

## **SERVICE QUALITY, TREATMENT STANDARDS, AND ACCOUNTABILITY IN RELATION TO CAPACITY AND DEMAND**

### **A CAADPE POSITION PAPER**

The California Association of Alcohol and Drug Program Executives, CAADPE, has long supported improving the quality of alcohol and other drug abuse services through the implementation of treatment and prevention program standards linked to evidence based best practices and accountability measures. To this end we continue to work closely with the research community, local, state and federal governments and others by bringing the service providers' perspectives to deliberations aimed at improved treatment and prevention outcomes. This position paper has been developed with that intent.

Historically, the California system of alcohol and drug abuse services has been underfunded in relation to the needs of the State's general population. Those members of the population who are able to access services continue to enter treatment with an increasingly complicated mix of problems in addition to their alcohol and drug use. Among others, these problems include co-occurring mental illness, HIV/AIDS, Hepatitis C, homelessness, and unattended medical needs. At the same time, the publicly funded service system has suffered from years of flat or reduced funding, and service reimbursement rates that have neither reflected the rising costs of basic program operations, such as insurance, wages, facility rent and utilities, nor the increased costs associated with the public's demand for greater accountability in the form of maintaining higher professional standards for staff, better financial accounting procedures and better program outcomes

In a consistently limited or restricted funding environment, both funding entities and service providers continually struggle with the problem of how to balance an ever growing need for services with the demand for improved service effectiveness and the costs associated with both. None of the options typically used to solve the problems have been ideal.

One option frequently used to address the economic problem is to try serving more people by reducing the duration of funded treatment eligibility, reducing the frequency of client treatment contact, or placing participants in lower levels of care than indicated by clinical assessment. These attempts to artificially increase program capacity by reducing standards of care are inconsistent with research findings on what constitutes effective treatment for chronic diseases like addiction. Such strategy is analogous to treating diabetes or hypertension with half the indicated medication.

These solutions are largely self-defeating as people who fail to get adequate services the first time they enter treatment add to the demand by returning to treatment again and again.

A second option that is often used by funding entities is to shift the service priorities of one funding source to meet the need in another area where lack of funding is perceived as

more critical. In a service system that is inadequately funded to begin, with this solution, only shifts the problem of access to services from one segment of the population to another. More often than not, the shift is from serving those whose problems are perceived as less severe, or whose problems are less visible, to those seen as having more severe problems or those whose problems are more visible. This solution is also self-defeating because it fails to recognize that the nature of addiction problems are such that those who fail to get treatment in one setting today will show up later in another setting, needing treatment, often exhibiting more severe and more difficult problems, adding to the burden on the treatment system.

A third option to the problem is to maintain current treatment standards with existing funding priorities and to accept first-come-first-served waiting lists where the demand for services exceeds the currently funded capacity. Obviously, this option is not ideal because it does not provide treatment at a time when people may be most ready for it. However, it is an honest alternative that acknowledges the current inadequate level of funding to serve the needs of Californians. Moreover, it does not attempt to disguise the funding problem by compromising current standards of care that, in many cases, we know are barely adequate to effectively treat addiction problems.

**In light of the continued public demand for program accountability and improved treatment outcomes, CAADPE has taken the position to recommend against any efforts to compromise existing treatment service standards through measures such as reducing the frequency of client treatment contact, reduced length of treatment, and placement of clients in levels of care inconsistent with their assessed need.**

CAADPE encourages the continued effort to improve treatment outcomes across the entire drug and alcohol abuse service system through the implementation of proven best practices. In doing so, CAADPE recognizes that the implementation and maintenance of these standards in a time of funding constraints may result in first-come-first-served waiting lists for some services, including those provided in criminal justice settings. We believe that this approach is more acceptable than compromising service quality.

Recent analyses of treatment services provided under the Substance Abuse and Crime Prevention Act have documented the benefits of providing effective drug abuse treatment services. If our communities are to continue deriving the benefits of effective treatment, treatment standards in all settings must not be compromised. To provide lesser care is a disservice that only undermines the public's confidence in the entire treatment system. **CAADPE believes that the citizens of California, no matter what their status, have the right to receive treatment as good as, if not better, than that provided elsewhere.** Our position stated here is directed toward that goal.