Report to the General Assembly

An Act Concerning the Department of Public Health's Oversight Responsibilities relating to Scope of Practice Determinations:

Scope of Practice Review Committee Report on
Licensed Alcohol and Drug Counselors

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State of Connecticut
Department of Public Health
Report to the General Assembly

An Act Concerning the Department of Public Health's Oversight Responsibilities relating to Scope of Practice Determinations for Health Care Professions: Licensed Alcohol and Drug Counselors

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Executive Summary

In accordance with Connecticut General Statutes (CGS) Section 19a-16d through 19a-16f, the Connecticut Association of Addiction Professionals (CAAP) submitted a scope of practice request to the Department of Public Health to revise the scope of practice of Licensed Alcohol and Drug Counselors (LADCs) to align more closely with the education and training required for licensure. The CAAP used the 2011 Scope of Practice in the Field of Substance Use Disorder Counseling, developed with support from the Substance Abuse and Mental Health Services Administration (SAMSHA), to guide the proposed updated scope.

A scope of practice review committee was established to review and evaluate the request as well as subsequent written responses to the request and additional information that was gathered through the review process. The committee was supportive of an updated scope of practice for LADCs and recognized that the current scope of practice was outdated and restrictive. The group acknowledged the growing need for trained addiction professionals to address substance abuse disorders, and especially in light of the current opioid crisis facing Connecticut and the nation.

In reviewing and evaluating the information presented, the scope of practice committee focused on assessing any public health and safety risks associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training.
Although the committee met once, the group was supportive of the concept of updating the scope of practice for LADCs in Connecticut.

Background

Connecticut General Statute Section 19a-16d through 19a-16f establishes a process for the submission and review of requests from health care professions seeking to revise or establish a scope of practice prior to consideration by the General Assembly. Under the provisions of this act, persons or entities acting on behalf of a health care profession that may be directly impacted by a scope of practice request may submit a written impact statement to the Department of Public Health. The Commissioner of Public Health shall, within available appropriations, establish and appoint members to a scope of practice review committee for each timely scope of practice request received by the Department. Committees shall consist of the following members:

1. Two members recommended by the requestor to represent the health care profession making the scope of practice request;
2. Two members recommended by each person or entity that has submitted a written impact statement to represent the health care profession(s) directly impacted by the scope of practice request;
3. The Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, non-voting member of the committee.

Scope of practice review committees shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an assessment of any public health and safety risks that may be associated with the request, whether the request my enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. Upon concluding its review and evaluation of the scope of practice request, the committee shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The Department of Public Health (DPH) is responsible for receiving requests and for establishing and providing support to the review committees, within available appropriations.

Scope of Practice Request

The Connecticut Association of Addiction Professionals (CAAP) submitted a request for the Department to convene a scope of practice review committee regarding Licensed Alcohol and Drug Counselors (LADCs). The CAAP proposed using the description of the highest level category of substance use disorder counseling from the 2011 Scope of Practice in the Field of Substance Use Disorder Counseling, developed with support from the Substance Abuse and Mental Health Services Administration (SAMSHA) as the scope of practice for LADCs in Connecticut:

Practice of Independent Clinical Substance Use Disorder Counselor/Supervisor
An Independent Clinical Substance Use Disorder Treatment Counselor/Supervisor typically has a Masters or other post graduate degree and 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 Planning for SUDs and CODs, including initial, ongoing, continuity of care, discharge, and planning for relapse prevention;*
3. *Referrals;*
4. *Service Coordination and case management in the areas of SUDs and CODs;*
5. *Counseling, therapy, trauma informed care, and psycho-education with individuals, families, and groups in the areas of SUDs and CODs;*
6. *Client, Family and Community Education ;*
7. *Documentation;*
8. *Professional and Ethical Responsibilities;*
9. *Clinical supervisory responsibilities for all categories of SUD Counselors*

The 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.

Impact Statements and Responses to Impact Statements

The Connecticut Hospital Association submitted an impact statement requesting to participate on the review committee describing that a scope of practice change would require hospital policies and procedures to be changed. The CAAP provided a response. Both letters are included in the appendices.

Scope of Practice Review Committee Membership

In accordance with the provisions of Public Act 11-209, a scope of practice review committee was established to review and evaluate the scope of practice request submitted by The Connecticut Association of Addiction Professionals. Membership on the scope of practice review committee included representation from:

1. Connecticut Association of Addiction Professionals
2. Connecticut Chapter of the National Association of Social Workers;
3. Connecticut Counseling Association;
4. Connecticut Division of the American Association of Marriage and Family Therapy;
5. The Connecticut Hospital Association; and
6. The Commissioner's designee (chairperson and ex-officio, non-voting member).

Scope of Practice Review Committee Evaluation of Request

Health & Safety Benefits

Committee participants agreed that Licensed Alcohol and Drug Counselors (LADCs) are a valuable resource to address the opioid epidemic. The group also agreed that the current scope of practice is outdated and restrictive in relationship to the qualifications for licensure as an LADC. Enhancing the scope of practice to align with the education and training required to become an LADC will ensure that the LADC workforce can continue to provide important treatment services to individuals with substance use disorders (SUDs) and co-occurring disorders (COD).

Access to Healthcare

The expansion and clarification of the LADC scope of practice will help to ensure that the pool of licensed professionals in Connecticut is working to the full extent of their education and training. The expansion in scope to clarifies that LADCs can assess, diagnose, and treat SUDs and CODs will provide assurance and clarification to employers and consumers of the services that LADCs are authorized to provide. Recent circumstances created some confusion among some service providers regarding the scope of practice of LADCs. The current opioid crisis amplifies the need for access to licensed professionals working to the full extent of their education and training to provide substance use disorder services.

Laws Governing the Profession

Chapter 376b of the Connecticut General Statutes governs alcohol and drug counselors in Connecticut. This chapter defines the requirements for certification and licensure as an alcohol and drug counselor. Certified Alcohol and Drug Counselors (CADCs) are not required to have a Master's Degree. However, the current scope of practice in this chapter applies to both licensed and certified alcohol and drug counselors.

Current Requirements for Education and Training and Applicable Certification Requirements

The current requirements for Connecticut licensure as an LADC are:

- Attainment 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;
- Three hundred hours of supervised practical training in alcohol and drug counseling;
- A minimum of two years of supervised paid work experience or unpaid internship that entailed working directly with alcohol and drug clients;
- 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;
- 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.

Summary of Known Scope of Practice Changes

The current scope of practice for alcohol and drug counseling in the Connecticut General Statutes 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, (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 overall scope of practice has not drastically changed since inception. However, specific descriptions of services were added (A-E above) as a result of Public Act 16-43 An Act Concerning Opioids and Access to Overdose Reversal Drugs. The language intends to promote the services of LADCs for primary medical providers to refer patients who exhibit early warning signs of opioid abuse, to addiction specialists for evaluation and treatment recommendations in the management of pain meds.

In 2017, language was in section 22 of Public Act 17-146 added to the LADC chapter in the Connecticut General Statutes to clarify that an LADC may provide services to individuals with CODs:

> *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 20-74s(a)(4).

There have been no significant changes to the scope of practice for LADCs commensurate with the 2013 revision to education requirements for licensure. This revision required a master's degree in social work, marriage and family therapy, counseling, psychology, or a related field.

Impact on Existing Relationships within the Health Care Delivery System

The LADCs describe an existing and collegial relationship with other licensed health practitioners, especially other licensed mental health practitioners. There were no negative impacts on existing relationships within the health care delivery system identified. The other professions that participated in the scope of practice meeting for LADCs did not indicated objections to the concepts discussed. However, there was discussion that that the scope of practice should not restrict the type of professional that may supervise an LADC or the setting in which an LADC may work.

Economic Impact

The major economic impact described is that ensuring licensed addiction professionals are able to work to the full extent of their training and education which will help address the economic impact of the costly opioid epidemic. Additionally, LADCs may be provided more opportunities for employment with a clearly stated scope of practice that matches their education and training.

Regional and National Trends

Enhancing the LADC scope of practice will more closely align Connecticut with states that have adopted or are in the process of adopting the SAMSHA standards.

Other Health Care Professions that may be impacted by the Scope of Practice Request as Identified by the Requestor

LADCs intend to continue to work with other licensed health care professionals, especially those in the mental health field, to address the current opioid epidemic and substance use disorders in general. No professions expressed opposition to the concepts discussed at the scope of practice meeting. However, there was discussion that the scope of practice should not restrict the type of professional that may supervise an LADC or the setting in which an LADC may work.

Description of How the Request Relates to the Professions Ability to Practice to the Full Extent of the Profession's Education and Training

Educational standards for Licensed Alcohol and Drug Counselors (LADCs) were revised without a commensurate expansion of the scope of practice. The scope of practice committee agreed that the current scope of practice for LADCs is restrictive and outdated, and does not reflect the level of care an LADC is educated and trained to provide to people with substance use disorder. There is also no differentiation in scope of practice between certified alcohol and drug counselors (NOT masters trained) and LADCs. The committee agreed that the training and education of LADCs qualifies those licensed to assess, diagnose, and treat substance use disorders and co-occurring disorders, and that this is not clearly reflected in the current scope of practice for LADCs in Connecticut statute.

Findings/Conclusions

The scope of practice committee met on November 28, 2017. The committee did not complete discussion and deliberation on the proposal at the meeting. The Department attempted to schedule another meeting for the group, but the CAAP declined to meet again in December because it was working on its 2018 legislative agenda.

The Department did not feel that it would be valuable to convene the committee members for a second meeting without the participation of the CAAP. However, the Department was committed to fulfilling its statutory responsibility to submit a report to the Public Health Committee since the CAAP proposal was one of the two proposals, out of six submitted, that the Department selected for the process.

The review committee was supportive of revising the scope of practice to clearly state that an LADC can screen, assess, and diagnose substance use disorders and co-occurring disorders. There was no opposition to this concept expressed, but the proposed language from the SAMHSA document raised some questions and did not seem appropriate for statute. The reason for these questions is that some of the SAMHSA document language was describing a multi-tiered licensing structure that did not apply to the two-tiered structure in Connecticut including some ambiguous language regarding supervision and settings that might cause confusion in statute.

The review committee also discussed the concept of an LADC with a specialized addiction certification (e.g. gambling addiction certification) being able to treat that addiction in the absence of an addiction to substances. Although the review committee seemed receptive to the concept, the CAAP rejected the idea. The CAAP expressed that an LADC can treat a non-substance addiction like gambling addiction as a co-occurring disorder, but not as a "stand alone" condition. The CAAP referenced the perspective of its national association and experts in the field of addiction.

Although the proposal was related to LADCs, the group recognized that the scope of practice for an LADC could not be revised without taking the scope of practice of Certified Alcohol and Drug Counselors (CADCs) into consideration. CADCs do not possess a master's degree, but there is no scope of practice differentiation between LADCs and CADCs in current statute.

The Department continued to communicate with the CAAP after the November 28th meeting to discuss the need for clear statutory language and a differentiation of scope between LADCs and CADCs. The CAAP explained that the intention for the addition of A-E to the Alcohol and Drug Counselor scope through Public Act 16-43 was specific to LADCs. Therefore, the CAAP believes that the proposed scope of practice for CADCs should be the scope prior to Public Act 16-43 that applied to both CADCs and LADCs.

A draft revised scope of practice for LADCs was discussed. The CAAP was generally supportive of the draft language. The language was also shared with the members of the committee and no objection was expressed. The draft language for the scope of practice for LADCs discussed is:

<u>"Practice of alcohol and drug counseling" by a licensed alcohol and drug counselor means the clinical evaluation of substance use disorders and clinical co-occurring disorders including screening,</u>

assessment, and diagnosis; treatment planning for substance use disorders and co-occurring disorders; counseling, therapy, trauma-informed care, and psychoeducation with individuals, families, and groups in the areas of substance use disorders and co-occurring disorders; 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 Department and the CAAP also discussed the scope of a certified alcohol and drug counselor (CADC) as it had been prior to the addition of A-E above via Public Act 16-43.

"Practice of alcohol and drug counseling" by a certified alcohol and drug counselor 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.

The CAAP may also ask for clarification that an LADC is among the mental health professionals that can provide supervision to those in training to become a CADC or LADC.

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Appendix A

Scope of Practice Law

Scope of Practice Law

Connecticut General Statutes
19a-16d - 19a-6f

Sec. 19a-16d. Submission of scope of practice requests and written impact statements to Department of Public Health. Requests for exemption. Notification and publication of requests. (a) Any person or entity, acting on behalf of a health care profession that seeks to establish a new scope of practice or change a profession's scope of practice, may submit a written scope of practice request to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(b) (1) Any written scope of practice request submitted to the Department of Public Health pursuant to subsection (a) of this section shall include the following information:

(A) A plain language description of the request;

(B) Public health and safety benefits that the requestor believes will be achieved should the request be implemented and, if applicable, a description of any harm to public health and safety should the request not be implemented;

(C) The impact that the request will have on public access to health care;

(D) A brief summary of state or federal laws that govern the health care profession making the request;

(E) The state's current regulatory oversight of the health care profession making the request;

(F) All current education, training and examination requirements and any relevant certification requirements applicable to the health care profession making the request;

(G) A summary of known scope of practice changes either requested or enacted concerning the health care profession in the five-year period preceding the date of the request;

(H) The extent to which the request directly impacts existing relationships within the health care delivery system;

(I) The anticipated economic impact of the request on the health care delivery system;

(J) Regional and national trends concerning licensure of the health care profession making the request and a summary of relevant scope of practice provisions enacted in other states;

(K) Identification of any health care professions that can reasonably be anticipated to be directly impacted by the request, the nature of the impact and efforts made by the requestor to discuss the request with such health care professions; and

(L) A description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training.

(2) In lieu of submitting a scope of practice request as described in subdivision (1) of this subsection, any person or entity acting on behalf of a health care profession may submit a request for an exemption from the processes described in this section and section 19a-16e. A request for exemption shall include a plain language description of the request and the reasons for the request for exemption, including, but not limited to: (A) Exigent circumstances which necessitate an immediate response to the scope of practice request, (B) the lack of any dispute concerning the scope of practice request, or (C) any outstanding issues among health care professions concerning the scope of practice request can easily be resolved. Such request for exemption shall be submitted to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(c) In any year in which a scope of practice request is received pursuant to this section, not later than September fifteenth of the year preceding the commencement of the next regular session of the General Assembly, the Department of Public Health, within available appropriations, shall: (1) Provide written notification to the joint standing committee of the General Assembly having cognizance of matters relating to public health of any health care profession that has submitted a scope of practice request, including any request for exemption, to the department pursuant to this section; and (2) post any such request, including any request for exemption, and the name and address of the requestor on the department's web site.

(d) Any person or entity, acting on behalf of a health care profession that may be directly impacted by a scope of practice request submitted pursuant to this section, may submit to the

department a written statement identifying the nature of the impact not later than October first of the year preceding the next regular session of the General Assembly. Any such person or entity directly impacted by a scope of practice request shall indicate the nature of the impact taking into consideration the criteria set forth in subsection (b) of this section and shall provide a copy of the written impact statement to the requestor. Not later than October fifteenth of such year, the requestor shall submit a written response to the department and any person or entity that has provided a written impact statement. The requestor's written response shall include, but not be limited to, a description of areas of agreement and disagreement between the respective health care professions.

Sec. 19a-16e. Scope of practice review committees. Membership. Duties. (a) On or before November first of the year preceding the commencement of the next regular session of the General Assembly, the Commissioner of Public Health shall, within available appropriations allocated to the department, establish and appoint members to a scope of practice review committee for each timely scope of practice request submitted to the department pursuant to section 19a-16d. Committees established pursuant to this section shall consist of the following members: (1) Two members recommended by the requestor to represent the health care profession making the scope of practice request; (2) two members recommended by each person or entity that has submitted a written impact statement pursuant to subsection (d) of section 19a-16d to represent the health care professions directly impacted by the scope of practice request; and (3) the Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, nonvoting member of the committee. The Commissioner of Public Health or the commissioner's designee shall serve as the chairperson of any such committee. The Commissioner of Public Health may appoint additional members to any committee established pursuant to this section to include representatives from health care professions having a proximate relationship to the underlying request if the commissioner or the commissioner's designee determines that such expansion would be beneficial to a resolution of the issues presented. Any member of such committee shall serve without compensation.

(b) Any committee established pursuant to this section shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an

assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. The committee, when carrying out the duties prescribed in this section, may seek input on the scope of practice request from the Department of Public Health and such other entities as the committee determines necessary in order to provide its written findings as described in subsection (c) of this section.

(c) The committee, upon concluding its review and evaluation of the scope of practice request, shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The committee shall provide the written findings to said joint standing committee not later than the February first following the date of the committee's establishment. The committee shall include with its written findings all materials that were presented to the committee for review and consideration during the review process. The committee shall terminate on the date that it submits its written findings to said joint standing committee.

Sec. 19a-16f. Report to General Assembly on scope of practice review processes. On or before January 1, 2013, the Commissioner of Public Health shall evaluate the processes implemented pursuant to sections 19a-16d and 19a-16e and report to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a, on the effectiveness of such processes in addressing scope of practice requests. Such report may also include recommendations from the committee concerning measures that could be implemented to improve the scope of practice review process.

Appendix B

Committee Membership

Licensed Alcohol and Drug Counselors
Committee Membership

All participating organizations are reflected; however substituted individual committee members may not be listed

Name of Organization	**Committee Members**
CT Department of Public Health (DPH)	Christian Andresen, Chairperson, Ex-Oficio Meghan Bennett
CT Association for Addiction Professionals (CAAP)	Susan Campion, LADC, LMFT Darlene Shuff-Porter
CT Association of Marital & Family Therapists (CTAMFT)	Kate McGetrick
CT Counseling Association (CCA)	Reginald Holt, Ph.D
CT Psychological Association (CPA)	Barbara Bunk, Ph.D Traci Cipriano Steven Moore, Ph.D
CT Hospital Association (CHA)	Karen Buckley
National Association of Social Workers - CT (NASW)	Thomas Broffman, Ph.D

Appendix C

Original Scope of Practice Request and Attachments

Connecticut Association of Addiction Professionals

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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 Statues-*Alcohol and Drug Counselors, Chapter 376, Section 20-74s (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 20-74s 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 medic al 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 statue 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 statue 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 Statue, 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 20-74s(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 statues 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 statues to discern if the disorder of Gambling is included in the state's statues 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 statues.**

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'sl 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 special 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:**

- **Nine times greater risk of congestive heart failure.**
- **12 times greater risk of liver cirrhosis.**
- **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".10 11. 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" inN Engl J Med 2016; 374:1253-1263March 31, 2016DOI: 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 Statue, Chapter 376 6

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

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

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

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-l 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 d o 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 anIC&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 statue.
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 20-74s(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 20-74s 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 statues 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 (**Section20-74a.)** 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. An recovering individuals 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 form 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 tof 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 <u>license by profession model</u>. 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 statue. 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 statue.

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 stature 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' statue 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 Professional's 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 statue.

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 statue, 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 statue) 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 statue, 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 Statue, 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 Statue) 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 Jaw 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 Syste*ms:

- " 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

CT Association of Addiction Professionals' Evidence Archives

Appendix D

Impact Statements

CONNECTICUT HOSPITAL ASSOCIATION

MEMORANDUM

TO: Meghan Bennett, Practitioner Licensing and Investigations Section
Connecticut Department of Public Health

FROM: Karen Buckley, Vice President, Advocacy

DATE: September 28, 2017

SUBJECT: Impact Statement – Scope of Practice Request – Connecticut Association of Addiction Professionals

The Connecticut Hospital Association (CHA), a trade association representing 27 acute care hospitals in Connecticut, submits this impact statement, in accordance with Chapter 368a of the Connecticut General Statutes, in response to the scope of practice change requested by the Connecticut Association of Addiction Professionals. The change requested would modify the current scope of practice of Alcohol and Drug counselors to specifically permit screenings, diagnosis and treatment plans and referral options as it relates to substance use and the creation of an opioid use consultation report.

A change to the current scope of practice, even if just to provide clarification as suggested in the submission, will lead to changes in the delivery of care to patients with substance and opioid use dependency. Connecticut hospitals are actively involved in addressing the significant mental health, substance and opioid use issues with which patients present. Connecticut's hospitals employ or utilize a significant number of licensed healthcare professionals including physicians, advanced practice registered nurses, physician assistants, and other allied health professionals and believe that the request will impact the delivery of care to hospital patients and require hospital policies and procedures to be changed.

If the Department appoints a Scope of Practice Review Committee, CHA respectfully requests an appointment to the Committee.

KMB:ljs
By E-mail
cc: Susan Campion, LADC, LMFT, President, Connecticut Association of Addiction Professionals

Appendix E

Response to Impact Statements

Connecticut Association of Addiction Professionals

Meghan Bennett,
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: meghan.bennett@ct.gov
c/Chris Andresen, Section Chief of the DPH Licensing Division
c/K. Buckley, Vice-President Advocacy, CT Hospital Association
Date: October 11, 2017

Response to Impact Statement submitted Karen Buckley, Vice President Advocacy, CT Hospital Association

Dear Ms. Bennett:
I am replying, as President of the CT Association of Addiction Professionals, to a "scope of practice " impact statement submitted by a Ms. Buckley of the Connecticut Hospital Association regarding our Association's submission of its 2017 Scope of Practice to the Review Committee on Scopes under the auspices of the CT Department of Public Health. the LADC 's current scope of practice. With all due respect to Ms. Buckley, it is quite difficult for me to her comments on the scope of service cited in :

AN ACT CONCERNING OPIOIDS AND ACCESS TO OVERDOSE REVERSAL DRUGS. 2016 HB 5053Sec. 6. Subdivision (4) of subsection (a) of section 20-74s 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.

I may be mistaken, but I understood that responses from affected parties on the **2017** submitted revisions for a professional Scope of Practice was to the proposed content of changes. Ms. Buckley's comments refer to the 2016 Law contained in Governor Malloy's omnibus legislation. It is important to note that the CAAP legislation underwent intense scrutiny by a multitude of- individuals, stakeholders, legislators, and state residents. **Section 6** (CAAP public policy) went through the required process for the passage of legislation (scope of practice included)- public and submitted testimonies at the Public Health Committee Hearing on the CAAP proposed legislation, unanimous approval by the Public Health Committee to vote the Section out of the PHC Committee, and unanimous approval by the General Assembly. CAAP learned after the passage of the legislation that there were approximately **50** proposed bills related to the state's Opioid Epidemic in 2016.

The CAAP legislative initiative was created as a specialty health resource for CT PCPS-- if the PCP chooses to engage the LADC,. The LADC proposed policy went thru a lengthy, transparent, and inclusive process to become law.

On behalf of CAAP, I think that it will be helpful for the CT Hospital Association to gain a clear understanding of the Scope of Service that Ms. Buckley presents "will lead to changes in the delivery of care to patients with substance abuse and opioid use issues." More concerning and puzzling was her statement that CAAP's request will impact the "...delivery of care to hospital patients and require hospital policies and procedures to be changed." ????

Introduction

Because Ms. Buckley specifically questions the LADC Scope of Practice on Opioid Abuse that became law in 2016, I will address her points.

- The Scope of Practice relative to opioid use refers to **services rendered on an out-patient basis. There is no mention in the law of these specialized services being performed by LADCs in hospital settings.**
- The law, as in the 2017 Scope or Practice, does not refer or detract from the role, qualifications, and services of LADCs colleagues, licensed medical and allied healthcare professionals, who work in CT hospitals.
- The opioid law's language emphatically states that LADCs **"may"** perform the specialized prevention and early intervention services. **A PCP is the sole authority in patient care** and therefore, **may choose** to refer to an LADC based upon the PCP's clinical judgement of what services are needed to aid his or her patient, who presents with early warning signs of opioid abuse.
- Ms. Buckley's comments raise yet another area of confusion. The Review Committee, as well as, state residents are aware of the current budget crisis, serious cutbacks in behavioral health services including treatment for opioid abuse addiction. Since 2015 till the present, there have been countless community presentations, TV, multi-media, and print stories from hospitals reporting the crushing burden on medical staff, allied health professionals, and especially ER personnel caused by the admission of opioid addicted patients. CT hospitals understandably emphasize the severe financial costs associated with the treatment of opioid addiction. The LADC opioid-related Scope of Practice's intent and goal is **to prevent and intervene in an individual's dependence on opioids, as the early warning signs appear. This goal is both enlightened, pragmatic, and most importantly human in its intent to avoid the horrific medical, psychological, financial, and social consequences of opioid dependence. The law, as intended, is meant to lessen the burden of treatment of opioid dependence in a hospital setting.**
- 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 and healthcare 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.

Introduction to CAAP.

The Connecticut Association of Addiction Professionals (CAAP) represents over 850 credentialed addiction specialists. It is the State Affiliate for the National Association of Alcohol and Drug Abuse Counselors. The Association is 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**. The licensed addiction specialist, LADC, is the statutorily recognized (law passed in 1998) professional provider of addiction services in Connecticut, who has met credentialing requirements, which encompass best practice standards of care in the treatment of addictions.**

In the 2015 Spring Edition of NAADAC's publication, "Advances in Addiction and Recovery", Connecticut 's license, LADC, was nationally recognized as one of the five state licenses that established the national standard and precedent in meeting the fundamentals of excellence in the licensure of addiction specialists.

Supportive Evidence for the 2016 LADC Scope of Practice Law

Connecticut's policy to intervene in the early stages of opioid abuse reflects the call to action by two of the leading national experts on Addiction- *Nora D. Volkow, M.D., (Chief of NIDA)and A. Thomas McLellan, Ph.D. in their joint article on "Opioid Abuse and Chronic Pain" in N Engl J Med 2016; 374:1253-1263March 31, 2016DOI: 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.pp.105".

The following section provides a more detailed narrative of the origin, evidence, best practice standards of evidence-based treatment, and contribution to fighting the deadly barriers of Shame and Stigma in seeking help for opioid abuse and dependence.

CAAP's Role in Creating Groundbreaking Public Policy to Meet the Challenge of the State's Opioid Epidemic.

As previously noted in June 2016, the CT General Assembly passed Governor Malloy's Omnibus Opioid Abuse legislation. Over 50 bills on opioid abuse were submitted- only 10 proposals were included in the final legislation. CAAP's bill was included in the legislation. The bill was the **only treatment section** contained in the final legislation.

The law provides the statutory authority for Licensed Alcohol and Drug Counselors (LADCs), within their scope of practice, to offer state residents specialized evidence-based, early prevention and intervention services to halt the development of dependence on pain meds. As the law states primary medical provider refer their patients, who exhibit early warning signs of opioid abuse, to addiction LADCS for evaluation and treatment recommendations. The LADC will provide the PCP with an *Opioid Consultation Report* for the PCP and patient to review and discuss the Report's recommendations for treatment services.

An Example of an Intervention: How the Addiction Specialist/LADC, as a member of a primary care interdisciplinary team, meets the challenge of CT's prescription opiate and heroin epidemic

Connecticut's prescription opiate and heroin epidemic is ravaging cities and towns with overdoses and deaths. The state's heroin-related deaths have shot up from 174 in 2012 to **over 1,000** in 2017. Meanwhile, the use of heroin doubled nationally from 2007 to 2012. It would be presumptuous to infer that addiction specialists alone can solve this multi-faceted health crisis.

Research has clearly shown that for many active opioid addicts the first step to heroin addiction began with a visit to their doctor/MD for **pain management**. As an intervention for the pain, many well-intentioned 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 LADC/addiction specialist, as a key provider in meeting the challenge of active substance use disorder, will utilize his or her skill sets to conduct rapid diagnosis, assessment of disease progression, and develop a treatment plan based upon best practice standards for opiate addiction. By intervening at the time of the patient's entry into the primary care setting, the threat of overdose and/or death can be immediately addressed.

The specialized services of a licensed alcohol and drug counselor (LADC) can offer valuable interventions, like **specialized prevention and early intervention services to halt a dependence on prescription opioids.** If opioid dependence is diagnosed, the LADC will provide the **crucial compliance oversight guidance** to determine the level of clinical intervention- tapering of meds under the PCP's supervision to referral to medication- assisted therapy The LADC will render a recommended treatment plan, facilitate referrals to specialized services for patients encountered and treated by CT pediatricians, school –based clinics, internal medicine MDs, community health centers, and other clinics.

Conclusion:
It needs to be restated that the CT Association of Addiction Professionals' goal with the submission of this 2017 Scope of Practice document is not to compete with the state's licensed behavioral health, medical, and allied healthcare 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. On behalf of CAAP, I extend my appreciation to Ms. Buckley for her interest in CAAP's mission.

Submitted by,
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From **CAAP Archives:**

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.

Submitted by,
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jcbi

Appendix F

Message to Committee Members

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

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

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

January 9, 2018

Dear LADC Scope of Practice Review Committee Participants:

Thank you for participating at the November 28 scope of practice review committee convened in response to the request submitted by the CT Association of Addiction Professionals (CAAP). I appreciate the collegial and supportive participation by the organizations that attended. The CAAP proposal was one of two proposals (out of six submitted) to be selected for the process this year.

The scope of practice review process is described in Sections 19a-16d through 19a-16f of the Connecticut General Statutes and provides health professions an annual opportunity to request that the Connecticut Department of Public Health (DPH) convenes a committee to review and evaluate a new or revised scope of practice prior to the legislative session. The committee includes up to two members from the organization that submitted the request, and up to two representatives from each organization that submits an impact statement in response to the request. DPH may also appoint additional members from health care professions having a proximate relationship to the underlying request.

The process typically involves a minimum of two committee meetings. The committee meetings provide an opportunity to discuss the content of the proposal including the public health and safety benefits, any impacts to health care delivery system, and how the request may impact other professions. The outcome of the committee, per the statutes, is a report based on the discussions, debate, and deliberations during the committee meetings.

There will be no additional meetings scheduled for the LADC scope of practice review committee. The Department will be providing an abbreviated report to the Public Health Committee on the discussion that occurred during the meeting and some subsequent communication with the CAAP. I am writing to make sure that the report is reflective of the discussion and update you on subsequent communication.

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

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Please contact me by email or phone if you have any questions or comments. I'm also open to convening a conference call if enough of you feel that would be helpful or necessary.

Here is a summary of what the Department plans to share in the report it is required to submit to the Public Health Committee:

November 28, 2017 meeting:

- Educational standards for Licensed Alcohol and Drug Counselors (LADCs) were increased without a commensurate expansion of the scope of practice.

- Committee participants supported the concept of enhancing and expanding the LADC scope of practice in Connecticut's statutes to reflect the education and training required to become an LADC. These requirements include:
    - attainment 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;
    - three hundred hours of supervised practical training in alcohol and drug counseling;
    - at least two years of supervised paid work experience or unpaid internship that entailed working directly with alcohol and drug clients;
    - 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;
    - 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.

- The current scope of practice for LADCs is restrictive and outdated, and does not reflect the level of care an LADC is educated and trained to provide to people with substance use disorder. There is also no differentiation in scope of practice between certified alcohol and drug counselors (NOT masters trained) and LADCs. The following is the current scope of practice in statute that applies to both certified and licensed alcohol drug counselors:

> (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 committee agreed that the training and education of LADCs qualifies those licensed to assess, diagnose, and treat substance use disorders and co-occurring disorders and that this is not clearly reflected in the current scope of practice for LADCs in Connecticut statute.

- The CAAP used the 2011 document "Scope of Practice & Career Ladder for Substance Use Disorder Counseling" that was supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), to guide its proposal for a revised LADC scope of practice in Connecticut's statutes. The proposed scope of practice in the CAAP request came directly from this document:

    - "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 committee did not disagree with most of the content of this proposed scope of practice, but felt that some of the language might be confusing and unnecessary (e.g. settings, supervision) for the purposes of a scope of practice in statute. The group did agree that the LADC scope of practice should include assessing, diagnosing, and treating substance use disorders and co-occurring disorders.

- The group also discussed the concept of an LADC treating non-substance related addictions such as gambling. The CAAP feels that the LADC's primary role is to treat substance use disorders and that non substance related addictions could be treated as a co-occurring disorder, but not as a stand-alone condition. The CAAP referenced DSM classifications and perspectives of the national addiction professionals association.

Post November 28th activity:

The Department has been in contact with the CAAP to discuss the upcoming legislative session and the CAAP's efforts to revise the scope of practice in Connecticut's statutes. A draft revised proposed scope of practice for LADCs based on the proposal and discussed between the DPH and the CAAP is:

"Practice of alcohol and drug counseling" by a licensed alcohol and drug counselor means the clinical evaluation of substance use disorders and clinical co-occurring disorders including screening, assessment, and diagnosis; treatment planning for substance use disorders and co-occurring disorders; counseling, therapy, trauma-informed care, and psychoeducation with individuals, families, and groups in the areas of substance use disorders and co-occurring disorders; 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 Department and the CAAP also discussed the scope of a certified alcohol and drug counselor (CADC) as it had been prior to the addition of A-E above via Public Act 16-43. The CAAP explained that the intention for the recently added A-E was to apply to the LADC only. Therefore the proposed clarified scope of practice for a CADC would be the scope prior to Public Act 16-43:

"Practice of alcohol and drug counseling" by a certified alcohol and drug counselor 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.

The CAAP may also ask for clarification that an LADC is among the mental health professionals that can provide supervision to those in training to become a CADC or LADC.

Next Steps:

The next step will be for the Department to provide a report to the Public Health Committee. The legislature may decide to propose language to amend the alcohol and drug counselor language in the statutes. All legislative proposals are available for public review and comment. The report from the Department is not a legislative proposal and only provides information to the legislature for its consideration when making decisions about proposing or reviewing proposed language. The CAAP is responsible for advocating for the change in statute related to the scope of practice.

You will receive a copy of this report when it is finalized.

I hope this information is helpful. Please contact me if you have any questions or would like to discuss this more.

Sincerely,

Christian D. Andresen

Christian D. Andresen
Practioner Licensing & Investigations Section