An LAO Report

Services Are Cost-Effective to Society

Substance Abuse Treatment in California

Introduction

Alcohol and drug abuse is a significant problem in California and, more generally, in the nation. The National Institute on Drug Abuse, for example, estimates that the economic costs to society resulting from alcohol and drug abuse in the U.S. exceeded $250 billion in 1995.

LAO Findings

We identify several problems in the state's substance abuse treatment system. These include lengthy waiting lists in a number of counties, no statewide plan for addressing the demand for treatment services, and a need in particular for treatment services aimed at adolescents.

The *1999-00 Budget Act* appropriates $354 million to the Department of Alcohol and Drug Programs (DADP) for treatment services. The DADP estimates that an additional $330 million would be needed annually to fully fund the system—that is, to provide treatment to all persons who would seek it if such services were available. The department also estimates that it would cost $63 million annually (subsumed in the preceding estimate) to create enough new treatment slots to serve all persons currently on the counties' waiting lists for these services.

Research indicates that substance abuse treatment is cost-effective to society in general. While the research generally indicates that treatment results in savings to government, we did not find a reliable estimate of cost-effectiveness specifically to government—that is, a comparison of the public savings and costs of program interventions.

LAO Recommendations

We recommend that the department submit a plan to address existing county waiting lists for substance abuse treatment, and that the Legislature consider this plan in the 2000-01 budget process. We further recommend that the department develop a long-term plan to address the potential increase in the demand for substance abuse treatment if more services become available. This plan should include consideration of provider capacity, ways to develop additional capacity if needed, identification of optimal modes of treatment for both adults and adolescents, strategies to overcome the barriers to increasing the treatment of adolescents, and state-level efforts to coordinate service delivery among public providers, including the counties, the state prison system, and the California Youth Authority.

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July13, 1999

BACKGROUND

California's Alcohol and Drug Treatment System

Overview. The DADP coordinates California's substance abuse prevention and treatment efforts, in consultation with counties, providers, service recipients, and other stakeholder groups. The treatment system is primarily administered by the counties, although county officials must comply with a number of state and federal regulations regarding provider licensing and the allowable uses of certain funding streams. Treatment is also provided by other public entities—such as the state prison system and the California Youth Authority—and by private organizations.

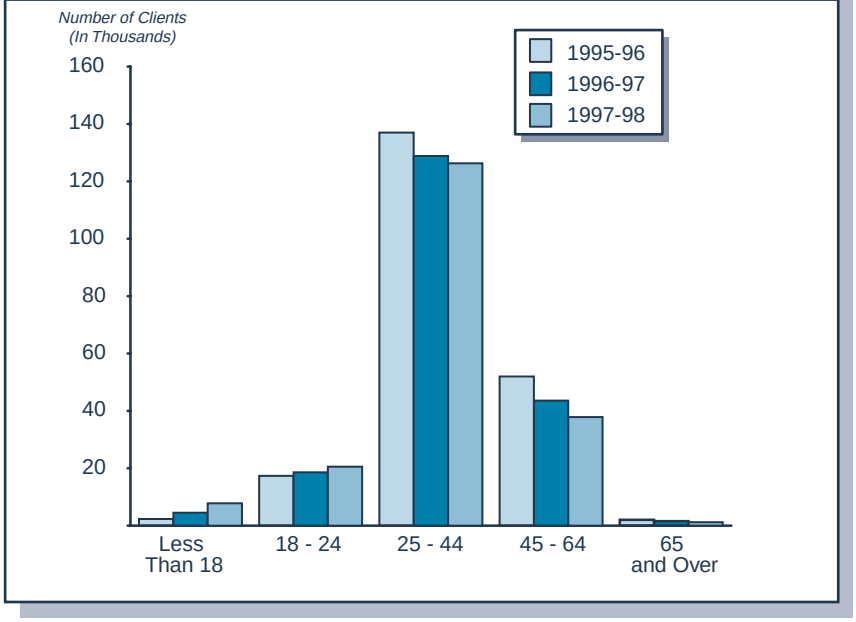
The department licenses more than 1,800 programs statewide, about half of which receive public funding. In addition, DADP collects client characteristics data from these providers and county-level data on treatment capacity, enrollment, and waiting lists. Little information is collected regarding treatment outcomes.

Characteristics of Treatment Recipients. Since July 1995, more than 600,000 Californians have received publicly funded treatment of some type. Of these, 64 percent were male and 36 percent female. The average age of those in treatment has dropped slightly in recent years, from 38 in 1995-96 to 36 in 1997-98, due to an increasing proportion of adolescents and young adults (see Figure 1). People in treatment represent a variety of races and ethnic backgrounds, although the treatment population is predominately white.

Numerous Funding Sources. Counties receive an annual allocation of federal and state funds from DADP, a portion of which must be matched using county funds. In 1999-00, the department will allocate more than $300 million to counties for the provision of substance abuse treatment.

Figure 1

Substance Abuse Treatment
Age of Client Population



These funds come from a variety of sources (see Figure 2), including the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, state and federally funded Medi-Cal program reimbursements, and the state General Fund.

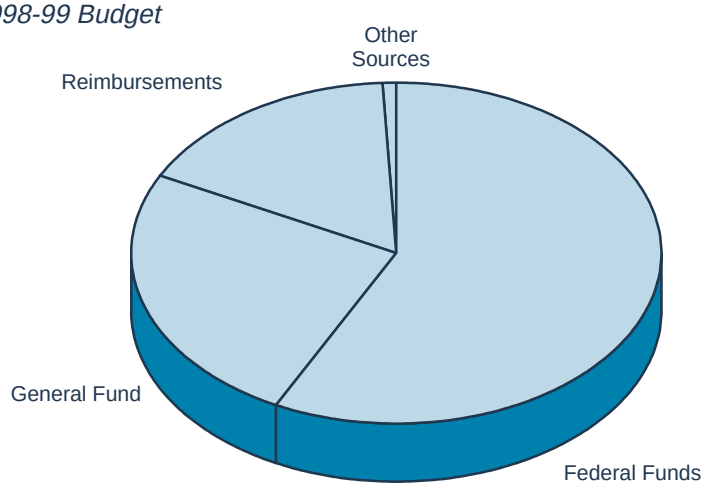
The federal and state allocations are primarily based on historical funding levels and vary widely among counties. This variation is largely due to differing amounts of federal grants that counties received during the 1970s and 1980s, prior to the current federal policy of providing block grants to each state. The state initially used the county grant amounts as a basis for allocating the federal block grant funds. As a result, counties that had been more aggressive in pursuing federal grants received a disproportionate share of the block grant. The current allocation formula, moreover, is only partially based on indicators of need.

Service Provision Varies. Some counties provide counseling and other treatment services directly, some contract with private treatment programs, and others offer both direct and contract services. San Francisco and Los Angeles Counties, for example, contract with a wide variety of community-based providers offering a range of treatment services. In contrast, Tehama and Shasta Counties hire staff to conduct counseling sessions at county offices and contract for other services, such as more intensive residential treatment, only when necessary. In general, urban counties are likely to contract for a larger percentage of treatment services than rural counties.

Figure 2

Substance Abuse Treatment Major Sources of Funding

1998-99 Budget



Types of Substance Abuse Treatment

Substance abuse treatment programs can be categorized in a number of ways. We have grouped the common treatment programs into two main categories, detoxification and recovery (see next page). Each category includes a range of treatment options, both residential and outpatient. All of these treatment options are available in California, although each county offers a different mix of services.

Detoxification. Detoxification is the process of withdrawing

from alcohol or other drugs, which may be done in an outpatient or residential program. Detoxification is primarily seen as a short-term way to stabilize clients and prepare them to move into the recovery phase of treatment. Detoxification by itself is not considered an effective means of treating substance abuse.

Recovery. Outpatient and residential treatments that help addicts remain sober are included in this category. They are clustered into four main groups, each encompassing a wide variety of programs with different approaches to recovery (see Figure 3). These programs may include group, individual, or family counseling; education and vocational training; social skills training; and other components that help participants change their lifestyles in order to maintain sobriety. Many programs have both an active treatment component and an "aftercare" component that supports clients when they are back in the community and at a greater risk of relapsing. Aftercare commonly includes participation in a self-help group, including "12-step" programs.

California's Treatment Mix. Just under 70,000 publicly funded treatment slots were available on

Figure 3

Common Types of Substance Abuse Treatment

Detoxification
Outpatient—Used primarily for people addicted to methamphetamine, crack cocaine, tranquilizers, and other drugs that require some supervision during detoxification. There are no time limits for the program, and the average participation time is seven to ten days.
Residential—Used primarily for people addicted to alcohol. Clients are often brought to this type of program by a law enforcement agency, where they are held for an average of 72 hours and encouraged to enter a recovery program.
Methadone—A 21-day outpatient program that utilizes a tapered dosage of methadone to help clients overcome addiction to heroin. This method of treatment is required for most clients before they are allowed to receive long-term services through a Narcotic Treatment Program provider.
Recovery
Outpatient Drug Free—The least intensive service provided to clients, offering group and individual counseling sessions. Participants average five counseling sessions per month and are encouraged to stay in treatment at least 120 days to achieve the best results. There is no limit to the number of counseling sessions a participant may attend.
Residential Drug Free—This service removes clients from the environment that promotes or enables their addictive behavior, replacing it with a recovery environment promoting sobriety. The average length of stay is 90 days, although many providers include a formal aftercare program that includes return visits to the facility and ongoing counseling. Most resident drug free programs focus on pregnant and postpartum women and include parenting skills and other life skills as part of their curriculum.
Day Treatment Drug Free—Participants generally attend counseling sessions and classes three to four days a week for four to five hours per day. The most common participants in these programs are pregnant and postpartum women and children under 21.
Narcotic Treatment Program—An outpatient service that utilizes methadone or levo-alpha-acetylmethadol (LAAM) to help clients remain free of narcotics. Narcotic treatment clinics are also required to provide medical evaluations, treatment planning, and counseling. Methadone generally is taken daily, while LAAM is taken every 72 hours. This is considered a long-term treatment method, with an average participation of one year.

September 30, 1998, according to DADP. Recovery programs accounted for 92 percent of the available slots, while detoxification programs made up the remaining 8 percent. Fifty percent of the recovery slots were in outpatient drug free programs, with an additional 35 percent in narcotic treatment programs (see Figure 4). About 10 percent of the recovery slots were in residential treatment programs, and less than 4 percent were in day treatment programs.

Treatment Effectiveness

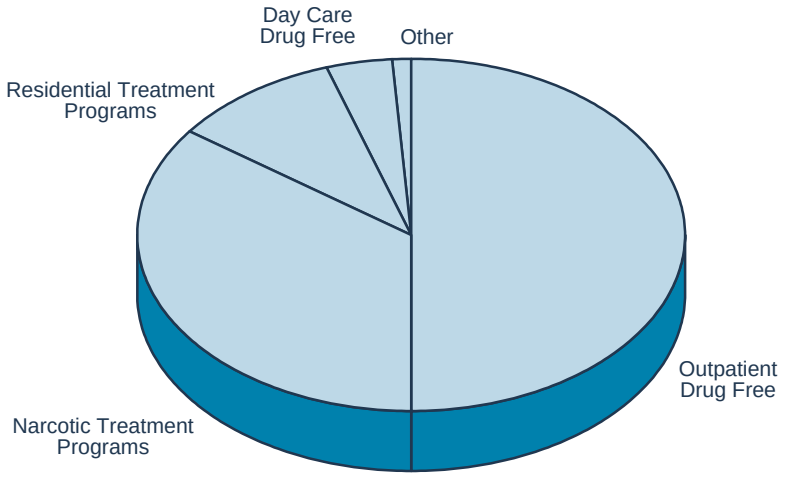
Does Treatment Work? A recent review of more than 600 research studies, conducted by the nonprofit organization Physician Leadership on National Drug Policy, found substantial evidence that drug addiction treatment is effective at reducing substance abuse, crime, and medical costs. Numerous longitudinal research studies have found that, in general, substance abuse treatment is effective for individuals. Research participants generally report using alcohol and other drugs less often and in smaller quantities after they participate in treatment. Some studies have also measured lifestyle changes among treatment participants, finding less risky sexual behavior, fewer suicidal thoughts, and a greater ability to find and retain employment.

Some research studies have concluded that substance abuse treatment is cost-effective for society as a whole. The societal benefits of substance abuse treatment usually are measured in terms of avoided costs to individuals and governments—such as for emergency room visits, criminal activity, and welfare and disability payments—that would likely have occurred in the absence of treatment. The 1994 California Drug and Alcohol Treatment Assessment (CALDATA) study, conducted by the National Opinion Research Center in conjunction with DADP, analyzed costs and outcomes for California residents who received treatment between October 1, 1991 and September 30, 1992. Researchers calculated that $200 million spent on treatment during that time yielded $1.5 billion in avoided costs to society in

Figure 4

Substance Abuse Treatment Recovery Programs Available in California

September 1998



the first year after treatment, a 7:1 return on investment. Most of the savings were due to the decrease in the treatment clients' criminal activity, which includes avoided costs to the criminal justice system and the victims of crime. While some of the savings could be attributed to federal, state, and local governments, the CALDATA study did not specifically identify such savings.

In a recent review of cost-effectiveness studies, the Center for Alcohol Studies reported that the benefits of substance abuse treatment outweigh the costs. Depending on such factors as the type and length of treatment and client characteristics, the benefit-to-cost ratios ranged from 2:1 to 10:1. A number of studies using data from the Treatment Outcome Prospective Study found a 4:1 benefit-to-cost ratio.

Research on substance abuse treatment, however, often is problematic. For example, data collected from treatment recipients may not always be reliable, most studies lack control groups (randomly assigned comparison groups that do not receive the treatment), and it is difficult to generalize the results of one treatment program to others that may be similar but not exactly the same. A recent General Accounting Office (GAO) report examined some common limitations of the research on substance abuse cost-effectiveness, noting that even the most widely respected studies generally lack control groups, thus limiting the conclusions that can be drawn. In addition, the GAO indicated that the common practice of using self-reported data on drug use and criminal activity before and after treatment may tend to overstate treatment effectiveness. The GAO suggested increased use of objective tests such as urinalysis to confirm self-reported data.

Which Treatment Is Best? Research directly comparing one type of treatment against another is uncommon. Instead of singling out a particular treatment, researchers have generally found that any of the treatment programs studied achieve better outcomes than no treatment at all. The studies that have attempted to compare different types of treatment programs have generally been unable to show significant differences in the outcomes of these programs. Interestingly, several studies have found that outpatient treatment can be just as effective as inpatient treatment (although they caution that residential treatment still is needed in many cases, particularly for those with severe addictions). Outpatient treatment is, on average, less expensive than residential treatment, and it has become the most common form of substance abuse treatment.

How Much Treatment Is Needed? Researchers have consistently found better outcomes for addicts who remain in treatment longer. The Drug Abuse Treatment Outcome Study analyzed data from more than 10,000 clients at programs in 11 cities. This study generally found significantly better results for clients who remained in treatment for at least three to six months than for those who had left within the first three months of treatment. Researchers have theorized that the length of time clients remain in treatment is an indication of the overall quality of their experi-

ence, including their relationships with program counselors, whether they are satisfied with the treatment services available to them, whether they are able to participate in ancillary services such as education and job training, and whether they participate in support groups after "graduating" from treatment.

Why Isn't Treatment 100 Percent Effective? Although numerous researchers have found treatment to be both effective and cost-effective, they acknowledge that treatment doesn't always work. People with substance abuse addictions may enter numerous treatment programs, maintaining periods of sobriety before relapsing and eventually seeking treatment again. The question of what makes treatment effective for one person and ineffective for another has not been definitively answered.

Summary. A substantial amount of research has been amassed indicating that substance abuse treatment is generally effective for individuals and cost-effective for society as a whole. However, further research is necessary to quantify the type and amount of savings that can be achieved as well as the types of treatment that work best for certain individuals.

Redesigning California's Treatment System

At the direction of the Legislature, DADP formed an advisory committee in 1995 to investigate the feasibility of a managed care model for treatment services. In May 1997, rather than recommending a managed care system, the committee recommended designing a new "system of care" in which providers, counties, and the state collaborate to provide high quality, cost-effective treatment services. Specifically, the committee set forth five major goals:

- Access to prevention, intervention, treatment, and recovery services for all segments of the population.
- Quality, effective substance abuse services.
- Coordination with and access to other affected service systems, such as mental health.
- Accountability and continued improvement within the drug and alcohol system.
- Improved client outcome measures.

Since the initial report to the Legislature, the project—known as the System of Care Redesign, or SOCR—has changed somewhat. Currently, its main thrust is the creation of a computerized outcome measurement system that will enable the state to collect more client data than is currently collected through the Client Alcohol and Drug Data System. The department hopes to collect data on clients' level of functioning before, during, and after treatment to determine which types of treatment work better for certain clients. According to the department, these data ultimately will help counties and providers to choose the best type of treatment for each client.

The redesign project was authorized until October 31, 2001 by Chapter 389, Statutes of

1998 (SB 2015, Wright), which requires the department to submit annual status reports during the budget process. The computer system will be developed and pilot-tested with the assistance of the Drug Abuse Research Center in the University of California at Los Angeles, using a three-year, $1.5 million grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The department anticipates piloting the system with 35 providers in 12 counties, encompassing about 12,000 to 15,000 clients. A sample of 2,700 clients will be interviewed as part of the pilot program.

LAO FINDINGS

Our review of California's substance abuse treatment system has led us to reach a number of conclusions regarding statewide treatment needs and the capacity of the current system to meet those needs. Our findings, which are discussed in detail below, are summarized in Figure 5.

System of Care Redesign Is Worthwhile

The goals of the redesign effort are ambitious, and the collection of outcome data is likely to provide a basis for improving the delivery of substance abuse prevention and treatment services. In addition, the collection of

Figure 5

Summary of LAO Findings
California's Substance Abuse Treatment System

- ***Treatment Is Cost-Effective.*** Research indicates that substance abuse treatment is cost-effective from the perspective of society. We did not find a reliable estimate of cost-effectiveness specifically to government.
- ***Redesign Project Promising.*** The department's System of Care Redesign project is likely to provide data that will facilitate improvements in the delivery of substance abuse prevention and treatment.
- ***County Waiting Lists Understated.*** A majority of counties report waiting lists for treatment, but these lists understate the potential demand for treatment if services were available.
- ***Full Funding of Treatment System.*** The department estimates that an additional $330 million would be needed to fully fund California's treatment system (serve all persons who would seek treatment if available).
- ***Costs to Fund Waiting Lists.*** An estimated $63 million (contained in Full Funding amount above) is needed to create enough new treatment slots to treat everyone currently on a waiting list.
- ***Few Adolescents in Treatment.*** Despite recent increases in the number of adolescents in treatment, only 10 percent of the estimated number of adolescents who need publicly funded treatment receive it, compared to 17 percent for adults.
- ***Plan Lacking.*** California lacks an overall plan to address the need for substance abuse treatment.

outcome measures may improve accountability for the use of public funds and ultimately allow the Legislature to target funding to programs that have a proven record of effectiveness. Despite these potential advantages, we caution against viewing the project as a solution for all of the problems with the existing treatment system for several reasons, including:

- ***Uncertain Implementation Timelines.*** We do not anticipate full implementation of the redesign until 2002 and possibly later. The SAMHSA grant that will be used to develop a computerized outcome system runs through September 2001, while the enabling state legislation authorizes the department to test the system through October 2001. The DADP must report its findings to SAMHSA in September 2001. However, due to the Governor's Executive Order requiring that all computer projects that are not mandated or addressing Year 2000 problems be deferred, the Department of Information Technology (DOIT) denied approval for the assessment data system, a crucial component of the project. The DADP will still collect data from providers, but will not be able to develop the system needed to measure treatment outcomes or create linkages to other data systems until the assessment data system is approved. At the time this report was prepared, the department did not know when DOIT would reconsider the decision.

- ***Limited Data Collection.*** The measurement system will only collect data on the population in treatment, which may not be representative of everyone who needs it. While the system should provide rich information on those who are able to access treatment, it will not take the place of local or statewide needs assessments examining substance abuse trends, treatment demand, and gaps in treatment services. As currently designed, it will not collect data on individuals on the waiting lists, whether they eventually receive treatment services, or how long they wait for treatment.

- ***Methodology Limitations.*** The project does not employ a random assignment experimental methodology (using control groups), which is the best scientific method for determining program effects.

Fiscal Estimates to Address Need for Treatment

As discussed previously, the research indicates that substance abuse treatment results in net savings to society. While the fiscal impact on government—state and local governments in California in particular—has not been delineated, we believe the evidence on program effectiveness is sufficient to warrant additional action at the state level to address the need for such treatment.

Waiting Lists Understate Potential Demand for Services. On September 30, 1998, there were 5,000 people on the counties' waiting lists for substance abuse treatment. For applicants who

move from the waiting list into a treatment program, the number of days spent on the waiting list depends on the type of treatment sought. The average wait is 14 days, with waits ranging from an average of 6 days for residential detoxification programs to an average of 37 days for methadone maintenance services. More than half the applicants on the lists at the end of September were seeking residential drug free services. Approximately 20 percent were waiting for outpatient methadone maintenance services. Another 10 percent were seeking outpatient drug free services.

We note that waiting lists are an imprecise measure of the demand for treatment services and generally understate the number who would seek services if they were available. In many counties, for example, the lists are controlled by individual providers who may place limits on the length of their waiting lists or require people seeking treatment to call in on a daily basis in order to remain on the list. The availability of services also plays a role. If a county does not offer a particular type of treatment (due to a lack of providers, for example), there will be no waiting list for it, although there may be a substantial need for it. In addition, in counties with long waiting lists, potential clients might feel it is not worth the time to sign up for treatment because it could be weeks or months before a slot becomes available.

The DADP estimates that it would cost $63 million annually to create enough new treatment slots (approximately 5,000) to accommodate the current average monthly number of people on the waiting list. To a large extent, this represents the cost of reducing the "backlog," in that many of the people on waiting lists do eventually receive services; but we also note that waiting may reduce the effectiveness of the services provided to some persons and cause others to "give up"and forgo treatment.

We note that providing sufficient funds to accommodate the existing waiting lists is likely to have the effect of increasing the demand for treatment services, in which case waiting lists would still be in evidence. This occurs because the availability of treatment slots has an effect on the number of persons who would choose to seek such services.

Costs to Accommodate Potential Demand for Services. Substance abuse prevalence rates are generally considered to be conservative estimates of the need for treatment. This is because the studies on which the rates are based undercount the populations at high risk for substance abuse, partly because they rely on self-reported data. Prevalence studies estimate that 8.2 percent of youth and 15 percent of adults need substance abuse treatment. Based on these prevalence rates, we estimate that about 3.3 million Californians aged 12 through 64 need treatment for substance abuse problems.

The DADP estimates that an additional $330 million would be needed annually to serve everyone who needs treatment and would seek it if available. This amount would fund about 56,000 additional treatment slots. The department's estimate assumes that (1) 15 percent of the

people who need treatment will seek it, (2) 26 percent of the adults and 54 percent of the adolescents in that group will need *publicly* funded treatment, and (3) about 70,000 publicly funded treatment slots are currently available.

We note that this estimate includes treatment costs but does not include the cost of new facilities that might be needed in order to expand the system. We also note that the cost of adolescent treatment is based on nonresidential treatment services for youth, including the relatively low-cost outpatient drug free and day care drug free treatment. Many people we interviewed while researching this report, however, told us that more residential services are needed for adolescents. If those services were developed, the average treatment cost would increase.

We also expect that the expansion of treatment services would tend to have the effect of reducing the "prevalence rate" that reflects the proportion of the population that needs treatment, thereby reducing future annual costs. This will depend on a number of factors, including how many people relapse and seek additional treatment, the types of treatment accessed, and the effectiveness of treatment.

Finally, we note that the department's estimate of potential costs is subject to considerable uncertainty. It is based, in large part, on national prevalence studies which are not specific to California and which depend on subjective definitions of what constitutes substance abuse.

Treatment for Adolescents

Trends in Drug Use Among California Youth. Adolescent drug use is measured by numerous national, state, and local surveys. These surveys generally show that a smaller percentage of California youth use alcohol and tobacco than in the rest of the nation, while a higher percentage use illicit drugs.

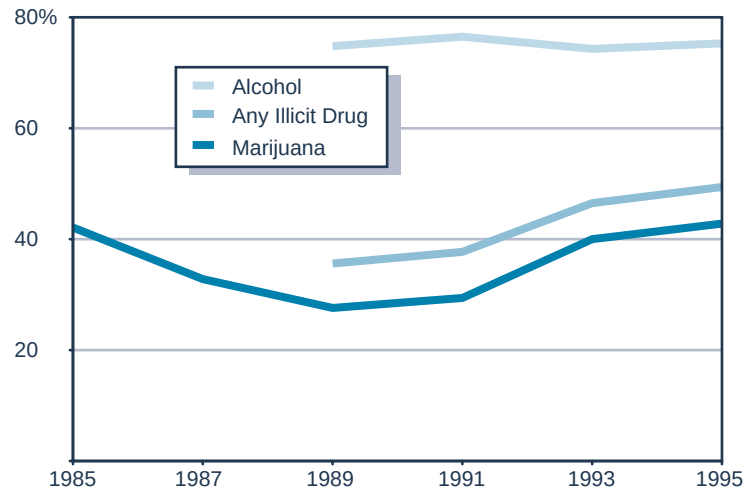
The Southwest Regional Laboratory/WestEd has surveyed California middle- and high-school students biennially since 1985. The most recently published results, which are from the 1995 survey, reflect many of the same trends seen in nationwide studies from the same period. Overall, the use of alcohol has decreased slightly since reaching its highest point in 1991, although half of seventh graders, two-thirds of ninth graders, and three-fourths of 11th graders reported some drinking during the six months prior to the survey. In contrast, rates of marijuana use have been increasing since the 1991 survey, hitting an all-time high in 1995. The percentage of students reporting the use of any illicit drug has also increased. Figure 6 (see page 12) shows the rates of alcohol, marijuana, and any illicit drug use during the six months prior to the survey for 11th grade respondents. For 11th graders, the rates of use for alcohol, though much higher than for other drugs, appear to have leveled off somewhat, while the rates for marijuana and any illicit drug use show an upward trend beginning in 1991.

Availability of Services. Although adolescents (ages 12 through 17) represent a greater proportion of the treatment population today than in

Figure 6

State Trends in Drug Use Among Adolescents[a]

1985 Through 1995



[a] Percentage of 11th graders reporting substance use during six months prior to survey.

1995, a smaller percentage of adolescents than adults receive publicly funded treatment they need. Only 10 percent of the estimated number of adolescents who need publicly funded treatment receive it, while approximately 17 percent of adults who need such treatment receive it. (We note that these are rough estimates, based on the prevalence studies cited earlier in this report.)

In 1995-96, just over 2,300 adolescents were admitted to detoxification and recovery programs—about 1 percent of all clients. By 1997-98, the number of adolescents receiving services had grown to 7,800, or about 4 percent of the treatment population. Despite the growing numbers of adolescents in treatment, at any given time an estimated 800 youth (ages 12 through 17) are on waiting lists for treatment. The DADP cannot estimate how many of those adolescents are ultimately served or how long they wait for services.

Barriers to Residential Treatment. California's treatment system was developed to serve adults, not children (perhaps because adults comprise the vast majority of those needing services). As is the case for adults, the youths who do receive treatment generally participate in outpatient drug free programs, typically in group or individual counseling sessions. Very little residential treatment is available, particularly for adolescents.

Organizations that wish to provide residential treatment for adolescents may find it difficult to do so because of restrictive licensing regulations. Residential facilities may only serve adults unless they apply for a waiver, and those receiving waivers can serve no more than three adolescents at a time. Statewide, only three residential substance abuse treatment facilities have waivers to serve adolescents and they provide a total of five beds. In addition, DADP has certified 31 group homes, licensed by the Department of Social Services (DSS), to provide drug and alcohol treatment services. However, there are no standards for the level of services provided and no treatment protocols. Neither DADP nor DSS has

data on the number of adolescents who receive treatment in the group homes.

Other Barriers to Treatment. Adolescents face a number of other barriers to treatment—for example, access to transportation to service sites. In addition, there are few youth-only services and few proven models for treatment designed to meet the unique needs of adolescents.

The different developmental stages of adolescence are barriers as well. Depending on their level of maturity, adolescents may have difficulty recognizing and admitting to a substance abuse problem.

Treatment Gap Not A New Issue. Adolescent treatment has been a topic of concern to the Legislature for many years. Recently, legislation was enacted—Chapter 866, Statutes of 1998 (AB 1784, Baca)—requiring DADP to collaborate with counties and service providers to increase the availability of such treatment. The *1998-99 Budget Act* earmarked nearly $5 million to fund this legislation. In April 1999, DADP allocated a total of $4.75 million to 20 counties. The Adolescent Treatment Program (ATP) grants ranged from $50,000 to $900,000 and will fund such projects as a new multicounty residential treatment facility, neighborhood-based youth center programs, and day treatment programs at continuation school sites. The target populations for the ATP grants include adolescents who are on probation, involved in gangs, or attending alternative and continuation schools.

In order to further increase adolescent access to effective treatment, we recommend that legislation be enacted requiring the department to identify effective treatment models for adolescents and strategies to remove barriers to treatment of adolescents. At a minimum, we believe the department should (1) evaluate existing adolescent treatment programs, (2) examine current treatment licensing and certification regulations to determine whether they allow adequate access to a range of treatment options for adolescents, (3) develop options for improving access, and (4) estimate the cost of these options.

Ensuring Coordinated Delivery of Services

Although most substance abuse treatment services are provided through the counties, the state correctional agencies provide a substantial amount of treatment services for criminal offenders. The California Department of Corrections (CDC) currently has about 5,000 treatment slots in state prisons for inmates, and the department is in the process of acquiring 1,000 more slots in community-based correctional facilities. In addition, the Department of the Youth Authority currently has more than 1,100 slots in its facilities. Both CDC and the Youth Authority also contract with counties and local drug treatment providers to provide services to parolees in the community.

We have recommended that the Legislature expand substance abuse treatment services to state inmates and parolees for two primary reasons. First, substance abuse among offenders tends to be a significant contributor to their

criminal behaviors. Second, studies have shown that effective treatment can reduce future recidivism of offenders and thus save the state and local government (and society generally) substantial sums of money.

It is important, however, that treatment services in state correctional agencies be coordinated with DADP, the counties, and local treatment providers in order to ensure that the services are effectively delivered. In this respect, we note that some local treatment providers have pointed out that they are required to provide different levels and kinds of services to county probationers and state parolees—due to the differences in the governing regulations of county probation departments and the CDC—even though the services that are needed are not dependent on which agency has jurisdiction over the client. Consequently, we believe that there is a need for state-level efforts to facilitate the coordination of substance abuse treatment services among the counties, the CDC, and the Youth Authority.

LAO RECOMMENDATIONS

Recommend State Plan to Address Need for Treatment

There are gaps in substance abuse treatment availability in California, as evidenced by estimates of unmet need, lengthy waiting lists, and the small percentage of adolescents who receive publicly funded treatment. How much treatment is needed, where treatment should be increased or decreased, and what kinds of new programs should be established, however, are less certain. Recent funding increases have been aimed at specific needs such as youths, state prisoners, pregnant and parenting mothers, and drug court participants, but these initiatives have not been part of an overall strategy to reduce substance abuse through effective treatment.

Consequently, we recommend that DADP submit a plan to address existing county waiting lists for substance abuse treatment, and that the Legislature consider this plan in the 2000-01 budget process. We further recommend that the department develop a long-term plan to address the potential increase in demand for treatment if more services become available. This plan should include, but not be limited to:

- An assessment of statewide and local needs that takes into account drug use trends among adolescents and adults, county waiting lists, and other indicators.
- Identification and dissemination of effective modes of treatment.
- Improved collection and utilization of waiting list data so that individuals can be followed as they move off the waiting lists and into treatment programs.

- Recommendations on phasing in treatment expansion to the extent necessary to address potential increases in demand for services, taking into account the need for new providers to be established and new staff to be hired.
- An assessment of various funding options that could help offset General Fund costs, including anticipated increases in the SAPT Block Grant, consideration of whether existing limitations on Drug/Medi-Cal expenditures should be continued, and federal and private grants.
- Recommendations on the allocation of funds in a manner that takes local needs into account.
- Strategies to overcome the barriers to treatment of adolescents.
- Recommendations to facilitate the coordination of service delivery among providers, including the county departments, the state prison system, and the California Youth Authority.

We note that the department recently completed its initial comprehensive statewide household survey to measure substance use and abuse among California adults. The survey collected considerable information, breaking down the sample by poverty level, sex, race, age, and geographic region. The department indicates that it intends to further analyze the data to determine whether any conclusions may be drawn from the information that was collected. This survey, while limited in scope, is an important first step in the assessment of needs at the statewide as well as local level.

CONCLUSION

Although substance abuse treatment is not 100 percent effective, a substantial amount of research indicates that it is cost-effective when considering the benefits to society in general and may be cost-effective to government as well. Available evidence suggests there is a need for increased treatment services for adults and particularly for adolescents, and that regulatory changes may be warranted in order to facilitate an increase in the treatment options for adolescents.

In order to address the issues that we have identified, we recommend that the DADP:

- ***Develop Short-Term and Long-Term Statewide Plans to Address the Need for Treatment Services.*** These plans would

include an assessment of local and statewide needs, various funding options, recommendations on phasing in new services, and consideration of funding allocation methodologies that take treatment needs into account.

- ***Identify Effective Treatment Models and Strategies to Overcome Barriers to Treatment of Adolescents.*** This would include a review of current statutes and regulations to determine changes that would increase access to a range of treatment services and an estimate of the costs associated with those changes.

Acknowledgments

This report was prepared by Cathy Senderling and Deborah Franklin, under the supervision of Charles Lieberman. The Legislative Analyst's Office (LAO) is a nonpartisan office which provides fiscal and policy information and advice to the Legislature.

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