority to treat individuals with co-occurring disorders. On behalf of CAAP, I accepted the language. We also discussed the submission of the SAMSHA Tier IV Scope of Practice during the DPH allotted date. The following is the corrective language. It would be included in the DPH Revisor Bill.

Nothing in this section shall prohibit or limit the ability of a licensed alcohol and drug counselor from practicing alcohol and drug counseling with an individual diagnosed with a co-occurring mental health disorder other than alcohol and drug dependency provided the licensed alcohol and drug counselor works within the scope of practice outlined in CGS 20-74s(a)(4)

A week later, Mr. Andresen sent a copy of a letter that he distributed to Connecticut's substance abuse treatment agencies, programs, and other venues providing SA TX. I am attaching the correspondence for the record.

The CAAP Board of Directors knows that its members, supporters, and state residents, who are consumers of SA TX services will agree that this remedy is of great benefit to the state's substance abuse professionals at a time of severe financial crisis for all state behavioral health service providers.

This outcome demonstrates one of CAAP's guiding principles- **Collaboration**. On behalf of CAAP, I want to express our gratitude to Senator Gerratana, Senator Looney, the leadership of the Public Health Committee, Chris Andresen and staff of DPH's Licensing Division, and the dedicated members of CAAP, for their valued support.

1. COPY OF DPH LETTER SENT TO LICENSED MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT AGENCIES STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H. Commissioner

Dannel P. Malloy Governor

Nancy Wyman Lt. Governor

May 16, 2017

Dear Connecticut Licensed Mental Health and Substance Abuse Treatment Agencies,

It has come to the Department's attention that there may be some confusion regarding the statutory scope of practice for Licensed Alcohol and Drug Counselors (LADCs) in Connecticut and the types of clients that the Law permits LADCs to serve. The scope of practice for LADCs in the Connecticut General Statutes, pursuant to Section 20-74s (a)(4) reads:

"Practice of alcohol and drug counseling" means the professional application of methods that assist an individual or group to develop an understanding of alcohol and drug dependency problems, define goals, and plan action reflecting the individual's or group's interest, abilities and needs as affected by alcohol and drug dependency problems, and may include, as appropriate, (AJ conducting a substance use disorder screening or psychosocial history evaluation of an individual to document the individual's use of drugs prescribed/or pain, other prescribed drugs, illegal drugs and alcohol to determine the individual's risk/or substance abuse, (BJ developing a preliminary diagnosis for the individual based on such screening or evaluation, (CJ determining the individual's risk for abuse of drugs prescribed for pain, other prescribed drugs, illegal drugs and alcohol, (DJ developing a treatment plan and referral options for the individual to ensure the individual's recovery support needs are met, and (EJ developing and submitting an opioid use consultation report to an individual's primary care provider to be reviewed by the primary care provider and included in the individual's medical record. "

he statutes related to LADCs do not restrict the type of client that a LADC can serve. LADCs may provide services to individuals with a substance use disorder, to individuals with co-occurring disorders or to individuals without a substance abuse disorder diagnosis who are affected by alcohol and drug dependency problems. However, like any licensed professional, LADCs must work within the boundaries of the scope of practice for their profession established in statute. Please be aware that a statutory scope of practice delineates the boundaries of the services a licensed professional can provide within their practice and the services allowed by licensure may or may not align easily with reimbursement decisions by third party payers. We hope that this information is helpful.

s~ Christian D. Andresen, Section Chief,

Practitioner Licensing and Investigations Section Connecticut Department of Public Health

2. Copy of DSS Notification on Reimbursement Policies for *Psychiatric Diagnosis Evaluation/ 90791* Department of Social Services:

interChange Provider Important Message

Attention: Licensed Alcohol and Drug Counselors (LADCs) The Department of Social Services (DSS) has approved procedure code 90791 “Psychiatric Diagnostic Evaluation” to be covered for Licensed Alcohol and Drug Counselors (LADCs) effective for dates of service October 1, 2016 and forward. DXC Technology updated their system on Thursday, April 13, 2017 to allow these services to be processed. LADC providers can resubmit any previously denied claims containing procedure code 90791 starting Thursday April 13, 2017. Prior Authorization (PA) is required for this service and any claims submitted without a PA from Beacon Options will be denied with Explanation of Benefits (EOB) code 3003 “Prior Authorization is Required for Payment of this Service”. **For additional information on the scope of practice for LADC providers, please refer to Provider Bulletin 2017-01 “Scope of Practice for Licensed Alcohol and Drug Counselors – Updated Policy Transmittal”.**

III. EXTRACT from Surgeon General’s Report “Facing Addiction”

November 17, 2016

KEY FINDINGS from Chapter 6 on *Health Systems*:

- “ Well-supported scientific evidence shows that the traditional separation of substance use disorder treatment and mental health services from mainstream health care has created obstacles to successful care coordination. Efforts are needed to support integrating screening, assessments, interventions, use of medications, and care coordination between general health systems and specialty substance use disorder treatment programs or services.
- Supported scientific evidence indicates that closer integration of substance use-related services in mainstream health care systems will have value to both systems. Substance use disorders are medical conditions and their treatment has impacts on and is impacted by other mental and physical health conditions. Integration can help address health disparities, reduce health care costs for both patients and family members, and improve general health outcomes.
- Supported scientific evidence indicates that individuals with substance use disorders often access the health care system for reasons other than their substance use disorder. Many do not seek specialty treatment but they are over-represented in many general health care settings.
- Promising scientific evidence suggests that integrating care for substance use disorders into mainstream health care can increase the quality, effectiveness, and efficiency of health care. Many of the health home and chronic care model practices now used by mainstream health care to manage other diseases could be extended to include the management of substance use disorders.
- Insurance coverage for substance use disorder services is becoming more robust as a result of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act. The Affordable Care Act also requires non-grandfathered individual and small group market plans to cover services to prevent and treat substance use disorders...”

**The Centers for Disease Control and Prevention (CDC) summarizes strength of evidence as: "Well-supported": when evidence is derived from multiple controlled trials or large-scale population studies; "Supported": when evidence is derived from rigorous but fewer or smaller trials; and "Promising": when evidence is derived from a practical or clinical sense and is widely practiced.*

Submitted by Susan Campion, LADC LMFT

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