

A Planning Approach for Assessing County-Level Need, Demand, and Capacity in Drug and Alcohol Treatment Services in California

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Introduction

Total public spending for drug and alcohol treatment and prevention programs in California is approaching more than \$1 billion annually, in a “system” that operates primarily through county governments, schools, and prisons.¹ The system is fragmented, with more than fifteen separate identifiable funding streams, and no single focal point for decision-making about treatment programs. This fragmented pattern resembles a patchwork quilt of funding, with each new piece leading to a new and largely separate planning process which is not informed by previous efforts.

In seeking a more comprehensive approach to decision-making about treatment, this assessment of county-level planning has sought to build on prior reports and analyses, as well as work performed by CFF staff at the county level in more than a dozen counties over the past several years. The project team has developed a comprehensive planning tool that would enable county governments to plan for use of limited resources for the most effective programs in a consolidated network of treatment² programs.

The policy context of this study includes several recent changes in the California governmental setting for decisions about alcohol and other drug (AOD) treatment, including

- The state’s worsening budget crisis and the recent debate over realignment proposals that accompanied the Governor’s proposed budget;
- The implementation of Proposition 36;
- The March 2003 report of the Little Hoover Commission on drug and alcohol treatment, which called for wider coordination of fragmented programs and strengthened county-level planning;
- The continued movement toward treatment outcomes accountability under the federal Performance Partnership Grant requirements and the state’s CalOMS process;
- The recent experience with treatment capacity expansion under CalWORKs;
- The impact of “faster clocks” affecting substance-abusing parents in the child welfare system under the Adoption and Safe Families Act; and
- The experience of drug courts throughout the State.

In addition to work by Children and Family Futures at the county level, this review will build upon the LAO analysis of treatment capacity completed in July 1999, the RAND analysis of Proposition 36 issued in November 2000, prior and ongoing

UCLA/ISAP [previously DARC] work on needs assessment, and the Little Hoover Commission report on AOD treatment.

The budget context

Fiscal realities constrain and force decisions about both (1) *the total amount* of AOD treatment spending and (2) *the allocations* of AOD treatment spending among different agencies, modalities of treatment, drugs of choice, ethnic, gender-specific groups, and geographic areas.

In the past, counties have allocated the AOD-related funding under their control based on four primary factors:

- The mandates and categorical requirements attached by state and federal sources to each funding stream; the reimbursements available for treatment provided to certain clients under Medi-Cal regulations;
- Because local Boards of Supervisors must approve provider contracts, there is almost always a political overlay. In county operated systems, union and civil service issues come into play. Even among community based providers, there are at times tacit agreements that “carve up” the turf in a county. Sometimes the characteristics and needs of the system override the needs of the community.
- The counties’ perceptions and their analysis of
 - a. The need for treatment, and
 - b. The capacity of existing or new treatment providers to provide treatment and improve client outcomes.

The view from Realityville

From the vantage point of county agencies with responsibility for AOD programs, the one constant in AOD policy and funding is uncertainty at all levels of government. County AOD Administrators are expected to manage the system, but has little control over the macro level policy and funding decisions that drive the system. The toolkit we have developed is intended, at a minimum, to recognize this reality and to help AOD Administrators to have more control over the decisions made outside their own sphere of control which affect AOD programs and outcomes in their county.

The first three of these factors have been dominant in most planning. As one county official succinctly put it in interviews with CFF staff, “Categorical money drives the composition of the system.” To the extent that need and capacity have been taken into account, it is usually based upon projections of national or statewide prevalence data, combined with information about current services utilization, and modified by counts of “slots” in current programs.

But tools and options exist for improving county-level planning, and some counties have begun to use these. Estimates of treatment need have been developed by the state in a number of studies, most recently those of UCLA’s ISAP in 2001. These estimates of *need* have been modified by assessment of clients’ *demand* for treatment, reflecting the fact that many clients, who may objectively need treatment based on its consequences in their lives, will not seek it or stay enrolled in programs they enroll in voluntarily or to which they are referred.

The need for a better method of planning and allocating treatment funding arises in three overlapping challenges:

- The budget crisis,
- The challenge to county-level capacity created by the Governor's proposed realignment of some AOD roles and funding to counties, which although set aside in this year's budget, may recur as the state addresses its ongoing structural funding issues, and
- The challenge of proving that investments in treatment should be protected and expanded.

A final point on budget realities needs re-emphasis: AOD costs are not separate from the rest of the state budget.

The biggest opportunity to cut Medicaid costs is by preventing and treating substance abuse and addiction. Governors who want to curb child abuse, teen pregnancy and domestic violence in their states must face up to this reality: unless they prevent and treat alcohol and drug abuse and addiction, their other well-intentioned efforts are doomed.³

These projected cost offsets are a critical part of the calculation of how treatment investments affect long-term spending.

Fragmented funding creates a fragmented system: the patchwork quilt

The several streams of funding for substance abuse treatment are sub-divided into a number of programs in multiple state agencies. In recent years, as each of a series of new funding sources has become available, planning for treatment services shifts in the direction of those new funds, with the scope of the shift determined in part by the scale of the new funding. Each time this shift happens, the State's substance abuse community re-focuses its attention on the issues specific to the new funding source and target population. This results in new pieces being added to or subtracted from a patchwork quilt of funding sources—with more than fifteen different funding sources for treatment in some counties. As a result, there is no overall planning strategy for allocation of funds based on a comprehensive plan for treatment capacity expansion at the State or County level. In testimony before the Little Hoover Commission last summer, the current head of the state Department of Alcohol and Drug Programs acknowledged that

There are significant opportunities to improve the delivery of services, which are currently characterized by limited coordination, outdated infrastructure, and inconsistent application of sound business, prevention, and treatment principles.

With the advent of Proposition 36, a new cycle in the funding of substance abuse treatment in California began, and the question of California's substance abuse treatment capacity was again highlighted. Proposition 36 funds are large enough—at

roughly one-eighth of the statewide funding now available for public treatment programs from all sources—to add significant new capacity to the system. However, without clear definitions of treatment *need, demand and capacity*, these new funds are in jeopardy of becoming just the latest addition to the patchwork quilt, without a clear relationship to other funding streams and capacity. To shift the analogy, it is as though a forest fire is being fought on several fronts, with equipment and personnel rushed away from the current front each time a new outbreak occurs, regardless of the overall size and direction of the whole fire.

Before moving to considering proposed remedies, it is essential to recognize how far apart the ideals of system reform and current practice really are in a fragmented system. One recent review of the ideal system called for

- no wrong door to treatment - from any part of the human services array of agencies;
- a seamless system of appropriate services - to the client and his/her family;
- long-term, comprehensive attention to what is a long-term problem⁴

These are unquestionably desirable attributes of a reformed system. But they are so far from today's system that without setting forth a clear path to get from here to there, it is simply not credible for state leaders to issue repeated calls for the development of a system of care, when the fragmentation of the current system is worsening annually as a result of adding or subtracting patches on today's patchwork system.

A reality-based approach to ensuring better use of existing funding streams is critical to making two cases: the case for more resources and the case for streamlined use of existing resources (and, in times of budget crisis, to protect the current system from further cuts). We believe the planning framework we have laid out can help achieve this reality-based improvement.

The Remedies

There is no single tool or response that can by itself resolve today's fragmentation, since its origins are multiple. Some of its roots lie in federal policy; others flow from state policy that responds more to separate political impulses than to the need to build a broad system of care.⁵ But a critical part of the remedy is a stronger planning effort at the local level, closest to clients and communities, where client need, client demand, and system capacity can all be assessed in light of local conditions. These key concepts of *need, demand and capacity* can help describe the system and its clients as a whole, rather than as isolated programs and categories of eligibility.

As an example, if adolescent treatment is seen as a major need in a county, and law enforcement agencies have added to the demand for treatment by referring and/or mandating treatment for arrested or diverted youth, the capacity of the system to provide such services becomes critical. The next element of planning is determining how much of the total inventory of funding

available to the county is available for adolescent treatment. Once that is known, then the final and more difficult question becomes how does adolescent treatment need, modified by demand, compare with other populations' needs for treatment? This process would take need, demand, and capacity into account in arriving at an allocation for adolescent treatment that reflects all three factors. At present, however, the amount of adolescent treatment in a given county is primarily a reflection of the amount of categorical funding available for that type of treatment.

The process of weighing need, demand, and capacity as part of an effort to create a balanced system of care requires a series of steps which counties do not typically go through at present, since each new funding stream tends to create its own planning process or mandates without regard to the rest of the system. The data collection and analysis required to work across allocations would represent additional work, and it is not realistic to expect counties, whether large or small, to go through a substantially more complicated and lengthy planning process. But in interviews and work with a number of counties, it has become evident that improvements can and should be made to the current process that would have at least four beneficial effects:

- It would improve the quality and credibility of allocation decisions made by policy leaders and their staffs;
- It would improve the accountability of providers and funders for the most effective use of limited funds,
- It would expand the ability of the AOD treatment unit to mobilize other agencies' resources beyond its own directly controlled funds, which are often critical to client success; and
- It would identify the needs that are most often neglected in a fragmented funding system.

The tool we have developed in consultation with county staffs would enable progress in all four of these areas. In its initial, 5-page format (with explanatory background materials), it represents an incremental improvement that could be adopted by all counties or by regional consortia working with more than one county at a time, as in the Northern Counties Consortium. It could be adopted on a voluntary basis, and it could eventually qualify counties for bonus funding for capacity-building activities. Alternatively, elements of it could be mandated by the state, recognizing the need to allow time for local capacity to be built to respond to such a mandate.

Core Concepts

The key ideas in the proposed planning framework that we have set forth in the 5-page planning guide are the need for

- Greater emphasis upon the demand for treatment as well as the need for it, taking into account the mandated demand created by court referrals and

- the other demands for treatment created by referrals from other health and human services agencies, especially welfare and child welfare agencies;
- Greater emphasis upon the support services needed during and after treatment to achieve treatment success, along with recognition that access to these services is typically not under the control of the local AOD agency;
 - Greater emphasis upon the capability of the planning agency at the county level and the treatment provider at the community level to track client placement and progress through more in-depth treatment monitoring than is now typically done;
 - Planning that includes the full array of funding streams available to the county, not just the state general funds and block grant funds allocated by ADP.

In framing the issues of need, demand, and capacity as separate elements of local strategic planning for substance abuse treatment programs, it is important to reflect the lessons of the past several years of AOD treatment programs. Three of the most important of those lessons can be stated as follows:

- Assessment of client needs should adopt a *whole-family approach*, since responding to the needs of families of treatment clients, including parents and siblings of youth clients, is critical to many individuals' success in treatment and to preventing future need for treatment among their children.
- Developing collaborative funding and service links with other non-AOD agencies is critical to program success, since many clients require *supportive services from other systems* in order for AOD treatment to be effective and often these clients' AOD needs are first identified in other systems, not the formal AOD system. Such services include mental health, probation supervision, employment counseling, child development, transportation, services for the effects of domestic violence, and prevention of future family violence, in order for AOD treatment to be effective.
- Treatment that is embedded in an understanding of the *community norms and cultural values* in which it is being provided (including gender-specific practice) appears to be more effective in engaging clients than "one size fits all" treatment, and is more likely to be able to overcome NIMBY and other barriers to community acceptance of and support for treatment and recovery.

If these three lessons—the need for a *whole-family, whole-system, community-embedded* response to clients' needs—are taken seriously, the definitions of need, demand, and capacity must change, from a focus on single clients within the boundaries of the AOD system to a wider definition of family needs and a wider concern with the resources of non-AOD agencies. At the same time, prior emphasis on planning for *inputs* and *outputs*—clients entering the system, enrolled in program slots, and successfully completing or dropping out—must move to a wider concern for *outcomes* and the effectiveness of treatment.⁶ CalOMS offers the potential for

realizing this benefit, but the key test will be designing this system so that it is broader than the current system. That will require filling in the extensive gaps created by existing information systems—notably in the services needed by family members. Recommendations from the Little Hoover Commission report of March 2003 address these gaps directly, and propose much closer links to other agencies serving family members.

Realistic expectations in complicated settings with tight budgets

It will not advance the cause of better planning to urge local agencies to seek a level of planning complexity that is unrealistic or unaffordable. In addition to the difficult budget climate during the next few years, counties face considerable complexity in making choices among different targets for their allocations of treatment funding.

Allocations can be made to

- at least a dozen different funding streams in some counties,
- six different modalities of treatment,
- more than a dozen different potential target groups, multiplied by multi-ethnic diversity in virtually all counties,
- multiple providers operating in public, non-profit, and for-profit modes, with some that are community-based and others that are part of large conglomerates, and
- at least eight different drugs of choice to be targeted.

If funding allocations were aimed at each of these categories, they would be spread across several thousand different cells in a vast matrix. The task of deciding which of these different potential targets to emphasize is unquestionably complicated, and any proposed innovations must meet the test of reality in responding to that complexity.

Yet this complexity presents an opportunity, as well as barriers. If strategic policy meant that counties were able to select highest-priority targets for more flexibly allocated funding, accountability for results would operate both at program/agency levels and at the county level as well. Under the current funding fragmentation, it remains irresistible for counties to blame the categorical system for their inability to concentrate resources on any one priority group or problem. With one-third of the funding discretionary and two-thirds categorical, the tendency to blame the categorical restrictions may obscure the flexibility that exists in both the discretionary and the categorical funding—which can in some cases be satisfied with overlapping allocations to dually identified groups.

With clearer priorities, there would be targets amidst all the complexity that would be justified based on an analysis of need, demand, and capacity. And those targets could receive adequate dosage and investments to make a difference, rather than funding being spread across multiple sub-allocations to smaller programs—many of which are too small to have any lasting effect.

The feasibility of adding NDC elements to county planning

In our interviews with county officials, we found both a readiness to improve current practices and a concern that a too-elaborate system, whether voluntary or imposed by the state (or federal government) simply would not be implemented without added resources or other incentives. The ISAP studies for ADP make clear that the state's current methods of estimating, need, demand, and capacity could be refined. Extending that same conclusion to the county level is not difficult, but leaves an open question: if better measures *could* be used, what will make it more likely that they *will* be used?

There appear to be at least three critical incentives for the new planning approach, which are not guaranteed, but represent potential policy shifts:

- the potential for these changes to serve as the basis for new discretion granted to counties in combining funding streams, based on new accountability standards;
- an assurance that the approach would remain voluntary, rather than mandated; and
- an assurance that state incentive funding will be available for the counties that move most rapidly toward these changes.

County Adaptation of Statewide Estimates

At the state level, the methods used by ISAP yield an estimate of total statewide need for public and private treatment of 2.36 million persons, compared with 330,000 who need *and are likely to seek* publicly funded programs, less the 130,000 client level of current capacity in the system [prior to Prop 36]. The drop-off from 1.32 million persons who need publicly funded treatment to 330,000 who represent potential demand is based on the assumption that 990,000 persons in need will not enroll due to their own motivation, systems barriers, or other reasons.

At the county level, counties may be able to extract enough detail from the statewide estimates of need to get ballpark estimates of total need, by simply taking a population percentage of the total or by including local data on need that may suggest that local need is higher or lower than statewide averages. But the ISAP assumptions about demand could also be revised to better reflect local realities, including

- recent efforts to improve access to treatment, such as improved and centralized screening in some counties, support services provided to clients on waiting lists, and improved outreach;
- recent innovations in client engagement approaches, e.g. use of recovery mentors and other peer support persons in some counties;

- recent expansion of treatment capacity that in itself may increase demand due to lower waiting lists;
- recent expansion of support services needed to enable clients to enroll and stay enrolled, such as child care, transportation, or part-time work for outpatient clients; and
- referral rates from the courts, CPS, and CalWORKs that may increase client motivation and enrollments in all three cases.

In other words, the statewide 75% dropoff rate from need to potential demand should not automatically be applied in every county, depending upon the extent of its current and prospective efforts to improve client engagement. A new approach to planning such as that set forth in our 5-page framework can take local efforts at client engagement more fully into account.

Parallel Experience in Other States

It is difficult to generalize about state and local practices in treatment planning. A GAO report in 2000 on state planning and evaluation efforts included information on treatment planning and analysis in states. One of its conclusions was that

SAMHSA does not currently know the outcomes of states' drug abuse treatment programs supported with SAPT block grant funds... some states are assessing the effectiveness of their treatment programs using various outcome indicators.⁷

Washington and New York were described as states that have moved furthest in measuring the effectiveness of drug treatment.

Even in its support of state-level outcomes projects, federal agencies have not widened their perspective to include all federal funding allocated to treatment—or the strategies states use in making allocations among different programs. Despite their extensive efforts in supporting improvement of accountability information systems, the federal Center for Substance Abuse Treatment has not combined these materials into a full package of suggested planning approaches (as has been done in the prevention field in the Decision Support System model developed by CSAP). The State Treatment Needs Assessment Program provides federal support to some states in improving their planning capacity, but it has not developed the kind of model produced in the parallel CSAP effort.

The State Role in California

While the focus of this assessment is the county-level strategic planning process, several of the county officials we interviewed pointed out how important the state's

role could be in support of county efforts to improve planning. The primary areas of emphasis were

- The potential value of an annual “all-funds” summary of the different funding streams coming through the state agencies to the county level; one official contrasted the willingness of CalWORKs officials to include county allocations in the totals and the client tracking systems developed at the time CalWORKs emerged with the lack of such connections with the Department of Corrections programs, which may be funding the same treatment agencies funded by the county but do not regularly inform counties of their funding levels or results; and
- The need for continued support, despite the difficult budget situation, of the CalOMS process to strengthen county capacity to collect and analyze client outcomes.

As the Little Hoover report emphasizes, the state can set a tone of accountability for results which carries to the county and provider level, and can be very powerful. Some elements of this role require visible and sustained leadership, while other aspects of it are heavily managerial. As an example of the latter kind of task, the county-level administrators have emphasized how helpful it would be to their planning and analysis to have their CADDs and CalOMS data fed back to them quickly from the state—or to design the system so that they capture the data “going out.” A specific example: details on length of stay of clients enable a county to monitor demand, since, paradoxically, increased retention will lead to increased demand, as the number of slots opened up by the early dropouts decreases. Similarly, the credibility improvement resulting from an Arizona-type inventory of funding would be a solid demonstration of the state’s willingness to do what it can to improve the quality of county-level planning without mandates, working across state agencies rather than placing the entire burden for compiling such information on local governments.

The Role of Other Agencies and Their Resources

Assessing need, demand, and capacity, as discussed above, requires giving much greater emphasis to other agencies whose clients and resources are unavoidably linked with the AOD treatment agencies and their funders. These include

- Parents in the welfare and child welfare systems whose income support and continued parental rights depend in part on their successful completion of treatment programs;
- Dually diagnosed mental health clients;
- Youth, for whom meeting their other needs in the foster care, juvenile justice, education and special education, and mental health systems depend in part on their dealing with their substance abuse problems.

Yet few counties have developed the policy-level and client/community-level connections needed to work effectively with these other agencies. In part, this flows from a planning process that relegates these non-treatment agencies' critical roles to the sidelines, ignoring their potential impact on all three of the components of the planning approach we are suggesting:

- *Need*, in which other agencies' identification of clients with substance abuse problems in their caseloads is a supplementary resource for assessing need that goes beyond the efforts of the AOD treatment system;
- *Demand*, in which other agencies' referrals to AOD treatment create different levels of demand, from suggestions that clients seek voluntary enrollment to mandated, fully coercive referrals from agencies and courts with the legal authority to end parental rights, sanction welfare recipients, and incarcerate parents; and
- *Capacity*, in which these agencies' resources determine whether AOD treatment agencies have the capacity to provide the child care, health, employment, and transportation services needed to make treatment effective for many clients.

The final point is critical; the case for expanding treatment for clients from these other agencies' caseloads, and whose treatment may keep them out of these caseloads, rests on the cost avoidance benefits of clients whose foster care costs, welfare costs, or incarceration costs will be reduced or eliminated with successful treatment. Since resources controlled by these agencies are already supplementing treatment capacity in some counties, including direct purchase of treatment slots and support services such as child care, it is vital for county-level inventories to account for these resources in assessing total capacity. Where these resources are not yet available in support of treatment, or not yet available in proportion to the need for them, county AOD agencies should consider what data on cost offsets would be most persuasive with policy leaders in making a case for these resources.

A special opportunity may exist in the area of child welfare-substance abuse overlap, in the work of the Department of Social Services Stakeholders Redesign project, which has been developing a strategic plan for the redesign of the child welfare system, which places great emphasis upon community partnerships with other agencies. Efforts have been under way in recent months in the Stakeholders process to work through a joint committee including several leaders of county child welfare and AOD treatment agencies who have worked closely at the local level. The recommendations emerging from this joint action group will underscore the importance of this particular connection between county-level planning for the future of child welfare and its need for treatment as a critical resource for substance-abusing parents and their children.

The Issue of Demand: Client Engagement, Families and Interagency Capacity

The need to look harder at the issue of demand than has customarily happened is underscored by the recent report of the federal Office of National Drug Control Policy:

According to a survey by the Department of Health and Human Services, the overwhelming majority of drug users who need treatment fail to recognize it, a fact that would not come as a surprise to those with a loved one who has battled drug dependency. Of the estimated five million individuals who needed but did not receive treatment in 2001, fewer than 8 percent felt they actually needed help.⁸

This argues for *client engagement* receiving much greater attention, which in turn argues, again, for closer ties to the “sending agencies” with which AOD treatment agencies work. At the same time, it also argues for greater attention to family members’ needs as they affect the addicted family member’s treatment and recovery. Using this emphasis on client engagement, a county’s assessment of its own capacity would need to include how well it is prepared to provide the support services, outreach, family emphasis, and interagency linkages required to improve client engagement and recovery—rather than judging its treatment capacity solely in terms of the treatment agencies’ available slots.

A County Report Card as A Planning Tool

All counties have access to the on-line 26-indicator reports developed by the Department of Alcohol and Drug Programs and its contractor, EMT. This framework has the advantage of comparing counties to other counties in a similar set, but the data lags considerably (some indicators are more than three years old) and some of the data items are debatably not the best measures of risk or protective factors at the county-wide level.

Counties should therefore consider developing their own versions of the EMT data, selecting those indicators that the county itself believes to be the best measures of countywide progress and success. For planning purposes, this would ensure that some of the most useful data is kept in readily consolidated format, rather than having to be compiled ad hoc each time a request for data is made. The process of deciding which indicators should go in the annual indicators report has value in itself, because it requires participants to review what data is available and which items are the best measures of trend lines and progress, as well as

New guidance from a “dashboard”

In addition to tracking clients from other agencies and family members, a dashboard could provide county policy leaders with monthly updates on the critical measures of system performance:

- Length of stay
- Dropout rates and demographics
- Engagement: time from 1st contact to appointment
- Waiting list/appointment backup
- Counselor/client ratio
- Primary/secondary drugs used
- Client satisfaction rates: “would you recommend this program to a friend?”

raising the issue of whether program investments are adequate to “move the needle,” i.e. to make a detectable change on a county-wide basis.

Some counties have also considered developing a shorter-range “dashboard” of performance measures, such as clients referred from key agencies and positive discharges, which could be used by agency leadership to monitor month-to-month progress and caseloads in ways not typically done at the top of county agencies. Such a dashboard could emphasize “shared clients,” i.e. those referred into treatment from CalWORKS, CPS, mental health, probation, and other caseloads. Current CADDs categories of referrals are not adequate to capture county-level data on where clients come from; they do not, for example, include clients originally entering treatment who are later enrolled in these programs for which they are eligible or from which they need services.

Funding and Implementing the Planning Guide

If this guide to planning is reviewed and found useful to county officials, the question arises as to how county staff could implement it, and with what support from the state and other sources.

Separate planning efforts are now under way or proposed for adolescents needing treatment, welfare and child welfare clients, dually diagnosed clients, and incarcerated persons. Each of these ultimately becomes a form of special pleading for each of these groups without reference to the total pool of available funds. Each of these claims is defensible; each of these groups needs and deserves more funding from a larger total pie. But in the short run (and probably the medium run as well), the pie is unlikely to grow larger without other major policy interventions beyond the scope of this project, including changes in parity and federal funding.

So what is a well-intentioned county staff to do in sorting through these claims with finite resources? Part of the answer lies in the effort recommended by this planning approach—looking harder at the resources of other agencies. But part of it also depends upon a sustainability plan that sets out the best options for funding the staff it would take to move seriously toward this new capacity.

Funding for a planning effort along the lines of this planning guide could come from at least four sources:

1. a small percentage set aside from each funding stream for administration funding dedicated to planning efforts;
2. private funding from local or regional foundations;
3. a set aside from the “accountability dividend” that would result from shifting funding from the least effective to the most effective programs over a three-year period;
4. state funding for planning efforts, either from existing funding streams or as a part of likely increases in alcohol taxes in response to the 2003-2004 budget crisis (legislation was introduced in November 2002 that would increase taxes

but with all the funding going for services; the argument here is that investments are also needed in planning capacity).

Issues Not Addressed

This planning process proposed in this paper is not assumed to address all relevant issues in the treatment system. There are important issues and continuing barriers to improved access and outcomes in AOD treatment that must be recognized as needing attention. The most important of these are

- the impact of insurance coverage parity in affecting funding streams;
- the role of managed care in building (and limiting) interagency systems of care; and
- The existence of recovery resources outside the publicly funded system. These would include private sector programs, private practitioners, twelve step and other peer support programs. The proposed federal funding for treatment vouchers for faith-based programs represent another example of private based, publicly funded treatment for which California's fair share could be as much as \$25-30 million.

All of these affect the critical area of resources available to treatment agencies and to the other agencies that seek to help them perform their mission. But to the extent that the approaches in this paper and the tool accompanying it would equip the county agency with better tools for engaging in these negotiations with public and private providers and gatekeepers, knowing more about who is in the public system could not help but strengthen the hand of the counties in building their ties with external providers and funders.

Conclusion: Better Planning Demands Clearer Policy

In the final analysis, the managerial shifts proposed to achieve better planning at the county level will only happen if they reflect policy shifts at state and local levels. Many pilot projects have demonstrated that training alone, or information systems changes alone, or even funding stream changes alone, are by themselves inadequate if they merely represent old missions in new packages. It will take the kind of commitment summarized in the Little Hoover report to achieve the policy shift that will make better planning happen:

Given the consequences of addiction and the opportunity for recovery the State's ultimate goal should be that those needing treatment should receive it. Until then, the State needs to make sure that available resources are targeted at those whose addiction imposes the greatest consequences on public dollars and private lives....In setting goals, the State should assess the impact of abuse and addiction on health, social service, criminal justice and

other public systems. The assessment should be designed to enable counties to assess their specific needs, document the consequences of addiction in their communities and target resources to clients posing the greatest social and financial costs.

NOTES

¹ In contrast, the Center on Substance Abuse and Addiction at Columbia University in 2000 estimated that 12% of the California state budget, or a total of \$10 billion, is devoted to spending that is caused by the consequences of alcohol and drug addiction. It should be emphasized that a large portion of these funds are not under the direct control of either the Department of Alcohol and Drug Programs or their county counterparts. The intent of the planning approach in this report is that greater coordination among still-autonomous agencies should and could be achieved, but it is recognized that many different agencies are involved and that these funds are not under the control of any single agency.

² The primary focus of this assessment is on treatment programs, although their overlap with prevention programs will also be discussed.

³ “Drug Abuse Treatment Policy: A Report to the Little Hoover Commission.” Gary Jaeger, MD President, California Society of Addiction Medicine, Sacramento, California. May 23, 2002.

⁴ From SAMHSA website http://www.samhsa.gov/grants/planning/csat25_cooccTA.htm

⁵ We use the term system of care as the State Department of Alcohol and Drug Programs has, to mean, “a quality integrated coordinated, seamless system of alcohol and other drug prevention, early intervention, and recovery/treatment services for families and communities...[with] built in accountability to measure outcomes and societal costs and benefits related to alcohol and other drug treatment services.” From K. Jett testimony to Little Hoover Commission, May 23, 2002.

⁶ It should be noted that there is a fundamental bias built into the current definition of capacity by the state: “The maximum number of clients/participants who could be enrolled for alcohol or drug treatment at any one time, using the public funds available to this treatment provider by federal, state, and/or county government” (DATAR definition, California). This definition focuses upon numbers of clients, rather than client outcomes, and thus creates an incentive for more enrollments rather than more effective enrollments and treatment. Unless there is a powerful corrective for this effect, capacity means numbers, not effectiveness, with negative effects especially for those clients needing longer treatment and aftercare services. The state’s efforts in support of the CalOMS effort provide such a corrective, but the definition of capacity still reflects an earlier era in which “head and bed counts” were what mattered most. A better definition might be “The maximum number of clients/participants who could be enrolled *and served effectively* for alcohol or drug treatment at any one time, using the public funds available to this treatment provider by federal, state, and/or county government.” This raises the further issue of dynamic capacity. If a program’s static capacity is 30 beds, how many people can be served over the course of a year? Leaving the dropout issue aside, if the planned length of stay is 90 days, dynamic capacity would be 120 persons. The qualifier “served effectively” cited above helps deal with the dropout element of the equation. Ultimately what is needed is to move away from capacity narrowly defined as static beds and slots and focus more on *throughput* – the capacity of the system to produce outcomes. So, rather than 120 clients in the door over the course of a year, it would be 45 people per year clean and sober after treatment.

⁷ *Drug Abuse Treatment: Efforts Under Way to Determine Effectiveness of State Programs* (GAO/HEHS-00-50, Feb. 15, 2000).

⁸ *The President’s National Drug Control Strategy, 2003*, Washington, D.C.: Office of National Drug Control Policy. <http://www.whitehousedrugpolicy.gov/publications/policy/ndcs03/index.html>