Evaluation of Proposition 36: The Substance Abuse and Crime Prevention Act of 2000

2009 Report

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Executive Summary

In November 2000, California voters passed Proposition 36 (Prop 36), which was enacted into law as the Substance Abuse and Crime Prevention Act of 2000. The UCLA Integrated Substance Abuse Programs (UCLA) has an interagency agreement with the Department of Alcohol and Drug Programs to conduct an independent evaluation. This 2009 report is the latest in a series of annual assessments.[1] The State of California discontinued funding of SACPA on July 1, 2009, but the sentencing law remains in effect. The goal of UCLA's evaluation reports is to provide stakeholders and policymakers with information to aid in decisions about Prop 36 practices and funding.

This report describes a number of signs of promising progress among Prop 36 program performance and client outcomes.

- New evidence indicates that at treatment discharge, Prop 36 offenders had reduced drug use, engaged in less criminal activity, were less likely to be homeless, and experienced reduced levels of family conflict compared to their levels on these measures at admission.
- During treatment, Prop 36 clients also made improvements in employment and in receiving social support.
- After passage of Prop 36, California prisons have been increasingly used less to incarcerate drug offenders and more to incarcerate violent criminals.
- In recent years, statewide crime trends for drug, property, and violent crimes have fallen faster in California than in the rest of the nation.
- A new pilot project on process improvement methods developed by the Network for the Improvement of Addiction Treatment (NIATx) demonstrated the ability of such methods to produce improvements in waiting time, no-show rates, group and individual session attendance rates, 30-day continuation rates, and overall number of admissions. These findings replicate and extend successes seen in an earlier pilot project. Furthermore, survey data shows that these methods are spreading quickly to treatment programs throughout the state.
- Treatment completion rates rose. It is unclear how much of this increase may be attributed to improvements in treatment delivery and how much may be due to recent changes in data collection methods, treatment requirements, and other factors.

This report also describes some outcomes and performance measures that appeared less positive.

- As in previous evaluation reports, the most recent cohort of Prop 36 offenders were arrested more often than a pre-Prop 36 comparison group. This may be due in part to reduced incarceration in the Prop 36 group, and therefore more time in the community to commit crimes. The higher arrests were primarily for drug and property, not violent, crimes.

[1] For past reports, see: http://www.uclaisap.org/prop36/html/reports.html

- Treatment show rates fell. It is unclear how much of this decrease may be attributed to changes in practices and how much may be due to recent changes in data collection methods.

Beyond these overall statewide performance and outcome measures, this report also examines challenges that remain for specific populations:

New data in this report shed light on reasons for the underrepresentation among women in Prop 36. Results suggest that this may be related to the specific family obligations and treatment needs of women, including child care for which there are scarce resources. Improvements targeting these needs (e.g. child care) may increase participation.

Likewise, interviews suggest that the underrepresentation of young Hispanic males in residential treatment may be due in part to the higher tendency among this group to work as laborers who cannot take time away from work due to the economic burden it would present for themselves and their families. Gaps in culturally responsive treatment for Hispanics also present a challenge. Addressing these issues may increase participation and outcomes among this population.

Prop 36 participants who are on probation generally experience better outcomes than those on parole. Yet for parolees too there is a promising practice that may help. Interviews and preliminary data suggest that parolees being supervised by specialized agents may do better than those on standard mixed caseloads.

Clients with co-occurring disorders also remain a challenge. Clients diagnosed with cognitive disorders had the lowest treatment completion rates; those with adjustment disorders and substance use disorders were more likely to be arrested on a felony charge. For clients with co-occurring disorders, a recommendation to improve outcomes is also available. Integrated Dual Diagnosis Treatment is an evidence-based treatment of co-occurring disorders that the Federal Substance Abuse and Mental Health Services Administration recommends as the preferred treatment for co-occurring disorders. Preliminary evidence suggests that drug treatment programs may have increased the use of IDDT from FY 2006/2007 to 2007/2008, though there is some evidence that it may not always be implemented with full fidelity.

Opiate users represent another challenging population, and prescription opiate use is a potential future danger. Prop 36 opiate users who received Narcotic Treatment Program (NTP) maintenance had the greatest reductions in their opiate use from treatment intake to discharge when compared to opiate users who received outpatient drug-free or non-NTP detoxification treatment. UCLA suggests greater availability and use of NTPs. Unfortunately, use of NTPs is actually declining among Prop 36 opiate users, despite being the best medically recommended treatment for opiate addiction.

Beyond the special populations described above, at a broader level, stakeholders have cited a number of challenges and have described ways that they have responded, including at times trying to find ways to circumvent the law in order to implement what

they regard as improvements, such as finding ways to impose short jail sanctions. There appears to be broad consensus among stakeholders that inadequate funding and restrictions on jail sanctions are two major barriers to improving outcomes. One option to address these issues would involve stakeholder collaboration to offer revisions to the Prop 36 law and place it before the voters in a referendum.

Program performance measures and the additional promising practices from high-performing counties are also described in this report and can be used to encourage innovations and measure their effects.

Brief summaries of each of the report chapters follow. The chapters themselves provide further detail on the evaluation methods, results, and recommendations within each topic heading.

Chapter 1: Characteristics of Prop 36 Offenders

This chapter describes the numbers and characteristics of Prop 36 participants, with survey information added where relevant to aid interpretation of the data.

The Prop 36 "pipeline" typically proceeds in a number of steps that can be characterized as eligibility, referral, assessment, and treatment entry. Prop 36 stakeholders indicated that most eligible offenders agreed to participate in Prop 36, but among those who declined the most common perceived reason was offender preference for incarceration or for other treatment options.

Of those offenders who did agree to participate in fiscal year (FY) 2007-2008, 80% were assessed. Of these, 83% were admitted to treatment. Common stakeholder-cited perceived reasons for treatment no-show included drug use relapse and no intent to enter treatment.

In Prop 36's seventh year most treatment clients were men (73.3%) and non-Hispanic White (40.7%), while 36.8% were Hispanic and 14.3% were African-American. The average age at treatment entry was 35.5 years. Nearly half of Prop 36 treatment clients had never received treatment before. These characteristics were mostly similar to those in previous years, but over the last seven years there has been a steady increase in the percentages of Prop 36 offenders who are parolees, Hispanic, older, and had longer drug use histories. An increase in unemployment was apparent, though this may have been at least partially attributable to a change in the data system used to measure employment.

Compared to drug court referrals, at treatment entry, more Prop 36 clients were more likely to be male, methamphetamine users, and employed. Prop 36 clients also were more likely to have long drug use histories and to have used their primary drug in the month prior to treatment entry. However, Prop 36 clients were also less likely to be homeless or to have been incarcerated in jail in the prior 30 days. Differences in client characteristics like these must be taken into consideration when comparing Prop 36 outcomes to those of other criminal justice options such as drug court.

Information on Prop 36 client characteristics by county is also provided, and county-level variation in characteristics was evident. County-level variation in client characteristics must be considered if efforts are made in the future to compare Prop 36 program performance or outcomes by county.

From treatment intake to discharge there were improvements among Prop 36 offenders in several key outcome areas. Compared to treatment intake, at treatment discharge fewer Prop 36 offenders had used their primary drug, engaged in criminal activity, were homeless, or had experienced family conflict, and more Prop 36 offenders were employed and had received social support.

Chapter 2: Treatment Placement and Wait Time, Treatment Completion and Non-Completion, Early Treatment Dropout, Treatment Outcome Indicators, and Treatment Re-entry

This chapter examines various aspects of treatment, including wait time, placement, and outcomes.

In Proposition 36's seventh year (2007-2008), as in earlier years, most offenders were placed into outpatient drug-free treatment (84.1%). About one-third of Prop 36 offenders were reported as having to wait to enter treatment and the mean number of waiting days was 12.7. The percentage of Prop 36 offenders who waited for treatment and the average number of days waited varied by treatment modality.

The Prop 36 treatment completion rate reached a high of 40.7% of those discharged from treatment in the program's seventh year. One possible explanation is that this reflects improvements in treatment, for example due to higher funding levels and/or rapidly increasing use of process improvement strategies during this period (see Chapter 8). However, several other possible reasons may also have contributed to changes in treatment completion rates over time, including the recent transition to a new drug treatment data system, changes in the methodology for calculating completion rates, and potentially changing requirements for treatment completion. Treatment completion continues to be an imperfect measure, though one that plays an integral part in the law. Variation in Prop 36 treatment completion rates was evident by county; this may be attributable not only to differences in quality of treatment but also to differences in the characteristics of counties and of the clients being treated, and differing definitions of treatment completion being applied in different counties.

Compared to treatment completers, non-completers were more likely to be parolees, unemployed, African American, to have less education, to have used their primary drug recently, and to have been arrested or incarcerated in jail prior to treatment entry.

About one-third of Prop 36 treatment non-completers were clients who left treatment within 30 days of treatment entry. In general, the characteristics that distinguished these early treatment dropouts were similar to the characteristics that differentiated all

treatment non-completers from treatment completers, although the rate of homelessness at treatment entry was higher among early treatment dropouts.

Outcome measures showed Prop 36 clients improved on a number of outcome measures from admission to discharge. At discharge fewer Prop 36 offenders had used their primary drug, interacted with the criminal justice system, or experienced family conflict, while more were employed and reported having social support. Improvements were greater among treatment completers than non-completers.

Approximately 25% of discharged Prop 36 treatment clients re-entered treatment within the following 12 months to begin a new treatment episode. This generally occurred about four to five months after discharge from the prior episode. The last treatment discharge record on file 12 months after initial treatment discharge indicated completion for 41.0% of clients.

Chapter 3: Gender Differences Among Prop 36 Clients

There is a substantial amount of research on gender differences among substance abuse treatment populations, but relatively little is known about the effects of gender within the Prop 36 client population specifically. Informed by FY 2007-2008 CalOMS data on substance abuse treatment differences, this chapter compares the characteristics of Prop 36 women and men, examines differences in treatment experiences, and summarizes gender differences in selected Prop 36 treatment outcomes. As context, data on women and men referred to treatment by other non-Prop 36 mechanisms is also presented.

Women make up 27% of Prop 36 clients, in contrast to 32% of all non-Prop 36 criminal justice referrals and 41% of all non-criminal justice referrals. Prop 36 women are older and are less likely to have young children compared to other women in treatment. In contrast, men in Prop 36 were slightly more likely to have young children compared to men referred to treatment through other mechanisms (21.0% vs. 17.4%).

Women were much more likely not to be in the labor force compared to men, and men were over twice as likely to be employed full time. Compared to Prop 36 men, Prop 36 women were about twice as likely to report having medical problems and receiving mental health and general health services (including Medi-Cal). However, Prop 36 women were much less likely than all other women in treatment to be Medi-Cal eligible (25.0% vs. 44.4%).

The underrepresentation of women in Prop 36, compared to other criminal justice treatment and non-criminal justice pathways to treatment may be related to the specific family obligations and treatment needs that women have, including child care, which was found to be provided by a minority of Prop 36 programs – only 17.5% of programs surveyed provided child care on-site.

Chapter 4: Methamphetamine Use Special Study

Just over half of all Prop 36 treatment clients reported methamphetamine (meth) as their primary drug. This chapter examines the characteristics of these users relative to other Prop 36 clients and to non-Prop 36 meth using clients. In terms of age, race/ethnicity, length of primary drug use, and rates of injection use Prop 36 meth users were more similar to non-Prop 36 meth users than to Prop 36 users of other drugs. On other characteristics, Prop 36 meth users were more similar to other Prop 36 users of other drugs: gender, education, employment, and rates of admission to outpatient treatment.

Prop 36 meth users had treatment completion and retention rates similar to other Prop 36 clients, but had rates higher than those for the non-Prop 36 groups. Prop 36 meth users also showed improvement in multiple outcome domains. The percentage of Prop 36 meth users with any primary substance abuse decreased from 50.9% in the 30 days preceding episode admission to 24.8% at discharge. This relative decrease was similar to that among Prop 36 non-meth users and non-Prop 36 meth users. Re-offending rates were very similar for Prop 36 meth and non-meth users.

Chapter 5: Parolees in Prop 36: Barriers to Participation and Future Trends

Parolees from the California Department of Corrections and Rehabilitation (CDCR) may become eligible for Prop 36 if they commit a Prop 36 eligible parole violation or are subject to new local court charges that are Prop 36 eligible. This chapter examines parolee outcomes, key barriers to success, and one promising practice.

Compared to probationers, parolees reported less education, were more frequently homeless, were more likely to report use of heroin or cocaine/crack, and were more likely to report injection drug use. More parolees were referred to long term residential treatment and they waited significantly less time to enter such treatment than probationers. Parolees had shorter treatment stays in both outpatient and residential treatment than probationers. A smaller percentage of parolees reached major treatment benchmarks in outpatient treatment than probationers, but parolees and probationers did not differ in terms of the percentage reaching major treatment benchmarks in residential treatment.

According to focus group and key informant interviews, key barriers to participation among parolees in Prop 36 included transportation, employment/treatment time conflicts, unstable housing, lack of interest in treatment, and lack of family support. Parole agents also believed that motivation for treatment and criminal sophistication were factors related to parolee performance in Prop 36.

Specialized (Prop 36 only) parole agents reported that they had more time to "work" their cases because they had a caseload of only 50 individuals as compared to the typical 70 to 100 individuals in a standard mixed caseload. It was also reported that specialization allowed agents to develop more knowledge of the resources that are available to help P36 parolees be successful. Preliminary analyses of administrative data suggest that parolees on specialized caseloads may have better results than those on mixed caseloads.

Chapter 6. Proposition 36 Special Populations: Hispanic Men Under 26

Since its inception, the number of Hispanic offenders in Prop 36 has been growing. Hispanics represent the second largest racial/ethnic group in Prop 36, with Non-Hispanic Whites being the first. Previous UCLA analyses have found that Hispanic Males under the age of 26 in particular are less likely to receive residential treatment. This chapter explores the needs of this group, and of Hispanics more generally, in Prop 36.

Analyses indicated that, although there are some highly culturally responsive programs for Hispanics in Prop 36, the overall treatment system may be low in cultural responsiveness. Prop 36 treatment providers reported a number of specific measures they have taken to increase cultural responsiveness for Hispanics. These include employing ethnic/cultural matching between treatment provider and client, for example providing bilingual treatment information to clients, and employing Spanish speaking counselors. However, data suggest a relative paucity of drug treatment services offered in Spanish.

The most frequently cited barrier to treatment entry was drug using peer group affiliations, followed by language barriers and work obligations. Key informant interviews with Prop 36 providers suggested a barrier to treatment entry for young Hispanic males. They often worked as laborers being paid "under the table" and any time away from work represented an economic hardship for them and their families. With regards to outcomes, all participants showed gains across a wide range of domains at treatment discharge relative to intake.

Key recommendations based on survey responses, focus group discussions, and key informant interviews include the following: (a) there is a need for increased emphasis on cultural responsiveness (CR) among Prop 36 treatment providers including increasing CR residential treatment programs, continued CR training for providers, and systematic incorporation of CR practices among treatment providers serving a high number of Hispanic clients; (b) there is a clear need to attract, train, and retain Spanish speaking treatment providers for Prop 36; (c) there is a need for educational interventions; (d) there is a need to address employment and economic considerations to increase access to residential treatment services for Hispanics in Prop 36; (e) there is a need for family interventions, including parenting training, for Hispanic males under 26 as many reported having young children at home; (f) there is a need for increased emphasis on HIV testing and prevention among Hispanics as they are at greater risk than the general population for HIV infection; (g) there is a need to address economic barriers to participation in treatment early in treatment; income sensitive payment plans for drug testing and court imposed fines may help to facilitate retention.

Chapter 7: Co-Occurring Disorders in Proposition 36

According to the research literature, approximately 37% to 53% of all individuals diagnosed with a substance use disorder have also been diagnosed with a co-occurring mental illness disorder in their lifetimes. This chapter examines the treatment and outcomes of clients with co-occurring disorders within Prop 36.

Within Prop 36 only a few of the drug treatment programs surveyed reported not having clients with co-occurring drug and mental health disorders; however, the majority of drug treatment programs reported that they did not employ personnel trained to treat mental health disorders. Additionally, about 40% of Prop 36 Assessors reported that they did not conduct a mental health screening during the Prop 36 assessment process.

Prop 36 clients appearing in Department of Mental Health databases (Diagnosed Group) were less likely to complete drug treatment than those located in the DMH databases (Comparison Group), with clients diagnosed with a cognitive disorder having the lowest completion rate. The Diagnosed Group was also more likely than the Comparison Group to be arrested at least once in the 30 month follow-up period for drug, property, and, rarely, violent crimes. Offenders diagnosed with adjustment disorders and substance use disorders were more likely to have a felony arrest in the 30 month follow-up period.

Integrated Dual Diagnosis Treatment (IDDT) is an evidence-based treatment of co-occurring disorders that the Federal Substance Abuse and Mental Health Services Administration recommends as the preferred treatment for co-occurring disorders. Drug treatment programs reported an increase in the use of IDDT from 2006/2007 to 2007/2008; however, there are some inconsistencies in the reporting of this information.

California has two separate departments with two separate means for funding the drug treatment and mental health treatment systems. ADP's funding includes Prop 36, while DMH's includes Prop 63. Data indicate the drug treatment programs have had limited success in accessing Prop 63 funds. UCLA continues to recommend that drug treatment and mental health service administrators find ways to integrate these funding sources to improve treatment for individuals with co-occurring disorders.

Chapter 8: Process Improvement

Process improvement is a systematic problem solving approach that organizations can use to develop a deeper understanding of client needs, restructure the workflow to more effectively respond to client and staff needs, and make the most efficient use of available resources The Network for the Improvement of Addiction Treatment (NIATx) was formed as a joint venture of the Robert Wood Johnson Foundation and the Center for Substance Abuse Treatment to promote process improvement specifically in substance abuse treatment. Statewide, awareness of NIATx and use of process improvement methods increased dramatically between 2007 and 2009.

Building upon an earlier pilot project described in the 2008 Proposition 36 Evaluation Report, in 2007-2008 a new demonstration project took place in Los Angeles County to determine whether treatment programs receiving minimal support and no financial assistance could successfully adopt process improvement methods to reduce no-shows, improve participation in individual and group counseling sessions, and increase continuation rates. This chapter summarizes the methods and results of this pilot project.

Participating treatment programs used a variety of innovative strategies, including: consolidation of multiple assessment appointments, increased contact with prospective clients, in-house intake appointments, daily check-in calls with clients on a waiting list, bus tokens, alteration of intake and assessment appointment times, reminder phone calls, assignment of clients to a primary counselor at time of assessment, distribution of weekly group and individual session appointment schedules, regular meetings between new clients and staff from various departments, satisfaction questionnaires, adjustment of meal, mail, and medication times to better accommodate clients' schedules, and a welcome/orientation group to encourage continued participation in treatment.

The vast majority of agencies were able to demonstrate improvements. Aggregate data from participating programs revealed a 42% reduction in wait time from initial contact to assessment/intake appointment; a 44% reduction in no-shows to intake, assessment, or admission appointments; a 19% increase in post-admission session-by-session attendance; and a 6% increase in 30-day continuation. These positive findings suggest that such procedures continue to be promoted throughout the state drug treatment system.

Chapter 9: Narcotic Treatment Programs

Opiate users in Prop 36 experience outcomes far worse than those of other Prop 36 participants. This chapter examines this challenge.

A primary reason for poorer outcomes among Prop 36 opiate users has been the limited use of narcotic treatment programs (NTP) such as methadone maintenance. Despite its acknowledgement as the best treatment for opiate dependence, very few Prop 36 opiate users receive placement in NTP. In fact, the use of NTPs in Prop 36 has decreased steadily over the past three years. Only about half of the counties reported referring Prop 36 participants to NTPs. In FY 2005-06, 16.5% of Prop 36 opiate users received NTP, decreasing to 11.8% in 2007-08. This is compared to 66.2% in 2007-08 for non-criminal justice clients with a primary opiate problem. Prop 36 opiate users who received NTP maintenance had greater reductions in their opiate use from treatment intake to discharge when compared to opiate users who received other types of non-NTP treatment.

Prop 36 opiate users who appeared more stable at intake were more likely to receive detoxification or outpatient drug-free drug treatment, whereas those with unstable living arrangements, poor social support and family conflict were more likely to be placed in more intense treatments such as NTP maintenance and residential drug treatment.

As repeatedly noted in prior evaluation reports, to improve treatment outcomes among Prop 36 opiate users, the provision and utilization of NTPs must be enhanced. NTP should be available to all Prop 36 opiate users regardless of county of residence. UCLA recommends the use of buprenorphine as an alternative to methadone especially in counties where methadone is unavailable.

With the current rise in prescription opiate abuse, especially among adolescents and young adults, the number of opiate users in Prop 36 may increase in the coming years.

While NTPs may not be the appropriate treatment placement for every Prop 36 opiate user, NTPs are important tools in the treatment of opiate dependence.

Chapter 10 Key components of Prop 36 program success: Lessons from six high performing counties

To gain an in-depth understanding of what practices or policies were responsible for Proposition 36 program successes, focus groups were conducted with key stakeholders in six high-performing counties from February to April 2009. Discussion topics covered key elements of success, recommendations for best addressing specific sub-groups of Prop 36 clients, current programmatic needs, the impact of California's ongoing state budget crisis, and other current needs.

Seven key components of Prop 36 program success emerged from the focus groups with county stakeholders: (1) engage the client quickly, (2) monitor client progress, (3) cultivate buy-in among clients, (4) cultivate buy-in among key stakeholders, (5) attract a judge who works well with clients and stakeholders, (6) build and maintain a diverse and high-quality treatment system, and (7) diversify funding resources and support for the program. Within these broader components, specific strategies were identified by several counties as the reason for their success. Since these components and strategies were not formally evaluated it is not possible to comment on their effectiveness. These ideas represent potential areas for further research.

Chapter 11: Arrests and Crime Trends

This chapter examines arrest trends within the Prop 36 population, as well as broader statewide crime trends in relation to national trends.

In years 4, 5, and 6, Prop 36 treatment completers had fewer re-arrests over a 12 month follow-up period than offenders who did not complete treatment. This was also true of Year 1 offenders tracked over a 6 year follow-up period. The percentage of all Prop 36 eligible offenders being arrested each year remained relatively stable in years 4, 5, and 6, but remained higher relative to a comparison group of offenders in the pre-Prop 36 era.

Crime trends are notoriously difficult to attribute to narrow policy efforts; rather they result from the convergence of many factors. Therefore crime trend patterns cannot be definitively causally attributed directly or indirectly to the effects of Prop 36. Descriptively, in the years before and after Prop 36 was passed in 2001, the violent crime rate in California decreased faster than rates did in the rest of the nation, though not as fast as they had prior to Prop 36 implementation. Overall property crime rates and drug arrest rates increased slightly in California initially after Prop 36 took effect, but in subsequent years have decreased to a greater extent than in the rest of the nation.

UCLA examined incarceration patterns before and after Prop 36 implementation to assess whether these trends may have plausibly contributed to patterns in crime trends. After Prop 36 implementation, the composition of California's state prison population changed.

The drug offender population in California's prisons dropped by 7.4 percentage points while the population incarcerated for crimes against persons (murder, non-negligent manslaughter, forcible rape, robbery, and aggravated assault) increased by almost the same amount, 6.8 percentage points. In 2007 approximately 15,000 more offenders were incarcerated for crimes against persons than would have been the case if the percentages had not changed. This suggests that one aim of Prop 36 has been achieved, even if the degree to which Prop 36 contributed cannot be definitively determined. California prisons are being used more to house those who commit violent crimes and less for those who commit drug crimes. This may plausibly have contributed in part to the drop in violent crime while property crimes and drug arrests increased, at least initially.

To assess an additional potential contributor, UCLA examined the increase in the number of sworn law enforcement officers in California. California's increase in law enforcement officers was slightly larger than increases seen in the rest of the nation. These increases, although modest, may have played a role in some of the crime reductions, but cannot explain all patterns in the crime trends.

The inability to determine, among all possible contributors, the degree to which Prop 36 has played a part these trends is a major shortcoming of this type of research. Although these analyses represent an attempt to begin examining cumulative potential explanations, other unexamined factors may have contributed to the trends. Continuing research and more sophisticated analyses are needed to clarify these possibilities.

Chapter 12: Performance Measurement

Increasing pressures for cost containment and improved outcomes are prompting substance abuse treatment delivery systems to develop performance measurement capabilities. While various performance and outcomes measurement initiatives and efforts are underway, this is still an emerging area in a field that is transitioning from an acute care to a chronic care approach to understanding and supporting recovery.

To date, the most widely used performance measures for substance use treatment programs include initiation, engagement, retention, and use of evidence-based practices. Continuity of care measures and surveys of clients' experience with care are also currently under development and testing. Although a number of program performance measurement models exist, further testing and refinement are necessary, especially regarding different settings and special client populations. Caution must also be exercised to anticipate and address unintended consequences.

Preface

Darren Urada, Ph.D.

In November 2000, California voters passed Proposition 36, which was enacted into law as the Substance Abuse and Crime Prevention Act, beginning July 1, 2001.

This report has four sections. The first section describes the characteristics of clients and treatment in Proposition 36. The second section provides information on special populations. The third section describes promising practices. The fourth section describes outcomes, statewide crime trends, and the development of performance measures.

Background

In November 2000, California voters passed Proposition 36 (Prop 36), which was enacted into law as the Substance Abuse and Crime Prevention Act of 2000. Prop 36 represented a major shift in criminal justice policy. Adults convicted of nonviolent drug offenses in California who meet eligibility criteria can now be sentenced to probation with substance abuse treatment instead of either probation without treatment or incarceration. Offenders on parole who commit nonviolent drug offenses or who violate drug-related conditions of their release may also receive treatment. Offenders who commit non-drug violations of probation/parole may face termination from Prop 36. Consequences of drug violations depend on the severity and number of such violations. The offender may be assigned to more intensive treatment, or probation/parole may be revoked.

As part of the new law, the state was required to secure an independent statewide evaluation of the effects of Prop 36. The California Department of Alcohol and Drug Programs (ADP) chose the University of California, Los Angeles Integrated Substance Abuse Programs (referred to as UCLA throughout this report) to conduct an initial evaluation of Prop 36, from 2001 to 2006. Upon completion of this evaluation, ADP contracted with UCLA to perform a second, shorter evaluation in 2007, then a third round of evaluation which began in January 2008 and is scheduled to continue through December 2010.

Evaluation Overview

The goal of past and present Proposition 36 evaluation reports is to provide state and national policymakers with a unique source of information needed to make decisions about Prop 36 in California and similar programs elsewhere.

Data for this evaluation were collected in surveys of county stakeholders, focus groups (semi-structured in-depth discussion) with stakeholders, observation (e.g., recording of issues raised, perceptions noted, decisions and agreements reached) at meetings, conferences, and other events, county records, and statewide datasets maintained by human services and criminal justice agencies.

While the "gold standard" for program evaluation is experimental comparison in which potential participants are randomly assigned to a program group (offered an opportunity to participate) or a comparison group (not offered that opportunity), experimental comparison was not feasible in the Proposition 36 evaluation because randomization would have meant denying or delaying participation by offenders legally entitled to participate in Proposition 36. It was therefore necessary to take a "quasi-experimental" approach where such comparisons were relevant. In this approach, the comparison groups were composed of subgroups of the people who participated, and a comparison group that was composed of people who would have been eligible for the program if it had existed at the time of their conviction.

Organization of the Report

This report has four sections. The first section describes the characteristics of clients and treatment in Proposition 36. The second section provides information on special populations. The third section describes promising practices. The fourth section describes outcomes, statewide crime trends, and the development of performance measures. A final chapter summarizes the current state of Prop 36 and provides the framework of a plan to implement much needed changes.

Darren Urada, Ph.D. is the principal investigator of this evaluation. Other UCLA researchers who had roles in the Prop 36 evaluation include Elizabeth Evans, M.A., Joy Yang, M.P.P., Bradley T. Conner, Ph.D., Michael Campos, Ph.D., Lynn Brecht, Ph.D., M. Douglas Anglin, Ph.D., Jia Fan, M.S., Jeremy Hunter, M.A., Beth Rutkowski, M.P.H., Cheryl Teruya, Ph.D., Christine Gardiner, Ph.D., Rachel Gonzales, Ph.D., Christine Grella, Ph.D., Richard Rawson, Ph.D., Michael Prendergast, Ph.D., Nelson Tiburcio, Ph.D, Bryce Lowe, Katie Shaw, and Yih-Ing Hser, Ph.D.

For copies of previous Proposition 36 evaluation reports, see:
http://www.uclaisap.org/prop36/html/reports.html
For more information about the evaluation see:
http://www.uclaisap.org/prop36/index.html
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Chapter 1: Characteristics of Proposition 36 Offenders

Elizabeth Evans, Jeremy Hunter, and Darren Urada

Of offenders who were referred to Prop 36 during Fiscal Year 2007-08 about 67.5% entered drug treatment, representing a treatment show rate that is lower than rates estimated for previous Prop 36 years. Prop 36 stakeholders indicated that most eligible offenders agreed to participate in the Prop 36 program. Stakeholders also reported that offenders who declined the program were more likely to be male, younger, not employed, homeless, and a persistent or chronic offender; and preference for incarceration or for other treatment options were most commonly reported as reasons for offender refusal of the Prop 36 program. Stakeholder-cited reasons for treatment no-show included drug use relapse and no intention to enter treatment.

Similar to earlier years, in Prop 36's seventh year most treatment clients were men (73.3%) and non-Hispanic White (40.7%), while 36.8% were Hispanic and 14.3% were African-American. Mean age at treatment entry was 35.5 years. Methamphetamine was the most commonly reported primary drug problem (52.6%), followed by marijuana (14.4%), cocaine/crack (14.2%), alcohol (8.9%), and heroin (8.6%). About half of Prop 36 treatment clients had received treatment before (50.9%). Most Prop 36 offenders admitted to treatment were on probation (82.7%) and the others (17.3%) were on parole. Prop 36 parolees and probationers differed on some characteristics at treatment entry.

Analysis of changes in client characteristics over time showed that over seven years there has been a steady increase in the percentages of Prop 36 offenders who were parolees, Hispanic, older, and had longer drug use histories. Also, a dramatic change occurred in the employment status of Prop 36 treatment clients over the past two years, with the unemployment rate increasing by 21%. To better understand this trend, information is provided from the perspective of treatment programs on current practices for addressing the employment and educational needs of Prop 36 clients.

This year's report also includes new information on a range of behaviors and measures that have such as level of family and social support, criminal justice system interactions, and health and mental health measures. Also provided is information on a new treatment referral type, drug court referrals, and data on Prop 36 client characteristics by county. Together, these data indicate the range of needs among the Prop 36 population and show how the characteristics of Prop 36 clients vary in comparison to other clients in treatment and also by county.

Finally, from treatment intake to discharge there were improvements among Prop 36 offenders in several key areas. Compared to treatment intake, at treatment discharge fewer Prop 36 offenders had used their primary drug, engaged in criminal activity, were homeless, or had experienced family conflict, and more Prop 36 offenders were employed and had received social support.

With some exceptions, the number of offenders who enter drug treatment under Prop 36 and the characteristics of those offenders have remained mostly unchanged over the years. However, California faces a significant budget crisis that can be expected to impact the Prop 36 program in the future. Information contained in this chapter can aid efforts to understand who is served by Prop 36 and how the program can be adjusted to accommodate fluctuating fiscal constraints while meeting present and future needs.

Introduction

This chapter describes the "pipeline" of offenders entering Prop 36 during Fiscal Year (FY) 2007-08, Prop 36's seventh year of operation. Three steps in the pipeline are covered: referral of the offender to Prop 36, completion of the assessment process, and entry into the treatment program to which the offender was assigned. Show rates at assessment and treatment (i.e., the percentage who completed the assessment process and the percentage who went on to enter treatment) in this year are compared to those in Prop 36's prior years. This chapter also reports characteristics of offenders who entered treatment during FY 2007-08 and provides information on changes in the status of offenders at treatment discharge compared to treatment intake.

Prop 36 Pipeline

Individuals convicted of a nonviolent drug offense, typically possession of or being under the influence of an illicit drug, are eligible for Prop 36. As shown in Appendix 1.1, there are some eligibility exceptions as well as differences in eligibility criteria for probationers and parolees.

Some offenders who are eligible for Prop 36 may decide not to participate. Those also eligible for a "deferred entry of judgment" program[2] such as PC 1000 may choose that option because they can participate without entering a guilty plea; participation in Prop 36 is contingent on having been found guilty of a Prop 36-eligible offense. Moreover, depending on local policy and practice, offenders may be eligible for both Prop 36 and drug court. Finally, routine criminal justice processing may seem preferable to offenders who face only a short jail sentence or disposition that they view as less onerous than the requirements of Prop 36 participation. For these reasons, from a social policy perspective it is important to assess the acceptance of Prop 36 by eligible offenders (i.e., how many chose to participate in Prop 36 when offered that option?).

Offenders who were eligible and chose to participate in Prop 36 were ordered to complete a treatment assessment and enter treatment. This group is known as those "referred" to Prop 36. Assessment entails a systematic review of the severity of the offender's drug use and other problems, a decision regarding appropriate placement in a drug treatment program, and identification of other service needs. Upon completion of the assessment, offenders must report promptly to the assigned treatment. Therefore referral is the first step identifiable in the Prop 36 pipeline, completion of assessment is the second step, and treatment entry is the third. A subsequent step, treatment completion, is discussed in Chapter 2.

Information on the number of offenders who entered Prop 36 ("referred") and who appeared for assessment ("assessed") was compiled by the Department of Alcohol and Drug Programs based on information submitted by individual counties to the SACPA

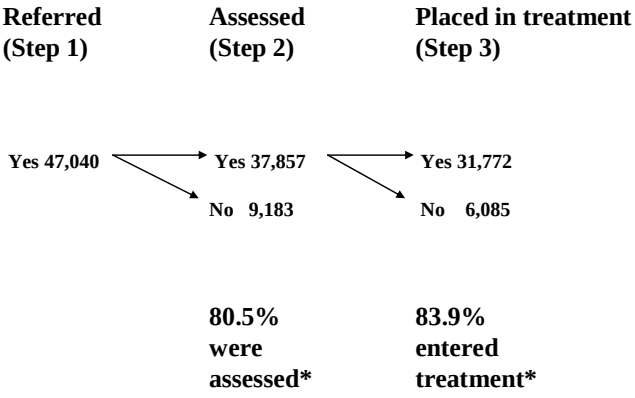
[2] Many first-time California drug offenders can avoid criminal convictions by opting for deferred entry of judgment (DEJ) under Penal Code sections 1000-1000.4. Diversion may include education, treatment, or rehabilitation. Entry of judgment may be deferred for a minimum of 18 months to a maximum of three years. Although there are limitations, successfully completed diversion leads to a dismissal of the charges.

Reporting Information System (SRIS). Information on the number of offenders who completed treatment is based on data from the California Outcomes Measurement System (CalOMS). SRIS was created specifically for Prop 36 monitoring and evaluation. CalOMS, was implemented in 2006 and replaced ADP's earlier California Alcohol and Drug Data System (CADDS).

Offenders Referred

According to county responses supplied to ADP via the SRIS data system, 47,040 offenders were referred to Proposition 36 for treatment during FY 2007-08 (see Figure 1.1). This includes offenders referred by the county courts and probation officers and by parole agents[3]. For FY 2007-08, ADP continued a statewide effort to improve and validate the referral numbers reported via telephone contacts with county staff to ensure that referral counts and assessment were being generated using consistent methods (e.g. unique individuals being reported rather than events). These efforts began in FY 2005-2006. Thus, more recent referral numbers may be more accurate than numbers reported in prior years, and comparisons to referral counts prior to 2005-06 should be made with caution.

Figure 1.1
Prop 36 Offender Pipeline, July 2007 to June 2008



*** The overall percentage of referrals entering treatment was 31,772 / 47,040= 67.5%.**

[3] The SRIS manual defines "referrals" as probationers and parolees sent to the Proposition 36 program from the court, probation department, or parole authority.

Offenders Who Decline the Prop 36 Program

Representatives of county public defender and district attorney offices were asked whether offenders who were eligible but declined to participate in the Prop 36 program were more likely to be members of certain demographic groups (see Appendix A for more information on the Stakeholder Survey). Public defender representatives were also asked to indicate possible reasons eligible offenders declined the Prop 36 program. A response was received from the Public Defender Office of 14 counties and the District Attorney Office of 10 counties. Although too few counties responded to relevant items on the survey to permit analysis of county-level variation in measures, data are useful for identifying areas for further discussion. Due to the relatively small number of respondents, caution must be exercised in interpreting these responses. It is unclear whether the responses received are representative of those among the rest of the state.

When asked to estimate the proportion of eligible offenders who declined the Prop 36 program, seven of the twelve public defenders that responded indicated that this was "rare" or provided an estimate of 10% or less. Responses from the remaining counties varied widely, including two responses indicating nearly half (40 and 45%) of eligible offenders decline the Prop 36 program. Notable percentages of Public Defender and District Attorney respondents also indicated that offenders who declined the Prop 36 program were more likely to be male, younger, not employed, homeless, and a persistent or chronic offender.

Public defenders were also asked to indicate the top three reasons offenders declined the Prop 36 program. The reason most commonly cited by public defenders as the top reason was that the offender preferred incarceration. This was listed as the top reason by one third of the public defenders and was cited as one of the top three reasons by seven of the twelve respondents. Offender preference for other treatment options for which he/she was eligible (for example, deferred entry of judgment, PC1000, and drug court) was the most common second reason listed. Other reasons cited by at least one third of the public defenders who responded included: offender believed the Prop 36 program was too difficult or onerous, offender was subject a parole hold or there were other conflicts with parole requirements, offender lacked motivation for treatment or wanted to keep using drugs, and offender was a misdemeanant and wanted to avoid formal probation. Other less frequently cited options, including lack of transportation and an inability to pay Prop 36 fees and fines, were cited by no more than one public defender as top reasons for individuals initially declining Prop 36 (these may be reasons for failure to complete treatment. See Chapter 2)

Offenders Assessed

Based on county responses in SRIS, in FY 2007-08, an estimated 37,857 Prop 36 offenders, including probationers and parolees, completed their assessment. In FY 2006-07, ADP initiated a statewide effort to improve and validate the numbers via telephone contacts with each county to ensure that the reported counts were generated using standardized methods. The assessment numbers may therefore be more accurate than numbers reported in prior years, and comparisons to counts prior to 2006-07 should be made with caution.

Offenders Entering Treatment

The estimated total of Prop 36 offenders placed in treatment during FY 2007-08, based on CalOMS admission data, was 31,772.[4]

Across Prop 36's earlier years, the estimated overall show rate (i.e., percentage of offenders who were referred to Proposition 36 and went on to be assessed and to enter treatment) hovered around 70%. The 67.5% statewide show rate for 2007-08 is the lowest estimate for any Prop 36 year to date. While this may in part be due to changing methods of data collection, this may also be attributable in part to the effect of cuts to statewide Prop 36 funding in FY 2007-08. The effect of these budget cuts is discussed elsewhere (Urada et al., 2009).

Prior research has shown that one-third to one-half of drug users who schedule a treatment intake appointment (including those referred by criminal justice, other sources, and themselves) actually keep their appointment (Donovan et al., 2001; Kirby et. al., 1997; Marlowe, 2002). In a sample of drug users in Los Angeles, Hser and colleagues (1998) found that 62% of drug dependent people interviewed for a research study and who asked for a treatment referral followed up on the referral they were given. Altogether, show rates seen in Prop 36 compare favorably with show rates seen in other studies of drug users referred to treatment by various entities including self-referral.

No-Show Rates

State and county stakeholders have expressed interest in no-show rates (i.e., offenders who chose Prop 36 but who did *not* complete an assessment or enter treatment) so that barriers can be identified and addressed to reduce no-show rates. For a direct look at this issue, pipeline show rates can be converted to no-show rates by subtracting from 100%. Therefore, in 2007-08 the no-show rate is 100%-67.5% = 32.5%.

Note that no-show offenders may have failed to complete assessment or to enter treatment for various reasons. For example, these offenders may have decided to decline Prop 36 participation after initial acceptance, or they may have absconded from criminal justice supervision, died, or committed crimes or probation/parole violations that precluded further participation. A recent study on Prop 36 offenders who did not enter treatment (Evans et al., 2008) found that compared to offenders who did enter treatment, offenders who did not enter treatment were younger, not employed, had a more severe criminal history, and were less personally motivated to enter treatment. This study also reported that fewer untreated offenders felt treatment-ready and more accepted the Proposition 36 program only upon recommendation by others rather than by internal motivators. Reasons offenders cited for not entering treatment included re-arrest, no desire for treatment, and assignment to a program that was too far away.

[4] The number of unique individuals in the pipeline does not match the numbers that will be discussed later from CalOMS due to the differing definitions utilized in defining a Prop 36 offender. When reporting to SRIS, counties are instructed not to count offenders who were reported in the prior reporting period. Clients in CalOMS may have entered Proposition 36 treatment during the current and past years as separate episodes, however the numbers using either definition are similar. To ensure that treatment placement numbers are defined consistently with the referral and assessment numbers, therefore, the CalOMS numbers here represent a count of individuals who did not enter treatment during the prior year.

To explore barriers to treatment entry further, UCLA surveyed county stakeholders on reasons offenders opted for the Prop 36 program but did not enter treatment. According to Probation Department staff who responded to the survey (21 counties participated in the survey, of which 17 provided reasons for treatment no-shows), the reason that accounted for the highest proportion of treatment no-shows was that the offender started using drugs again, followed by no intent on the part of the offender to enter treatment. One of these two answers represented the highest response for 15 of the 17 respondents. In the two other cases, the dominant response was offender re-arrest shortly after sentencing.

Characteristics of Treatment Clients

This section reports characteristics of offenders who entered treatment during FY 2007-08, Prop 36's seventh year of operation. To explore whether client characteristics may have changed over time, information on the characteristics of Prop 36 clients during earlier years is also provided in this report. Characteristics covered in the analysis include race/ethnicity, sex, age, primary drug, and drug problem severity. Prop 36 probation and parole referrals are shown separately so that any differences within the Prop 36 treatment client population will be apparent.

There are four notable changes to how client characteristics are presented in this year's report. First, all analyses for Fiscal Years 2006-07 and 2007-08 are based on the CalOMS, and not the previous CADDS, data system. Second, information from a range of measures that are now collected under the CalOMS system is reported in the section of the Chapter titled "New Measures." This section includes data on other client characteristics, level of family and social support, criminal justice characteristics, health and mental health measures, health testing information, and family status. Third, as was done in past years, characteristics of clients who entered treatment during FY 2007-08 but who were not part of Prop 36 are shown for comparative purposes. New to this report, information on drug court referrals is shown separately. This change results in the presentation of data on a total of five, instead of four, groups: Prop 36 probation, Prop 36 parole, drug court referrals, other criminal justice referrals, and non-criminal justice referrals (e.g., a healthcare provider or employee assistance program). The purpose of comparing treatment clients by referral source is to determine the ways in which Prop 36 clients were similar to, or different from, other clients in the state's treatment population[5]. Information on drug court referrals was broken out to respond to Prop 36 stakeholders' interest in understanding differences and similarities in client characteristics and treatment outcomes that may exist between the Prop 36 program and drug court procedures. Finally, the characteristics of Prop 36 clients entering treatment during Fiscal Years 2006-07 and 2007-08 are provided by county in Appendix 1.2.

[5] The CalOMS admission record for each client indicates the referral source as Prop 36 (court/probation or parole), drug court, other criminal justice, or non-criminal justice. Clients sent from other criminal justice referral sources may be on probation, parole, incarcerated, or participating in a non-Prop 36 diversion program (for example, deferred entry of judgment). Non-criminal justice clients were those referred by a healthcare provider, employee assistance program, themselves, or other sources but not by the criminal justice system. If a client had admissions from more than one referral source during the year, including Prop 36 and a non-Prop 36 source, the Prop 36 admission was selected and used for these analyses.

Analyses at the county level showed variation in some client characteristics by county. Statewide analyses continued to show that the 2007-08 cohort was similar to cohorts of prior years. For all analyses, sample sizes were too large to permit meaningful interpretation of statistical tests. Thus, although statistical tests were conducted, results are omitted from the presentation of data.

Figure 1.2 shows the breakdown of clients entering treatment by referral source as indicated in CalOMS. In its seventh year, Prop 36 accounted for 24.0% of clients entering treatment (19.8% were referred by probation; 4.2%, by parole). Prop 36 clients accounted for 14.8% of all treatment clients in the law's first year, 21.2% in the second, 22.4% in the third, 25.9% in the fourth, 25.9% in the fifth, and 25.5% in the sixth. Thus the share of treatment capacity occupied by Prop 36 clients increased rapidly in initial years but appears to have reached a stable level in recent years.

Figure 1.2
Treatment Clients by Referral Source
(CalOMS)

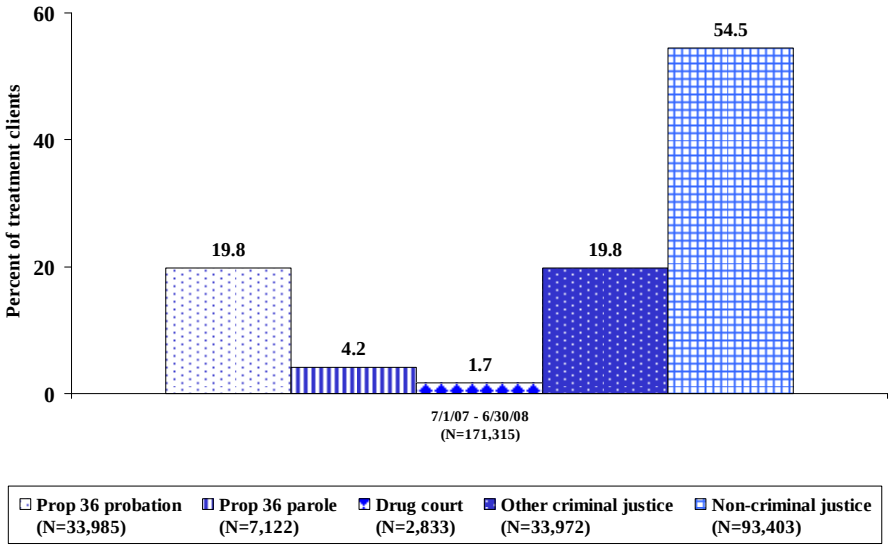
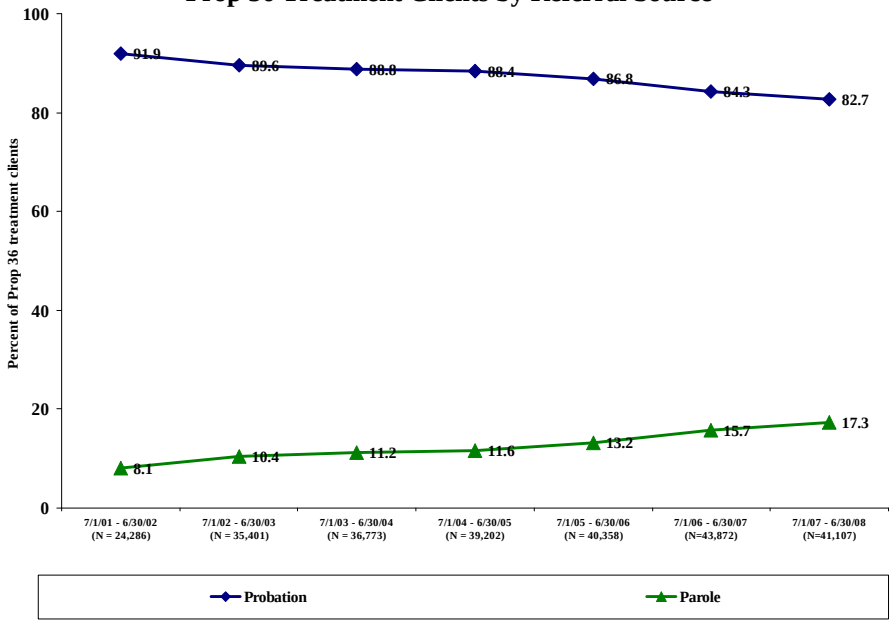


Figure 1.3 shows that most of Prop 36's seventh-year offenders (82.7%) were sentenced to probation or were already on probation when they committed their Prop 36 eligible offense. The others (17.3%) were parolees entering Prop 36 due to a new offense or a drug-related parole violation. Since treatment providers must select a single referral source in the CalOMS system, offenders simultaneously supervised by both parole and probation ("dual supervision") are counted in only one of these categories. This means that the absolute number of offenders under probation or parole supervision reported in Figures 1.2 and 1.3 may be somewhat undercounted. Also shown in Figure 1.3, the parolee portion of the Prop 36 client population has steadily increased over time. In the first year, 8.1% of Prop 36 treatment clients were parolees, and in the second, third, fourth, fifth, sixth, and seventh years, the percentages of Prop 36 treatment clients who

were parolees was 10.4%, 11.2%, 11.6%, 13.2%, 15.7%, and 17.3% respectively. More information on parolees who participate in Prop 36 is provided in Chapter 5.

Figure 1.3
Prop 36 Treatment Clients by Referral Source



Race/Ethnicity

The racial/ethnic composition of Prop 36 treatment clients is presented in Figure 1.4. In Prop 36's seventh year, almost half of Prop 36 treatment clients were non-Hispanic Whites (40.7%). Hispanics (36.8%), African-Americans (14.3%), Asian/Pacific Islanders (3.2%), Native Americans (1.3%), and other groups (4.0%) constituted the other half of the Prop 36 client population. Figure 1.4 also shows the racial/ethnic composition of Prop 36 clients over seven years. The percentage of non-Hispanic White clients has steadily decreased as the percentage of Hispanic clients has steadily increased over the years. Both are consistent with trends in the overall California population growth over the same period (California Department of Finance, 2007).[6] Other than this, there was virtually no change in the racial/ethnic composition of Prop 36 clients across years.

Figure 1.5 presents race/ethnicity of Prop 36 probationers and parolees separately and of clients referred by non-Prop 36 sources in Prop 36's seventh year. The racial/ethnic composition of all five groups was similar.

[6] In 2001, the Department of Finance (DOF) estimated 47% of the population was White and 33% Non-Hispanic White. In 2007, the estimates were 43% White and 36% Non-Hispanic White.

Figure 1.4
Race/Ethnicity of Prop 36 Treatment Clients

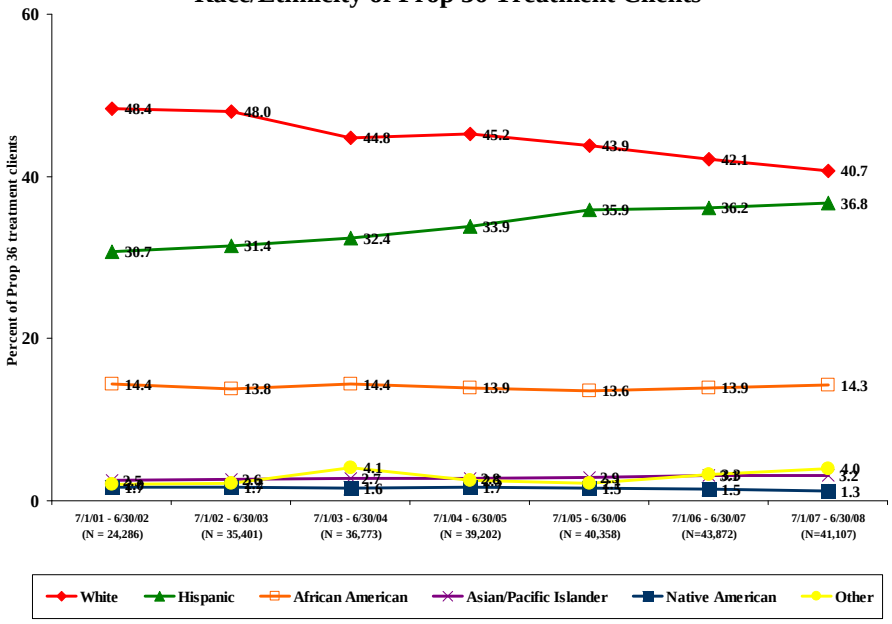
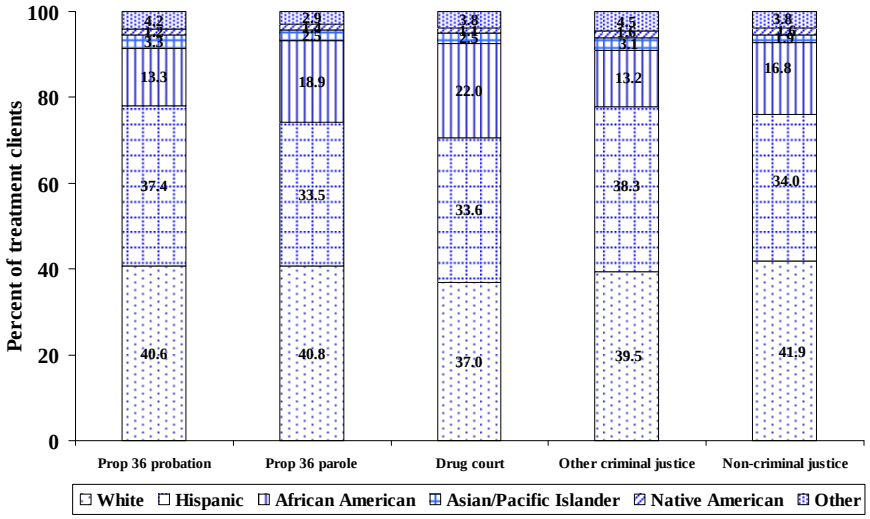


Figure 1.5
Race/Ethnicity of Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N =171,315)



Sex

Clients referred to treatment by Prop 36 in its seventh year were 73.3% men and 26.7% women (See Figure 1.6). This pattern is similar to the pattern in Prop 36's prior years.

Figure 1.7 shows the sex breakdown for Prop 36 clients referred by probation and parole and for drug court, other criminal justice sources, and non-criminal justice referrals. A majority of treatment clients in all groups were men, but this pattern is more pronounced among clients referred to treatment by Prop 36, especially by Prop 36 parole sources, and other criminal justice entities than among non-criminal justice referrals. These results are partly a reflection of the enduring difference between men and women in the seriousness of their criminal involvement (Blumstein et al., 1986; Gottfredson & Hirschi, 1990), which determines the likelihood of receiving jail and/or probation rather than prison. More information on the women who participate in Prop 36 is provided in Chapter 3.

Figure 1.6
Sex of Prop 36 Treatment Clients

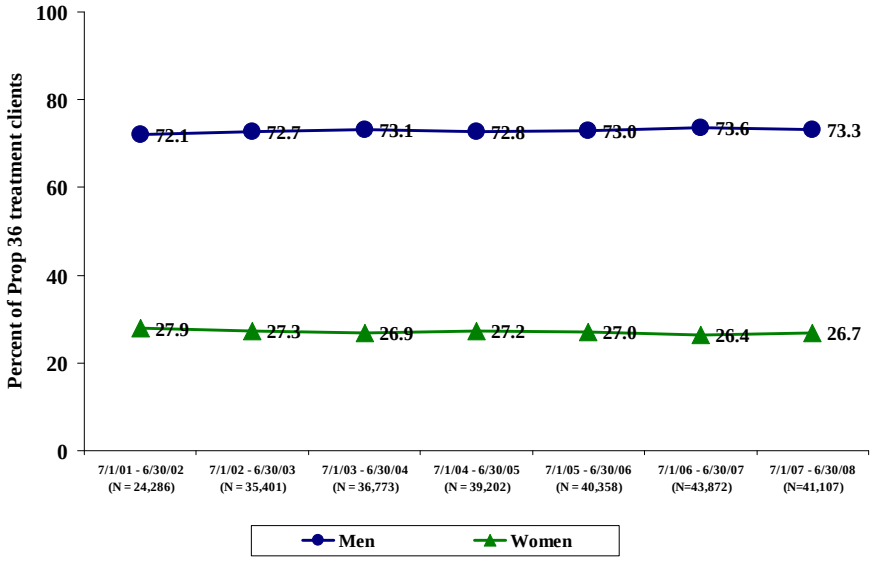
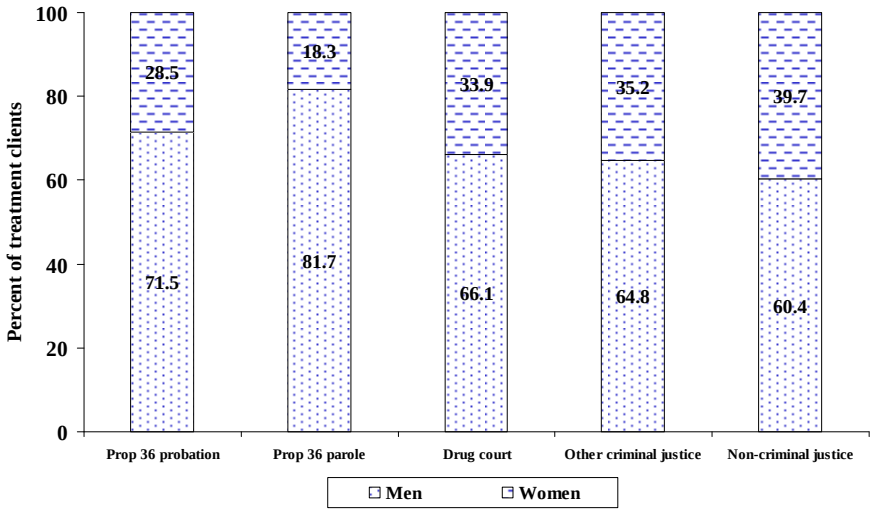


Figure 1.7
Sex of Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 171,315)



Age

In Prop 36's seventh year, the average (mean) age among clients referred to treatment by Prop 36 was 35.5 (standard deviation = 10.7) years. Figure 1.8 shows the distribution in age among Prop 36 clients. Most (58.1%) Prop 36 clients were between 26 and 45 years old. Less than one-fifth was 25 years old or younger (21.9%) or was 46 years old or older (20.1%). Over the past two years there was a slight increase in the number of Prop 36 offenders who are 46 years old or older and a decrease in those 25 years old or younger.

As shown in Figure 1.9, Prop 36 clients referred by parole were older than those referred by probation. Non-criminal justice referrals included more clients in the oldest age bracket. Mean age of clients by referral source was 35.3 years for Prop 36 probationers, 36.6 years for Prop 36 parolees, 34.5 years for drug court referrals, 30.5 years for other criminal justice referrals, and 34.3 years for non-criminal justice referrals (data not shown).

Figure 1.8
Age of Prop 36 Treatment Clients

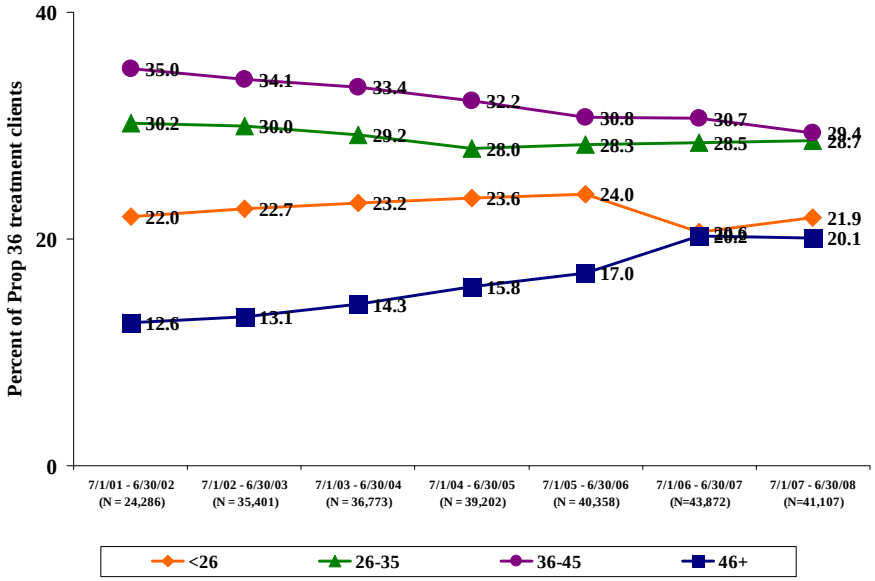
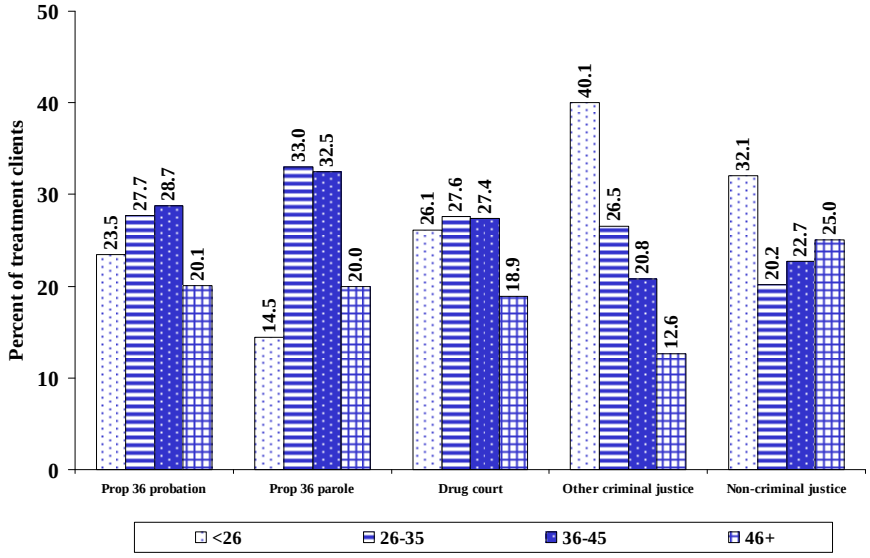


Figure 1.9
Age of Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 171,315)

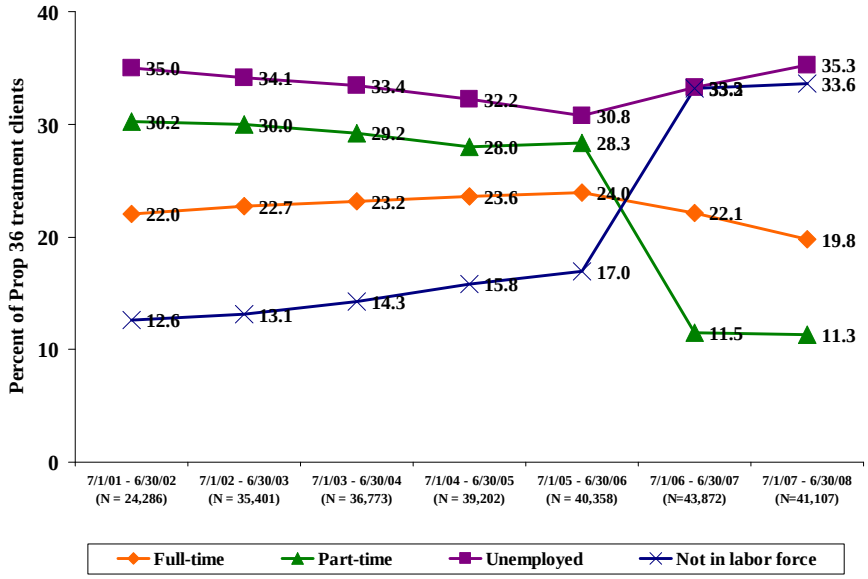


Employment Status

Being employed is among one of the few factors that has been associated with Prop 36 treatment success (Hser et al., 2007) and ample research has demonstrated the strong positive association between employment and positive substance abuse treatment outcomes (Buck, 2000; SAMHSA, 2000).

Figure 1.10 shows the employment status of Prop 36 clients at treatment entry over the seven years. Data indicate that compared to prior years, a dramatic change occurred in employment status starting in FY 2006-07 and that this changed continued into FY 2007-08. During these years, the percentage of Prop 36 offenders who are not in the labor force has almost doubled (from 17.0% to 33.6%) and the unemployment rate has steadily increased (from 30.8% to 35.3%). Conversely, the percentage of Prop 36 offenders who were employed part-time decreased by more than half (from 28.3% to 11.3%) and rates of full-time employment decreased steadily (from 24.0% to 19.8%).

Figure 1.10
Employment Status
Among Prop 36 Treatment Clients



It is likely that these changes are partly a reflection of California's economic crisis. The dramatic shift in employment status patterns may also be partly due to data coding changes of the new CalOMS data system, which includes a new category, "Unemployed Not Seeking Work" that did not exist in the older CADDS system. For Figure 1.10, the "Unemployed Not Seeking Work" category was combined with the "Not in the Labor Force" category.[7] Note that if the "Unemployed Not Seeking Work" category were combined with the "Unemployed Seeking Work" category, the unemployment rate would

[7] Using the CalOMS categories to indicate employment status at treatment intake, 19.8% of Prop 36 offenders were employed full-time, 11.3% were employed part-time, 35.3% were unemployed and seeking work, 21.4% were unemployed and not seeking work, and 12.2% were not in the labor force.

reach 56.6%, representing an increase of about 25% from FY 2005-2006. These data suggest that some of the clients who may have been coded as "part-time" in CADDS are now being reported as "unemployed not seeking work" in CalOMS. Further research is needed to confirm whether this is really the case and if there may be other reasons for the shift in employment patterns among Prop 36 clients.

Only about one-third (31.1%) of Prop 36 probationers and parolees were employed full- or part-time in FY 2007-08 (Figure 1.11). As shown in Figure 1.12, when compared to other types of clients entering treatment, more Prop 36 offenders reported being employed. Overall, very few Prop 36 offenders were enrolled in school (5.5%) or job training (2.3%) at treatment entry (data not shown). When compared to others in drug treatment, the percentage of Prop 36 offenders receiving job training was similarly low for all groups but the percentage of Prop 36 offenders enrolled in school was notably low (Figure 1.13).

Figure 1.11
Employment Status
Among Prop 36 Treatment Clients

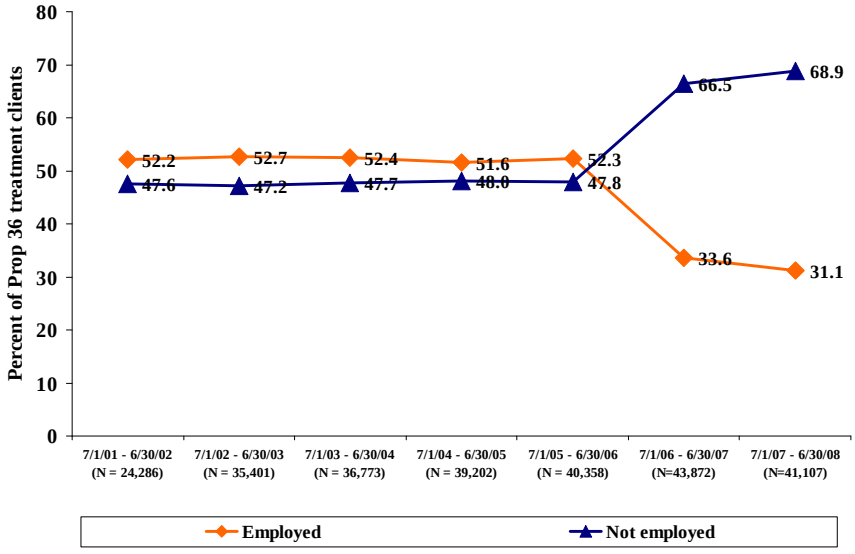


Figure 1.12
Employment Status
Among Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 171,315)

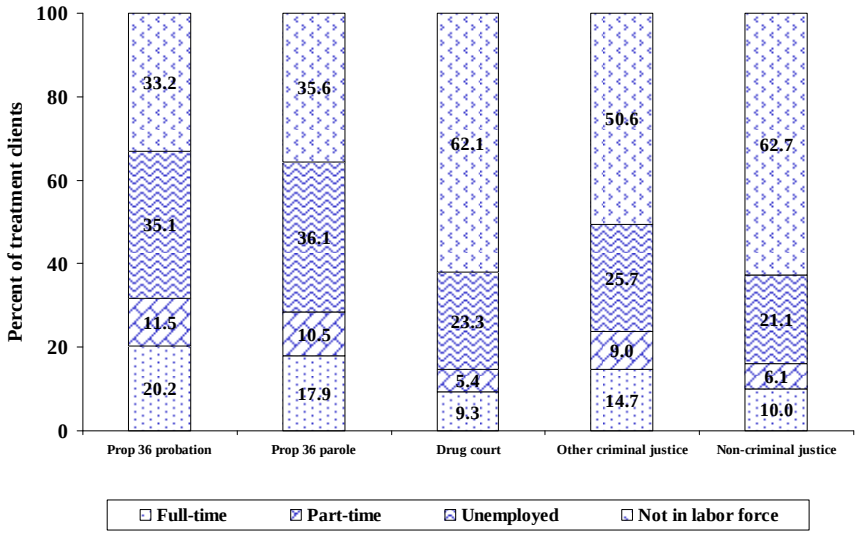
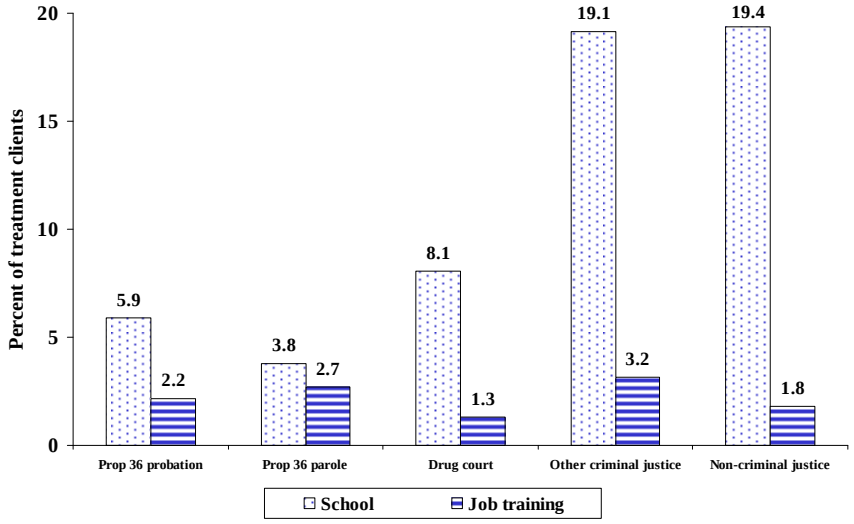


Figure 1.13
Enrollment in School or Job Training
Among Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 171,315)



Prop 36 Program Elements for Addressing Employment and Educational Needs

In 2008 data was collected from drug treatment providers via the Treatment Provider Survey on the employment and educational needs of Prop 36 clients. Due to the recent dramatic change in the employment status of Prop 36 clients (as noted in Figure 1.10) and California's current economic recession, in the following section more information is provided on funding sources for Prop 36 employment and educational services, criteria for assessing needs, provision and utilization of relevant services, and barriers to making improvements in this domain.

Funding sources

According to drug treatment programs that responded to the survey (see Appendix B for more information on the 2008 Treatment Provider Survey), most treatment providers (74.5%) did not allocate any Prop 36 funds to improve the employment status of Prop 36 clients and only about one in ten (10.7%) treatment programs reporting using alternative sources of funding to support or expand employment services for Prop 36 clients (data not shown). As shown in Table 1.1, treatment programs reported the existence of linkages with other organizations to address the employment and educational needs of Prop 36 clients. The most commonly reported system linkages were between drug treatment programs and CalWORKS (63.8%), Adult Education programs (51.7%), and Community Colleges (47.4%), and relatively fewer drug treatment programs reported linkages with CalJOBS (24.6%) or the Workforce Investment Board (17.5%). About one-quarter of programs (26.7%) reported linkages with other systems such as local employment agencies and employers and regional job fairs and training programs.

Table 1.1 System linkages to address employment and educational needs of Prop 36 drug treatment clients

(N=63 drug treatment programs)

System	*% Yes*
CalWORKs	63.8
Adult Education	51.7
Community Colleges	47.4
CalJOBS^{SM}	24.6
Workforce Investment Board	17.5
Other	26.7

Data Source: UCLA Proposition 36 Treatment Provider Survey

Assessment of needs

Treatment programs reported using a variety of criteria to determine which Prop 36 clients should be targeted to receive employment and educational services. As shown in Table 1.2, the three most commonly reported criteria included client unemployment at treatment entry (81.4%), client desire to work or improve employment status (81.4%), and client desire for employment services (81.0%).

Table 1.2 Assessment of Prop 36 client need for employment/educational services
(N=63 drug treatment programs)

Criteria	*% Yes*
Client was unemployed at treatment entry	81.4
Client said he/she wanted to work or improve employment status	81.4
Client said he/she wanted employment services	81.0
Client was not in labor force at treatment entry	74.6
Client lacked a High School diploma/GED	74.1
Client lacked basic literacy skills	69.0
Client had not been paid for work in 30 days prior to treatment entry	67.2
Client employment severity score from the Addiction Severity Index (ASI)	58.6
Probation/parole/judge required client to receive services	53.4
Client was employed part-time at treatment entry	43.1

Data Source: UCLA Proposition 36 Treatment Provider Survey

Provision and utilization of services

Treatment programs reported that about two-thirds of Prop 36 clients received some type of employment or education services while in drug treatment during FY 2007-08. Table 1.3 shows the type of services that were offered and whether services were provided on-site at the same program that the client received drug treatment, off-site by referral or cooperative agreement with another organization, or not at all. The most commonly provided services included life skills training, vocational counseling, and classes to obtain a High School diploma or GED. Services were more frequently offered off-site at a location that was different from where the client received drug treatment. Also, relatively fewer treatment programs reported offering paid or nonpaid work experience/placement.

Table 1.3 Employment and educational services available to Prop 36 clients
(N=63 drug treatment programs)

	On-site %	*Off-site %*	*Not provided %*
Life skills training	66.7	14.3	23.8
Vocational counseling	23.8	42.9	30.2
Classes to obtain High School diploma or GED	15.9	44.4	33.3
Literacy classes	12.7	39.7	41.3
Technical, trade, vocational skills training	12.7	44.4	41.3
Training on professional behavior	31.8	25.4	42.9
Assignment to an employment specialist	14.3	39.7	42.9
Paid or nonpaid work experience/placement	9.5	28.6	57.1
English as a Second Language (ESL) classes	0.0	25.4	65.1

Data Source: UCLA Proposition 36 Treatment Provider Survey

Treatment programs reported that employment and educational services were most often provided to Prop 36 clients in writing (65.0%) for example via pamphlets or handouts, although programs also indicated that services were provided in-person (45.8%) for example by a teacher or other educator, by computer (44.1%), or by other media (22.0%) such as DVDs or video. Very few programs (19.7%) offered Prop 36 clients with incentives (positive or negative) to encourage utilization of employment or educational services (data not shown).

Treatment programs also reported that limited funding was the most common barrier to the provision or utilization of employment and education services (79.7%). As shown in Table 1.4, other barriers included restrictive reimbursement policies (58.2%), disinterest for such services among clients (56.5%), lack of evidence-based services and interventions (31.7%), and inadequate treatment staff training (29.0%). Other barriers included inability to work while in treatment due to program restrictions, residing in a community with few job opportunities, lack of local resources that would support employment including transportation, and mental illness.

Table 1.4 Barriers to the provision or utilization of employment and education services
(N=63 drug treatment programs)

Barriers	*% Yes*
Limited funding	79.7
Restrictive reimbursement policies	58.2
Disinterest among clients	56.5
Lack of evidence-based services/interventions	31.7
Inadequate treatment staff training	29.0
Other	35.5

Data Source: UCLA Proposition 36 Treatment Provider Survey

Barriers to employment

Treatment programs were asked to rate the extent to which listed reasons explained why Prop 36 clients who were capable of working remained unemployed. Possible responses to the question reflected a 0 to 3 scale, with 0 equal to "Not at all," 1 equal to "Limited extent," 2 equal to "Moderate extent," and 3 equal to "Great extent." When the mean score for each reason was calculated, the primary reason for continued unemployment among Prop 36 offenders included lack of adequate job skills, followed by poor work history, reluctance among employers to hire offenders, lack of confidence or self-esteem, inability to find a job, and lack of knowledge on how to look for work (Table 1.5). Reasons that treatment programs reported as least responsible for continued unemployment included client inability to get along with co-workers/supervisors, a preference to engage in illegal activities, a preference to rely on unemployment or disability insurance, no desire to work, and dislike of the kinds of jobs that are available.

Table 1.5 Reasons for continued unemployment among Prop 36 clients
(N=63 drug treatment programs)

Reason	*Score* (0-3 scale)
Lacked adequate job skills	2.43
Had a poor work history	2.40
Faced reluctance among employers to hire offenders	2.29
Lacked confidence, self-esteem	2.22
Could not find a job	2.20
Did not know how to look for work	2.02
Believed no jobs were available	1.92
Preferred to rely on support from others	1.85
Did not want to look for work	1.77
Could not balance demands of Prop 36 program & working	1.75
Lacked resources to address practical barriers	1.73
Could not maintain a job	1.71
Lacked basic competency in reading, writing, or math	1.67
Did not know how to act professionally in the workplace	1.63
Did not like the kinds of jobs that were available	1.60
Did not want to work	1.57
Preferred to rely on unemployment or disability insurance	1.38
Preferred to engage in illegal activities	1.12
Could not get along with co-workers/supervisors	1.05

Data Source: UCLA Proposition 36 Treatment Provider Survey

In summary, the information that is provided in this section is based on data collected from a relatively small sample of drug treatment programs. Thus findings may not reflect all current practices and data must be interpreted with caution. However, this information is congruent with other reports on employment assistance for Prop 36 offenders (Evans, 2008) and it may be useful for identifying areas for program improvement and further study.

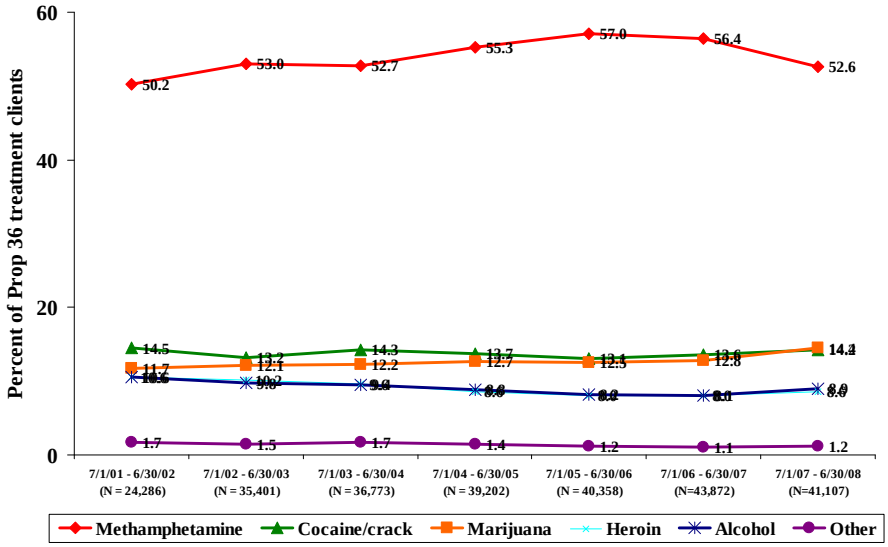
Prop 36 funds may be used specifically to provide employment and vocational training as part of drug treatment but few treatment programs report allocating any Prop 36 funds to improve the employment or educational status of clients and even fewer programs report using alternative sources of funding to support or expand such services. While there are some linkages between drug treatment and other organizations to address client needs and most programs report offering some type of employment and educational services, many of those services are offered off-site or focus more on general life skills training than on areas identified as being of greatest need, that is job skills development and work experience opportunities. From the perspective of drug treatment programs, lack of funding remains a primary barrier to the provision and utilization of employment and educational services. Furthermore, assessment of need for services includes client employment status at treatment entry and other commonly used criteria focus on desire

for services or for work. While client motivation level is undoubtedly a key element in making improvements to employment status, employment services may also benefit individuals who do not express an explicit interest in work or desire for services.

Primary Drug

According to client self-report, as depicted in Figure 1.14, methamphetamine was the most common primary drug used by Prop 36 clients in the seventh year (52.6%), followed by marijuana (14.4%), cocaine/crack (14.2%), alcohol (8.9%), and heroin (8.6%). Although Prop 36 targets offenders with illicit drug offenses, heavy drinking is quite common among people who use illicit drugs. These figures are largely unchanged from Prop 36's earlier years, except that the proportion of clients who reported methamphetamine as their primary drug has increased nearly every year until leveling off in FY 2006-2007. More information on methamphetamine trends, related problems and users who participate in Prop 36 is provided in Chapter 4.

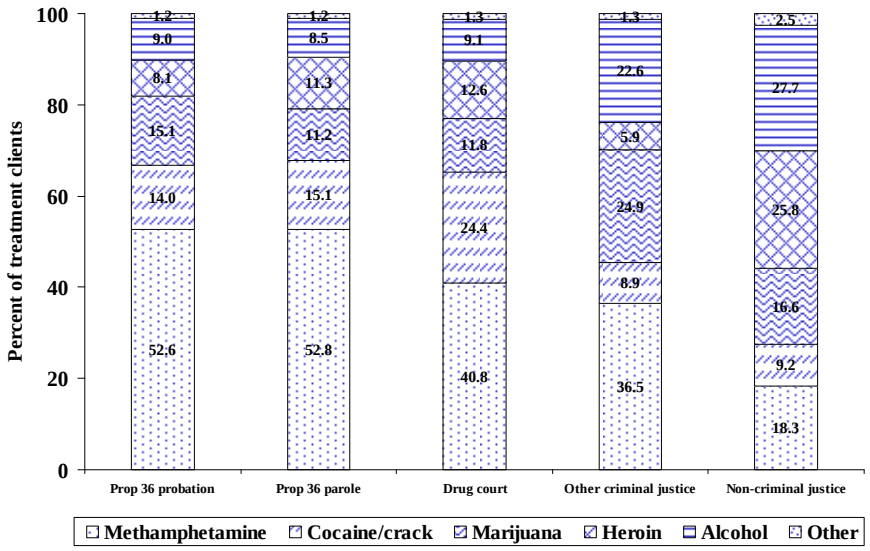
Figure 1.14
Primary Drug
Among Prop 36 Treatment Clients



Primary drug by referral source is presented in Figure 1.15. As was true in Prop 36's earlier years, methamphetamine use was more common among Prop 36 clients than among the other client groups. Moreover, within the Prop 36 treatment population, heroin use was more common among parolees (11.3%) than among probationers (8.1%). Heroin use was most prevalent among non-criminal justice clients (25.8%) than among criminal justice clients, possibly because heroin users may, on their own initiative (self-referral), seek methadone treatment to avoid the symptoms of heroin withdrawal.

Moreover, heroin users entering treatment are typically older than other types of users and are therefore less likely to be involved with the criminal justice system. Cocaine use was more prevalent among drug court referrals (24.4%) and among other criminal justice referrals alcohol (22.6%) and marijuana (24.9%) use were more prevalent.

Figure 1.15
Primary Drug
Among Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 171,315)



Drug Problem Severity
Three measures of drug problem severity were analyzed: years of primary drug use, frequency of recent drug use, and prior treatment experience.

Figure 1.16 shows that in FY 2007-08, almost one-third (28.0%) of Prop 36 offenders report having used their primary drug for 21 or more years. Over the past two years, the percentage who report having used for five years or less has decreased and the percentage who report having used for 21 or more years has increased. This change in trends may be attributable to an increase in older offenders entering Prop 36 treatment in recent years, as shown in Figure 1.8.

Figure 1.17 shows years of primary drug use by referral source for the seventh year population. Prop 36 parolees reported longer primary drug histories than Prop 36 probationers, drug court referrals, and other criminal justice referrals. More than one-third (32.6%) of Prop 36 parolees reported having used their primary drug for more than 20 years.

About half (50.2%) of Prop 36 clients reported using their primary drug in the month prior to treatment admission (data not shown). Incarceration before referral to Prop 36 and reluctance among offenders to admit recent drug use likely impact this rate. [8]

[8] A prior Prop 36 report (see 2004 report) reported that about 60% of offenders who reported no drug use in the month before treatment entry had been in jail (55.8%) or inpatient healthcare (3.3%). Also see Figures 1.24 in this chapter for more information on incarceration in the prior 30 days among these groups.

Figure 1.16
Years of Primary Drug Use
Among Prop 36 Treatment Clients

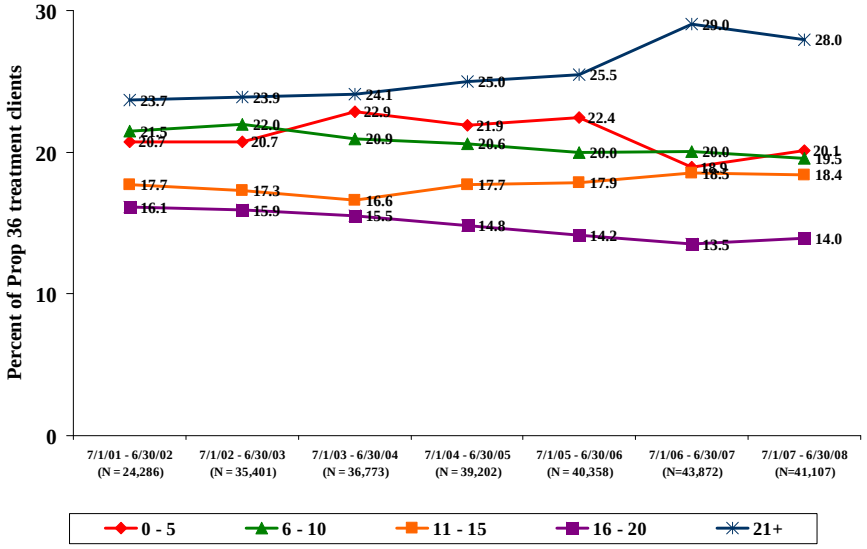
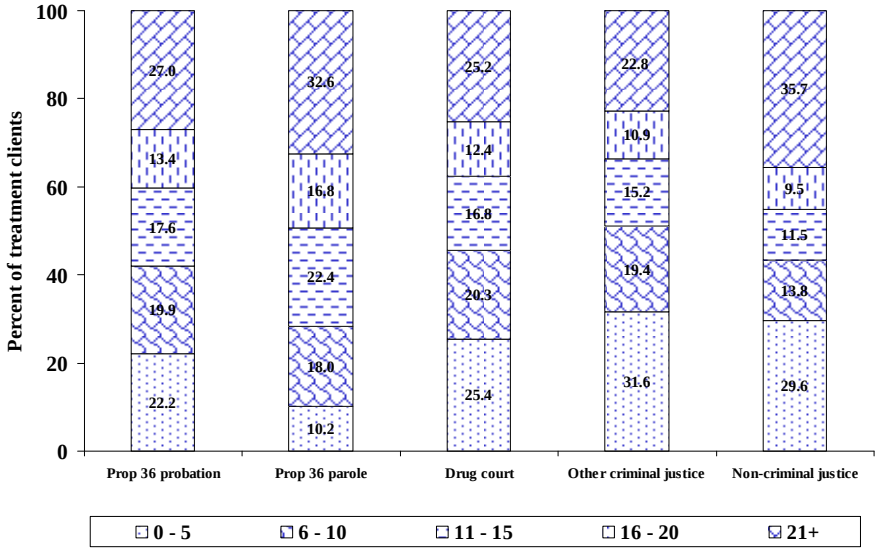


Figure 1.17
Years of Primary Drug Use
Among Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 171,315)



As shown in Figure 1.18, among all criminal justice referrals, the recent drug use rate was highest among Prop 36 parolees (57.7%) and lowest among drug court referrals (36.4%). Non-criminal justice clients were far more likely to report drug use in the past month (73.1%). Of Prop 36 clients who did report use of their primary drug in the prior month, mean days of use was 9.9 days (data not shown). Analysis of mean days of use by referral source showed that of clients who did report use of their primary drug in the prior month, mean days of use was similar for Prop 36 probationers and parolees (about 10 days), 14.7 days for drug court referrals, 10.5 days for other criminal justice referrals, and 18.3 days for non criminal justice referrals (Figure 1.19).

Figure 1.18
Used Primary Drug in Past 30 Days
Among Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 171,315)

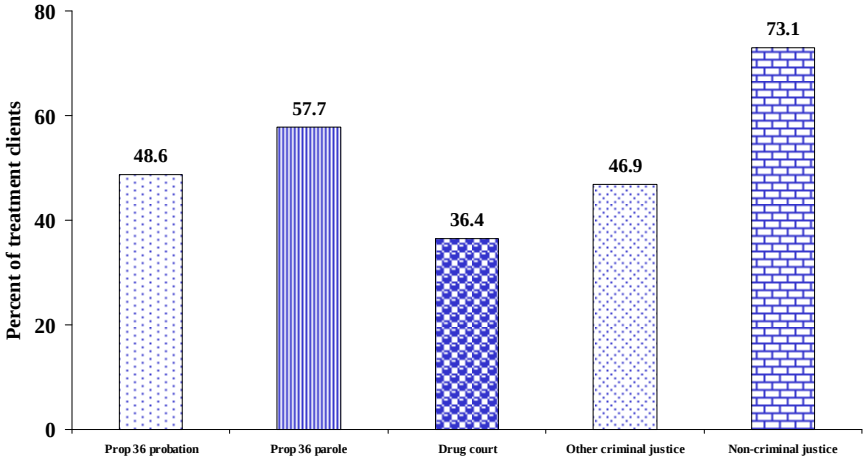
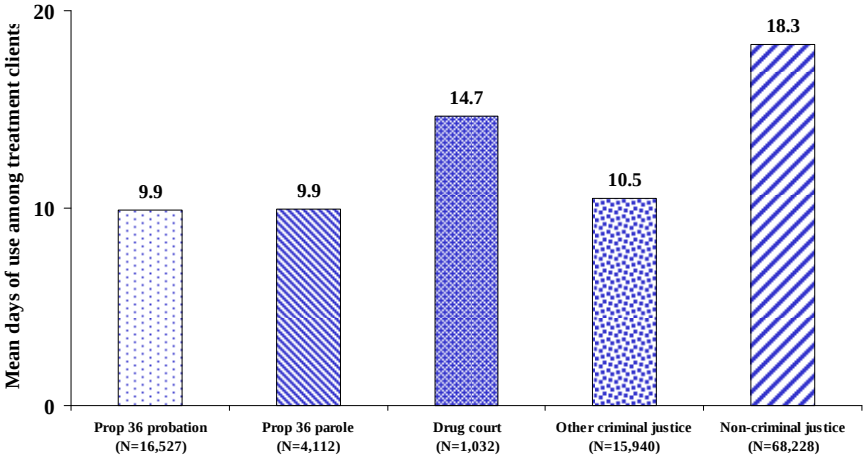


Figure 1.19
Days of Use of Primary Drug in Past Month
Among Treatment Clients Who Reported Use* by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 105,839)



*Analysis is limited to clients who reported at least one day of use. Clients who reported zero days of use are omitted.
Standard deviations are 10.2, 10.5, 11.1, 10.6, and 11.5, respectively.

Prior treatment

About half of Prop 36 clients (50.9%) entering treatment reported having had prior experience in drug treatment and of Prop 36 clients who reported at least one prior admission to treatment, the mean number of prior admissions was 2.2 (data not shown).

Figure 1.20 compares prior treatment experience among clients from all referral sources. Prior treatment was reported by 50.6% of Prop 36 probationers, 52.4% of Prop 36 parolees, 52.4% of drug court referrals, 40.7% of other criminal justice referrals, and 47.1% of non-criminal justice referrals. Of those who reported at least one prior admission to treatment, the mean number of prior admissions was 2.2 among Prop 36 probationers, 2.3 among Prop 36 parolees, 2.6 among drug court referrals, 2.1 among other criminal justice referrals, and 3.5 among non-criminal justice referrals (Figure 1.21).

Figure 1.20
Had Prior Treatment
Among Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 171,315)

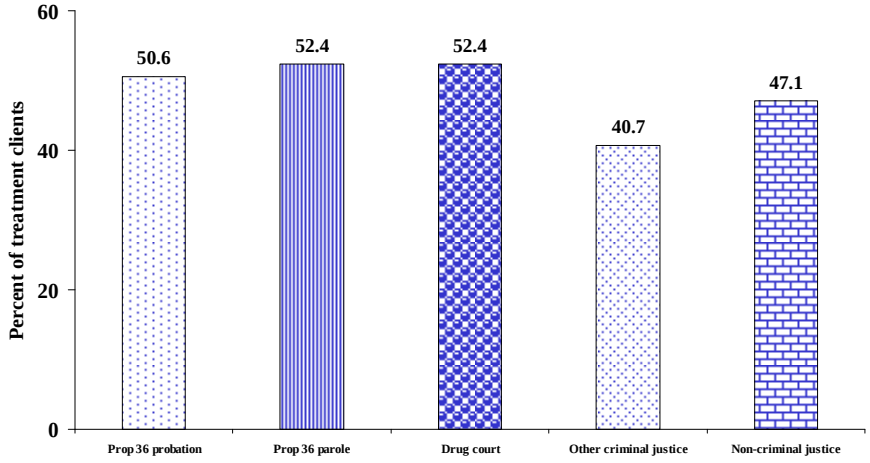
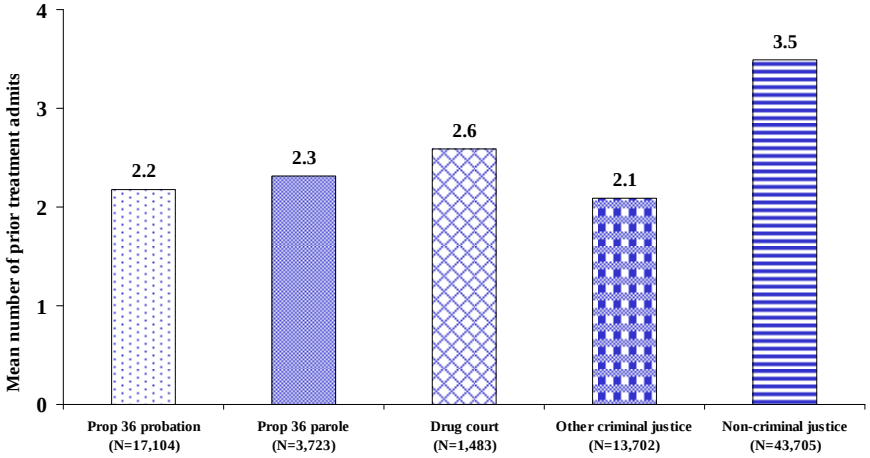


Figure 1.21
Prior Treatment Admissions
Among Treatment Clients with Prior Treatment* by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 79,717)



*Analysis is limited to clients who reported at least one prior admit. Clients who reported zero prior admits are omitted.
Standard deviations are 2.1, 2.3, 2.6, 2.1, and 3.5, respectively.

Variation by county

The characteristics of Prop 36 clients entering treatment during Fiscal Years 2006-07 and 2007-08 are provided by county in Appendix 1.2. There were notable variations in client characteristics by county among Prop 36 offenders entering treatment during FY 2007-08.[9] For example, as shown in Table 1.6 the percentage of Prop 36 offenders referred by probation ranged from 100% to 32.0% among counties (none of the counties had no Prop 36 probation referrals), with 29 counties having the same or a greater percentage of Prop 36 probationers than the statewide average of 82.7% and 27 counties having a smaller percentage of Prop 36 probationers than the statewide average. As another example, the percentage of Prop 36 offenders who were Hispanic ranged from 78.1% to 0.0% among counties (3 counties had no Prop 36 clients who were Hispanic), with 17 counties having the same or a greater percentage of Prop 36 Hispanics than the statewide average of 36.8% and 39 counties having a smaller percentage of Prop 36 Hispanics than the statewide average.

These data illustrate that to some degree, different counties serve different types of Prop 36 offenders. Notably, the prevalence of some types of Prop 36 clients (e.g., parolees; users of heroin, marijuana, or cocaine; race/ethnicity that is African American, Hispanic, Asian American/Pacific Islander, or Native American) is low or non-existent in some counties and the prevalence of other characteristics (e.g., race/ethnicity that is White; not employed; methamphetamine users; prior treatment experience) is high or relatively commonplace in other counties. Differences like these are most likely a reflection of each county's general drug using offender population and, as demonstrated by comparing data from FY 2006-07 to data from FY 2007-08, characteristics within counties may

[9] Two counties that had no Prop 36 admission data in CalOMS during FY 2007-08 and these counties were omitted from county-level analyses.

change over time. However, it appears that some counties are serving greater numbers of "tougher to treat" Prop 36 offenders (i.e., offenders with a greater level of need for intense or specialized services as indicated by general demographics such as age, race/ethnicity, and sex, as well as other measures such as criminal severity, primary drug problem, and employment status). County-level variation in Prop 36 client characteristics, in addition to county setting, size, and context (e.g., geographical location, urban versus rural setting, employment rate, population size, crime rate, criminal justice diversion options other than Prop 36 that are available to drug offenders etc.), must be considered if efforts are made in the future to compare Prop 36 program performance or outcomes by county.

Table 1.6 Variation in Prop 36 client characteristics among counties

	Statewide average (% or Mean)	Range among counties (% or Mean)	County average = 0 (No. of counties)	County average ≥ statewide average (No. of counties)	County average < statewide average (No. of counties)
Referral Source					
Probation	82.7%	100 - 32.0%	0	29	27
Parole	17.3%	67.2 – 0.0%	2	27	29
Race/ethnicity					
White	40.7%	100 - 16.5%	0	43	13
Hispanic	36.8%	78.1 – 0.0%	3	17	39
African Amer	14.3%	43.2 – 0%	13	10	46
Asian/Pac Isl	3.2%	9.6 – 0.0%	17	12	44
Native Amer	1.3%	16.7 – 0.0%	9	27	29
Sex					
Women	26.7%	100 – 0.0%	1	25	31
Men	73.3%	100 – 0.0%	1	21	35
Age	35.5 years	41.9 - 28.0 years	--	26	30
Employment Status					
Employed (full- or part-time)	31.1%	50.0 – 0.0%	1	23	33
Not employed	68.9%	100 - 50.0%	0	33	23
Primary Drug					
Methamphetamine	52.6%	88.5 – 0.0%	1	34	22
Cocaine/crack	14.2%	40.1 – 0.0%	11	9	47
Marijuana	14.4%	33.3 – 0.0%	3	31	25
Heroin	8.6%	50.0 – 0.0%	6	19	37
Alcohol	8.9%	100 – 0.0%	1	35	21
Prior drug treatment	50.9%	78.1 – 0.0%	1	36	20

Data Source: CalOMS, FY 2007-08 admission dataset

New Measures

Most measures featured in this section are new to the CalOMS system and are being reported here on the Prop 36 population for the first time. Behaviors that were not measured prior to CalOMS cannot be tracked over time as yet. Trends spanning the CalOMS years will be tracked in future reports.

Some issues related to CalOMS data validity and accuracy and the potential effects of the changeover from CADDS have been explored elsewhere (Rawson et al., 2008) but more research is needed to better understand how the issues identified may impact information that is reported on the Prop 36 population. Future Prop 36 evaluation reports will compare CalOMS self-reported measures to equivalent measures derived from official records maintained in statewide administrative datasets.

Other Characteristics

At entry into treatment, 3.9% of Prop 36 offenders reported being a military Veteran, 11.5% were homeless, 15.2% were receiving disability benefits, and 7.0% had used a needle to inject drugs in the prior 30 days. Examination of these measures by referral source (Figure 1.22) showed similarities across groups with the following exceptions: the percentage of clients who were homeless was greatest among non-criminal justice clients (20.0%) and drug court referrals (19.3%), more non-criminal justice clients were receiving disability benefits (19.5%), and needle use was most common among non-criminal justice referrals (21.2%) and Prop 36 parolees (10.7%).

Family and Social Support

One out of ten Prop 36 offenders reported living with someone who used drugs (10.4%), few Prop 36 offenders experienced family conflict (7.2%) prior to treatment entry and more than one-third (43.5%) received some kind of social support (defined as having participated in any social support recovery activities such as 12-step meetings, other self-help meetings, religious/faith recovery or self-help meetings, or other supportive interactions with family or friends) (data not shown). The pattern of these behaviors was similar by treatment referral source (Figure 1.23), with more Prop 36 probationers reporting social support (44.8%) than all other types of referrals and more non-criminal justice referrals reporting living with a drug user (17.1%) and family conflict (15.4%).

Figure 1.22
Other Characteristics
Among Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 171,315)

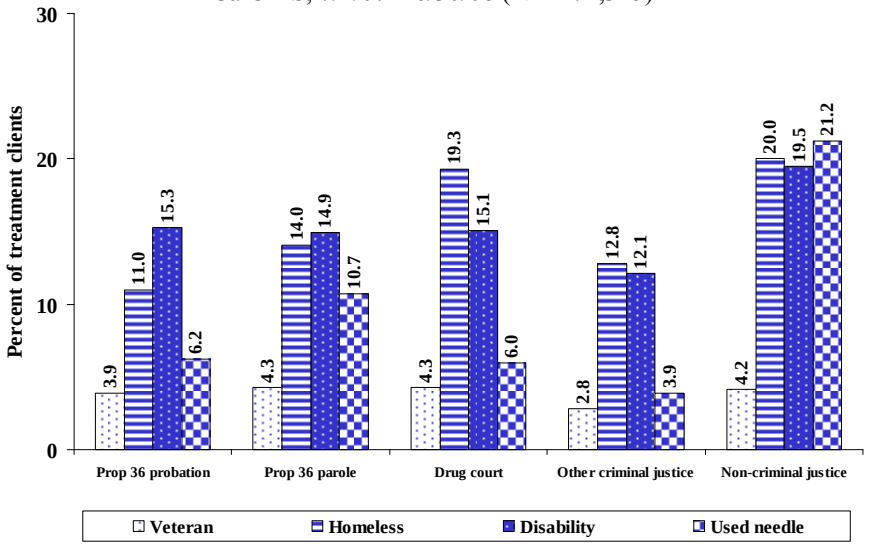
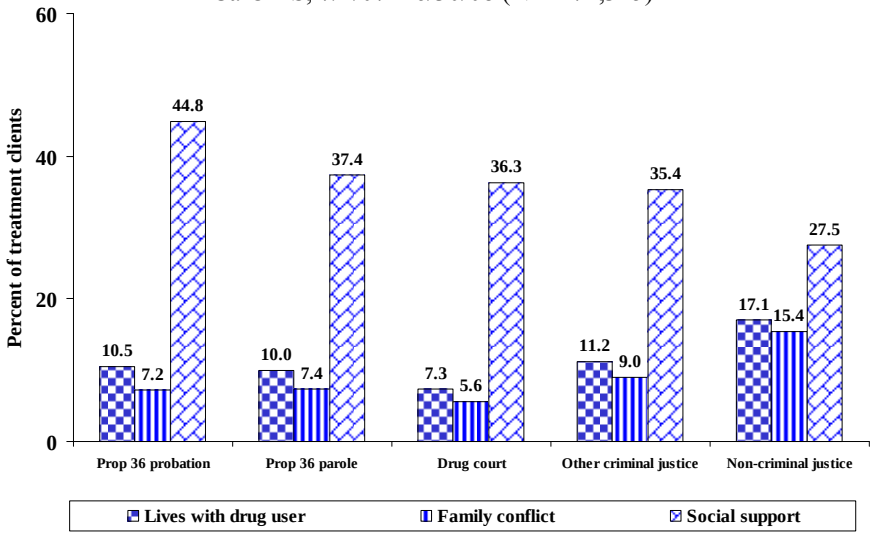


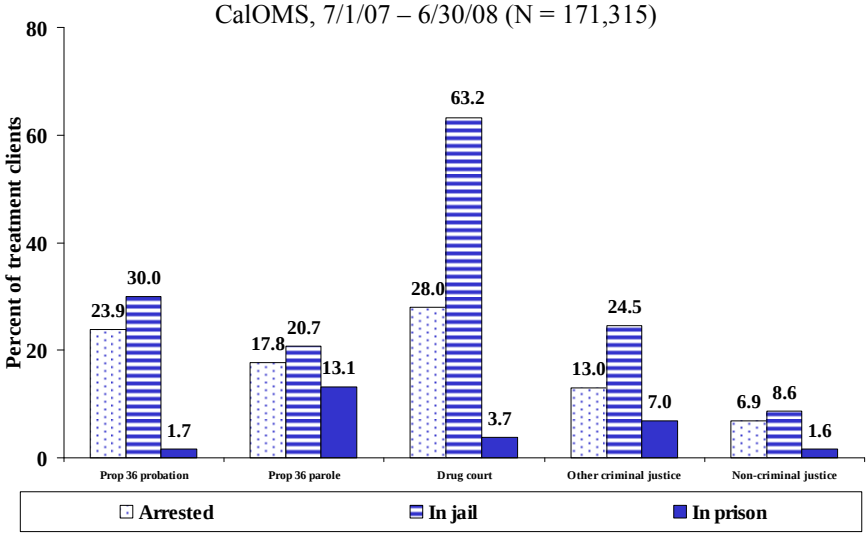
Figure 1.23
Family and Social Support
Among Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 171,315)



Criminal Justice System Interactions

About one-quarter of Prop 36 offenders reported having been arrested (22.9%) or incarcerated in jail (28.3%) in the 30 days prior to treatment entry, and very few had been in prison (3.7%). Some differences in these interactions were evident by referral source (Figure 1.24). Compared to other clients in treatment, in the 30 days prior to treatment entry more Prop 36 parolees had been in prison (13.1%), many more drug court referrals had been in jail (63.2%), and fewer other criminal justice referrals had been arrested (13.0%). Criminal justice system involvement was lowest among those in the non-criminal justice group.

Figure 1.24
Criminal Justice System Interactions
Among Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 171,315)



Measures of Health Needs and Services Received

Few Prop 36 offenders reported being a Medi-Cal beneficiary (14.1%) or having experienced a health problem (14.9%) in the 30 days prior to treatment entry and even fewer had visited an Emergency Room (ER) (5.5%) or stayed in the hospital (1.6%) (data not shown). By referral source (Figure 1.25), receipt of Medi-Cal benefits was higher among drug court (16.8%) and other criminal justice (25.2%) referrals and the prevalence of all variables was highest among non-criminal justice referrals.

Health Testing

HIV risk behaviors are common among users of illicit drugs (Centers for Disease Control and Prevention, 2009). Injection drug use, the exchange of drugs for sex, and impairment of judgment regarding safer sex practices are behaviors that place individuals at higher risk for HIV infection (Committee on Substance Abuse and Mental Health Issues in AIDS Research, 1994). Effective HIV risk-reduction interventions for clients enrolled in drug abuse treatment programs are available (for a review, see Prendergast, Urada, & Podus, 2001) and some research has been conducted on the development of interventions to reduce HIV risk behaviors among the Prop 36 population specifically (Brecht et al.,

2008). However, very little information has been made available on rates among Prop 36 offenders of infection or testing for HIV, AIDS, or other illnesses for which drug users are at risk. Data on such measures was collected by CalOMS and it is summarized for the first time in the following section.

At treatment entry, few Prop 36 offenders reported having ever been tested for tuberculosis (TB) (2.4%), Hepatitis C (6.2%), or sexually transmitted diseases (STD) (3.1%), but more than half (64.9%) had been tested for HIV and slightly less than that had received HIV test results (57.4%) (data not shown). Testing rates were mostly similar across referral types (Figure 1.26) except that more Prop 36 parolees and non-criminal justice referrals had been tested for Hepatitis C (10.0% and 10.5%, respectively) and more Prop 36 parolees had been tested for HIV (75.3%) and more had received the HIV test results (66.8%).

Figure 1.25
Health Indicators
Among Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 171,315)

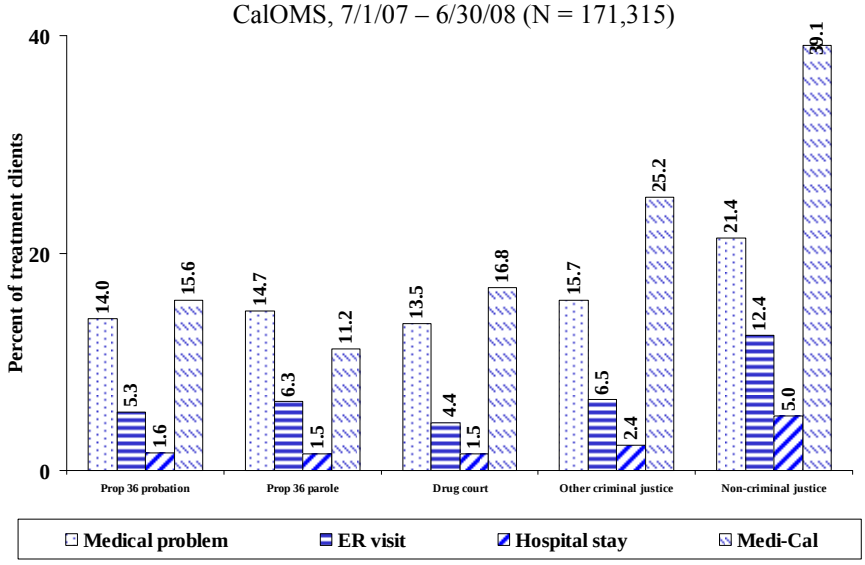
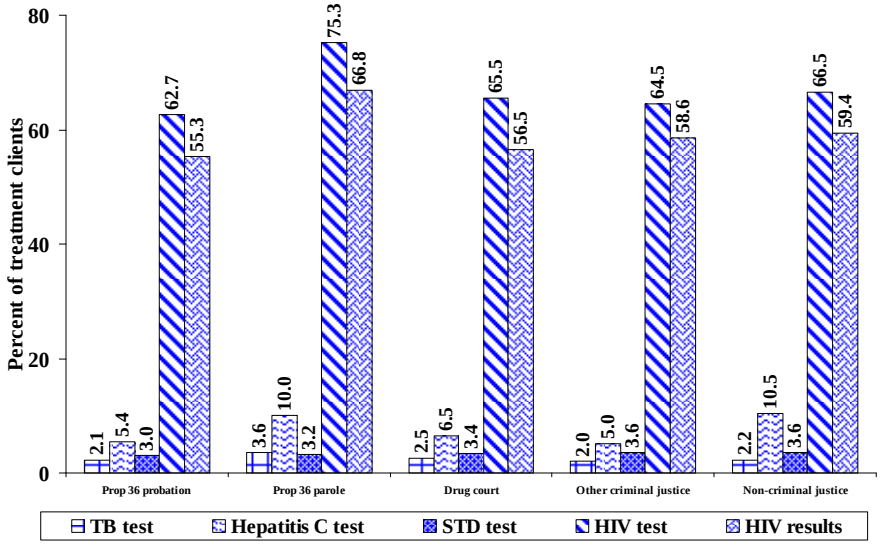


Figure 1.26
Health Testing
Among Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 171,315)



CalOMS does not collect information on the results of these tests. However, treatment providers who responded to UCLA's 2008 Treatment Provider Survey (N=63 of 101, or 62.4% response rate), indicated low prevalence rates of HIV infection among Prop 36 offenders entering treatment and relatively higher rates of Hepatitis C infection. Of treatment providers who responded to the survey, most programs (92.1%) indicated that between <1% and 5% of Prop 36 clients entering drug treatment at their program were HIV positive and of the remaining respondents, 4.8% indicated HIV positive infection rates of 10%, and 3.2% indicated infection rates of 20 to 25%. As for the prevalence of Hepatitis C infection among Prop 36 offenders, about one-third of treatment programs (32.1%) reported that approximately 6 to 10% of Prop 36 offenders who entered treatment were infected with Hepatitis C and another quarter of programs (24.5%) reported an infection rate of 2 to 5%. Of the remaining respondents, 13.2% indicated a Hepatitis C infection rate of 0%, 11.3% indicated a rate of 20 to 25%, 5.7% indicated a rate of 15%, 5.7% indicated a rate of 30 to 35%, and 7.5% indicated a rate of 40 to 45%.

Mental Health Measures

Under-reporting of mental health problems in the drug treatment data system has been noted in prior Prop 36 evaluation reports (Conner & Grella, 2008) and this continues to be an issue that impacts mental illness prevalence estimates. Some research has found that 55% to 69% of individuals diagnosed with an alcohol or other drug disorder also have been diagnosed with a co-occurring mental health disorder. Analyses based on CalOMS data identified few Prop 36 offenders who self-reported a mental health illness (16.0%) or use of psychiatric medication (9.7%) at treatment entry, and very few had visited an Emergency Room (1.8%) or psychiatric facility (1.0%) for a mental health problem in the prior 30 days (data not shown). Patterns were similar for all criminal justice referrals but different for the non-criminal justice referral group (Figure 1.27).

Prevalence of all of these behaviors was greatest among non-criminal justice referrals, and among Prop 36 women (see Chapter 3 for more information). Under-reporting of mental health problems in the drug treatment data system has been noted in prior Prop 36 evaluation reports (Conner and Grella, 2008) and this may continue to be an issue that impacts mental illness prevalence estimates. Moreover, the prevalence of co-occurring disorders among Prop 36 offenders entering treatment varies by program. Of treatment providers who responded to UCLA's 2008 Treatment Provider Survey (N=63 of 101, or 62.4% response rate), about one-third indicated that 20-25% of Prop 36 clients entering drug treatment at their program had been diagnosed with a co-occurring mental health disorder and slightly less than one-quarter of programs indicated a rate of 10-15%. Of the remaining programs that responded, about ten percent of programs each reported that the co-occurring disorder prevalence rate among Prop 36 offenders was >35%, 30-35%, 1-5%, and 0%.

Family Measures

Of Prop 36 women 4.5% were pregnant at entry into treatment. Almost half of all Prop 36 offenders had children (46.7%) and of these, about one-quarter (22.1%) had children under the age of five years old (data not shown).

The total number of children age 17 or younger whose parents entered Prop 36 treatment in FY 2007-08 was 39,308. Further, 6.6% of Prop 36 offenders had a child that lived with someone else and 3.5% of offenders had had their parental rights terminated. Patterns by referral type were similar (Figure 1.28, although termination of parental rights was more common among drug court referrals (5.6%), and more of those in the other criminal justice group had children (56.4%), had children under age 5 (33.9%), and had children that lived with someone else (19.2%).

Figure 1.27
Mental Health Indicators
Among Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 171,315)

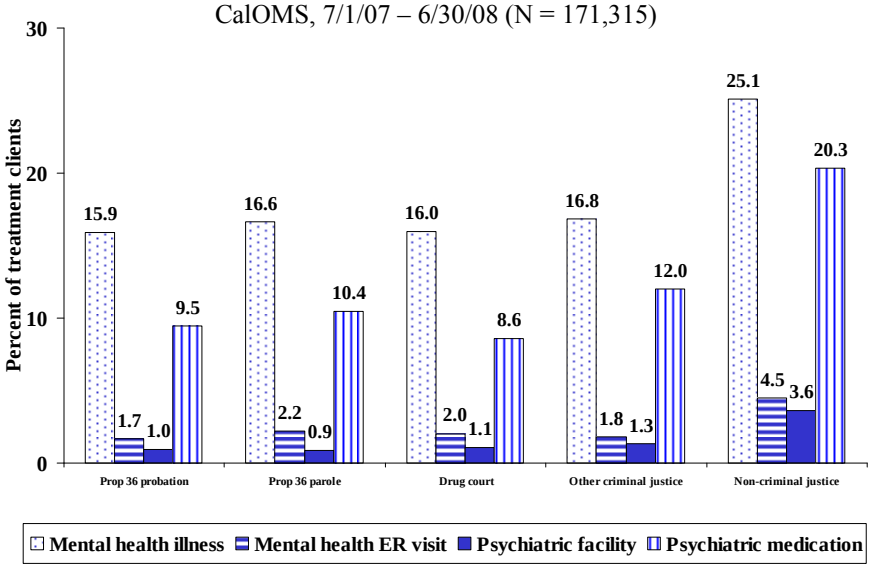
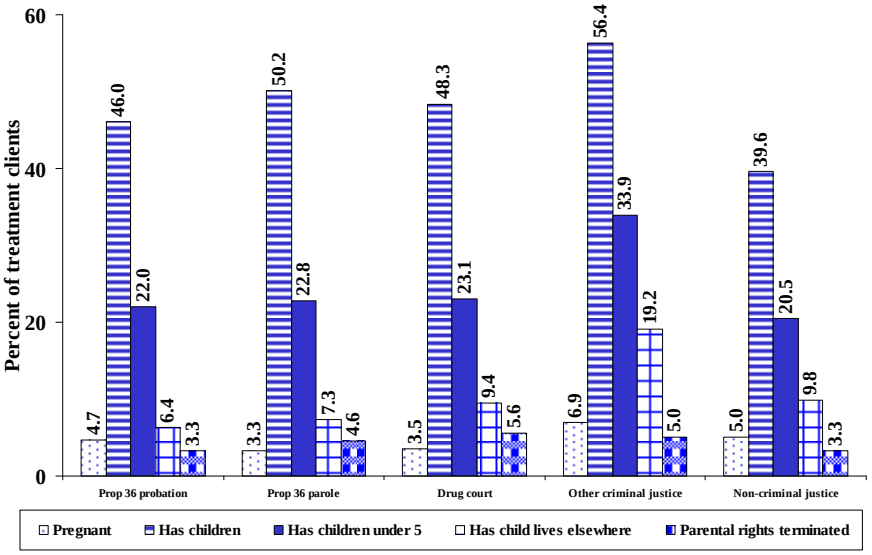


Figure 1.28
Family Indicators
Among Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 171,315)



Treatment Outcome Measures

Results for treatment outcome measures appear in Table 1.7. From treatment intake to discharge, fewer Prop 36 offenders reported using their primary drug in the prior 30 days (representing a 26.7% reduction). A similar decrease was evident from intake to discharge in the percentage of Prop 36 offenders who reported any criminal justice activity (24.5% reduction). Smaller decreases occurred in the percentages who were homeless (2.5% reduction), reported dependent living (2.1% reduction), or experienced family conflict (2.7% reduction). Likewise, from treatment intake to discharge, more Prop 36 offenders became employed (11.1% increase) and more also received some kind of social support (26.1% increase). As shown in Table 1.8, similar improvements in level of functioning were evident from treatment intake to discharge among other types of clients in drug treatment.

Table 1.7 Change in Status from Treatment Intake to Treatment Discharge Among Prop 36 Offenders
(N=20,649)

	Intake	Discharge	Difference
Past 30 days, %			
Used primary drug	52.3	25.6	-26.7
Any criminal justice activity (any arrests, jail or prison days)	31.9	7.4	-24.5
Living arrangement			
Homeless	12.0	9.6	-2.5
Dependent living	42.4	40.4	-2.1
Independent living	45.5	50.0	4.5
Employed (full- or part-time)	34.3	45.5	11.1
Social support			
None	53.1	31.5	-21.6
Some	38.6	48.4	9.7
Daily	8.3	20.2	11.9
Any	46.9	68.5	21.6
Family conflict	8.0	5.3	-2.7

Note: Analysis includes individuals who had a CalOMS admission record during FY 2006-07 and a CalOMS discharge record by December 31, 2008.

Table 1.8 Change in Status from Treatment Intake to Treatment Discharge Among Treatment Clients by Referral Source
(N=77,129)

	Prop 36 Probation (N=18,023)			Prop 36 Parole (N=2,626)			Drug court (N=1,150)			Other criminal justice (N=16,136)			Non-criminal justice (N=39,194)		
	Intake	Disch	Diff	Intake	Disch	Diff	Intake	Disch	Diff	Intake	Disch	Diff	Intake	Disch	Diff
Past 30 days, %															
Used primary drug	51.1	24.5	-26.6	60.1	32.9	-27.2	33.2	16.7	-16.5	45.4	22.1	-23.4	77.6	47.3	-30.3
Any criminal justice activity (any arrests, jail or prison days)	31.9	7.3	-24.6	32.0	7.7	-24.3	65.2	33.4	-31.8	28.3	6.3	-22.0	11.6	4.2	-7.4
Living arrangement															
Homeless	11.6	9.2	-2.4	15.3	12.3	-2.9	19.2	17.5	-1.7	13.3	10.2	-3.1	28.5	24.2	-4.3
Dependent living	42.3	40.2	-2.1	43.4	41.4	-1.9	51.6	49.3	-2.3	51.3	49.1	-2.2	36.4	38.7	2.2
Independent living	46.1	50.6	4.5	41.4	46.2	4.9	29.2	33.2	4.0	35.4	40.7	5.4	35.1	37.2	2.1
Employed (full- or part-time)	34.7	46.2	11.5	31.9	40.3	8.4	15.1	28.8	13.7	26.2	37.6	11.4	18.1	22.4	4.3
Social support															
None	52.3	30.9	-21.4	58.6	35.3	-23.3	60.7	16.4	-44.3	62.3	34.6	-27.7	68.1	39.9	-28.2
Some	39.5	49.3	9.7	32.5	42.2	9.7	28.5	39.1	10.6	27.9	39.6	11.7	25.7	38.7	12.9
Daily	8.2	19.8	11.6	8.9	22.5	13.6	10.8	44.4	33.7	9.9	25.9	16.1	6.2	21.4	15.3
Any	47.7	69.1	21.4	41.4	64.7	23.3	39.3	83.6	44.3	37.7	65.4	27.7	31.9	60.1	28.2
Family conflict	8.0	5.2	-2.8	8.0	6.0	-2.0	5.6	3.5	-2.1	9.0	5.0	-4.0	17.2	8.2	-9.0

Note: Analysis includes individuals who had a CalOMS admission record during FY 2006-07 and a CalOMS discharge record by December 31, 2008.

Summary

The 67.5% statewide show rate is lower than rates estimated for previous Prop 36 years. While this may in part be due to changing methods of data collection, this may also be partly attributable to the effect of cuts to statewide Prop 36 funding in FY 2007-08. The effect of these budget cuts is discussed further in Urada et al., 2009).

New to this year's report, Prop 36 stakeholders indicated that in most counties most eligible offenders agreed to participate in the Prop 36 program. Stakeholders reported that offenders who declined the program were more likely to be male, younger, not employed, homeless, and a persistent or chronic offender; and preference for incarceration or for other treatment options were most commonly reported as reasons for offender refusal of the Prop 36 program. Reasons offenders opted for Prop 36 but did not enter treatment included drug use relapse and no intention to enter treatment.

Similar to Proposition 36's earlier years, in its seventh year, most Proposition 36 treatment clients (73.3%) were men and about half (40.7%) were non-Hispanic White, while 36.8% were Hispanic and 14.3% were African-American. Mean age at treatment entry was 35.5 years. The primary drug of use for over half of Prop 36 treatment clients was methamphetamine (52.6%), followed by cocaine/crack (14.2%), marijuana (14.4%), alcohol (8.9%), and heroin (8.6%). A large portion of Proposition 36 treatment clients had received treatment before (50.9%). Unlike prior years, in Prop 36's seventh year there was an increase in the percentage of Prop 36 offenders who had longer drug use histories.

Compared to prior years, a dramatic change occurred in employment status starting in FY 2006-07 and this change continued into FY 2007-08. During these years, the percentage of Prop 36 offenders who were not in the labor force almost doubled (from 17.0% to 33.6%) and the unemployment rate steadily increased (from 30.8% to 35.3%). Conversely, the percentage of Prop 36 offenders who were employed part-time decreased by more than half (from 28.3% to 11.3%) and rates of full-time employment decreased steadily (from 24.0% to 19.8%). While findings may be due to early manifestations of California's changing economy, that has seen steady increases in unemployment in recent times, this finding must also be read with caution as recent changes in employment patterns among Prop 36 offenders may be partly due to changes in the categorization of employment status during the transition to CalOMS. Information provided from the perspective of treatment programs indicates that there are current practices for addressing the employment and educational needs of Prop 36 clients but that the lack of funding for such services is a key barrier. These findings are of particular concern since, as discussed in prior Prop 36 evaluation reports (Evans, 2008), being employed is among one of the few factors that has been associated with Prop 36 treatment success (Hser et al., 2007) and ample research has demonstrated the strong positive association between employment and positive substance abuse treatment outcomes (Buck, 2000; SAMHSA, 2000).

With the transition to CalOMS it became possible to include information in this report on a range of behaviors and measures that had not been reported on before. Analysis of the new measures showed that at entry into treatment, small but notable percentages of Prop 36 offenders reported being a Veteran (3.9%), homeless (11.5%), on disability (15.2%), a needle user (7.0%), pregnant (4.5%), medically ill (14.9%) or mentally ill (16.0%). Very few Prop 36 offenders (about 6% or less) reported having been tested for tuberculosis, Hepatitis C, or Sexually Transmitted Diseases, but more than half (64.9%) had been tested for HIV and had received the results of their HIV test (57.4%). Almost half of Prop 36 offenders had children (46.7%) and the total number of children age 17 or younger whose parents entered Prop 36 treatment was 39,308. About one-quarter of Prop 36 offenders had at least one child under the age of 5 (22.1%), and 6.6% of Prop 36 offenders had a child who was living elsewhere and 3.5% had had

their parental rights terminated. These data indicate the range of needs among the Prop 36 population. However, because many of these measures are also relatively new to the CalOMS system, issues related to under- or over-reporting of behaviors may exist and thus data must be interpreted with caution until additional years of data are available.

Most Proposition 36 offenders admitted to treatment were sentenced to probation or were already on probation (82.7%) when they committed their Proposition 36-eligible offense. The others (17.3%) were on parole. The proportion of Prop 36 participants referred by parole has steadily increased over the seven years since the program has been in operation. When examining differences between Prop 36 parolees and Prop 36 probationers, data showed that compared to Prop 36 probationers, more Prop 36 parolees were African American (18.9% vs. 13.3%), more were men (81.7% vs. 71.5%), parolees were older (36.6 vs. 35.3 mean years of age), more had used their primary drug for 21 or more years (32.6% vs. 27.0%), more had used their primary drug in the 30 days prior to treatment entry (57.7% vs. 48.6%), more were homeless (14.0% vs. 11.0%), fewer had social support (37.4% vs. 44.8%), more had been incarcerated in prison (13.1% vs. 1.7%) and fewer had been incarcerated in jail (20.7% vs. 30.0%), more had been tested for Hepatitis C (10.0% vs. 5.4%) and HIV (75.3% vs. 62.7%), more had received HIV test results (66.8% vs. 55.3%), and more parolees had children (50.2% vs. 46.0%). More information is provided on Prop 36 parolees in Chapter 5.

Also new to this report, data is presented on drug court referrals. Compared to drug court referrals, at treatment entry Prop 36 offenders were older (35.5 vs. 34.5 years old), more Prop 36 referrals were men (73.3% vs. 66.1%), more were employed (31.1% vs. 14.7%), more used methamphetamine (52.6% vs. 40.8%) and fewer used cocaine/crack (14.2% vs. 24.4%), more had longer drug use histories, more had used their primary drug in the prior 30 days (50.2% vs. 36.4%), fewer were homeless (11.5% vs. 19.3%), and fewer had been incarcerated in jail in the prior 30 days (28.3% vs. 63.2%). Differences in client characteristics like these warrant further investigation since they profile differential prognostic criteria and must be considered when comparing Prop 36 outcomes to outcomes of other criminal justice diversion options such as drug court.

As another new aspect of this year's report, information on Prop 36 client characteristics by county is provided and county-level variation in characteristics was evident. County-level variation in client characteristics must be considered if efforts are made in the future to compare Prop 36 program performance or outcomes by county.

Finally, from treatment intake to discharge there were improvements among Prop 36 offenders in several key areas. Compared to treatment intake, at treatment discharge fewer Prop 36 offenders had used their primary drug, engaged in criminal activity, were homeless, or had experienced family conflict, and more Prop 36 offenders were employment and had received social support.

Conclusion

In operation since 2001, the Prop 36 program has become an established court-supervised diversion option for drug offenders in California. With a few exceptions, the number of offenders who enter drug treatment under Prop 36 and the characteristics of the Prop 36 offenders appear to have remained mostly unchanged over the years. Data newly available indicate a wide range of health, mental health, and social problems among this population. While services to address such needs have been provided for in the Prop 36 funding, the proportion in need that actually receives such services has been relatively low. Over the past two years California developed a significant budget crisis that can be expected to affect the Prop 36 program in future years. It is hoped that the information contained in this chapter, in addition to findings from earlier research on Prop 36 (see Appendix 1.3 for a list of Prop 36 publications and reports),

will be used to understand who is best served by Prop 36, associated cost benefit tradeoffs, and how the program can be best adjusted to meet present and future needs.

References

Blumstein, A., Cohen, J., Roth, J., & Visher, C. (1986). Criminal careers and "career criminals." Washington, DC: National Academy Press.

Brecht, M.L., Stein, J., Evans, E., Murphy, D., & Longshore, D. (2008). Predictors of intention to change HIV sexual and injection risk behaviors among heterosexual methamphetamine-using offenders in drug treatment: A test of the AIDS risk reduction model. *Journal of Behavioral Health Services and Research*. Published online January 24, 2008.

Buck, M. (2000). Getting Back to Work; Employment Programs for Ex-Offenders, Field Report Series. Philadelphia, PA: Public/Private Ventures. http://www.ppv.org/ppv/publications/assets/94_publication.pdf

California Department of Finance (2007). Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA. Retrieved January 18, 2009 from http://www.dof.ca.gov/HTML/DEMOGRAP/Data/RaceEthnic/Population-00-50/RaceData_2000-2050.php

Centers for Disease Control (2009). Estimated numbers of persons living with AIDS at the end of 2007, by race/ethnicity and transmission category—50 states and the District of Columbia. Retrieved April 28, 2009 from: http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2007report/table13.htm

Committee on Substance Abuse and Mental Health Issues in AIDS Research. (1994). AIDS and behavior: An integrated approach (J. D. Auerbach, C. Wypijewska, & H. K. H. Brodie, Eds.). Washington, DC: National Academy Press.

Conner, B. & Grella, C. (2008). "The homeless mentally ill in Proposition 36" in Urada, D., et al., *Evaluation of the Substance Abuse and Crime Prevention Act 2008 Report*. Submitted to the California Department of Alcohol and Drug Programs.

Donovan, D.M., Rosengren, D.B., Downey, L., Cox, G.B., & Sloan, K.L. (2001). Attrition prevention with individuals awaiting publicly funded drug treatment. *Addiction, 96,* 1149-1160.

Evans, E. (2008). "Employment assistance in Proposition 36" in Urada, D., et al., *Evaluation of the Substance Abuse and Crime Prevention Act 2008 Report*. Submitted to the California Department of Alcohol and Drug Programs.

Evans, E., Li, L., & Hser, Y.I. (2008). Treatment entry barriers among California's Proposition 36 offenders. *Journal of Substance Abuse Treatment*, 35, 410-418. (e-pub online).

Gottfredson, M.R., & Hirschi, T. (1990). *A general theory of crime*. Stanford, CA: Stanford University Press.

Hser, Y.I., Evans, E., Teruya, C., Huang, D., & Anglin, M.D. (2007). Predictors of short-term treatment outcomes among Proposition 36 clients. *Evaluation and Program Planning, 30,* 187-196.

Hser, Y.-I., Maglione, M., Polinsky, M.L., & Anglin, M.D. (1998). Predicting drug treatment entry among treatment-seeking individuals. *Journal of Substance Abuse Treatment, 15,* 213-220.

Kirby, K.C., Marlowe, D.B., Lamb, R.J., & Platt, J.J. (1997). Behavioral treatments of cocaine addiction: Assessing patient needs and improving treatment entry and outcome. *Journal of Drug Issues*, *27,* 417-429.

Marlowe, D.B. (2002). Effective strategies for intervening with drug abusing offenders. *Villanova Law Review*, *47,* 989-1025.

Prendergast, M. L., Urada, D., & Podus, D. (2001). Meta-Analysis of HIV Risk-Reduction Interventions within Drug Abuse Treatment Programs. Journal of Consulting and Clinical Psychology, 69(3), 389-405.

Rawson, R., Gonzales, R., Brecht, M.L., et al. (2008). *Evaluation of the California Outcomes Measurement System (CalOMS) Final Report*. Submitted to the California Department of Alcohol and Drug Programs.

SAMHSA (2000). Treatment Improvement Protocol (TIP) Series 38: Integrating Substance Abuse Treatment and Vocational Services. Retrieved 4/1/2009 from: http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.68228.

Urada, D., Gardiner, C., & Anglin, D. (2009). Commentary : Current Status and Future of California's Substance Abuse and Crime Prevention Act (Proposition 36). http://www.uclaisap.org/prop36/html/reports.html

Chapter 2: Treatment Placement and Wait Time, Treatment Completion and Non-Completion, Early Treatment Dropout, Treatment Outcome Measures, and Treatment Re-entry

Elizabeth Evans, Jeremy Hunter, and Darren Urada

In Proposition 36's seventh year, as in earlier years, most offenders were placed into outpatient drug-free treatment (84.1%) and relatively few were placed in other types of care. Treatment placement patterns were the same regardless of primary drug type. Most heroin/opiate users did not receive narcotic treatment therapy. About one-third (30.5%) of Prop 36 offenders were reported as having to wait to enter treatment and the mean number of waiting days was 12.7. The percentage of Prop 36 offenders who waited for treatment and the average number of days waited varied by treatment modality.

The Prop 36 treatment completion rate reached a notable high of 40.7% of those discharged from treatment in the program's seventh year. There are several possible reasons for changes in treatment completion rates over time including improving treatment, the recent transition to a new drug treatment data system, changes in the methodology for calculating completion rates, and referrals dropping out prior to admission . Treatment completion rates were higher among Prop 36 probationers (43.3%) than among Prop 36 parolees (27.7%). Variation in Prop 36 treatment completion rates was evident by county and variation may be partly attributable to differences in the characteristics of counties, the type of Prop 36 client being treated, and the definition of treatment completion that is being applied.

More than half of Prop 36 treatment clients did not complete treatment (59.3%). Compared to treatment completers, non-completers were more likely to be African American and less likely to be White, non-completers had a lower education level, more were referred to treatment by parole, more were not working, fewer reported methamphetamine as the primary drug problem, more used their primary drug recently, and more had been arrested or incarcerated in jail prior to treatment entry. Also, more non-completers than completers were treated in an outpatient setting and fewer were treated in a long-term residential setting. At discharge, few non-completers were making satisfactory progress in treatment.

About one-third of the Prop 36 treatment non-completer group was an early treatment dropout (left treatment within 30 days of treatment entry). In general, the characteristics that distinguished early treatment dropouts were similar to the characteristics that differentiated all treatment non-completers from treatment completers, although the rate of homelessness at treatment entry was higher among early treatment dropouts.

Outcome measures showed that from treatment intake to discharge fewer Prop 36 offenders used their primary drug or interacted with the criminal justice system, however improvements were greater among treatment completers than non-completers. Similar patterns were evident from intake to discharge in rates of family conflict, employment, and social support. Similarly, Prop 36 early treatment dropouts made smaller gains from treatment intake to discharge than other types of treatment dropouts.

Finally, of Prop 36 offenders who were discharged from treatment approximately 25% had another episode of treatment within the following 12 months. More treatment non-completers than completers had additional treatment, but, for both groups, when additional treatment did take place, it occurred about four to five months after discharge from the prior episode and the number of additional treatment episodes over 12 months was approximately one. The mean number of days in treatment across all episodes examined was about 120 days for completers and for non-completers. The last treatment discharge record on file indicated that 54.1% of Prop 36 treatment completers and 37.8% of non-completers went on to complete treatment.

Introduction

Research on drug treatment effectiveness has shown that treatment completion and sufficient time in treatment are associated with favorable post-treatment outcomes such as abstinence from drug use, reductions in drug-related problems, and improved psychosocial functioning (Anglin & Hser, 1990; DeLeon, 1991; Hubbard et al., 1989, 1997; Simpson, 1979; Simpson et al., 1997; TOPPS II Interstate Cooperative Study Group, 2003; Zhang et al., 2003). Similar to the cited findings, previous Prop 36 evaluation reports have provided evidence demonstrating that treatment completion is related to improved offender functioning in multiple domains. Compared to Prop 36 treatment non-completers, treatment completers had significantly lower re-arrest rates and savings per offender were more than twice as high over 30- and 42-month follow-up periods (UCLA ISAP, 2006, 2008).

However, only about one-third of Prop 36 offenders who enter treatment, many for the first time, actually complete it (UCLA ISAP, 2006). Other large-scale studies of drug treatment effectiveness have reported completion rates ranging from one-third to two-thirds (Gerstein et al., 1994; Government Accountability Office, 2005; Hser et al., 2003; Substance Abuse and Mental Health Services Administration, 2002; TOPPS II Interstate Cooperative Study Group, 2003). Although Prop 36 offenders are at the lower end of this scale, as are offender populations generally, research on Prop 36 offenders also indicates that significant percentages of treatment dropouts are making satisfactory progress in treatment just prior to dropout, that about 20% of Prop 36 treatment dropouts are "early dropouts" (that is offenders who leave treatment within 30 days of entering care), and that some offenders, both dropouts and completers, re-enter care over time (Evans et al., 2008). This study also reported that at entry into treatment, compared to completers, Prop 36 treatment dropouts had lengthier criminal histories, lower motivation for treatment, more severe employment and psychiatric problems, and more were using drugs, especially heroin, at a more severe level. While information on treatment completion and retention has been presented in previous Prop 36 evaluation reports, for the first time, in this chapter, there is a special focus on analysis of longer-term statewide data on treatment non-completion, treatment re-entry, and associated issues.

This chapter consists of five sections dealing with treatment placement and wait time, treatment completion rates, the characteristics of treatment completers and non-completers, early treatment dropout, and treatment re-entry. First, the chapter reports the treatment modalities Prop 36 clients were placed in during Prop 36's seventh year, that is FY 2007-08 (July 1, 2007-June 30, 2008). Also discussed is the proportion of offenders who wait to enter treatment and typical treatment wait times. Second, the chapter reports results from analyses of treatment completion rates over seven years, beginning in FY 2001-02, when Prop 36 began, and ending with the most current year of available data, FY 2007-08. Third, the characteristics of clients who completed treatment during FY 2007-08 are compared to the characteristics of clients who did not complete treatment during the same time period. These characteristics include, for example, race/ethnicity, sex, and primary drug problem. County variation in treatment completion and non-completion rates is presented. Reasons and consequences of treatment non-completion

are also discussed. Treatment outcome measures are presented. Fourth, the chapter offers information on Prop 36's "early treatment dropouts", i.e., clients who left treatment within 30 days of entering treatment without completing it. Finally, treatment re-entry among Prop 36 clients is examined. This chapter does not provide information on the recovery phase that typically follows treatment discharge. Nevertheless, the findings from each section have implications for improving Prop 36 policy and practice.

Treatment Placement

CalOMS data were analyzed to determine the percentage of Prop 36 offenders entering each treatment modality during FY 2007-08. As shown in Figure 2.1 outpatient drug-free was the initial treatment placement for most offenders (84.1%). Long-term residential treatment (planned duration exceeding 30 days) was the second most common placement (11.6%). This pattern was the same regardless of the client's primary drug (see Figure 2.2). Treatment placement in this year was very similar to placement in the earlier years of the program.

Figure 2.1
Proposition 36 Treatment Clients by Modality
CalOMS, 7/1/07 – 6/30/08 (N = 41,107)

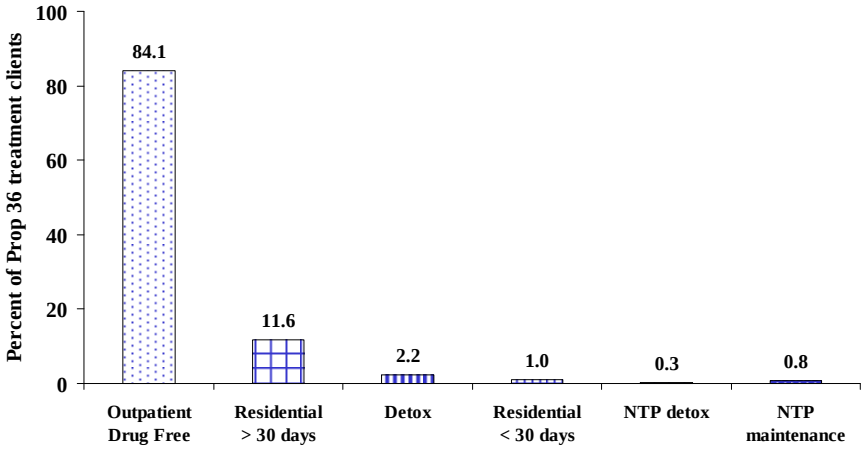
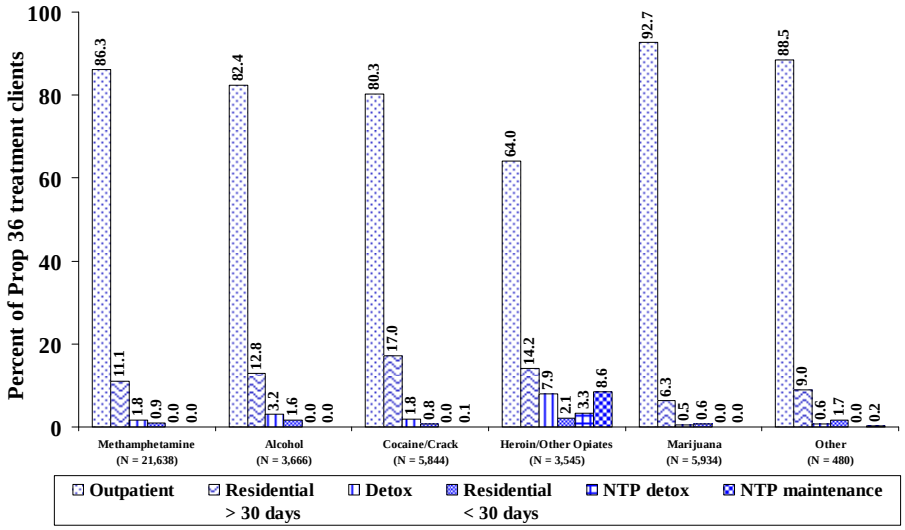


Figure 2.2
Primary Drug by Modality Among Proposition 36 Treatment Clients
CalOMS, 7/1/07 – 6/30/08 (N = 41,107)



Narcotic treatment programs (or "NTP," including NTP maintenance and NTP detoxification) and short-term residential treatment were rarely used in Prop 36. Methadone maintenance is the most effective option in treating heroin dependence (American Methadone Treatment Association, Inc., 2004; Mathias, 1997; National Institute on Drug Abuse, 1999; National Institutes of Health Consensus Conference, 1998). Thus it is notable that few heroin or other opiate users (11.9%) were treated with NTP detoxification or maintenance. Most heroin and other opiate users were placed in outpatient drug-free programs, which do not provide medication to alleviate the withdrawal symptoms associated with heroin dependence.

Treatment Entry Wait Time

About one-third (30.5%) of Prop 36 offenders were reported to have waited to enter treatment (data not shown) which was, as shown in Figure 2.3, less than the percentage of drug court referrals who were reported to have waited to enter treatment (48.6%) and similar to the percentage of other criminal justice (30.0%) and non-criminal justice (26.7%) referrals who were reported to have waited. Of those who were reported to have waited to enter treatment, the mean number of waiting days was 12.7 among Prop 36 offenders (data not shown), and 16.0 among drug court referrals, 17.6 among other criminal justice referrals, and 11.1 among non-criminal justice referrals (Figure 2.4).

Figure 2.3
Waited to Enter Treatment
Among Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 169,990)

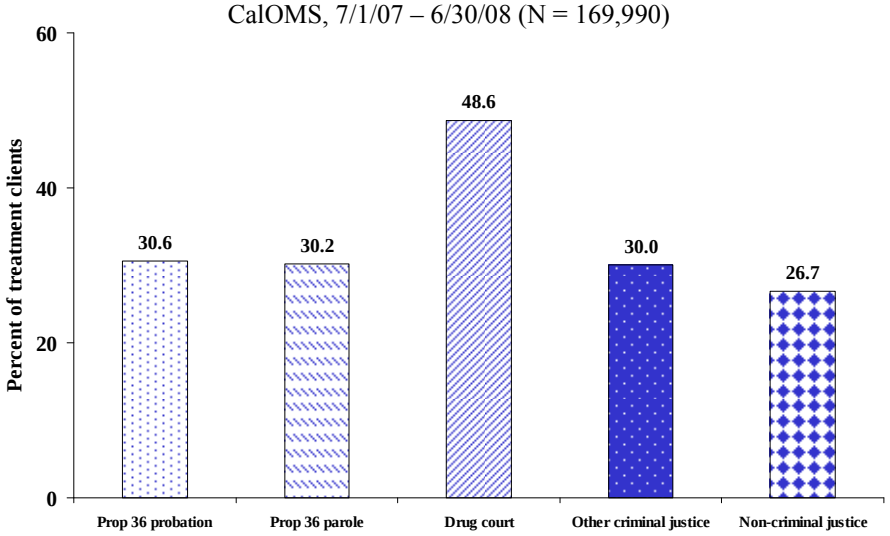
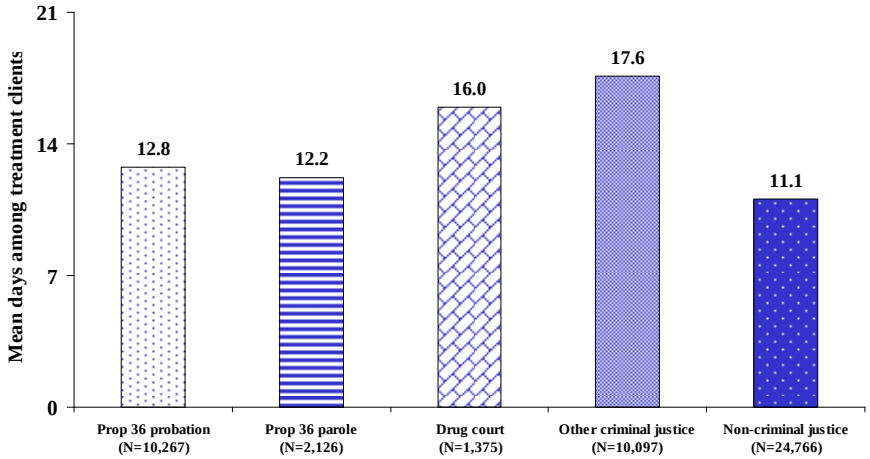


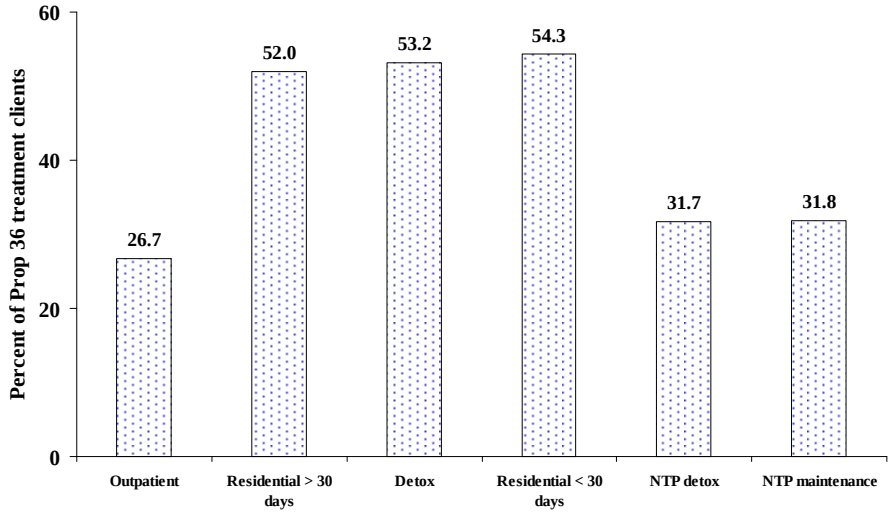
Figure 2.4
Days Waited to Enter Treatment
Among Treatment Clients Who Waited One or More Days* by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 48,631)



*Analysis is limited to clients who reported at least one wait day. Clients who reported zero wait days are omitted.

When wait time was examined by modality (Figure 2.5), analysis showed that fewer Prop 36 offenders were reported to have waited for outpatient treatment (26.7%) than for other types of care (52.0% waited for residential ≥30 days, 53.2% detox, 54.3% residential <30 days, 31.7% NTP detox, 31.8% NTP maintenance).

Figure 2.5
Waited to Enter Treatment by Modality
Among Prop 36 Treatment Clients
CalOMS, 7/1/07 – 6/30/08 (N = 41,107)



When this data is presented by referral type, this pattern of access to outpatient was also apparent (Figure 2.6), however the percentage of clients who were reported to have waited for non-outpatient types of care did vary by referral type. Of Prop 36 offenders who were reported to have waited to enter treatment, the average number of wait days varied by modality (Figure 2.7), with about a one-week wait for detox and NTP detox, about a two-week wait for outpatient and short- and long-term residential, and more than a two-week wait for NTP maintenance. For most modalities, the number of wait days varied by referral source (Figure 2.8).

Information that is presented in this section on the prevalence of waiting for treatment and on treatment wait times must be interpreted with caution. This information relies on CalOMS data which only collects data on individuals who entered treatment. Individuals who waited for treatment but did not enter treatment are not a part of the CalOMS dataset and these individuals are thus omitted from analyses. Also, of counties that completed the Lead Agency Section of UCLA's Prop 36 Stakeholder Survey (41 of 58 counties, 71% response rate; see Appendix A for more details), many indicated that in FY 2007-08, Prop 36 offenders were required to participate in activities while waiting to enter treatment. More than half of counties that responded reporting using self-help groups (55.6%), and other strategies included Prop 36 orientation sessions (48.6%), drug testing (44.4%), assignment to an alternate level of care (30.6%), drug education classes (22.9%), and other activities (19.4%).

Figure 2.6
Waited to Enter Treatment by Modality
Among Treatment Clients by Referral Source
CalOMS, 7/1/07 – 6/30/08 (N = 169,990)

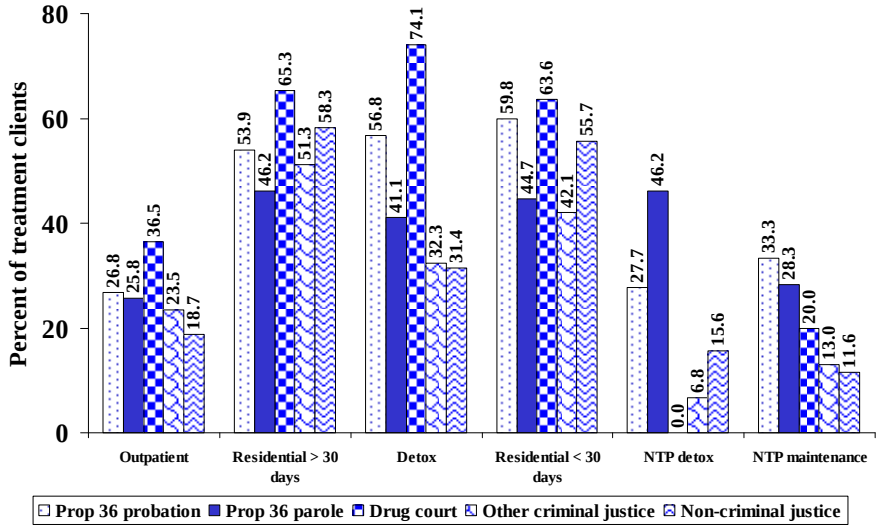
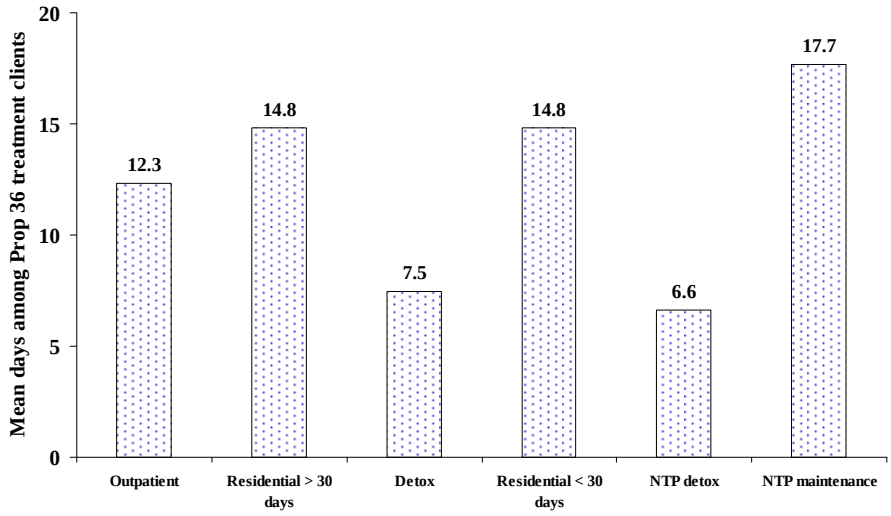
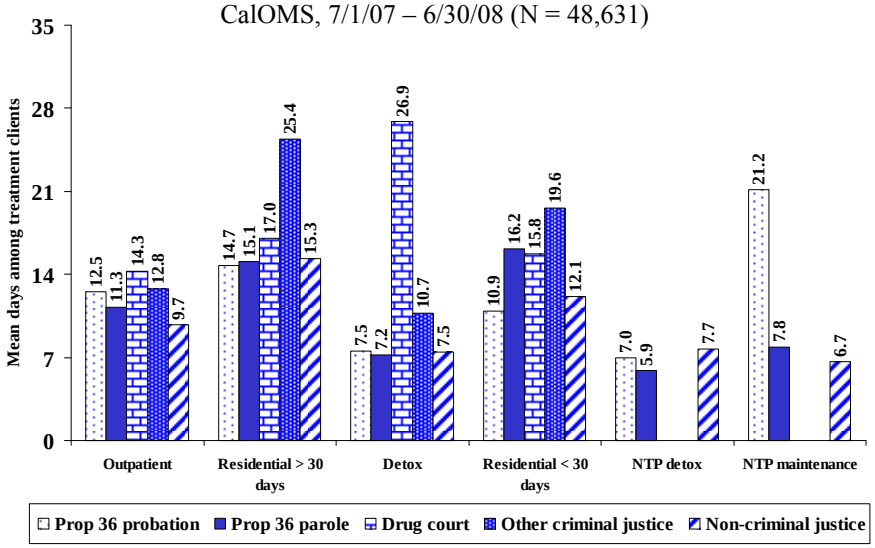


Figure 2.7
Days Waited to Enter Treatment by Modality
Among Prop 36 Treatment Clients Who Waited One or More Days*
CalOMS, 7/1/07 – 6/30/08 (N = 12,393)



*Analysis is limited to clients who reported at least one wait day. Clients who reported zero wait days are omitted.

Figure 2.8
Days Waited to Enter Treatment by Modality
Among Treatment Clients Who Waited One or More Days by Referral Source*
CalOMS, 7/1/07 – 6/30/08 (N = 48,631)



*Analysis is limited to clients who reported at least one wait day. Clients who reported zero wait days are omitted.
Note that data are not shown when small samples sizes (N≤10) in individual cells occurred.

Treatment Completion

Measuring Completion Rates

This report marks a methodological shift in the method for calculating Prop 36 treatment completion rates. Prior to this report, treatment completion rates were calculated by linking CADDS admission and discharge data for all individuals who were *admitted* to treatment during a given fiscal year. This methodology was applied to five Fiscal Years covering 2001 to 2006. Starting in January 2006, the state piloted a new drug treatment data system, CalOMS, and beginning in FY 2006-07 (July 1, 2006-June 30, 2007), CalOMS replaced the CADDS data system. Due to this transition to CalOMS, the method for calculating treatment completion rates was re-tooled to focus on individuals who were *discharged* during a given fiscal year. This new method was used to calculate the treatment completion rates for Fiscal Years 2006-07 and 2007-08 that are shown in Figure 2.9.

Further, analyses were conducted to examine how treatment completion rates changed when the new methodology was applied to prior years of CADDS data. Results are shown in Appendix 2.1. With the exception of the first and last years, Prop 36 treatment completion rates varied by only 2 to 3 percentage points in each year when comparing rates resulting from the new method (i.e., starting with individuals discharged during a given fiscal year and following them backwards in time to admission) versus rates resulting from the old method (i.e., starting with individuals admitted during a given fiscal year and following them forward in time until discharge). The first year (2001-2002) would be expected to be lower using the new method because people discharged during the first year were biased toward clients who were discharged early (i.e. non-completers). This is in fact the reason this method was not employed by the evaluation in

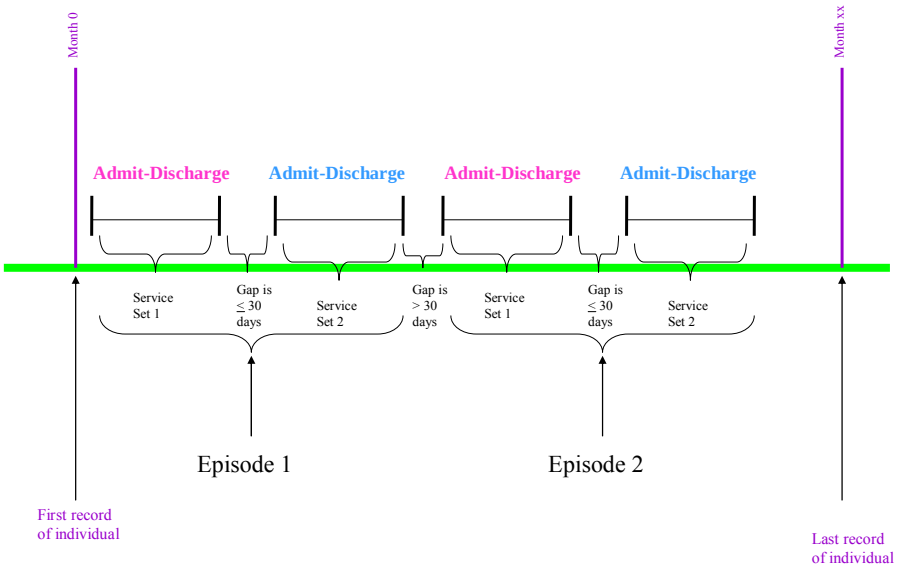
earlier years. Likewise, the last year of CADDS (2005-2006) might be expected to have lower completion rates because the database became locked, and clients who completed after long terms in treatment would not have been added to the database.[10] Therefore the direction of the differences in years one and five are mostly as expected. The fact that the other years did not differ by much suggests the method itself did not make an appreciable difference. Among other groups in treatment (i.e., the criminal justice non-Prop 36 group and the non-criminal justice group) there was greater variation in treatment completion rates by the methodology that was used. When the new methodology was applied, rates decreased by 2-9% among the criminal justice non-Prop 36 group and rates mostly increased by 2-6% among the non-criminal justice group. Also, as was true for the Prop 36 group, among the criminal justice non-Prop 36 group, the difference in completion rates for FY 2005-06 was largest.

In this report, treatment completion is determined by the status indicated on the last discharge record that was recorded in an episode of treatment. The definition of treatment episode utilizes the CalOMS concepts of service sets and treatment episodes. As shown in Diagram 2.1, an individual client can experience multiple service sets and treatment episodes over time and these events can occur consecutively, and even concurrently, in time. Within CalOMS, service sets that occur within 30 days of one another (meaning the date of discharge and the date of readmission are $\leq$30 days apart) are "tied together" into one treatment episode of care while service sets that occur more than 30 days apart (meaning the date of discharge and the date of readmission are >30 days apart) indicate the end of one treatment episode and the beginning of the next treatment episode. Using this definition of treatment episode for analyses in this chapter, if a client first enters outpatient treatment and is discharged without completing it, but then enters residential treatment 20 days later and completes the residential treatment (and does not re-enter treatment within 30 days from that discharge date), those events are combined into a single episode of treatment and, in this example, the client is counted as having "completed" treatment. Conversely, if during a treatment episode a client completes the first service set but does not complete the second service set, the client is not considered to have "completed" treatment.

As a measure of success, the single measure of treatment completion suffers from a number of problems, including lack of an adequately standardized definition among treatment providers and consequent susceptibility to subjective judgment regarding which and how many clients have "completed" treatment (for a full discussion of issues see Urada & Gonzales, 2008, p. 245-247). Despite such limitations, the measure continues to have relevance in the Prop 36 context because clients must complete treatment to fulfill requirements for Prop 36 program completion. Therefore, treatment completion continues to be reported as one Prop 36 benchmark, but readers are encouraged to also carefully consider other measures included in this report (e.g. show rates, treatment duration, early dropout rates, and recidivism) to supplement their understanding of Prop 36 performance and outcomes both overall and for subsets of Prop 36 offenders.

[10] An equivalent effect was not seen in non-Prop 36 clients for reasons that are unclear, but may be due to the fact that Prop 36 completers tend to have longer lengths of stay (Urada & Evans, 2008) and therefore Prop 36 completion rates would be more susceptible to such a database lock.

Diagram 2.1
CalOMS Service Sets and Treatment Episodes



Note: Service sets can overlap.

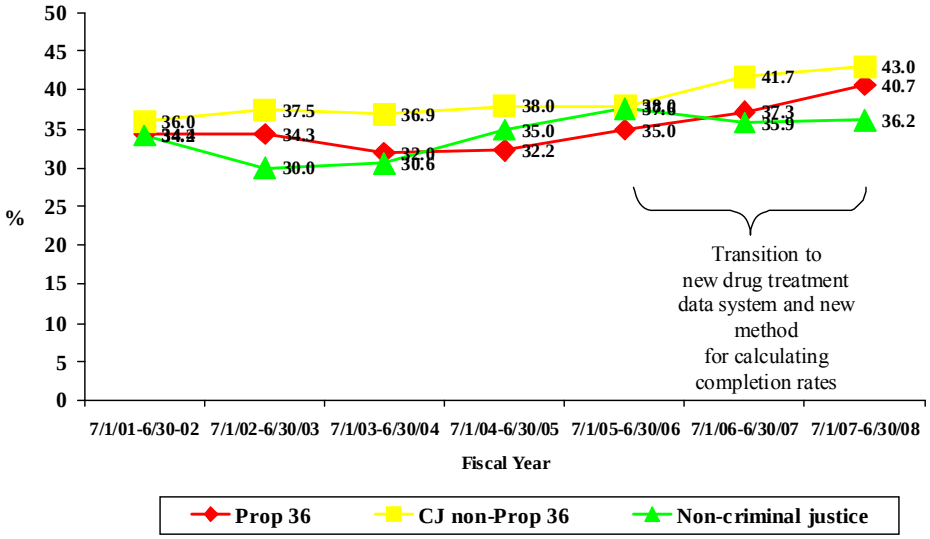
Prop 36 Treatment Completion and Non-Completion Rates

Using the new treatment episode methodology, during FY 2007-08, 38,945 Prop 36 individuals had an episode discharge record on file in CalOMS. Of these, 40 were marked as deceased at discharge and another 73 were missing an admission record. These were removed from the denominator, leaving a sample size of 38,832. Of these, the discharge status was marked as completed for 15,799 Prop 36 offenders (40.7%) and not completed for 23,033 individuals (59.3%). The not completed category includes individuals who left treatment before completion, regardless of satisfactory (n=4,142) or unsatisfactory progress (n=18,891) being made, and also 1,298 individuals who were incarcerated at discharge.

Figure 2.9 shows a seven year treatment completion trend line. Of Prop 36 offenders who were discharged from treatment during FY 2007-08, 40.7% completed treatment, representing a treatment completion rate that was somewhat lower than the rate for non-Prop 36 criminal justice clients and slightly higher than for non-criminal justice clients. Note that the last two fiscal years reported indicate rates using the new methodology described earlier.

Also shown in Figure 2.9, for the first four years of the program the Prop 36 treatment completion rate remained in a range of 32-34%; however, starting in FY 2005-06, the rate appears to increase slightly and then reached a notable high of 40.7% in FY 2007-08. Among the criminal justice non-Prop 36 group, completion rates have also risen recently, reaching a high of 43.0% in FY 2007-08. Completion rates among the non-criminal justice group have been steady between 35 and 36% for the last four years measured.

Figure 2.9
Treatment Completion Rates by Referral Source



Factors that May Explain Changes in Treatment Completion Rates over Time
One explanation for increases in completion rates is that they reflect a real increase in treatment success, which could have occurred for various reasons. For example, two factors that may have contributed include higher Prop 36 / Offender Treatment Program (OTP) funding during the period,[11] and steep increases in the statewide use of process improvement methods such as those promoted by the Network for the Improvement of Addiction Treatment during the period (NIATx) during 2007 and 2008 (see Chapter 8).

However, there are also several other possible explanations that may contribute to changes in treatment completion rates over time:

First, criteria for determining treatment completion may have fluctuated over time. For example, in 2006-2007 the median time in outpatient treatment for Prop 36 probation treatment completers was 211 days. In 2007-2008 completers spent about nine fewer days in treatment (202 days). While this is a relatively small difference (4.3%), to the extent that this may reflect an easing in treatment completion requirements, this may have contributed a small amount to the increase in treatment completion rates.

Second, rising completion rates may be a byproduct of offenders dropping out at earlier stages of the Prop 36 pipeline. That is, where waiting lists have appeared, offenders may increasingly drop out at that stage rather than during treatment. This appears to be

[11] Prop 36 / OTP funding reached a peak of $145 million in FY 2006-2007, compared to $120 million in prior years. This could have affected services delivered to clients discharged both in FY 2006-2007 and FY 2007-2008

supported by the finding discussed in Chapter 1 that the percentage of referred offenders who entered treatment reached a low in 2007-2008 as the completion percentage reached a high.

Third, as explained in the introduction to this section, starting with FY 2006-07, the methodology for calculating completion rates was changed to focus on discharges that occur during a particular year. As discussed above and in Appendix 2.1, however, this does not appear to have had a large effect.

Fourth, the transition to CalOMS may have impacted the data used to calculate completion rates. For example, CalOMS includes a greater number of unique personal identifiers than CADDS, and this aspect of CalOMS likely enhances the ability to link together multiple episodes that occur for an individual over time, increasing the total number of individuals available for analysis. However, from 2005 to 2007, an individual may have been admitted in CADDS and discharged in CalOMS and the degree to which "old" CADDS data was integrated into CalOMS has not been adequately investigated. Also, CalOMS includes "incarceration" as a possible discharge status whereas CADDS did not. Incarcerated individuals are included in the denominator of the rates shown for 2006-07 and for 2007-08, however prior to these years it is unclear how incarcerated individuals were documented in CADDS at discharge.

There may be other factors that impact completion rates over time. More research is needed to improve our understanding of this issue, and the County Alcohol and Drug Program Administrators Association of California is currently working on improving standardization of the definition of completion.

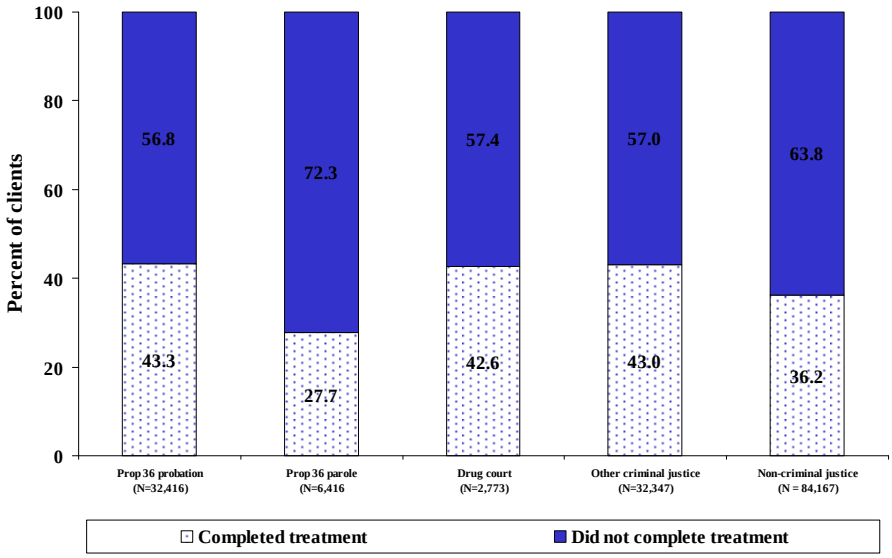
Treatment Completers and Treatment Non-Completers

Figure 2.10 shows the percentage of treatment completers and non-completers by treatment referral source. Treatment completion rates were higher among Prop 36 probationers (43.3%) than among Prop 36 parolees (27.7%). In comparison, "other criminal justice" referrals (43.0%) and drug court referrals (42.6%) had completion rates similar to that of Prop 36 probationers and the treatment completion rate among non-criminal justice referrals was 36.2%. Aside from Prop 36 parole, it is notable that statewide completion rates in all groups fell within a relatively narrow range, from 36.2% to 43.3%.

Figure 2.11 shows variability in Prop 36 treatment completion and non-completion rates across counties. In most counties, between 26% and 50% of Prop 36 offenders completed treatment and between 51% and 75% did not complete treatment, however in 12 counties the treatment completion rate was between 51 and 75% and in one county the rate exceeded 76%.[12]

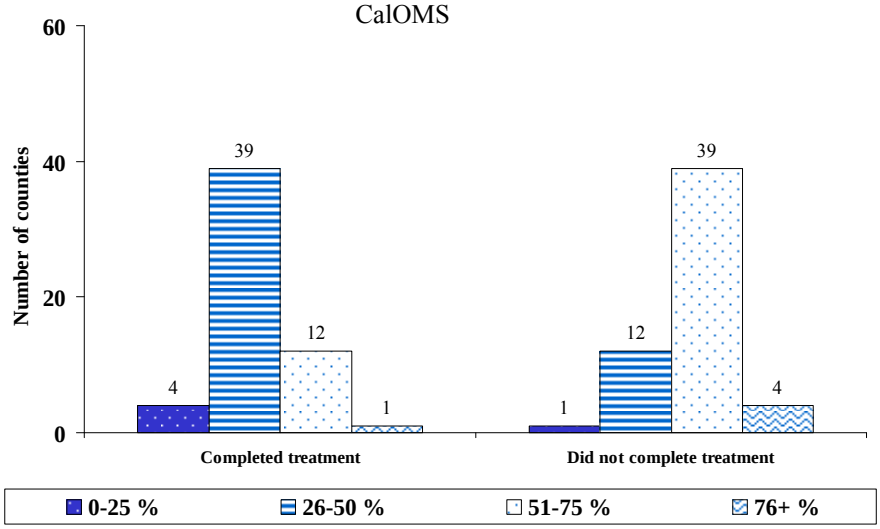
[12] Of the 13 counties with a treatment completion rate ≥51%, all but one had ten or more Prop 36 clients included in the analysis.

Figure 2.10
Treatment Completion and Non-Completion Rates
by Referral Source



Data Source: CalOMS data on unique clients who had a treatment episode that ended between July 1, 2007 and June 30, 2008.

Figure 2.11
County Variation in Proposition 36
Treatment Completion and Non-Completion Rates
CalOMS



Data Source: CalOMS data on unique Prop 36 clients who had a treatment episode that ended between July 1, 2007 and June 30, 2008.
Two counties lacked data and were omitted from analysis.

Table 2.1 shows how county-level variation in treatment completion rates may be influenced by differences in the characteristics of counties and also by differences in the type of Prop 36 clients being treated. Of counties with a Prop 36 treatment completion rate between 51 and 75%, most were very small-sized (41.7%), one-quarter was small-sized and another one-quarter was medium-sized, and relatively few were large-sized (8.3%). In comparison, more counties with a Prop 36 treatment completion rate between 26 and 50% were large-sized (30.8%), about the same proportion were medium- or small-sized, and fewer were very small-sized (25.6%). Also, of counties with a Prop 36 treatment completion rate between 0% and 25%, half were small-sized, half were very small-sized, and none were large or medium-sized.

There were also some differences in the characteristics of Prop 36 clients being served by countywide Prop 36 treatment completion rates. Compared to counties with a lower Prop 36 treatment completion rate, counties with a rate between 51 and 75% served a greater percentage of Prop 36 clients who were referred by probation (85.0% vs. 82.5% and 81.9%) and a smaller percentage referred by parole (15.0% vs. 17.5% and 18.1%).

These counties also served more White clients (51.7% vs. 39.9% and 37.4%), fewer Hispanic clients (27.6% vs. 37.0% and 55.0%), more female clients (29.6% vs. 26.5% and 25.3%), fewer male clients (70.4% vs. 73.5% and 74.7%), and fewer clients who have received drug treatment previously (48.3% vs. 50.7% and 64.9%). Compared to counties with a higher Prop 36 treatment completion rate, counties with a completion rate between 0 and 25% served more clients whose primary drug problem was heroin (13.1% vs. 8.1% and 8.4%), alcohol (13.2% vs. 10.5% and 8.7%) or marijuana (19.0% vs. 17.0% and 14.1%), and fewer clients whose problem was cocaine/crack (2.8% vs. 12.0% and 14.7%).

It is likely that there are other factors that impact Prop 36 treatment completion rates. Additional analyses are needed to examine relationships such as these between county characteristics and Prop 36 program performance and outcome measures.

Table 2.1 County and Prop 36 Client Characteristics by Countywide Prop 36 Treatment Completion Rate[13]

	Countywide Prop 36 treatment completion rate for FY 2007-08 was…		
	51 to 75% (N=12 counties)	26 to 50% (N=39 counties)	0 to 25% (N=4 counties)
County characteristics, %			
County Size[14]			
Large	8.3	30.8	0.0
Medium	25.0	23.1	0.0
Small	25.0	20.5	50.0
Very small	41.7	25.6	50.0
Client characteristics, %			
Referral Type			
Probation	85.0	82.5	81.9
Parole	15.0	17.5	18.1
Race/ethnicity			
White	51.7	39.9	37.4
Hispanic	27.6	37.0	55.0
African American	13.9	14.5	4.0
Asian/Pac Isl	1.9	3.3	0.4
American Indian	1.9	1.2	1.7
Other	3.0	4.1	1.5
Sex			
Women	29.6	26.5	25.3
Men	70.4	73.5	74.7
Employed	27.9	31.6	22.9
Primary Drug Type			
Methamphetamine	51.4	52.9	51.3
Cocaine/crack	12.0	14.9	2.8
Marijuana	17.0	14.1	19.0
Heroin	8.1	8.4	13.1
Alcohol	10.5	8.7	13.2
Other	0.9	1.2	0.5
Prior drug treatment	48.3	50.7	64.9

[13] One county with a treatment completion rate that exceeded 76% is omitted from analysis because less than ten Prop 36 clients were treated. Another two counties that lacked Prop 36 data in CalOMS are also omitted.

[14] County size reflects categories developed by the County Alcohol and Drug Program Administrators' Association of California (CADPAAC). Of California's 58 counties, 13 are large-sized, 12 are medium-sized, 14 are small-sized, and 19 are very small-sized.

Characteristics of Prop 36 Treatment Completers and Non-Completers

This section focuses on the characteristics of Prop 36 treatment completers and non-completers. Appendices 2.2 and 2.3 provide descriptive characteristics and information on treatment experiences of treatment completers and non-completers by referral source (i.e., Prop 36 probation, Prop 36 parole, drug court, other criminal justice, and non-criminal justice). In general, differences in characteristics between completers and non-completers referred to treatment by Prop 36 were very similar to differences found among clients referred to treatment by other sources.

At entry into treatment, Prop 36 treatment non-completers resembled treatment completers on many of the characteristics that were examined (Table 2.2). The few characteristics that differentiated treatment non-completers from completers included race/ethnicity, education level, treatment referral source, employment status, use of primary drug and primary drug type, and interactions with the criminal justice system just prior to treatment entry. Compared to treatment completers, fewer of those in the non-completer group were White (38.8% vs. 45.2%) and more were African American (15.6% vs. 11.2%), non-completers had a lower education level than completers, more non-completers were referred to treatment by parole (20.1% vs. 11.3%), more were unemployed (58.0% vs. 52.4%), fewer reported methamphetamine as the primary drug problem (53.0% vs. 57.4%), more had used their primary drug (55.9% vs. 45.3%) and more had been arrested (25.4% vs. 20.7%) or incarcerated in jail (30.9% vs. 27.8%) in the 30 days prior to treatment entry.

Table 2.2 Characteristics of Prop 36
Treatment Completers and Treatment Non-Completers
(N=38,832)

	Completers (N=15,799) 40.7%	Non-Completers (N=23,033) 59.3%
Age, Mean (SD)	36.0 (10.7)	35.0 (10.6)
Race,%		
White	45.2	38.8
Hispanic	35.2	37.2
African American	11.2	15.6
Asian/Pacific Islander	3.4	3.2
Amer. Indian/Alaskan Native	1.3	1.4
Other	3.8	3.7
Women, %	27.3	26.5
Education, %		
Less than High School	35.9	40.7
High School	45.4	44.0
Some college/college grad	18.7	15.3
Referred by, %		
Probation	88.7	79.9
Parole	11.3	20.1
Employment status, %		
Full- or part-time	35.0	30.3
Full-time	23.8	19.0
Part-time	11.2	11.3
Unemployed	52.4	58.0
Not in labor force	12.6	11.7
Primary drug, %		
Methamphetamine	57.4	53.0
Cocaine	12.8	14.5
Marijuana	12.8	15.1
Alcohol	9.1	7.8
Heroin	6.5	8.5
Other	1.4	1.1
Age at first use of primary drug, Mean (SD)	21.2 (8.7)	20.5 (8.3)
Prior alcohol or drug treatment, %	50.9	48.0
No. of prior treatment admits, Mean (SD)	2.2 (3.6)	2.2 (3.3)
Other characteristics, %		
Homeless	11.7	11.2
Pregnant	5.6	4.8

Table 2.2 Characteristics of Prop 36
Treatment Completers and Treatment Non-Completers
(N=38,832)

	Completers (N=15,799) 40.7%	Non-Completers (N=23,033) 59.3%
Tuberculosis	2.2	2.4
Hepatitis C	5.1	6.0
Sexually Transmitted Diseases (STD)	3.1	2.9
Ever diagnosed with mental health illness, %*	14.6	15.8
Has children under 18 years, %	46.9	47.1
In past 30 days, %		
Used primary drug	45.3	55.9
Arrested	20.7	25.4
In jail	27.8	30.9
In prison	3.2	4.0
Had medical problems	14.2	15.0
Used a needle	5.5	7.3
Had ER visit for medical problems	5.0	5.8
Had ER visit for psychiatric problems*	1.7	1.8
In psychiatric facility*	0.9	1.0
Took psychiatric medication*	9.1	9.2
Had family conflict	6.7	8.3

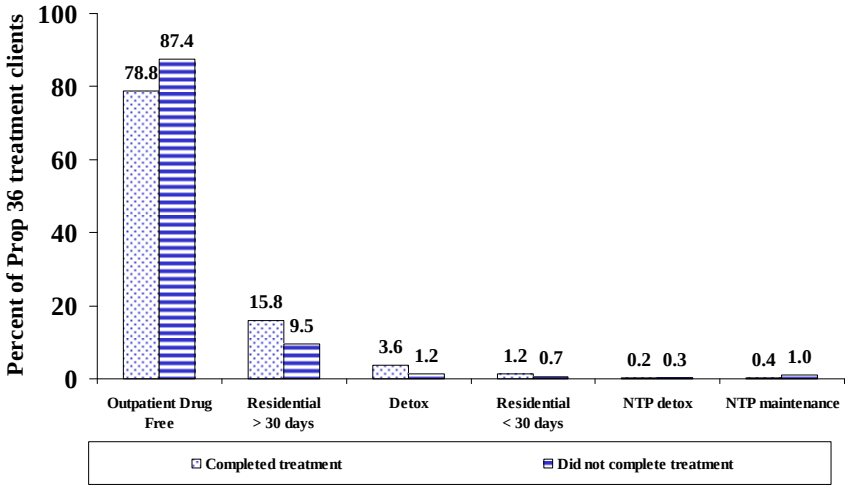
Data Source: CalOMS data on unique Prop 36 clients who had a treatment episode that ended between July 1, 2007 and June 30, 2008.

*Under-reporting of mental health problems in the drug treatment data system has been noted in prior Prop 36 evaluation reports (Conner & Grella, 2008) and this continues to be an issue that impacts mental illness prevalence estimates. Some research has found that 55% to 69% of individuals diagnosed with an alcohol or other drug disorder also have been diagnosed with a co-occurring mental health disorder. In contrast, analyses based on CalOMS data identified few Prop 36 offenders who self-reported a mental health illness. Given this discrepancy, mental health measures derived from CalOMS must be interpreted with caution.

Other differences between Prop 36 treatment completers and non-completers were revealed when examining treatment factors. Figure 2.12 shows that more non-completers than completers were first treated in an outpatient setting and fewer non-completers than completers were first treated in a long-term residential setting.[15] This may in part be due to different standards for treatment completion between outpatient and residential treatment. As expected, the median length of stay in most treatment settings was much shorter for non-completers compared to completers however non-completers did stay in NTP detoxification more than twice as long as did completers (118 days vs. 21 days) (Figure 2.13).

Analysis of retention by treatment discharge status (Figure 2.14) showed that most completers (85.6%) had 90 or more days of treatment. Among non-completers, 36.6% also had 90 or more days of treatment but another 32.4% were "early dropouts," meaning these offenders left treatment within 30 days of treatment entry. Characteristics of the "early dropout" group are presented in the next section. When discharged from treatment, most Prop 36 treatment non-completers were making unsatisfactory progress (82.0%) but a significant percentage (18.0%) was assessed as making satisfactory progress (data not shown).

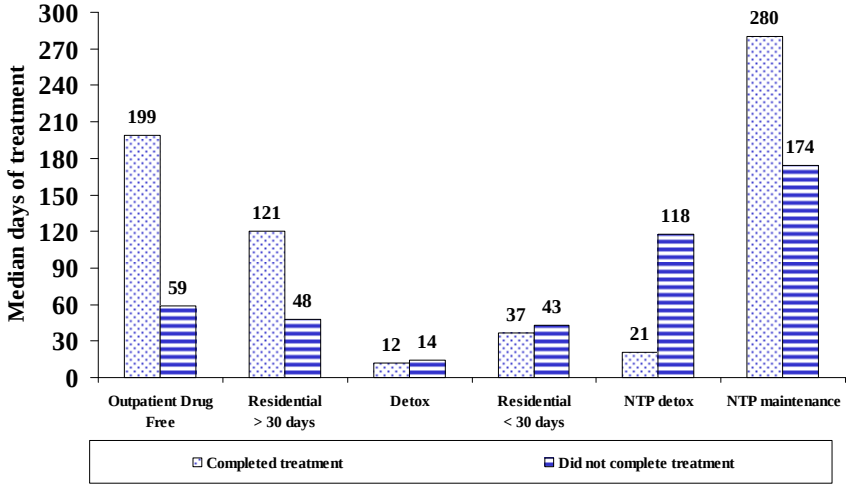
Figure 2.12
Modality by Treatment Discharge Status
CalOMS (N = 38,832)



Data Source: CalOMS data on unique Prop 36 clients who had a treatment episode that ended between July 1, 2007 and June 30, 2008.

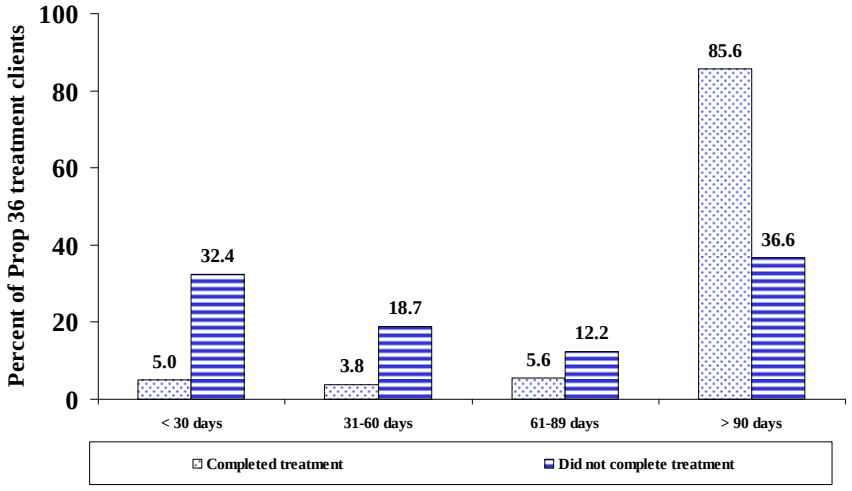
[15] During an episode of treatment, it is possible for a client to have been admitted into one service type and discharged from a different service type. For example, an individual could have been admitted to detoxification only and then transferred to and eventually discharged from outpatient drug free. For the data shown in Figures 2.12 and 2.13, if an individual received more than one service type, the first service type that was received is indicated.

Figure 2.13
Median Length of Stay in Treatment
Among Prop 36 Clients by Treatment Discharge Status
CalOMS (N = 38,832)



Data Source: CalOMS data on unique Prop 36 clients who had a treatment episode that ended between July 1, 2007 and June 30, 2008.

Figure 2.14
Retention by Treatment Discharge Status
CalOMS (N = 38,832)



Data Source: CalOMS data on unique Prop 36 clients who had a treatment episode that ended between July 1, 2007 and June 30, 2008.

Reasons and Consequences for Treatment Non-Completion

One recent study reported that, among a sample of Prop 36 offenders, the two most commonly reported reasons for treatment dropout, as reported by offenders, included low motivation for treatment (46.2%) and the difficulty of the Proposition 36 program given both its probation/parole and treatment demands (20.0%). The study also reported that consequences for treatment dropout included incarceration (25.3%) and permission to try treatment again (24.0%) (Evans et al., 2008).

Treatment programs that responded to UCLA's Prop 36 Treatment Program Survey (N=63 of 101, or 62.4% response rate; see Appendix B for more details) were asked to rate the extent to which listed reasons explained why some Prop 36 clients entered treatment but did not go on to actually complete it. Possible responses to the question reflected a 0 to 3 scale, with 0 equal to "Not at all," 1 equal to "Limited extent," 2 equal to "Moderate extent," and 3 equal to "Great extent." When the mean score for each reason was calculated, the primary reason for Prop 36 treatment non-completion, from the perspective of treatment providers, was relapse or an inability to stop using, followed by low motivation for treatment, weak social support, low self-esteem, and violation or probation or parole (Table 2.3). Reasons that treatment programs reported as least responsible for treatment non-completion included external pressure from employer, dislike of treatment facility, inability to pay the Prop 36 fees, dislike of treatment program therapeutic approach, and external pressure from family and/or friends.

Treatment programs were also surveyed about mechanisms to identify Prop 36 clients at greater risk for treatment non-completion and whether strategies were in place to reduce the number of treatment non-completers. Just over one-third of programs (37.1%) that responded to the survey indicated that procedures were used to identify an "at risk for treatment non-completion" Prop 36 client and 46.6% of treatment programs indicated using strategies to reduce the proportion of treatment non-completers (data not shown).

Survey data also indicated that in FY 2007-08, most treatment programs placed Prop 36 clients who were unmotivated for treatment into specialized group sessions to increase level of motivation (76.7%), and other programs formally assessed Prop 36 client readiness for change and for treatment (41.8%) (for example, using the SOCRATES or URICA assessments[16]). More than one-third of programs utilized Motivational Enhancement Therapy (MET) with Prop 36 clients (37.3%) and about half of these also used the MET fidelity measures (18.8%). Few programs used coupons or gift certificates as motivational incentives (for example, for clean urines, treatment compliance) (11.7%), and very few programs utilized formal Contingency Management[17] strategies with Prop 36 clients (5.2%). Data are shown in Table 2.4.

[16] "SOCRATES" or Stages of Change Readiness and Treatment Eagerness Scale and 'URICA" or University of Rhode Island Change Assessment.

[17] Contingency Management strategies involve systematic delivery of punishment or rewards, often in the form of vouchers for goods or services, based on outcomes such as abstinence, clinic attendance, and completion of non-drug related activities.

Table 2.3 Treatment Provider Cited Reasons for Non-Completion of Treatment by Prop 36 Clients
(N=63 treatment programs)

Reason	*Mean Score (0-3 scale)*
Relapse or inability to stop using	2.10
Low motivation for treatment	1.98
Weak social support	1.77
Low self-esteem or believe they cannot complete treatment	1.52
Probation/parole violation	1.50
Clients think Prop 36 treatment is too strict or controlling	1.48
Believe they do not have a drug problem or need treatment	1.47
Inability to access needed services	1.45
Clients think Prop 36 treatment is too long	1.38
Work schedules conflict with treatment requirements	1.19
Assigned to a level of care that does not meet needs	1.17
Incarceration	1.10
Mental health illness/crisis	1.05
Arrest or conviction on a non-Prop 36 eligible charge	1.02
No desire to pay the Prop 36 fees	1.00
Medical illness/emergency	1.00
Dislike of treatment program services	0.97
Dislike of treatment program staff	0.82
External pressure from family and/or friends	0.74
Dislike of treatment program therapeutic approach	0.73
Inability to pay the Prop 36 fees	0.69
Dislike of treatment facility	0.56
External pressure from employer	0.48
Data Source: Prop 36 Treatment Program Survey	

Table 2.4 Strategies to Enhance Prop 36 Treatment Retention and Completion
(N=63 treatment programs)

	%
Group sessions for unmotivated clients	76.7
Assessment of readiness for change/treatment	41.8
Motivational Enhancement Therapy (MET)	37.3
MET fidelity measures	18.8
Coupons/gift certificates as motivational incentives	11.7
Contingency Management (CM)	5.2
Data Source: Prop 36 Treatment Program Survey	

The Prop 36 Treatment Program Survey (see Appendix B for more details) asked treatment programs to indicate whether Prop 36 treatment completion rates at their program would improve if clients received strategies that were listed. As shown in Table 2.5, most programs indicated that treatment completion rates would be improved by a range of strategies including social support from clients' family and friends (91.8%), help with housing or a stable living environment (91.7%), employment assistance (80.3%), use of motivational enhancement therapy (79.7%), incentives to reward positive behavior (76.7%), access to transportation (76.7%), and brief jail stays for continued noncompliance (71.0%).

Table 2.5 Treatment Provider Cited Strategies for Improving Prop 36 Treatment Completion Rates
(N=63 treatment programs)

	% Yes
Social support from family and friends	91.8
Help with housing or a stable living environment	91.7
Employment/vocational assistance, or job placement	80.3
Motivational enhancement therapy strategies	79.7
Incentives to reward positive behavior (contingency management)	76.7
Access to transportation	76.7
Brief jail stays for continued noncompliance	71.0
Regular verbal praise or reprimand from the judge	68.3
More staff contact	68.3
More intensive treatment	61.3
More oversight/supervision from probation or parole	55.7
Smaller caseloads	53.3
Better trained staff	50.0
Data Source: Prop 36 Treatment Program Survey	

Treatment outcome measures

Results for treatment outcome measures appear in Table 2.6. From treatment intake to discharge fewer Prop 36 individuals in both the treatment completer and non-completer groups used their primary drug or interacted with the criminal justice system, however improvements were greater among the treatment completer group. Similar patterns were evident from intake to discharge in rates of family conflict, employment, and social support.

Table 2.6 Treatment Outcome Measures
Among Prop 36 Treatment Completers and Non-completers

	Completers (N=15,786)			Non-completers (N=7,335)		
	Intake	Disch	Diff	Intake	Disch	Diff
Past 30 days, %						
Used primary drug	46.1	10.8	-35.3	56.6	40.5	-16.1
Any criminal justice activity (any arrests, jail or prison days)	31.2	3.2	-28.0	37.5	13.8	-23.7
Living arrangement						
Homeless	11.7	8.7	-3.0	11.8	12.0	0.2
Dependent living	42.8	38.2	-4.6	48.2	46.9	-1.3
Independent living	45.5	53.2	7.7	40.0	41.1	1.1
Employed (full- or part-time)	35.0	49.5	14.5	31.3	32.4	1.4
Social support						
None	52.2	18.5	-33.7	61.1	52.1	-9.0
Some	38.8	55.4	16.6	33.9	37.5	3.6
Daily	9.0	26.1	17.1	5.0	10.4	5.4
Any	47.8	81.5	33.7	38.9	47.9	9.0
Family conflict	6.6	3.5	-3.1	9.4	7.6	-1.8

Data Source: CalOMS data on unique Prop 36 clients who had a treatment episode that ended between July 1, 2007 and June 30, 2008.

Prop 36 Early Treatment Dropouts

Some literature indicates that early treatment non-compliers are distinguishable from other types of treatment dropouts (De Weert-Van Oene et al., 2001; Stevens et al., 2008). Analysis of "early" Prop 36 treatment dropouts is needed so that treatment engagement strategies might be better targeted toward retaining these offenders in treatment for a sufficient period to initiate recovery.

About one-third (32.4%) of the Prop 36 treatment non-completer group was an early treatment dropout (see Figure 2.14). As shown in Table 2.7, Prop 36 early treatment dropouts were distinguishable from other treatment non-completers by several characteristics at treatment entry. Prop 36 early treatment dropouts were slightly younger (34.8 vs. 35.1 years), fewer were White (36.2% vs. 40.1%), early treatment dropouts had less years of education, more were referred to Prop 36 by parole (23.3% vs. 18.6%), fewer were employed (26.8% vs. 32.0%), more were homeless (13.8% vs. 9.9%), more had used their primary drug just prior to treatment entry (60.1% vs. 53.8%), more received long-term residential treatment (11.6% vs. 8.4%), and fewer were making satisfactory progress at discharge (13.2% vs. 20.3%).

In general, the characteristics that distinguished early dropouts were similar to the characteristics that differentiated all treatment non-completers from treatment completers, however more early treatment dropouts were homeless at treatment entry.

Table 2.7 Characteristics of Prop 36 Early Treatment Dropouts and Other Prop 36 Treatment Non-Completers

	Early Treatment Dropouts (Treatment retention ≤30 days) (N=7,472)	Other Treatment Non-Completers (Treatment retention >30 days) (N=15,561)
Age, Mean (SD)	34.8 (10.6)	35.1 (10.6)
Race,%		
White	36.2	40.1
Hispanic	39.1	36.3
African American	16.6	15.1
Asian/Pacific Islander	3.1	3.3
Amer. Indian/Alaskan Native	1.2	1.4
Other	3.8	3.7
Women, %	26.5	26.5
Education, %		
Less than High School	42.7	40.0
High School	43.4	44.3
Some college/college grad	13.8	16.0
Referred by, %		
Probation	76.7	81.4
Parole	23.3	18.6
Employment status, %		
Full- or part-time	26.8	32.0
Full-time	15.8	20.5
Part-time	11.0	11.5
Unemployed	61.2	56.4
Not in labor force	12.0	11.6
Primary drug, %		
Methamphetamine	52.0	53.5
Cocaine	15.8	13.9
Marijuana	14.3	15.5
Alcohol	8.4	7.6
Heroin	8.3	8.6
Other	1.2	1.0
Age at first use of primary drug, Mean (SD)	20.4 (8.2)	20.6 (8.3)
Prior alcohol or drug treatment, %	48.1	48.0
No. of prior treatment admits, Mean (SD)	2.2 (3.2)	2.2 (3.3)
Other characteristics, %		
Homeless	13.8	9.9

Table 2.7 Characteristics of Prop 36 Early Treatment Dropouts and Other Prop 36 Treatment Non-Completers		
Pregnant	4.9	4.8
Tuberculosis	2.6	2.3
Hepatitis C	6.2	5.8
Sexually Transmitted Diseases (STD)	2.9	2.9
Ever diagnosed with mental health illness	16.3	15.6
Has children under 18 years	47.3	47.1
In past 30 days, %		
Used primary drug	60.1	53.8
Arrested	26.6	24.8
In jail	32.0	30.3
In prison	4.2	3.9
Had medical problems	15.2	14.8
Used a needle	8.4	6.8
Had ER visit (medical problems)	6.0	5.8
Had ER visit (psychiatric problems)	1.8	1.8
Took psychiatric medication	9.1	9.2
Had family conflict	8.7	8.1
Waited to enter treatment, %	31.5	29.8
Days waited to enter treatment, Mean (SD)	11.3 (16.9)	11.6 (16.6)
Modality, %		
Outpatient	84.9	88.6
Residential < 30 days	0.8	0.6
Residential $\geq$ 30 days	11.6	8.4
Detox	2.2	0.7
NTP detox	0.2	0.4
NTP maintenance	0.3	1.3
Discharge status, %		
Satisfactory progress	13.2	20.3
Unsatisfactory progress	86.8	79.7
Data Source: CalOMS data on unique Prop 36 clients who did not complete treatment between July 1, 2007 and June 30, 2008.		

Treatment outcome measures

Results for treatment outcome measures appear in Table 2.8. From treatment intake to discharge fewer Prop 36 individuals in both the early treatment dropout and other dropout groups used their primary drug or interacted with the criminal justice system, however improvements were not as great among the early treatment dropout group. For both groups, the percentage of offenders who became homeless increased slightly from treatment intake to discharge. Fewer early dropouts but more other dropouts became

employed by treatment discharge. For both groups, there were increases in social support and decreases in family conflict from intake to discharge.

Table 2.8 Treatment Outcome Measures
Among Prop 36 Early Treatment Dropouts and Other Prop 36 Treatment Non-Completers

	Early dropouts (N=2,282)			Other dropouts (N=5,050)		
	Intake	Disch	Diff	Intake	Disch	Diff
Past 30 days, %						
Used primary drug	61.5	48.9	-12.6	54.3	36.7	-16.1
Any criminal justice activity (any arrests, jail or prison days)	40.1	21.3	-18.8	36.3	10.4	-23.7
Living arrangement						
Homeless	14.9	15.0	0.1	10.4	10.6	0.2
Dependent living	48.9	47.5	-1.4	47.8	46.7	-1.3
Independent living	36.2	37.5	1.3	41.7	42.8	1.1
Employed (full- or part-time)	26.1	25.4	-0.7	33.2	35.5	1.4
Social support						
None	63.5	56.4	-7.1	60.0	50.2	-9.0
Some	31.7	38.4	6.7	34.9	37.1	3.6
Daily	4.8	5.3	0.5	5.1	12.8	5.4
Any	36.6	43.7	7.1	40.0	49.8	9.0
Family conflict	10.0	7.5	-2.5	9.1	7.6	-1.8

Data Source: CalOMS data on unique Prop 36 clients who did not complete treatment between July 1, 2007 and June 30, 2008.

Treatment Re-entry

Of Prop 36 offenders who were discharged during FY 2006-07 (N=38,867), 22.6% had another episode of treatment over the following 12 months. Table 2.9 shows the percentage of Prop 36 offenders with another episode of treatment by whether their FY 2006-07 discharge record indicated treatment completion or non-completion. (Information by referral source is provided in Appendix 2.4.) Some treatment completers and non-completers had more episodes of treatment over 12 months, however about twice as many non-completers (28.9%) had episodes of treatment than completers (11.8%), perhaps utilizing provisions of Prop 36 to encourage re-engagement with treatment. The mean number of days between first discharge and next treatment episode was 148 for completers and 131 for non-completers. Over the 12 months following treatment discharge, completers had a total of 1.1 treatment episodes and non-completers had 1.2 episodes. The mean number of days in treatment across all episodes examined was 122.5 for completers and 120.6 for non-completers. When the status of the last discharge record on file was examined, 37.8% of non-completers and 54.1% of completers went on to complete treatment, and 62.2% of non-completers and 45.9% of completers went on to not complete treatment.

Table 2.9 Episodes of Treatment among Prop 36 Offenders Over 12 Months Following Prior Treatment Discharge[18]

	Prior treatment discharge status was…		
	Completed (N=14,483)	Did not complete (N=24,384)	Total (N=38,867)
Had another treatment episode which occurred within			
3 months of prior discharge, %	4.3	12.9	9.7
6 months of prior discharge, %	7.8	21.4	16.4
9 months of prior discharge, %	10.1	26.0	20.1
12 months of prior discharge, %	11.8	28.9	22.6
No. of days between prior discharge and next treatment episode, mean (SD)	148.4 (98.1)	131.3 (89.6)	134.7 (91.6)
No. of treatment episodes following prior discharge, mean	1.1	1.2	1.2
No. of days in treatment across all treatment episodes, mean (SD)	122.5 (101.6)	120.6 (106.8)	121.0 (105.8)
Status of last discharge on record indicated, %			
Treatment completion	54.1	37.8	41.0
Treatment non-completion	45.9	62.2	59.0

Note: Some records were omitted from analysis because (a) the episode number was missing from CalOMS or (b) treatment entry occurred <30 days from prior discharge.

Tracking and disentangling multiple episodes of care is a complex process. One limitation of this analysis is that it includes only those individuals who had data in CalOMS that indicated a "new" episode of treatment, meaning there was both a treatment admission and discharge record on file and the admission date for the new episode was >30 days from the date of the prior discharge date. An implication of this limitation is that the percentage of Prop 36 offenders who re-entered treatment may be under-reported. Further examination, especially over a longer follow-up period than the available data allowed, is needed.

Summary

In Prop 36's seventh year, as in earlier years, most offenders were placed into outpatient drug-free treatment (84.1%) and relatively few were placed in other types of care. Treatment placement patterns were the same regardless of primary drug type and, as was true in earlier years of the program, most heroin/opiate users did not receive narcotic treatment therapy. About one-third of (30.5%) of Prop 36 offenders were reported as having to wait to enter treatment and the mean number of waiting days was 12.7. The percentage of Prop 36 offenders who waited for treatment and the average number of days waited varied by treatment modality.

[18] Data Source: CalOMS data on unique Prop 36 clients who had a treatment episode that ended between July 1, 2006 and June 30, 2007.

The Prop 36 treatment completion rate reached a notable high of 40.7% of those discharged from treatment in the program's seventh year. In addition to more people completing treatment, several other possible reasons may explain changes in treatment completion rates over time including the recent transition to a new drug treatment data system and changes in the methodology for calculating completion rates. Treatment completion rates were higher among Prop 36 probationers (43.3%) than among Prop 36 parolees (27.7%). Variation in Prop 36 treatment completion rates was evident by county and variation may be partly attributable to differences in the characteristics of counties and the type of Prop 36 client being treated.

More than half of Prop 36 treatment clients did not complete treatment (59.3%). Compared to treatment completers, non-completers were more likely to be African American and less likely to be White, non-completers had a lower education level, more were referred to treatment by parole, more were not working, fewer reported methamphetamine as the primary drug problem, more had used their primary drug, and more had been arrested or incarcerated in jail prior to treatment entry. No differences were found between Prop 36 treatment completers and non-completers in measures of mental illness, but these measures are likely impacted by the common problem of under-reporting of mental illness within drug treatment data systems. Chapter 7 provides information on mental illness and the Prop 36 population that is based on analysis of data from multiple sources. More non-completers than completers were treated in an outpatient setting and fewer were treated in a long-term residential setting. At discharge, few non-completers were making satisfactory progress in treatment.

About one-third of the Prop 36 treatment non-completer group was an early treatment dropout, meaning left treatment within 30 days of treatment entry. In general, the characteristics that distinguished early treatment dropouts were similar to the characteristics that differentiated all treatment non-completers from treatment completers, however more early treatment dropouts were homeless at treatment entry.

Outcome measures showed that from treatment intake to discharge fewer Prop 36 offenders used their primary drug or interacted with the criminal justice system, however improvements were greater among treatment completers than non-completers. Similar patterns were evident from intake to discharge in rates of family conflict, employment, and social support. Similarly, Prop 36 early treatment dropouts made smaller gains from treatment intake to discharge than other types of treatment dropouts.

Finally, of Prop 36 offenders who were discharged from treatment about 22.6% had another episode of treatment within the following 12 months. More treatment non-completers than completers had additional treatment, however, for both groups, when additional treatment did take place, it occurred about four to five months after discharge from the prior episode and the number of treatment episodes over 12 months was approximately one. The mean number of days in treatment across all episodes examined was about 120 for both completers and non-completers. The last discharge record on file indicated that 54.1% of completers and 37.8% of non-completers went on to complete treatment.

Conclusion

Treatment completion is a significant legal milestone under Prop 36 and more investigation is needed to determine factors that would facilitate formal completion of treatment. Existing research has identified several program factors related to treatment completion (Meier & Best, 2006). Treatment completion has been associated with being treated by more experienced counselors (Meier et al., 2006), positive relationships with program staff (Ball et al., 2006), receipt of psychiatric services (Marrero et al., 2005), and living near treatment (Beardsley et al., 2003). Similarly, longer drug treatment retention has been associated with early therapeutic alliance (De Weert-Van Oene, et al., 2001; Meier et al., 2006), a brief induction at treatment entry (Harrison et al., 2007), new treatment protocols (Helmus et al., 2001), and legal coercion (Perron & Bright, 2008). Motivational enhancement therapies are empirically supported and familiar to substance abuse treatment providers (Herbeck et al., 2008; Madson & Campbell, 2006; Martino et al., 2008) and, although they might be less effective with some settings or populations (Winhusen et al., 2007), they have been shown to improve treatment utilization and outcomes (McKee et al., 2007; Ondersma et al., 2005; Rohsenow et al., 2004) and are generally thought to be an "active ingredient" of effective drug treatment (Moos, 2007). Also, matching of treatment setting to drug use severity has been associated with improved outcomes (Tiet et al., 2007) and individuals at high risk of dropout have been found to be especially likely to dropout when treated in a highly controlling treatment setting (McKellar et al., 2006).

Prop 36 clients at risk for treatment non-completion, especially "early" treatment dropout, require special efforts and need to be identified and targeted for receiving treatment engagement and retention strategies. Although more research is needed, data indicate that there are associations between non-completion of Prop 36 treatment and particular client characteristics (e.g., on parole, African American, male, lower education level, not employed, user of more severe drug, recent arrest or incarceration in jail, prior drug treatment). County characteristics and program factors also impact treatment completion rates. Low motivation for treatment is one of the most common reasons treatment providers cited for non-completion of Prop 36 treatment and many Prop 36 treatment programs reported utilizing strategies to increase client motivation levels. However, few programs formally assess for motivation level and even fewer reported using evidence-based practices to enhance motivation level such as Motivational Enhancement Therapy and Contingency Management. Research is needed to identify practices and policies specific to Prop 36 that promote higher treatment completion rates.

As the drug treatment field moves toward a chronic care model, the concept of treatment "completion" itself becomes increasingly problematic. In a continuing care context, treatment re-entry (whether earlier treatment episodes were completed or not) signifies continued engagement and help-seeking behavior and thus would represent a positive outcome. However, treatment re-entry may be limited or not always allowed under Prop 36 time limits. Other questions are raised by the transition to a continuing care concept of drug treatment. For example, should the first or last treatment episode be used to determine final Prop 36 treatment status, or should all treatment events that occur in

between, and concurrently, also be considered? How should the "outcome" observation period be defined for program evaluation purposes? What role do treatment retention, individual-level functioning, and longer-term outcomes play in determining Prop 36 program success? A recent study of Prop 36 offenders found that one-third of treatment dropouts experienced successful outcomes (defined in the analysis as no arrest, no drug use and employed in prior month) one year after assessment for treatment (Evans et al., 2008). Continued dialogue is needed on whether to alter the Prop 36 law, and measures of its performance, to look beyond treatment discharge, in favor of other behavioral and pro-social measures that may be more compatible with a continuing care framework. Currently UCLA is working with stakeholders to address these issues, and these efforts may lead to changes and improvements in the ways that Prop 36 practices, performance, and outcomes are reported in the future.

References

American Methadone Treatment Association, Inc. (2004). *Fact sheet: Why methadone treatment works*. American Association for the Treatment of Opioid Dependence. Accessed at: www.aatod.org/factsheet1_print.htm.

Anglin, M.D., & Hser, Y.-I. (1990). Treatment of drug abuse. In Tonry, M. & Wilson, Q. (Eds.), *Drugs and crime*. Chicago: The University of Chicago Press.

Ball, S. A., Carroll, K. M., Canning-Ball, M., & Rounsaville, B. J. (2006). Reasons for dropout from drug abuse treatment: Symptoms, personality, and motivation. *Addictive Behaviors*, *2*, 320-330.

Beardsley, K., Wish, E. D., Fitzelle, D. B., O'Grady, K., & Arria, A. M. (2003). Distance traveled to outpatient drug treatment and client retention. *Journal of Substance Abuse Treatment, 4,* 279-285.

De Leon, G. (1991). Retention in drug-free therapeutic communities. In Pickens, R.W., Leukefeld, C.G., & C.R. Schuster (Eds.), *Improving drug abuse treatment. NIDA research monograph 106* (DHHS Publication No. ADM 91-1754). Rockville, MD: National Institute on Drug Abuse. Accessed at: www.nida.nih.gov/pdf/monographs/download106.html.

De Weert-Van Oene, G. H., Schippers, G. M., De Jong, C. A., & Schrijvers, G. J. (2001). Retention in substance dependence treatment: The relevance of in-treatment factors. *Journal of Substance Abuse Treatment*, *20*, 253-261.

Evans, E., Li, L., & Hser, Y.I. (2008). Client and program factors associated with dropout from court mandated drug treatment. *Evaluation and Program Planning.*

Gerstein, D., Dean, R., Johnson, R., Foote, M., Suter, N., Jack, K., Merker, G., Turner, S., Bailey, R., Malloy, K., Williams, E., Harwood, H. & Fountain, D. (1994). *Evaluating Recovery Services: The California drug and alcohol treatment assessment (CALDATA) methodology report*. Sacramento, CA: California Department of Alcohol and Drug Programs.

Government Accountability Office. (2005). *Adult Drug Courts: Evidence Indicates Recidivism Reductions and Mixed Results for Other Outcomes*, Government Accountability Office. Accessed at http://www.gao.gov/new.items/d05219.pdf.

Harrison, S. R., Toriello, P., Pavluck, A., Ellis, R., Pedersen, E., Gaiennie, R., et al. (2007). The impact of a brief induction on short-term continuation in a therapeutic community. *The American Journal of Drug and Alcohol Abuse*, *33*, 147-153.

Helmus, T. C., Downey, K. K., Arfken, C. L., Henderson, M. J., & Schuster, C. R. (2001). Novelty seeking as a predictor of treatment retention for heroin dependent cocaine users. *Drug and Alcohol Dependence*, *61*(3), 287-295.

Herbeck, D. M., Hser, Y. I., & Teruya, C. (2008). Empirically supported substance abuse treatment approaches: A survey of treatment providers' perspectives and practices. *Addictive Behaviors*, *33*, 699-712.

Hser, Y.-I., Evans, E., Teruya, C., Hardy, M., Ettner, S., Urada, D., Huang, D., Picazo, R., Shen, H., Hseih, J., Anglin, M. D. (2003). *The California Treatment Outcome Project (CalTOP) final report*. Los Angeles, CA: UCLA Integrated Substance Abuse Programs. Accessed at: www.uclaisap.org/caltop/index.htm.

Hubbard, R.L., Marsden, M.E., Rachal, J.V., Harwood, H.J., Cavanaugh, E.R., & Ginzburg, H.M. (1989). *Drug abuse treatment: A national study of effectiveness*. Chapel Hill, North Carolina: University of North Carolina Press.

Hubbard, R.L., Craddock, S.G., Flynn, P.M., Anderson, J., & Etheridge, R.M. (1997). Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11,* 261-278.

Madson, M. B., & Campbell, T. C. (2006). Measures of fidelity in motivational enhancement: A systematic review. *Journal of Substance Abuse Treatment*, *31*, 67-73.

Marrero, C. A., Robles, R. R., Colón, H. M., Reyes, J. C., Matos, T. D., Sahai, H., et al. (2005). Factors associated with drug treatment dropout among injection drug users in Puerto Rico. *Addictive Behaviors*, *30*, 397-402.

Martino, S., Ball, S. A., Charla, N., Frankorter, T. L., & Carroll, K. M. (2008). Community program therapist adherence and competence in motivational enhancement therapy. *Drug and Alcohol Dependence.* [Epub ahead of print]

Mathias, R. (1997). NIH panel calls for expanded methadone treatment for heroin addiction. *NIDA Notes*, *12.* Accessed at: www.drugabuse.gov/NIDA_Notes/NNVol12N6/NIHPanel.html.

McKee, S. A., Carroll, K. M., Sinha, R., Robinson, J. E., Nich, C., Cavallo, D., et al. (2007). Enhancing brief cognitive-behavioral therapy with motivational enhancement techniques in cocaine users. *Drug and Alcohol Dependence*, *91*, 97-101.

McKellar, J., Kelly, J., Harris, A., & Moos, R. (2006). Pretreatment and during treatment risk factors for dropout among patients with substance use disorders. *Addictive Behaviors*, *31*, 450-460.

Meier, P. S., & Best, D. (2006). Programme factors that influence completion of residential treatment. *Drug and Alcohol Review*, 25, 349-355

Meier, P. S., Donmall, M. C., McElduff, P., Barrowclough, C., & Heller, R. F. (2006). The role of the early therapeutic alliance in predicting drug treatment dropout. *Drug and Alcohol Dependence*, *83*, 57-64.

Moos, R. H. (2007). Theory-based active ingredients of effective treatments for substance use disorders. *Drug and Alcohol Dependence*, *88*, 109-121.

National Institute on Drug Abuse (1999). *Principles of drug addiction treatment* (NIH Publication No. 99-4180). Washington DC: National Institutes of Health. Accessed at: www.nida.nih.gov/PODAT/PODATindex.html.

National Institutes of Health Consensus Conference (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association, 280*, 1936-1943. Retrieved on April 9, 2004, from www.odp.od.nih.gov/consensus/cons/108/108_intro.htm.Retrieved on April 9, 2004, from www.odp.od.nih.gov/consensus/cons/108/108_intro.htm.

Ondersma, S. J., Chase, S. K., Svikis, D. S., & Schuster, C. R. (2005). Computer-based brief motivational intervention for prenatal drug use. *Journal of Substance Abuse Treatment*, *28*, 305-312.

Perron, B., & Bright, C. (2008). The influence of legal coercion on treatment retention in substance abuse treatment. *Drug and Alcohol Dependence, 92*(1-3), 123-131.

Rohsenow, D. J., Monti, P. M., Martin, R. A., Colby, S. M., Myers, M. G., Gulliver, S. B., et al. (2004). Motivational enhancement and coping skills training for cocaine abusers: Effect on substance use outcomes. *Society for the Study of Addiction*, *99*, 862-874.

SAMHSA (2004). *Treatment Episode Data Set (TEDS) – 2004 discharges from Substance Abuse Treatment services.* Retrieved May 13, 2008, from http://www.oas.samhsa.gov/TEDSdischarges/2k4/tedsd2k4toc.cfm.

Simpson, D.D. (1979). The relation of time spent in drug abuse treatment to post-treatment outcome. *American Journal of Psychiatry, 136,* 1449-1453.

Simpson, D., Joe, G.W., & Brown, B.S. (1997). Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11,* 294-307.

Stevens, A., Radcliffe, P., Sanders, M., & Hunt, N. (2008). Early exit: Estimating and explaining early exit from drug treatment. *Harm Reduction Journal*, *5*(13). [Epub ahead of print]

Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2002). *Treatment Episode Data Set (TEDS): 1992-2000. National admissions to substance abuse treatment services* (Publication No. SMA 02-3727). Rockville, MD: Department of Health and Human Services. Accessed at: www.dasis.samhsa.gov/teds00/TEDS_2k_index.htm.

Tiet, Q. Q., Ilgen, M. A., Byrnes, H. F., Harris, A. H., & Finney, J. W. (2007). Treatment setting and baseline substance use severity interact to predict patients' outcomes. *Addiction*, *102*, 432-440.

TOPPS II Interstate Cooperative Study Group (2003). Drug treatment completion and post-discharge employment in the TOPPS-II Interstate Cooperative Study. *Journal of Substance Abuse Treatment, 25,* 9-18.

UCLA Integrated Substance Abuse Programs (ISAP) (2006). *Evaluation of the Substance Abuse and Crime Prevention Act: 2005 Report.* (Prepared for the California Department of Alcohol and Drug Programs). Los Angeles, CA: Author.

UCLA Integrated Substance Abuse Programs (ISAP) (2008). *Evaluation of the Substance Abuse and Crime Prevention Act: 2008 Report.* (Prepared for the California Department of Alcohol and Drug Programs). Los Angeles, CA: Author.

Urada, D., & Gonzales, R. (2008). Performance Monitoring & Outcome Measurement in Drug Treatment Systems. In: *Evaluation of the Substance Abuse and Crime Prevention Act 2008 Report*. 231-264.

Winhusen, T., Kropp, F., Babcock, D., Hague, D., Erickson, S. J., Renz, C., et al. (2007). Motivational enhancement therapy to improve treatment utilization and outcome in pregnant substance users. *Journal of Substance Abuse Treatment*, 35, 161-173.

Zhang, Z., Friedmann, P. D., & Gerstein, D. R. (2003). Does retention matter? Treatment duration and improvement in drug use. *Addiction*, *5*, 673-684.

Chapter 3: Gender Differences among Prop 36 Clients

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There is a substantial amount of research on gender differences among substance abuse treatment populations. However, relatively little is known about the effects of gender within the Prop 36 client population. Informed by Fiscal Year (FY) 2007-2008 CalOMS data on substance abuse treatment differences, this chapter compares the characteristics of Prop 36 women and men, examines differences in treatment experiences, and summarizes gender differences in selected Prop 36 treatment outcomes. As context, data on women and men referred to treatment by other non-Prop 36 mechanisms is also presented.

Women make up 27% of Prop 36 clients, in contrast to 32% of all non-Prop 36 criminal justice referrals and 41% of all non-criminal justice referrals. Prop 36 women are older and are less likely to have *young* children (5 years old and younger), than other women in treatment – 25.1% of Prop 36 women had young children compared to 34.6% of all other women in treatment. In contrast, men in Prop 36 were slightly more likely than men referred to treatment through other mechanisms to have *young* children (21.0% vs. 17.4%).

While a higher proportion of women compared to men reported their race/ethnicity as White (47.1% vs. 38.3%), a lower proportion of women compared to men reported their race/ethnicity as Hispanic (31.0% vs. 38.9%).

In the seventh year of Prop 36, women were much more likely not to be in the labor force (45.0%) compared to men (29.5%), and men were over twice as likely to be employed full time. Compared to Prop 36 men, Prop 36 women were about twice as likely to report having medical problems and receiving mental health and general health services (including Medi-Cal). However, Prop 36 women were much less likely than all other women in treatment to be Medi-Cal beneficiaries (25.0% vs. 44.4%).

The percent change of treatment outcomes for Prop 36 clients, by gender, from intake to discharge of treatment outcomes, including primary drug use within the past 30 days, arrests and incarcerations, living arrangements, employment, and social support indicators, were similar.

The underrepresentation of women in Prop 36, compared to other criminal justice treatment and non-criminal justice pathways to treatment may be related to the specific family obligations and treatment needs that women have, including child care, which was found to be provided by a minority of Prop 36 programs – only 17.5% of programs surveyed provided child care on-site. Future focus groups with women, including Hispanic women would provide a greater understanding of women's experiences in the Prop 36 program and identify potential treatment needs and barriers to treatment participation among this population.

Introduction

Approximately 10,000 women are referred to drug treatment through Prop 36 each year and women comprise approximately 27% of all Prop 36 treatment referrals (see Chapter 1). In comparison, women make up about 32% of all non-Prop 36 criminal justice treatment referrals and 41% of all non-criminal justice referrals. It is possible that women choose alternatives to Prop 36 treatment that are better suited to meeting women's needs (for example, family obligations), or women might experience difficulties or challenges in meeting the criteria for Prop 36 treatment.

To date there has been no comprehensive examination of potential gender differences in Prop 36 treatment experiences or longer-term post-treatment outcomes. Since Prop 36 has matured into an established sentencing law for drug offenders in California, understanding possible differences in the service needs, recovery processes, and outcomes of women compared to men offenders can help stakeholders appropriately modify the program to improve its effectiveness.

In this chapter, first we provide a brief review of the literature on gender differences among substance abuse treatment populations. Then we compare the characteristics of Prop 36 women and men who entered drug treatment during FY 2007-08. As context, the characteristics of women and men referred to substance abuse treatment through other mechanisms (that is "non-Prop 36 criminal justice" referrals and "non-criminal justice" referrals) during the same time-period are also described. All analyses utilize CalOMS treatment admission records. Finally, we conclude with a discussion of implications for policy and practice.

Background

Growing evidence suggests that substance abuse and attendant behaviors and attitudes differ for men and women. Women often enter treatment with more severe problems related to physical or sexual abuse histories, employment, drug use among partners or family members, child care responsibilities, and mental health disorders (Arfken, Klein, di Menza, & Schuster, 2001; Becker & Grilo, 2006; Brecht, O'Brien, von Mayrhauser, & Anglin, 2004; Hser, Evans & Huang, 2005; Marsh, Cao, & D'Aunno, 2004; Messina, Burdon, Hagopian, & Prendergast, 2006; Pelissier & Jones, 2005). Response to treatment has also been found to differ by gender. In particular, women are more likely to report a need for and receipt of mental health services than are men (Marsh et al., 2004). While actual differences may not be equivalent to self-reported differences, generally, women have been found to have greater problem recognition, less self-efficacy to remain abstinent in high-risk situations, and greater reliance on coping strategies of seeking support, accepting responsibility, and avoiding people or issues (Pelissier & Jones, 2006). Given these gender differences, treatment programs designed specifically to address women's unique needs and attitudes may be most beneficial (Ashley, Marsden, and Brady, 2003), yet women-specific programs are scarce and function within a male-oriented treatment system. In a review of literature on substance abuse treatment programming for women, Ashley, et al. (2003), concludes that there is evidence to

support that the following programming components may result in improved outcomes for women: (1) Child care, (2) Prenatal care, (3) Women-only admissions, (4) Supplemental services and workshops that address women-focused topics, (5) Mental health programming, and (6) Comprehensive programming. With some exceptions, few publicly-funded community-based treatment programs provide these components.

Research also indicates that men and women differ in their pathways to addiction and crime and these pathways affect accessibility and utilization of drug treatment (Adams, Leukefeld, & Peden, 2008; Bloom, Owen, & Covington, 2004). In a review of literature on gender responsive treatment, Grella (2008) summarizes data from the Office of Applied Studies, Substance Abuse and Mental Health Services Administration (OAS) that finds that a higher percentage of men tend to enter treatment through the criminal justice system compared to women, whereas women are much more likely to be referred to treatment through other community sources and agencies such as welfare or child welfare. Yet rising numbers of women in recent decades are also entering drug treatment through the criminal justice system, due to increasingly gender-neutral social control policies that are particularly strict on drug crime (Bloom et al., 2004). These policies have disproportionately impacted women negatively, especially poor women of color, and, because women are comparatively more likely to engage in drug-related crime, these policies account for a significant portion of the rise in the women's prison population (Bloom et al., 2004). However, compared to men, a higher proportion of women still enter treatment through non-criminal justice social services channels (Adams et al, 2008).

Despite studies documenting the special needs of drug-dependent women, with some exceptions (Arfken, Klein, di Menza, & Schuster, 2001), there appear to be few gender differences in treatment retention, completion rates, or post-treatment outcomes (Downey, Rosengren, & Donovan, 2003; Greenfield, Brooks, Gordon, Green, Kropp, McHugh, Lincoln, Hien, & Miele, 2006). Differences have appeared in some outcome areas, but post-treatment improvements in employment rates and income invariably remain smaller for women compared to men (Grella, Scott, & Foss, 2005; Oggins, Guydish, & Delucchi, 2001), and several studies have found that women make similar or greater post-treatment gains in most other domains, particularly in the areas of drug use and crime, even despite greater severity at treatment entry (Acharyya & Zhang, 2003; Hser, Evans & Huang, 2005; Marsh, Cao, & D'Aunno, 2004; Pelissier, Camp, Gaes, Saylor, & Rhodes, 2003). In sum, women who do manage to access treatment can achieve better outcomes than men despite a poorer pre-treatment prognosis.

Research on *predictors* of post-treatment outcomes of drug treatment has also revealed some gender differences (Green et al., 2002; Pelissier & Jones, 2005). Fiorentine, Anglin, Gil-Rivas, and Taylor (1997) found that although women demonstrated more risk factors in treatment research studies than men, their probability of relapse to drug use was equal or less than men's rate of relapse, and that this was predicted by heightened treatment engagement. As is generally acknowledged, regardless of gender, time in treatment and treatment completion are two of the best predictors of positive outcomes (Green et al., 2004; Messina, Burdon, Hagopian, & Prendergast, 2006; Messina, Wish, & Nemes, 2000). However, psychiatric disorders and victimization histories appear to have

a particularly negative impact on outcomes for women (Green et al., 2004; Greenfield et al., 2006). Yet neither single studies nor comprehensive assessments of large treatment systems have provided an unequivocal set of gender-specific predictors of treatment outcomes, underscoring the need for further research on gender variation in this area. Such research could reveal opportunities for tailoring treatment to meet the differential problems of men and women.

Because Prop 36 is routing a large and understudied population of women offenders to drug treatment, and information on gender differences in treatment outcomes is mixed, a thorough assessment of the characteristics, treatment experiences, and associated outcomes of Prop 36 participants by gender is critical.

Client Characteristics by Gender

In FY 2007-08, nearly 11,000 women entered treatment through Prop 36, accounting for 26.7% of all Prop 36 clients. In the same year, women accounted for 35.6% of admissions to treatment via all other referral sources (i.e., non-Prop 36 criminal justice and non-criminal justice referrals).

Mean age at admission was similar for men and women in Prop 36 – about 35.5 years old – however, Prop 36 women were slightly more likely than men to cluster in the early middle age group. As shown in Figure 3.1, a higher proportion of women were 36 to 45 years old than men (32.4% vs. 28.3%).

When comparing the age of Prop 36 women to that of women in treatment via other referral sources, differences in age were more striking—49.3% of Prop 36 women were aged 35 and younger, contrasted with 59.7% of all other women in treatment (Figure 3.1).

Figure 3.1
Distribution of Age
Among Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)

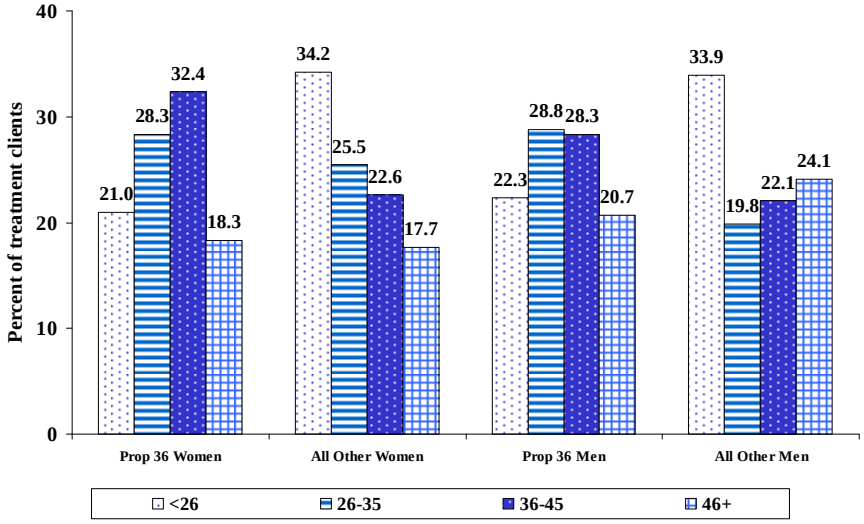


Figure 3.2 shows the race/ethnicity of Prop 36 clients and all other treatment clients by gender. Relative to Prop 36 men, Prop 36 women were more likely to be White (47.1% vs. 38.3%) and less likely to be Hispanic (31.0% vs. 38.9%). Participation in Prop 36 treatment by African Americans was comparable by gender. These patterns were similar among women and men entering treatment through all other referral sources.

Figure 3.2
Race/Ethnicity of Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)

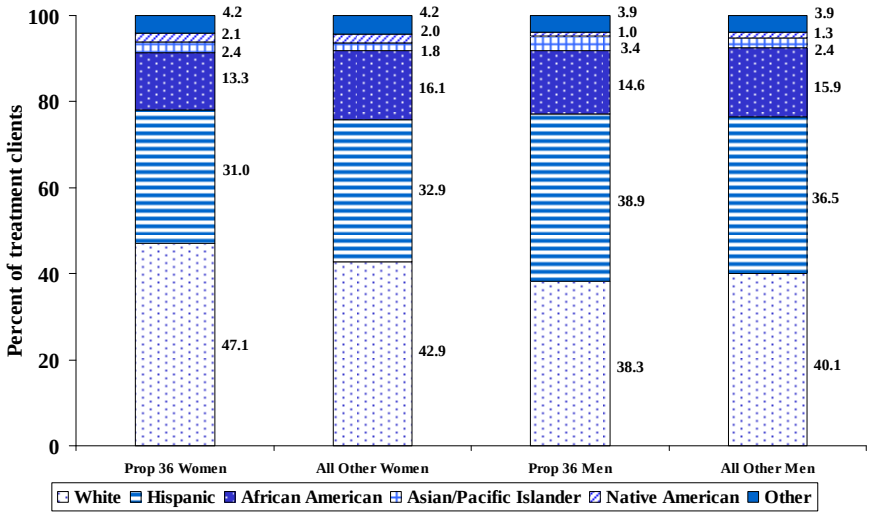
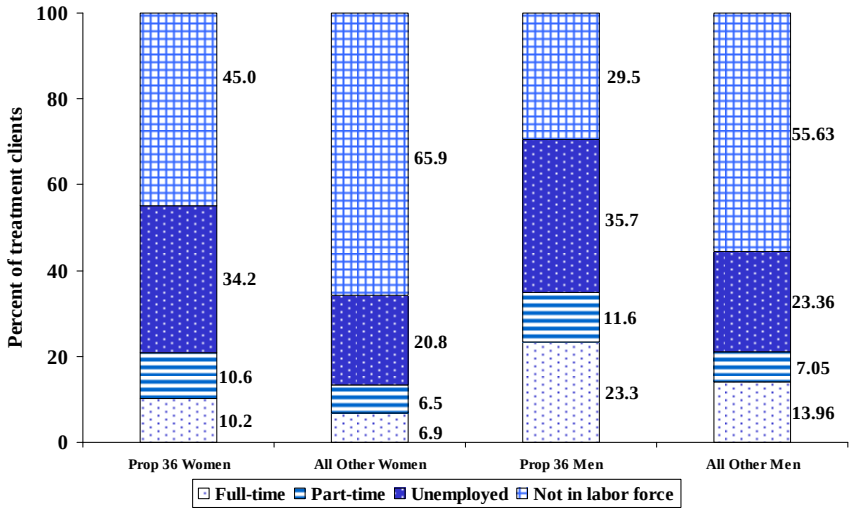
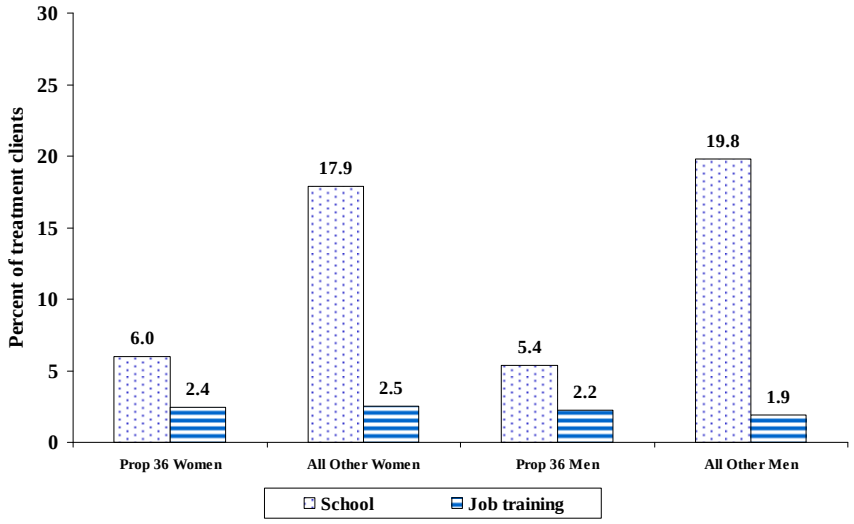


Figure 3.3
Employment Status
Among Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)



Gender differences in employment status at treatment admission are shown in Figure 3.3. Most Prop 36 clients of both genders were either unemployed or "not in the labor force" at treatment admission, however a greater proportion of women than men were not working (79.2% vs. 65.1%). Also, Prop 36 women were less likely than men to be employed (full- or part-time) in the 30 days prior to treatment admission (21.2% vs. 35.9%), and only about one in ten women had full time employment, compared to almost one-quarter of men. Despite these differences, compared to clients referred to treatment by other referral sources, Prop 36 clients were more likely to be employed at treatment intake.

Figure 3.4
Enrollment in School or Job Training
Among Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)



As shown in Figure 3.4, few Prop 36 women and men were enrolled in school prior to treatment entry (5-6%) and rates of school enrollment was much lower among Prop 36 referrals than among clients entering treatment by other referral sources. Very few clients (about 2%) in all of the groups examined reported enrollment in job training prior to treatment admission.

Regardless of gender and referral type, methamphetamine (meth) was the most commonly reported primary drug problem (Figure 3.5). Among Prop 36 referrals, a higher proportion of women compared to men reported meth as their primary drug problem (58.9% vs. 50.5%) and a lower proportion of women than men reported marijuana as their primary drug problem (9.5% vs. 16.2%). These differences by gender were similar to differences among clients referred to treatment by other sources.

Among Prop 36 offenders, there were no gender differences in years of use of primary drug (Figure 3.6). Over one-quarter of women and men in Prop 36 had used their primary drug for 21 or more years. Similar percentages of both genders had used their primary drug for each of the remaining years of use categories that were examined. In contrast, among clients referred to treatment through other mechanisms, a lower proportion of women than men had used their primary drug for 21 or more years (27.5% vs. 34.9%). On average, women and men in Prop 36 had used their primary drug for 14.5 years and 15.0 years, respectively (data not shown). However, larger gender differences were found between women and men referred by other referral sources, who, on average had 13.9 and 16.0 years of primary drug use, respectively (data not shown).

Figure 3.5
Primary Drug
Among Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)

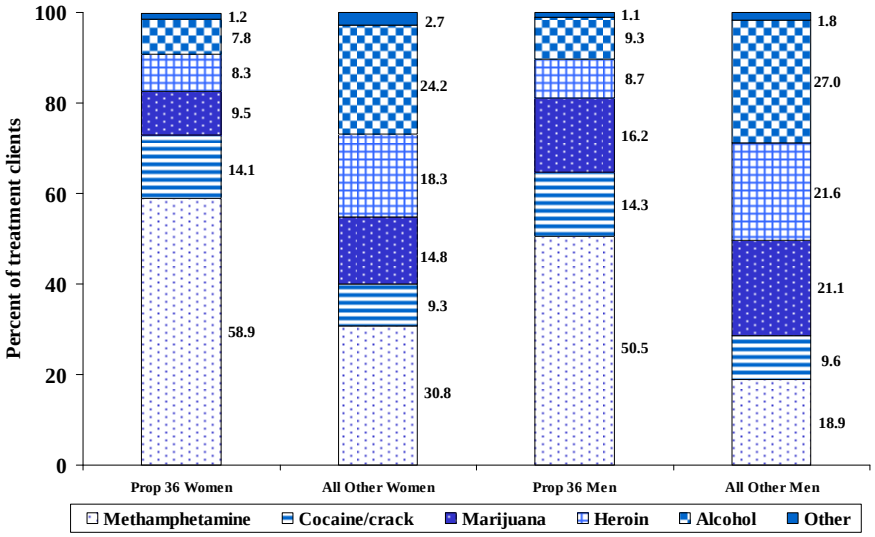
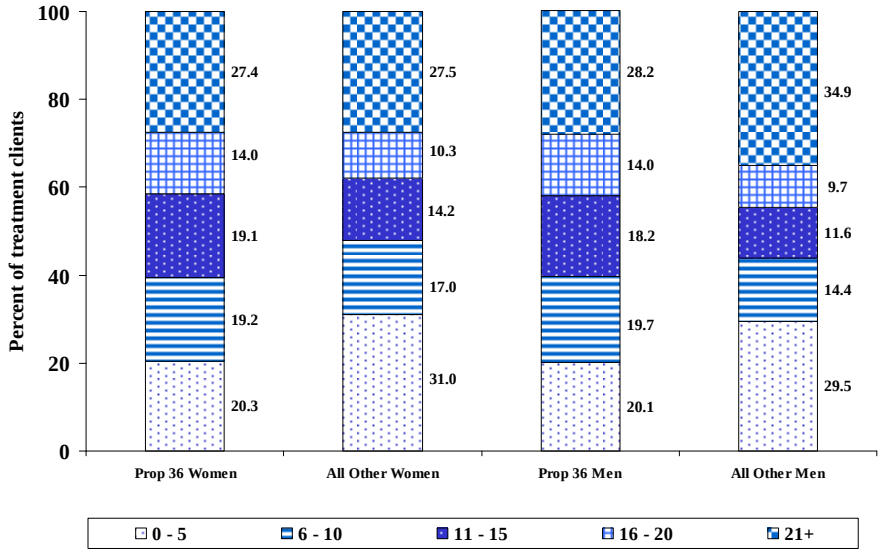


Figure 3.6
Years of Primary Drug Use
Among Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)



As shown in Figure 3.7, there were no gender differences among Prop 36 offenders with respect to their living arrangements. A minority of women and men were homeless (11.9% vs. 11.4%) and regardless of gender, most were living independently or dependently. Relatively few clients referred through the criminal justice system tend to report being homeless at treatment admission as most have been living in a controlled

environment prior to their admission to treatment. Living arrangement patterns were similar by gender among clients referred to treatment by other mechanisms.

Figure 3.7
Other Characteristics: Living Arrangements
Among Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)

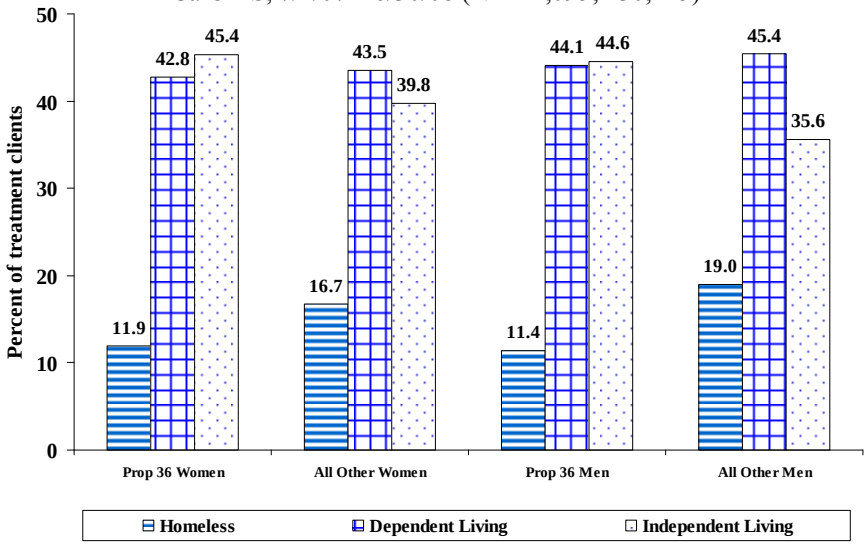


Figure 3.8
Other Characteristics: Veterans
Among Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)

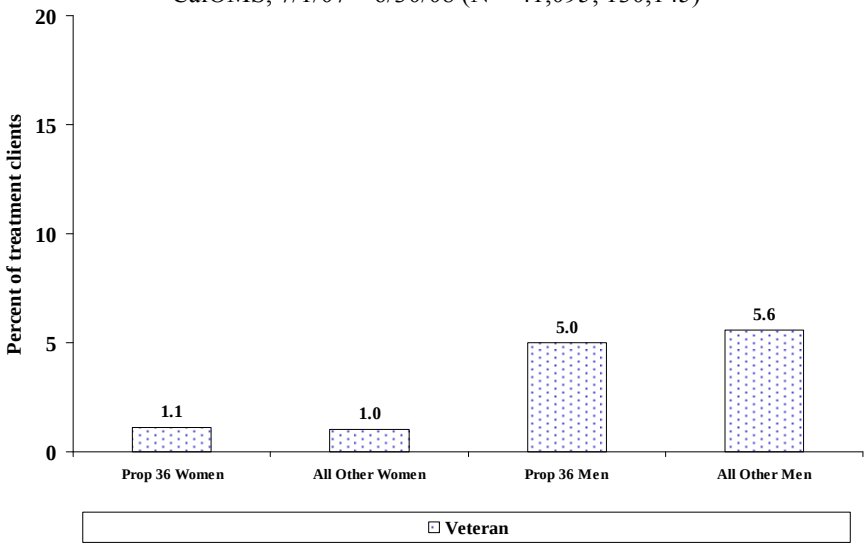


Figure 3.9
Other Characteristics: Disability
Among Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)

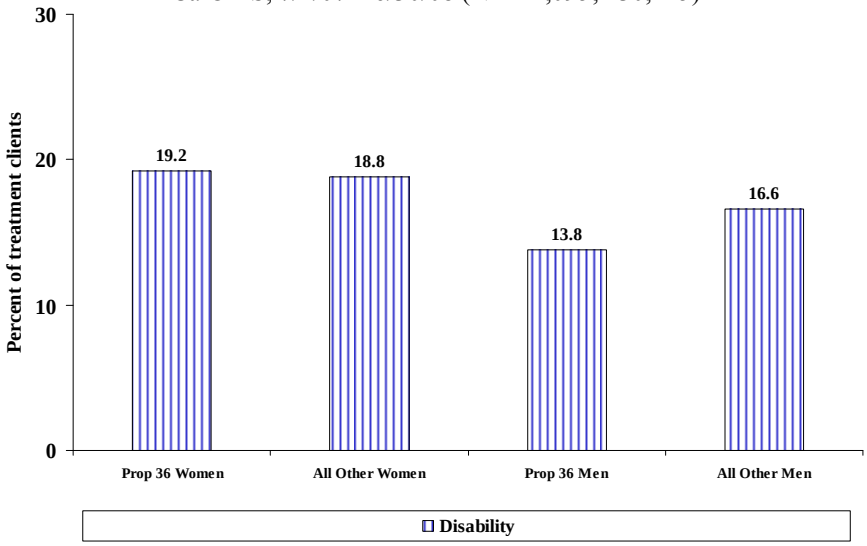
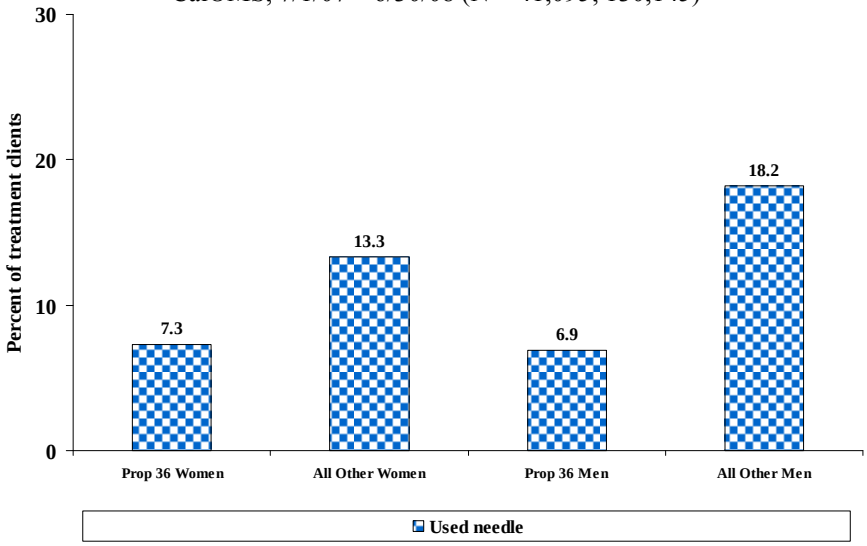


Figure 3.10
Other Characteristics: Needle Use Past 30 Days
Among Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)



Figures 3.8, 3.9, and 3.10 provide information on other characteristics of clients at treatment admission.

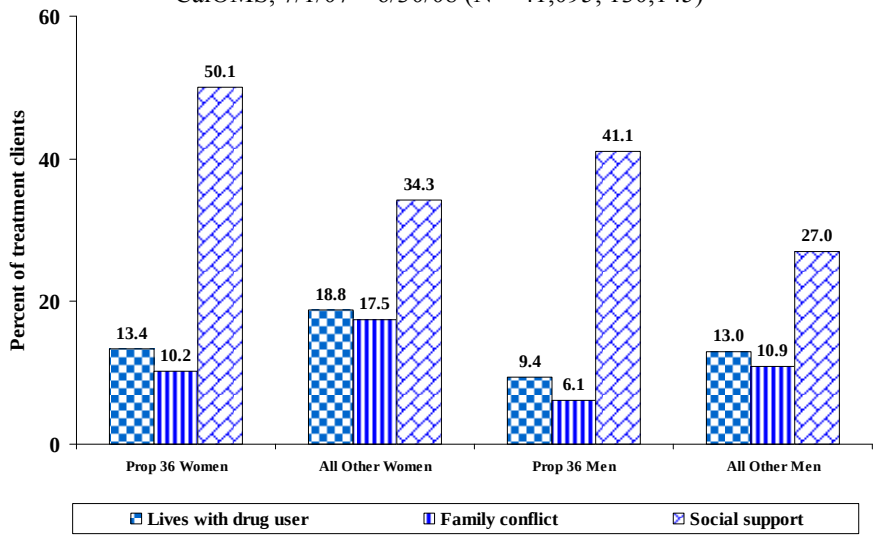
Regardless of referral type, women were less likely than men to be veterans (about 1% vs. about 5%) and a slightly greater proportion of women than men reported a disability

(about 19% vs. 14-16%). Disabilities include visual, hearing, speech, mobility, mental, and developmental disabilities. The most commonly reported category of disability was mental, which the research literature indicates tends to be more prevalent among women than among men.

Only about 7% of both Prop 36 women and men reported injecting drugs (Figure 3.10) at treatment entry. Needle use prevalence was higher among other types of clients referred to treatment (13.3% for all other women and 18.2% for all other men). Relatively low needle use among Prop 36 clients may be a reflection of the lower prevalence of heroin users participating in the Prop 36 program.

Analysis of several family and social support measures revealed differences between women and men (Figure 3.11). Among the Prop 36 group, a greater proportion of women than men lived with a drug user (13.4% vs. 9.4%) and had experienced family conflict (10.2% vs. 6.1%) in the 30 days prior to treatment admission. However, Prop 36 women were also more likely to receive some kind of social support compared to their male counterparts (50.1% vs. 41.1%) and, notably, rates of social support were highest among Prop 36 women than among any other client group examined. Prop 36 gender differences in the patterns of family and social support were similar to patterns evident among other types of clients in treatment.

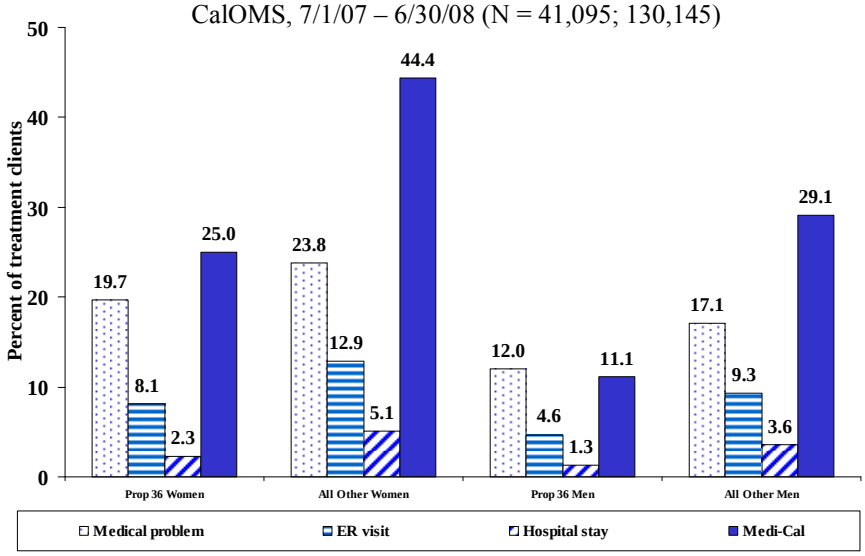
Figure 3.11
Family and Social Support
Among Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)



Gender differences were also evident in measures of health status (Figure 3.12). Among the Prop 36 group, a greater proportion of women than men reported a medical problem (19.7% vs. 12.0%), a higher percentage of women compared to men had visited an Emergency Room (8.1% vs. 4.6%), and similar percentages of both genders had a hospital stay (2.3% vs. 1.3%) in the 30 days prior to treatment admission. In addition, a higher percentage of Prop 36 women reported receipt of Medi-Cal benefits (25.0% vs.

11.1%). These patterns were similar to gender differences evident among other types of clients in treatment. Notably, however, when compared to other types of women in drug treatment, a lower proportion of Prop 36 women reported interactions for each of the health measures that were examined, and women in Prop 36 were much less likely to be Medi-Cal beneficiaries compared to women referred through other treatment mechanisms (25.0% vs. 44.4.%). Lower levels of health coverage through the Medi-Cal program among Prop 36 women may account for some differences in the prevalence of detection of health problems and the lower utilization of health services by Prop 36 women compared to all other women in treatment.

Figure 3.12
Health Indicators
Among Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)



As for Prop 36 gender differences in rates of communicable diseases and health testing (see Figure 3.13), at treatment entry, the proportion of Prop 36 women with tuberculosis was slightly lower than it was for men (1.7% vs. 2.7%), but a slightly higher proportion of women reported having Hepatitis C compared to men (7.6% vs. 5.7%). Women were twice as likely as men to report having a sexually transmitted disease (STD; 4.8% vs. 2.4%). Women in Prop 36 were also more likely than their male counterparts to have been tested for HIV (73.7% vs. 61.7%) and more likely to have received the results of their HIV test (66.6% vs. 54.0%). Patterns by gender were very similar regardless of treatment referral source.

Compared to Prop 36 men, about twice as many Prop 36 women reported a mental health disorder (26.1% vs. 12.3%), a mental health Emergency Room visit (2.6% vs. 1.5%), a psychiatric facility visit (1.3% vs. 0.8%), or use of psychiatric medication (15.3% vs. 7.6%) at treatment entry (Figure 3.14). Clients referred to treatment by other sources exhibited similar differences between women and men.

Figure 3.13
Communicable Diseases & HIV Testing
Among Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)

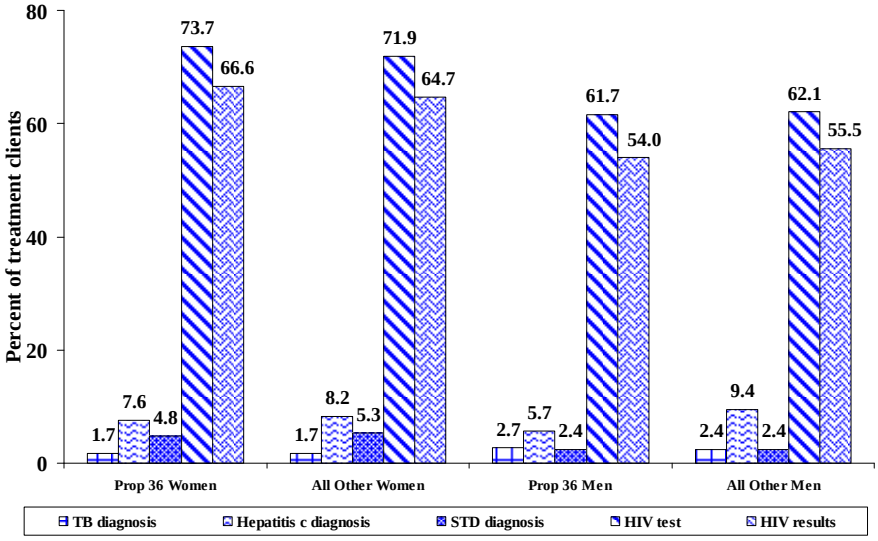
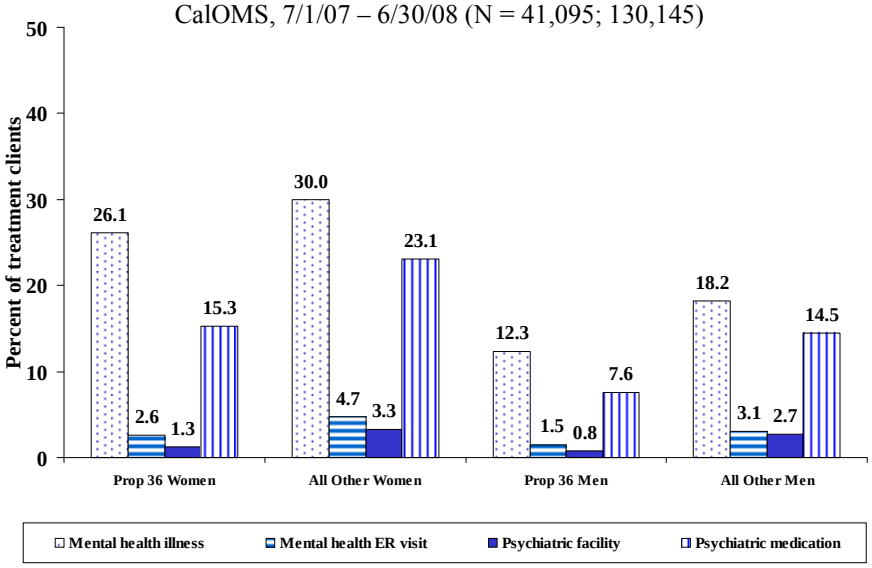


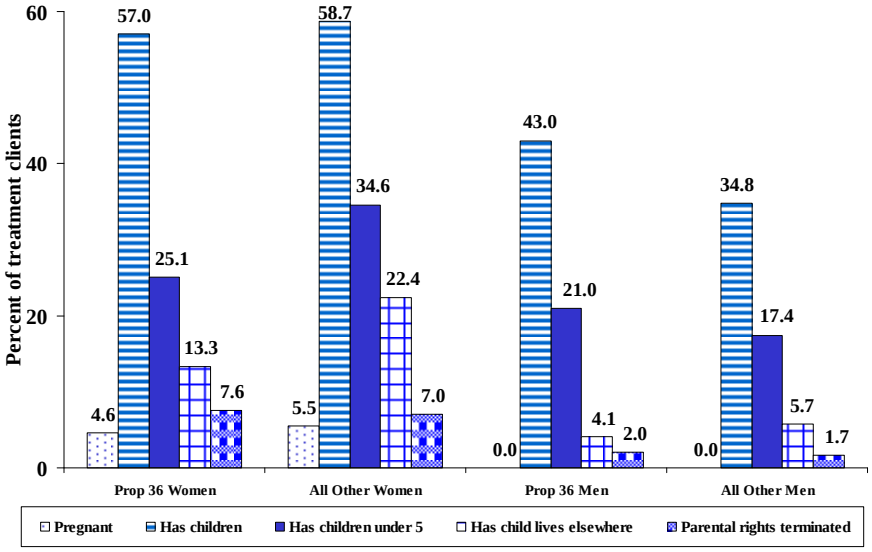
Figure 3.14
Mental Health Indicators
Among Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)



At treatment entry, 4.6% of Prop 36 women were pregnant (Figure 3.15). A higher proportion of Prop 36 women than Prop 36 men had children (57.0% vs. 43.0%), and women were slightly more likely to have children under age 5, compared to men (25.1%; 21.0%). Three times as many Prop 36 women as Prop 36 men had children living elsewhere (13.3% vs. 4.1%) or had had their parental rights terminated (7.6% vs. 2.0%).

Clients referred to treatment by other sources exhibited similar differences between women and men. Compared to other women in drug treatment, a smaller percentage of Prop 36 women had children under age 5 or had children who lived elsewhere due to a child protection order, however similar percentages of women in both groups had had their parental rights terminated.

Figure 3.15
Family Indicators
Among Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)



Prop 36 women with young children

Prop 36 women tend to be older than other women in treatment. Thus, it was expected that Prop 36 women would have fewer young children. In addition, because of gender differences in race/ethnicity among Prop 36 participants, in particular, a higher proportion of white women and a lower proportion of Hispanic women, racial/ethnic differences among women with young children were also expected. Women with young children have more diverse treatment needs, including perinatal and child care needs. Meeting these needs for clients with young children is important as the first 5 years of children's lives is a critical period for their later development. Treatment programs that play an active role in providing family-related or educational/employment services are better equipped to meet the needs of women with young children (Grella, et al, 2009). The following is a brief examination of these differences among Prop 36 clients and all other treatment clients, by gender.

As shown in Figure 3.16, Prop 36 women with young children (aged 5 and younger) who were in the youngest age category (less than 26 years) were more likely to have young children compared to Prop 36 men (41.1% vs. 27.2%). Gender differences were much less pronounced among participants aged 26-35 (42.8% v. 34.5). Among participants aged 36 and older, a slightly higher proportion of men compared to women had young children.

Prop 36 women were less likely to have young children when compared to women in treatment from other referral sources (Figure 3.17), and they were less likely to have children living elsewhere due to a child protection order (3.18 and 3.19).

Figure 3.16
Distribution of Ages of Prop 36 Clients with Young Children by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 10,787; 29,453)

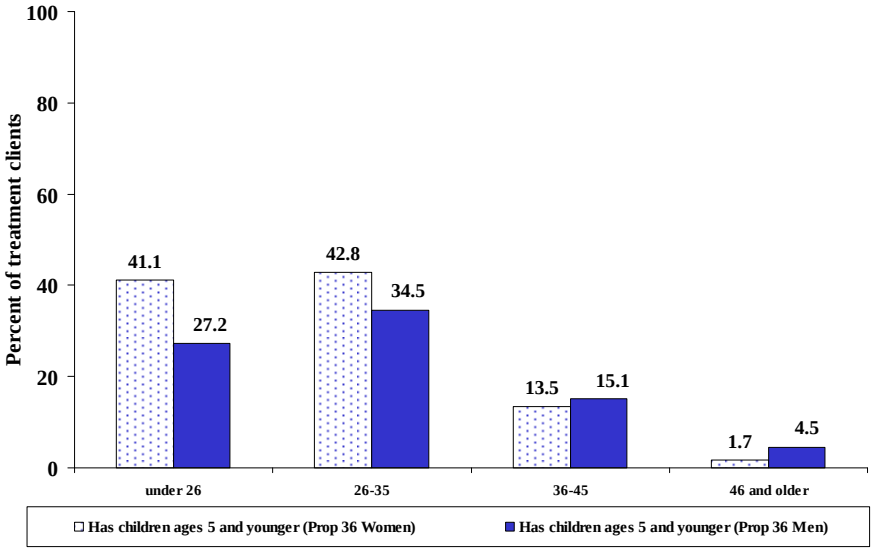


Figure 3.17
Distribution of Ages of All Other Clients with Young Children by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 42,577; 65,843)

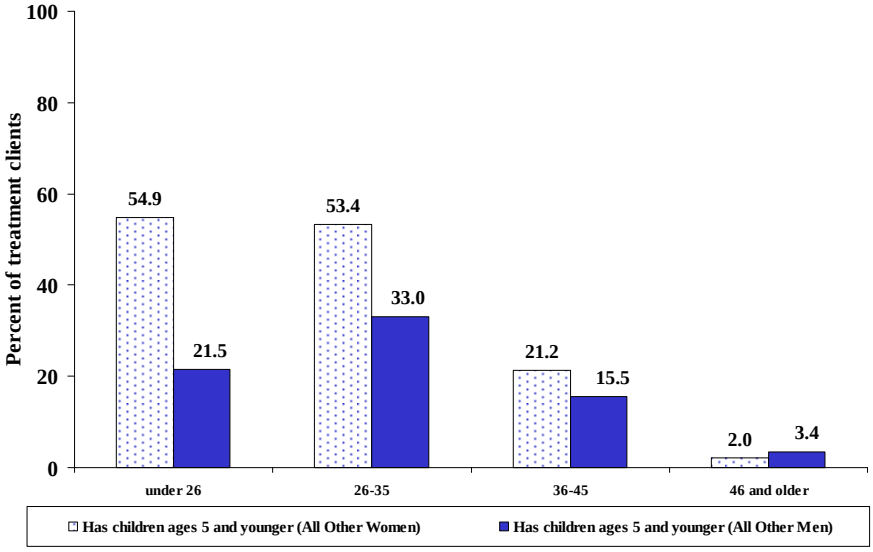


Figure 3.18
Distribution of Ages of Prop 36 Clients with Young Children Living Elsewhere Due to Child Protection Order by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 10,787; 29,453)

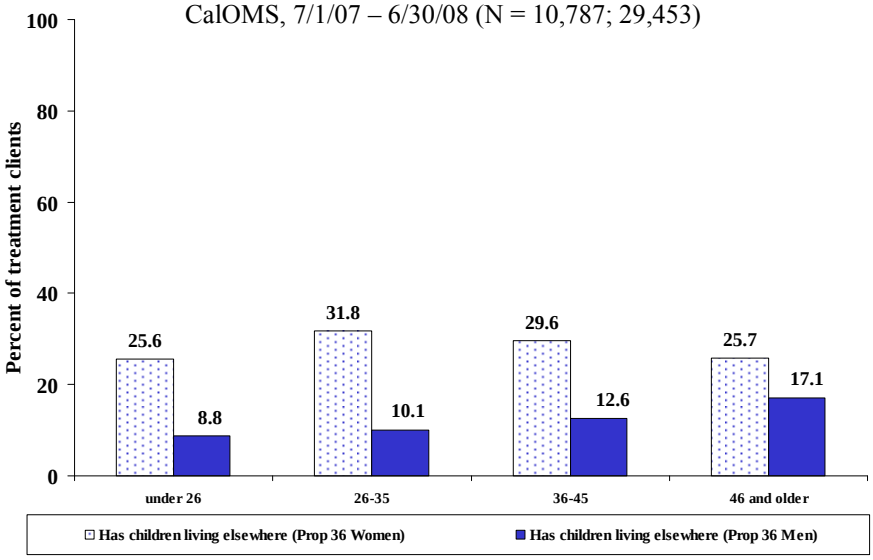
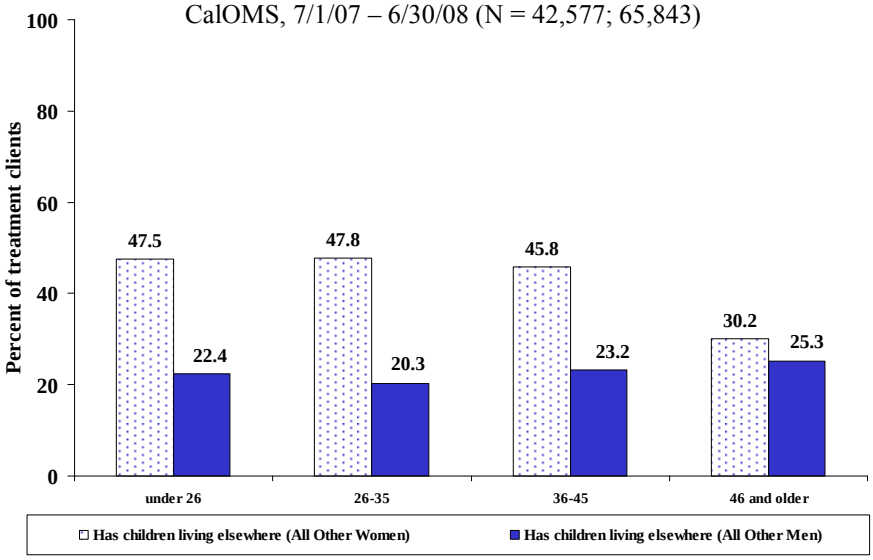


Figure 3.19
Distribution of Ages of All Other Clients with Young Children Living Elsewhere Due to Child Protection Order by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 42,577; 65,843)



The proportions of White, Hispanic, and Asian Prop 36 women with young children were higher than those of their male counterparts, but similar for Prop 36 women and men of other racial/ethnic groups (Figure 3.20). These findings differ from those for clients referred to treatment through other mechanisms. Women of all racial/ethnic groups who were referred to treatment through other sources were much more likely (over 13% points more likely) to have young children compared to men (Figure 3.21).

Figure 3.20
Ethnicity of Prop 36 Clients with Young Children
by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 10,787; 29,453)

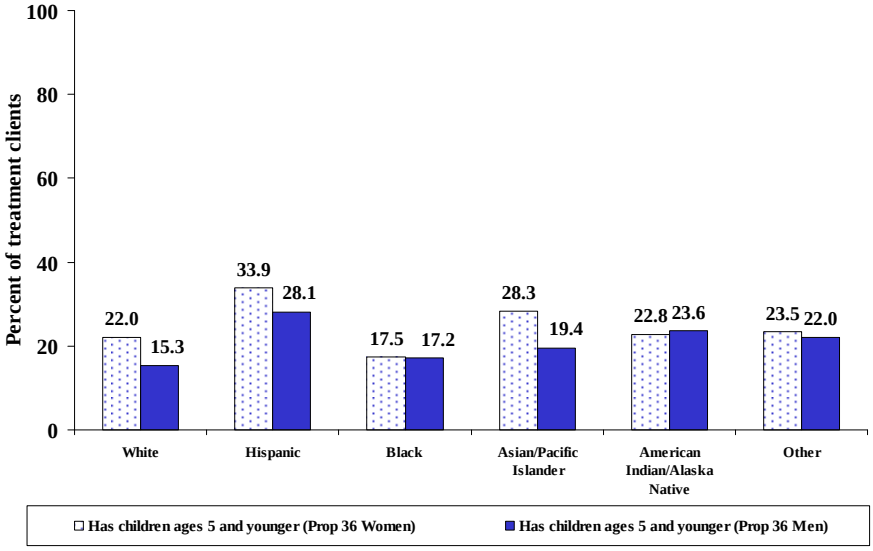
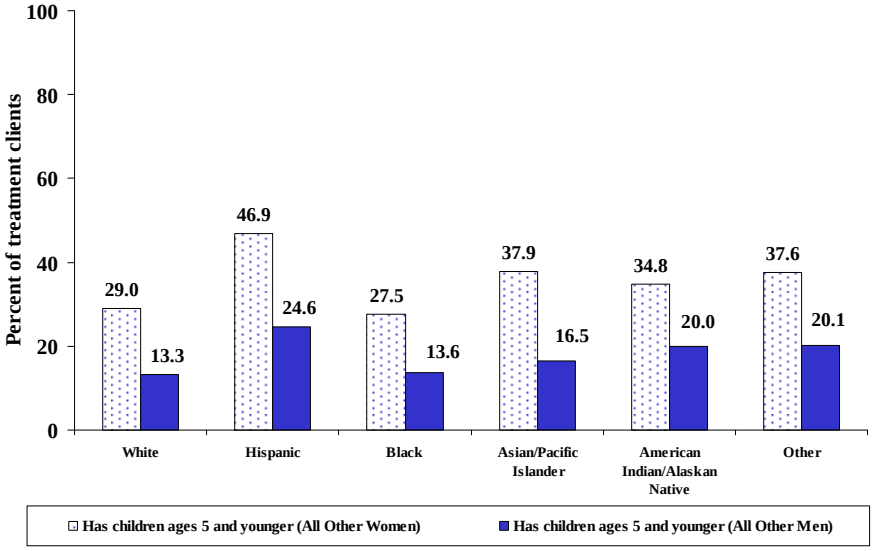


Figure 3.21
Ethnicity of All Other Clients with Young Children
by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 42,577; 65,843)

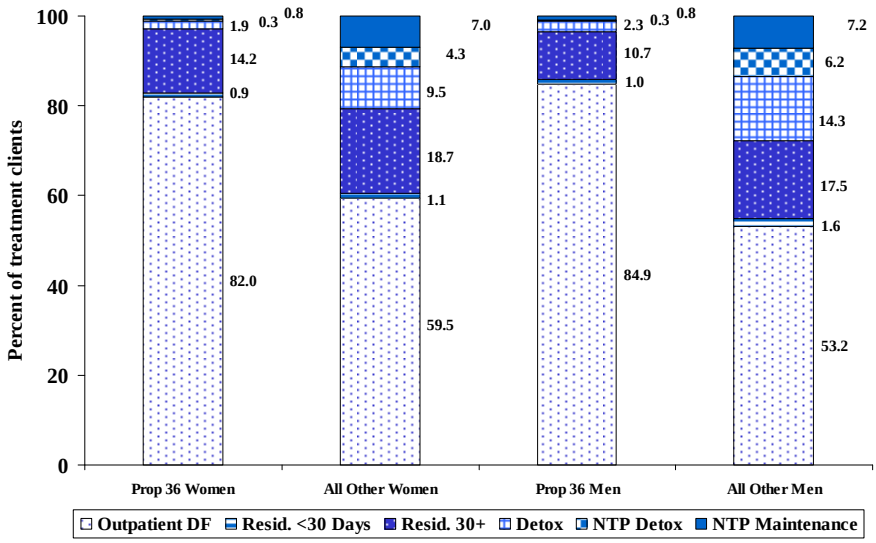


Treatment placement, retention, and services received

Like Prop 36 men, most Prop 36 women were placed in outpatient drug-free programs (Figure 3.22). However, a slightly greater proportion of Prop 36 women (14.2%) than men (10.7%) were placed in longer term (30 day and longer) residential care.

Also, when compared to others in drug treatment, both Prop 36 women and men were less likely to receive non-outpatient care, especially detoxification, NTP detoxification, and NTP maintenance. More information on Prop 36 treatment placement is provided in Chapter 2 and the use of NTP among Prop 36 clients is discussed in Chapter 9.

Figure 3.22
Treatment Placement
Among Prop 36 Clients vs. All Other Treatment Clients, by Gender
CalOMS, 7/1/07 – 6/30/08 (N = 41,095; 130,145)



The Prop 36 Treatment Provider Survey asked treatment providers to indicate the types of gender-responsive services that were provided to Prop 36 clients, and whether those services were located on-site or off-site. Results are shown in order of most commonly provided on-site services in Table 3.1.

Most programs reported providing women's support groups (63.5%). The same percentage of respondents reported not providing any child care services. Less than half of programs provided parenting skills training, family counseling, family education, family participation involvement programs, and domestic violence counseling. Less than one-third of programs provided marriage/family therapy or child care. Over 17% of respondents reported providing child care on-site and nearly 10% provided child care off-site through referral or cooperative agreement. Over half of programs offered transportation assistance, but over 30% did not provide these services.

Treatment providers were also surveyed about common barriers to treatment entry among Prop 36 women (data not shown). The most common barrier cited by programs was a drug-using partner or spouse. The second most common treatment provider-reported barrier was family obligations, followed by economic hardship/poverty, lack of transportation, and past or present physical or sexual abuse. These findings are consistent with the general literature that has found similar barriers to treatment seeking among women (Grella, 2009).

Table 3.1 *
Percent of Treatment Programs Reporting Gender-Responsive Services from 2008 Prop 36 Treatment Provider Survey **(N=68)**

Service Provided	On-site (%)	Off-site, by referral (%)	Not Provided (%)
Women's Support group	**63.5**	**9.5**	**25.4**
Transportation assistance	**55.6**	**11.1**	**31.7**
Parenting skills training	**47.6**	**22.2**	**28.6**
Family counseling	**44.4**	**20.6**	**33.3**
Family education	**44.4**	**19.0**	**39.7**
Family participation/involvement program	**39.7**	**15.9**	**41.3**
Prenatal/perinatal services	**34.9**	**25.4**	**36.5**
Domestic violence counseling	**27.0**	**34.9**	**33.3**
Marriage/family therapy	**25.4**	**28.6**	**42.9**
Child care	**17.5**	**9.5**	**63.5**

*** Row percentages may add up to more than 100% because "On-site" and "Off-site, by referral" categories are not mutually exclusive. Also, because not all programs provided answers to the above questions, row percentages may be less than 100%.**

Treatment outcome measures

At treatment discharge, a similar percentage of Prop 36 women and men reported primary drug use, criminal justice activity, and homelessness, but a greater proportion of men than women were employed (Table 3.2). Both men and women showed similar gains from treatment intake to discharge, with about a 30% reduction in the population who had used their primary drug, about a 25% reduction in the proportion who had engaged in any criminal activity, a 10% increase in the proportion who were employed, and about a 2%

reduction in the proportion who were homeless. Prop 36 men were more likely than Prop 36 women to report no social support at intake, but differences diminished at discharge.

Table 3.2
Treatment Outcome Measures Among Prop 36 Clients, by Gender

	Women (N=6,409)			Men (N=16,774)		
	Intake	Discharge	**Diff**	Intake	Discharge	**Diff**
Past 30 days, %						
Used primary drug	49.6	19.8	**-29.8**	49.7	21.0	**-28.7**
Any criminal justice activity (any arrests, jail or prison days)	33.9	6.6	**-27.3**	32.9	6.5	**-26.4**
Living arrangement						
Homeless	12.5	10.5	**-2.0**	11.5	9.3	**-2.2**
Dependent living	44.1	39.9	**-4.2**	44.7	41.4	**-3.3**
Independent living	43.5	49.6	**6.1**	43.9	49.3	**5.4**
Employed (full- or part-time)	22.3	32.1	**9.8**	38.1	48.7	**10.6**
Social support						
None	48.7	26.1	**-22.6**	57.5	30.4	**-27.1**
Some	41.3	49.4	**8.1**	35.7	49.8	**14.1**
Daily	10.0	24.5	**14.5**	6.9	19.7	**12.8**
Any	51.3	73.9	**22.6**	42.6	69.6	**27.0**
Family conflict	10.6	6.9	**-3.7**	6.3	3.9	**-2.4**

Data Source: CalOMS data on unique Prop 36 clients who had a treatment episode that ended between July 1, 2007 and June 30, 2008.

Discussion and Conclusions

Our analysis revealed several differences in Prop 36 client characteristics at treatment intake by gender. Compared to men, a greater proportion of women reported using methamphetamine as their primary drug, having family conflicts, receiving social support, having a mental health diagnosis, receiving mental health services, having medical problems, and receiving health services (including Medi-Cal). A lower proportion of Prop 36 women than men were employed and Hispanic compared to men.

Findings showed that Prop 36 women aged 35 and younger were more likely than their male counterparts to have young children, but Prop 36 women aged 36 and older were slightly less likely to have young children compared to Prop 36 men (Figure 3.16). The

findings on the relationships of age, ethnicity, and parental status of women in Prop 36, as compared with men in Prop 36 and as compared with other women in treatment, suggest that there are gender-specific selection pressures that result in an over-selection of women without younger children, particularly older women, into Prop 36. Conversely, there is an under-selection of women who have younger-age children into Prop 36, particularly among women who are younger or Hispanic. The underlying causes of these selection factors cannot be determined by these analyses. It may be that women with younger-age children are less likely to engage in criminal acts that result in their arrest and eligibility for treatment through Prop 36. It may also be that these younger mothers are more likely to come to the attention of the child welfare system (than the criminal justice system), which becomes a pathway for their referral to treatment. This latter point is supported by the finding that among all age groups, Prop 36 women are less likely to have children who are residing elsewhere because of a court order. Nevertheless, it may be possible that mothers with younger-age children are facing selective pressures that reduce their participation in Prop 36 – in ways that are not true for their male counterparts. More examination of the selection pressures that may influence participation in Prop 36 among mothers with young children, across age groups and ethnicity, but particularly younger mothers and Hispanics, is needed to understand these relationships.

Fosados et al. (2007) found that Prop 36 women were more likely than their male counterparts to receive services to treat psychiatric illness. This is consistent with the findings in the data presented here, wherein women reported more mental health problems, more psychiatric service utilization, and more psychiatric medication use, compared to men, and may suggest that female drug offenders in Prop 36 may be especially in need of mental health services.

Studies have found that women are more likely than men to have initiated and sustained narcotics use through a spouse or significant other (Grella, 2009; Sevigny & Coontz, 2008). Women are also more likely to have lived in abusive environments (Hser, Evans, & Huang, 2005). This is consistent with the findings reported here that women in Prop 36 are more likely than men to have lived with a drug user in the 30 days prior to admission and to have had a serious family conflict during that period. It is also consistent with treatment providers' perceptions of the most common barriers to treatment participation for women.

These studies along with our data suggest that women tend to be more interpersonal relationship-oriented compared to men and may benefit from a receiving gender responsive treatment and child care services using a relational approach (Grella, 2008). While most programs reported providing women's support groups on-site, and about one-third provided prenatal/perinatal services, one important service that is not provided by a majority of Prop 36 treatment programs is child care. Nearly two-thirds of treatment providers reported that child care is not provided either on-site or off-site. Limited child care services may account for relatively fewer women entering Prop 36 treatment compared to non-Prop 36 criminal justice treatment options and non criminal justice treatment.

Future focus groups with women in Prop 36 treatment would provide insight into gendered pathways and service needs. Focus groups with Hispanic women may also shed light on why they are underrepresented in Prop 36. It is likely that engaging gender-responsive interventions for women in Prop 36 that addresses their specific needs (including access to transportation and child care) will improve their treatment outcomes (Adams, et al., 2008). Since a common reason that women have for starting their narcotics use is family problems, special attention must be paid to these specific issues (Hser, et al., 1987).

Women in Prop 36 would likely benefit from a more integrated and coordinated system of care that would include access to gainful employment, social services, and gender-specific substance abuse treatment services (Velasquez, 1998). This system of care and the development of "pro-social" outcome measures (e.g., number of weeks employed, months in stable housing, health measures, etc.) may help improve treatment outcomes for women (Adams, et al., 2008). We recommend that specific continuum of care areas to inform policy and practice among Prop 36 women, such as family and social support and access to health services be further evaluated. Future focus groups with women, including Hispanic women would provide a greater understanding of women's experiences in the Prop 36 program and identify potential treatment needs and barriers to treatment participation among this population.

References

Acharyya, S., & Zhang, H. (2003). Assessing sex differences on treatment effectiveness from the drug abuse treatment outcome study (DATOS). *American Journal of Drug Alcohol Abuse, 29*(2), 415-44

Adams, S., Leukefeld, C.G., & Peden, A.R. (2008). Substance Abuse Treatment for Women Offenders: A Research Review. *Journal of Addictions Nursing, 19*(2), 61-75.

Arfken, C.L., Klein, C., di Menza, S., & Schuster, C. R. (2001). Gender differences in problem severity at assessment and treatment retention. *Journal of Substance Abuse Treatment, 20*(1), 53-7.

Ashley O.S, Marsden M.E., & Brady T.M. (2003). Effectiveness of substance abuse treatment programming for women: a review. *The American Journal of Drug and Alcohol Abuse. 29*(1):19-53

Becker, D.F., & Grilo, C. M. (2006). Prediction of drug and alcohol abuse in hospitalized adolescents: comparisons by gender and substance type. *Behaviour Research and Therapy, 44*(10), 1431-40.

Bloom, B. Owen, & Covington, S. (2004).Women Offenders and the gendered effect of public policy. *Review of Policy Research, 21*, 31-48.

Brady, K.T.; Grice, D.E.; Dustan, L. & Randall, C. (1993). Gender differences in substance use disorders. *American Journal of Psychiatry*, 150 (11), 1707-11.

Brecht, M.L., O'Brien, A., von Mayrhauser, C., & Anglin, M.D. (2004). Methamphetamine use behaviors and gender differences. *Addictive Behaviors, 29*(1), 89-106.

Comfort, M., Sockloff, A., Loverro, J., & Kaltenbach, K. (2003). Multiple predictors of substance-abusing women's treatment and life outcomes: a prospective longitudinal study. *Addictive Behaviors, 28*(2), 199-224.

Downey, L., Rosengren, D.B., & Donovan, D.M. (2003). Gender, waitlists, and outcomes for public-sector drug treatment. *Journal of Substance Abuse Treatment, 25*(1), 19-28.

Fiorentine, R., Anglin, M. D., Gil-Rivas, V., & Taylor, E. (1997). Drug treatment: explaining the gender paradox. *Substance Use and Misuse*, 32(6), 653–678.

Fosados R, Evans E, & Hser Y.-I. (2007). Ethnic differences in utilization of drug treatment services and outcomes among Proposition 36 offenders in California. *Journal of Substance Abuse Treatment 33*(4):391-9.

Green, C.A., Polen, M.R., Dickinson, D.M., Lynch, F.L., & Bennett, M.D. (2002). Gender differences in predictors of initiation, retention, and completion in an HMO-based substance abuse treatment program. *Journal of Substance Abuse Treatment, 23*(4), 285-95.

Green, C. A., Polen, M. R., Lynch, F. L., Dickinson, D. M., & Bennett, M. D. (2004). Gender differences in outcomes in an HMO-based substance abuse treatment program. *Journal of Addictive Diseases, 23*(2), 47-70.

Greenfield, S. F., Brooks, A. J., Gordon, S. M., Green, C. A., Kropp, F., McHugh, R. K., Lincoln, M., Hien, D., & Miele, G. M. (2007). Substance abuse treatment entry, retention, and outcome in women: a review of the literature. *Drug and Alcohol Dependence, 86*(1), 1-21.

Grella, C. E. (2008). From generic to gender-responsive treatment: Changes in social policies, treatment services, and outcomes of women in substance abuse treatment. *Journal of Psychoactive Drugs, SARC Supplement 5,* 327-343.

Grella, C.E. (2009). Treatment seeking and utilization among women with substance use disorders. In K.T. Brady, S.E. Back, & S.F. Greenfield (Eds.), *Women and Addiction: A Comprehensive Handbook.* New York: Guilford Publication, pp. 307-322.

Grella, C. E., Scott, C. K., & Foss, M. A. (2005). Gender differences in long-term drug treatment outcomes in Chicago PETS. *Journal of Substance Abuse Treatment, 28* Suppl 1, S3-12.

Grella, C. E., Needell, B, Shi, Y., Hser, Y. I. (2009). Do treatment services predict reunification outcomes of mothers and their children in child welfare? *Journal of Substance Abuse Treatment, 36*, 278-293.

Hser, Y.-I.; Anglin, M.D., & Booth, M.W. (1987). Sex differences in addict careers. 3. Addiction. *American Journal of Drug Alcohol Abuse,13*(3), 231-51.

Hser, Y.-I., Evans, E., & Huang, Y.C. (2005). Treatment outcomes among women and men methamphetamine abusers in California. *Journal of Substance Abuse Treatment, 28*(1), 77-85.

Hser, Y.-I.; Evans, E.; Teruya, C.; Huang, D., & Anglin, M.D. (2007). Predictors of short-term treatment outcomes among California's Proposition 36 participants. *Evaluation Program and Planning, 30*(2), 187-96.

Longshore, D., Urada, D., Evans, E, Hser, Y.-I., Prendergast, M., & Hawken, A. (2005). Evaluation of the Substance Abuse and Crime Prevention Act 2004 Report.

Marsh, J.C., Cao, D., & D'Aunno, T. (2004). Gender differences in the impact of comprehensive services in substance abuse treatment. *Journal of Substance Abuse Treatment, 27*(4), 289-300.

Messina, N., Burdon, W., Hagopian, G., & Prendergast, M. (2006). Predictors of prison TC treatment outcomes: A comparison of men and women participants. The American *Journal of Drug and Alcohol Abuse, 32*(1), 7-28.

Messina, N., Wish, E., Nemes, S., & Wraight, B. (2000). Correlates of underreporting of post-discharge cocaine use among therapeutic community clients. *Journal of Drug Issues, 30*(1), 119-132.

Oggins, J., Guydish, J., & Delucchi, K. (2001). Gender differences in income after substance abuse treatment. *Journal of Substance Abuse Treatment, 20*(3), 215-24.

Pelissier, B., & Jones, N. (2006). Differences in motivation, coping style, and self-efficacy among incarcerated male and female drug users. *Journal of Substance Abuse Treatment, 30*(2), 113-20.

Pelissier, B. M., Camp, S. D., Gaes, G. G., Saylor, W. G., & Rhodes, W. (2003). Gender differences in outcomes from prison-based residential treatment. *Journal of Substance Abuse Treatment, 24*(2), 149-60.

Pelissier, B., & Jones, N. (2005). A Review of Gender Differences Among Substance Abusers. *Crime & Delinquency, 51*(3), 343-372.

Sevigny, E.L., & Coontz, P.D. (2008). Patterns of Substance Involvement and Criminal Behavior: A Gender-Based Cluster Analysis of Pennsylvania Arrestees. *International Journal of Offender Therapy and Comparative Criminology, 52*(4), 435-53.

Urada, et al. (2008). Evaluation of the Substance Abuse and Crime Prevention Act of 2000: 2008 Report.

Webster, J.M., Rosen, P.J., McDonald, H.S., Staton-Tindall, M., Garrity, T.F., & Leukefeld, C.G. (2007). Mental Health as a Mediator of Gender Differences in Employment Barriers among Drug Abusers. *The American Journal of Drug and Alcohol Abuse, 33*(2), 259-265.

Velasquez, A. (1998). "An Integrated Systems Approach to Program Development and Implementation" in *Female Offenders: Critical Perspectives and Effective Interventions* (Ed. Ruth Zaplin). Aspen Publishers: Gaithersburg, MD.

Chapter 4: Methamphetamine Use Special Study

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On some characteristics, Prop 36 methamphetamine (meth) users were more similar to other (non-Prop 36) meth users in treatment than to users of other drugs in terms of several characteristics: older age (nearly 2/3 in the 26-45 age range compared to half or less in this range among users of other substances); race/ethnicity, with Whites and Hispanics comprising 88.3% for Prop 36 meth users and 87.3% for non-Prop 36 meth users compared to 65.5% and 73.0% for Prop 36 and non-Prop 36 users of other drugs; shorter histories of use of their primary drug (13.4 and 12.2 years for Prop 36 and non-Prop 36 meth users compared to 16.9-17.6 years for users of other drugs; and lower rates of injection use, at 12.2% and 15.0% for Prop 36 and non-Prop 36 meth users compared to 17.2% and 22.8% for users of other drugs.

On other characteristics, Prop 36 meth users were more similar to other Prop 36 users of other drugs than to non-Prop 36 clients (either meth or other drug users). These included: gender, with lower percentages of women (28.9% women among Prop 36 meth users and 23.3% among Prop 36 non-meth users) compared to non-Prop 36 clients groups (34.3% and 49.7% women); lower percentages of clients with less than high school education (33.3% and 39.7% for Prop 36 meth and non-meth users, respectively) compared to 43.7% - 45.3% for the non-Prop 36 groups; higher rates of employment (35.2% employed part- or full-time among Prop 36 meth users and 31.4% among Prop 36 non-meth users compared to 19.8% and 20.6% among non-Prop 36 groups); and higher rates of admission to outpatient treatment (84.7% for Prop 36 meth users and 81.7% for Prop 36 non-meth users, compared to 54.3% and 63.3% for the non-Prop 36 groups).

In terms of performance measures, Prop 36 meth users had similar treatment completion rates and retention to other Prop 36 clients. For example, 37.2% of Prop 36 meth users vs. 38.5% of Prop 36 non-meth users completed treatment; 60-day retention rates were 61.0% and 59.9%, respectively). These rates were higher than those for the non-Prop 36 groups (with completion at 34.5%-35.9% and 60-day retention at 46.6%-51.3%).

Prop 36 meth users showed improvement in all CalOMS outcomes domains. The percentage of Prop 36 meth users with any primary substance abuse decreased from 50.9% in the 30 days preceding episode admission to 24.8% at discharge. This relative decrease was similar to that of Prop 36 non-meth users and non-Prop 36 meth users. For other measures, Prop 36 meth users had patterns of improvement most similar to those of Prop 36 non-meth users.

Re-offending rates were again very similar for Prop 36 meth and non-meth users for several types of offenses: 56.5% and 57.2% for any arrest, 40.8% and 41.0% for drug arrests.

Methamphetamine (meth) abuse/dependence has been an increasing part of the overall drug problem in the U. S. over the past two decades. California has experienced particularly high rates of meth use and abuse, with a resulting impact on the substance abuse treatment system: meth was the primary drug for 35% of all treatment admissions in CA in FY 2006-07 (CA Dept. of Alcohol and Drug Programs, 2007). The Prop 36 population has contributed disproportionately to meth treatment admissions: in 2006-07 56.5% of Prop 36 treatment admissions reported meth or other amphetamines as their primary drug (see Chapter 1). The magnitude of the meth problem and the serious personal and social consequences and costs of meth abuse have motivated the following special study focusing on several questions related to treatment for meth use: 1) what are the characteristics of Prop 36 treatment clients whose primary drug was methamphetamine? 2) what are treatment outcomes for Prop 36 meth users? 3) what are characteristics of criminal justice outcomes for Prop 36 meth users? Subsequent analyses are planned to assess costs/benefits of substance use treatment for FY2006-07 Prop 36 clients whose primary substance was meth. The first section of this chapter provides an overview of the "meth problem," reviewing some reasons for addressing this issue. The second section briefly describes the methods used to answer the main questions. Then three sections of results are presented: 1) describing characteristics of Prop 36 treatment clients whose primary drug is meth, and providing a comparative context, describing characteristics of other groups of treatment clients (other Prop 36 clients whose primary drug is something other than meth, meth users not referred through Prop 36, and other drug users not in Prop 36); 2) assessing treatment performance and outcomes in several domains for Prop 36 meth users and comparative groups; 3) describing selected criminal justice outcomes (re-offending) for Prop 36 meth users and comparison to Prop 36 users of other substances.[19]

Introduction—Overview of the "Meth Problem"

Trends in Meth Use

Methamphetamine abuse has increased dramatically in the U. S. since the early 1990s and continues to be a major concern for law enforcement, drug treatment systems, and health and social service systems. While meth has been a major drug threat in western states since the early 1990s, a 2007 national survey of county sheriffs indicated that nearly half considered meth the major drug problem in their counties and 80% reported no decline in meth problem indicators during the preceding year (National Association of Counties, 2007). Increases in meth production resulted in an overall five-fold increase from 1997 to 2003 in meth laboratory seizures by law enforcement (National Drug Intelligence Center, 2006). Even as recent declines in overall production and seizures were being noted in 2004-08, there were commensurate increases in foreign production and meth trafficking into the U. S. (National Drug Intelligence Center, 2007, 2009). The

[19] This chapter distinguished methamphetamine as a primary drug and did not include "other amphetamines" in the meth category. Note that there were very few clients (<0.2%) who reported other amphetamines; these have been included in the non-meth groups.

National Survey on Drug Use and Health (NSDUH) showed that the number of meth users had tripled from 1995 to 2006, with other indicators showing similar trends (SAMHSA, 1996, 2008a; Maxwell & Rutkowski, 2008). While the 2007 NSDUH has shown a slight decline in rates of meth use from the previous year, it also estimated that over 13 million Americans have used meth at least once in their lives (SAMHSA, 2008a); and the impact on the treatment system remained high and stable (National Drug Intelligence Center, 2009). It is not yet known what longer term trends will be; and meth use/abuse remain at particularly high levels in many Western states including California.

As the prevalence of meth use has increased, the effect on the drug abuse treatment system has been marked. Nationwide, treatment admissions for meth increased more than 6-fold from 1993 to 2006, accounting for 8% of admissions in 2006 (SAMHSA, 2008b). National figures, however, fail to represent the effect of meth use in many affected states, including California. In 2002, meth admissions to the public treatment system in California were five times the number in 1992 (Brecht et al., 2005b). By FY 2006-07, meth accounted for 35% of all CA substance abuse treatment admissions (CA Dept. of Alcohol and Drug Programs, 2007; Rawson et al., 2008). In Los Angeles County (with the largest county population in the U.S.), treatment admissions for meth abuse/dependence were more than 2.5 times higher in 2007 than in 2000 (Brecht, 2008). Over half (57%) of the offenders participating in California's Prop 36 in FY2005-06 reported meth as their primary drug problem, with a similar rate for FY2006-07 (Urada et al., 2008b). While the rate of increase in treatment admissions for meth dependence appears to be slowing in some areas, meth continues to consume a significant proportion of available treatment resources in California.

Consequences and Correlates of Meth Use

The increase in meth prevalence has been of particular social concern, in part due to its physiological effects and related social consequences and costs. With higher levels of use, physical and mental health effects of meth can include cardiac problems, cerebral edema, paranoia and psychosis and other mental health problems, dental problems, and malnutrition (e.g., Glasner-Edwards et al., 2008; McKetin et al., 2006; Vik, 2007; Westover et al., 2008). High rates of sexual risk behavior by meth users and injection behaviors by some meth users increase the risk for a number of health issues including HIV, hepatitis, and tuberculosis transmission (Brecht et al., in press; Gonzales et al., 2008; Halkitis et al. 2008; Semple et al., 2004; Shoptaw & Reback, 2007; Volkow et al., 2007). Emerging evidence indicates that meth abuse is associated with a wide range of neurocognitive effects (Baicy & London, 2007; Krasnova & Cadet, in press; London, et al., 2004; McCann et al., 2008; Nordahl et al., 2003; Scott et al., 2007). Meth use can pose risks, not just for users themselves, but also for their children. For example, use of meth during pregnancy may result in decreased birth weight and other problems (Smith, et al., 2006). As a consequence of parental involvement with meth use, there are more children entering the foster care system and/or at risk for severe injuries because of environmental contact with meth, its precursor chemicals, or the process of manufacture (Messina et al., in press; Ostler et al., 2007).

While we do have considerable evidence about the acute and short-term physiological and psychological effects of meth, information is only beginning to emerge about how these problems are manifested as users age and experience lengthening meth use trajectories. For example, McKetin et al. (2008) found that the disparity in impaired physical health for meth users compared to the general population was greater for meth users 35-44 years than for younger meth users.

There appears to be a link between meth and criminality (e.g., Stretesky, 2008). High rates of arrest, incarceration, and reported criminal behavior are found among meth users who are in the criminal justice system or in treatment; for the latter, their numbers of arrests declined significantly along with declines in meth use following treatment (Brecht et al., 2006; Urada et al., 2007, 2008b). Violent behavior related to meth use has also been reported (Ernst et al., 2008). Associations of meth use with impulsivity and hostility may play a role in the meth-criminality link (Lapworth et al., 2009)

Social Costs of Meth Dependence

Drug abuse imposes a substantial burden on individuals and on their families and communities. The annual social and health costs associated with drug dependence in general in the United States were estimated to be approximately $180.9 billion in 2002 (ONDCP, 2004). The first national estimate of the cost of meth use was $23.4 billion for 2005, with results indicating that meth use may cost up to double the amount for other illicit drugs on a per user basis (Nicosia et al., 2009). Estimates have placed the cost to employers of meth use in the workplace at about $6.9 billion in California in 2004 (Brecht, 2005). Higher hospital costs were found for meth users than for non-meth users among minimally injured trauma patients (London et al., 2009). For the 1st year Prop 36 cohort (2001/02), half of whom were meth users, analyses found a benefit-cost ratio of 2 to 1 over a 42-month follow-up period (Hawken et al., 2008).

Treatment Outcomes for Meth Users

Evidence is accumulating that indicates the effectiveness of substance abuse treatment in reducing meth use, at least as much as for users of other drugs (e.g., Hser et al. in press; Brecht et al., 2006; Glasner-Edwards et al., 2008; Hillhouse et al., 2007; Lee & Rawson, 2008; Rawson et al. 2002, 2008; Roll et al., 2006; Shoptaw et al., 2008). In addition to decreases in meth use, improvements have also been noted in other domains, e.g. criminal involvement, employment, psychological, and sexual risk behavior outcomes (Brecht et al., 2006; Glasner-Edwards et al., 2008; Rawson et al., 2008; Shoptaw et al., 2008). Such improvements occurred both for clients referred through criminal justice channels and for those referred through other channels (Anglin et al., 2007; Brecht et al., 2005a). There is also evidence that meth users respond as well to treatment as most other clients (e.g. Luchansky et al., 2007; Rawson et al., 2008). Among Prop 36 clients, methamphetamine users had treatment durations and treatment completion rates that were comparable to users of other most other drugs and superior to those of heroin users (Urada et al., 2007; 2008a). However, treatment placement (residential or outpatient) also had an impact. Among daily users, the effect of residential placement on arrest outcomes

was strongest for Prop 36 offenders reporting methamphetamine as their primary drug (18% fewer felony, and 17% fewer misdemeanor arrests) (Hawken et al, 2007).

Methods

Data analyses were done in three parts to address the primary questions: 1) describe Prop 36 treatment clients whose primary drug was meth, and in order to provide a context for interpretation, compare to Prop 36 users of other drugs, non-Prop 36 meth users, and non-Prop 36 non-meth users; and 2) evaluate treatment performance/outcomes for Prop 36 meth users and comparison groups; and 3) describe criminal justice outcomes (re-offending) for Prop 36 meth users and compare to Prop 36 users of other drugs.

Performance measures are used at the program level to estimate and monitor the extent to which the actions of a program conform to standards of quality and usually summarize some aspect of the process of treatment, e.g. access, capacity, continuum of care, retention, and discharge status. Outcome measures are used at the client level for measuring change over time across life function areas expected to be influenced by treatment. Definitions of specific measures included in this analysis are described on the next page.

The first part of the analyses focused on unduplicated admissions to treatment (i.e. unique clients) for FY2006-07.[20] Data were from the California Outcomes Monitoring System (CalOMS).[21] For description and comparison, unduplicated admissions were divided into the following four groups: Prop 36 clients reporting meth as primary substance (Prop 36 meth); all other Prop 36 clients (Prop 36 non-meth); non-Prop 36 clients with meth as primary substance (non-Prop 36 meth); and all other non-Prop 36 clients (non-Prop 36 non-meth). Characteristics are described for the Prop 36 meth group and compared to the other groups.[22]

The second part of the analyses assessed treatment performance/outcomes for Prop 36 meth clients and other treatment client groups based on treatment "episodes" for unduplicated admissions in FY2006-07.[23] An episode of continuing care is defined as a contiguous sequence of one or more "service sets," each service set delineated by an admission and discharge to a specific type of service/modality. A treatment episode can include a single type of treatment service/modality or a sequence of treatment types/modalities for a given client. Specifically, if a discharged client was subsequently re-admitted within 30 days of the discharge, this re-admission was considered the

[20] If a client had admissions from more than one referral source during the year, including Prop 36 (either through probation or parole) and a non-Prop 36 source, the Prop 36 admission was selected and used for these analyses. If a client had more than one admission for Prop 36, then the earliest admission was selected. If a non-Prop 36 client had more than one admission, then the earliest admission was selected.

[21] The April 2008 CalOMS file was used for this analysis of unduplicated admissions.

[22] The large sample sizes produced statistical significance for comparisons across the four groups even with small percentage differences and are not reported.

[23] The December 2008 CalOMS file was used to identify episode discharges through 6/30/08; that is, allowing a minimum 12-month period for episode discharge.

beginning of a new service set, but part of the continuing episode of care.[24] For simplicity, we often use the term "client" to discuss outcome results, although this label refers to a "client episode" rather than to a specific admission record or single service set (i.e., admission to discharge). CalOMS records through June 2008 were examined to find the latest discharge for each identified FY06-07 admission used in the first part of the analyses. Of the FY2006-07 unduplicated admissions, 145,947 episodes were identified and used in description of CalOMS performance measures (discharge status and duration of treatment). Of these, a total of 73,805 had substance use outcome data available and were included in the assessment of CalOMS outcomes.[25]

CalOMS performance measures for these analyses included discharge status (at the end the episode or last available discharge record of the episode) and retention in treatment. Retention was calculated in days from the first admission in FY2006-07 to the end of or to the last available discharge record of that treatment episode (see also Technical Note 1). Retention was also considered in terms of 60-day and 90-day thresholds (i.e. less than 60 days vs. 60 days or more, and less than 90 days vs. 90 days or more).

CalOMS treatment outcomes were measured at admission and at discharge (that is, beginning and end/latest discharge of the treatment episode) as detailed in Table 4.1.

Table 4.1: Treatment Outcome Measures (from CalOMS data)

Domain	Measure
Substance Use: Alcohol/Drug	**Alcohol/drug use during past 30 days, in terms of 1) number of days and 2) no use vs. any use**
Employment/Education	**Current employment/education status, in terms of 1) employed vs. not employed and 2) employed and/or enrolled in school and/or job training vs. not employed/enrolled**
Crime & Criminal Justice	**Criminal justice system-related activity in past 30 days, in terms of any involvement vs. no involvement (based on no arrests, no jail days, and no prison days vs. any arrests, jail days, or prison days).**
Stability in Housing	**Current housing status, in terms of homeless, dependent, or independent living.**
Social Connectedness	**1) Family/social problems in past 30 days in terms of none vs. any days of serious family conflict; 2) Days with social support recovery activities in past 30 days in terms of none vs. any days.**

[24] If a client had more than one episode beginning in FY2006-07, we considered only one episode with the earliest admission date. See also Technical Note 1 for further detail on episodes (at end of chapter).

[25] N=67,435 of the episodes had a discharge record indicating "administrative discharge" and thus had no outcome data available because CalOMS does not require collection of outcome information for administrative discharges. An additional n=4,707 had missing substance use outcome data and were excluded from this analysis. See the CalOMS Evaluation (Rawson et al., 2008) for further discussion of differences between clients with administrative and non-administrative discharges.

The third part of the analyses was a *preliminary* assessment of criminal justice system outcomes for Prop 36 treatment clients. Because criminal justice system administrative data had not yet been fully processed for all CalOMS Prop 36 clients analyzed for CalOMS performance and outcome measures (parts 1 and 2 of the analysis), this preliminary analysis focused on a subset of the offender records used in Chapter 11, which contained records for offenders who became eligible for Prop 36 in FY2006-07. A subset (n=10,126) of these DOJ records for Prop 36-eligible offenders was identified for offenders with linkable CalOMS information for a Prop 36 treatment episode beginning in FY2006-07 or 2007-08.[26] The measure of re-offending was based on new arrests that occurred during the 12-month period after the Prop 36-eligible conviction. Separate measures were used to examine the percentage of offenders with a new arrest for any type of crime, drug offenses, property offenses, sex offenses, and violent offenses. For any offense and drug offenses, felonies and misdemeanors were also examined separately.[27]

Results: Characteristics of Prop 36 Meth Users and Comparative Groups

The sample of unduplicated FY2006-07 CalOMS admissions were distributed across the four comparison groups as follows: 14.3% Prop 36 meth users (the primary group of interest); 20.6% non-Prop 36 meth users; 11.1% Prop 36 non-meth users (that is, primary users of substances other than meth); and 54.0% non-Prop 36 non-meth users. Thus, meth users totaled 34.9% of the sample; and Prop 36 users totaled 25.1% of the sample. Considering only Prop 36 clients, more than half (56.3%) reported meth as their primary drug; however, only approximately one-fourth (27.6%) of the non-Prop 36 clients were primary meth users. Description of the four comparison groups appears in Table 4.2 and selected results are summarized in sections below. These tables and summaries provide a lot of good information.

Table 4.2. Characteristics of Prop 36 Primary Methamphetamine Users and Comparison to Prop 36 Users of Other Primary Substances, Non-Prop 36 Meth and Other Primary Drug Users, CalOMS FY 2006-07		
	Methamphetamine	Other Primary Drug

[26] Thus, part 3 of the analysis (re-offending) focuses on a *different* sample of Prop 36 clients than the analyses for parts 1 and 2 (description of Prop 36 admissions and assessment of CalOMS treatment performance/outcomes), overlapping with but not identical to offenders assessed in parts 1 and 2. To facilitate interpretation of results, an exploratory analysis examined some sources of potential bias by comparing the subset used in the part 3 analysis with other Prop 36 clients used in part 2 outcomes analysis for whom re-offense data were not yet available, in terms of several client and treatment characteristics as well as drug re-offenses. Results suggested that the part 3 sample may somewhat under represent Blacks and Hispanics, those with prior treatment episodes, and those admitted to residential treatment. Further analysis will explore criminal justice outcomes as more complete data become available for analysis.

[27] Violations of probation or parole were not counted unless the violation was a new offense resulting in arrest; issuance and execution of warrants were not counted.

	Prop36 n=24,686	Non-Prop36 n=35,483	Prop36 n=19,186	Non-Prop36 n=93,045
Age Group[a], %				
25 & younger	19.6	30.2	21.3	32.5
26-35	32.5	35.0	23.6	17.7
36-45	32.1	25.3	28.6	22.9
46+	15.7	9.5	26.6	26.9
Race/ethnicity, %				
White	50.0	48.7	32.0	40.2
Hispanic	38.3	38.6	33.5	32.8
Black	3.4	4.0	27.4	20.1
Asian/Pacific Islander	3.6	3.1	2.5	2.0
Amer. Indian/Alaskan Native	1.5	1.8	1.5	1.4
Other	3.3	3.8	3.2	3.5
Women[b], %	28.9	49.7	23.3	34.3
Education, %				
Less than High School	38.3	43.7	39.7	45.3
High School	46.4	40.8	42.7	35.7
Some college/college grad	15.3	15.5	17.6	19.0
Employment status, %				
Full-time	23.6	12.4	20.3	13.0
Part-time	11.6	7.1	11.1	7.6
Unemployed	35.1	26.7	30.5	20.7
Not in labor force	29.7	53.8	38.1	58.7
Yrs since first use of primary drug, Mean(SD)	13.4 (8.7)	12.2 (8.5)	17.6 (10.9)	16.9 (12.9)
Secondary drug reported, %	59.3	63.9	68.8	53.7
Injection drug use in past year[a], %	12.2	15.0	17.2	22.8
Prior alcohol or drug treatment[a], %	53.7	50.7	52.1	48.7
Referred by, %				
Probation	84.5	-	84.3	-
Parole	15.5	-	15.7	-
Modality, %				
Outpatient	84.7	63.3	81.7	54.3

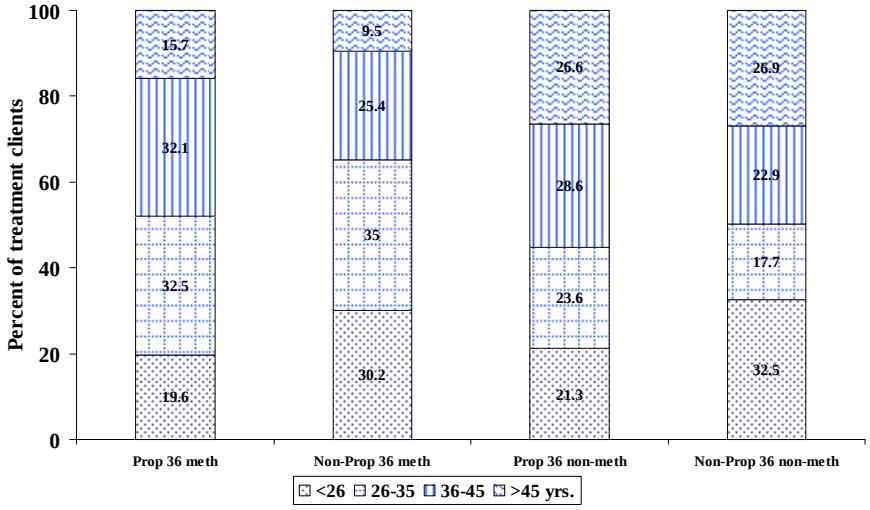
Table 4.2. Characteristics of Prop 36 Primary Methamphetamine Users and Comparison to Prop 36 Users of Other Primary Substances, Non-Prop 36 Meth and Other Primary Drug Users, CalOMS FY 2006-07				
	Methamphetamine		Other Primary Drug	
	Prop36 n=24,686	Non-Prop36 n=35,483	Prop36 n=19,186	Non-Prop36 n=93,045
Residential < 30 days	0.9	1.8	0.9	1.5
Residential ≥ 30 days	12.6	27.1	12.9	14.5
Detox	1.8	7.8	2.2	12.4
NTP detox	0.0	0.0	0.6	6.1
NTP maintenance	0.0	0.1	1.9	11.4
[a] the number of cases with missing data for any of these characteristics ranged from 68 to 958.				

Socio-demographics

The distribution of ages of Prop 36 meth users was 19.6% in the younger-than-26-years category, 32.5% 26-35 years, 32.1% 36-45 years, and 15.7% over 45 years (see Table 4.2 and Figure 4.1). This distribution was similar to that of non-Prop 36 meth users in terms of having a substantial majority in the middle adult age range of 26-45 years; yet there was a smaller percentage of younger Prop 36 meth users (19.6% under 26 years) than of non-Prop 36 meth users (30.2% under 26 years[28]). Users of other drugs (both Prop 36 and non-Prop 36 groups) had higher percentages (26.6% and 26.9%) in the oldest (46 and older) category than did the meth-using subgroups (15.7% and 9.5%).

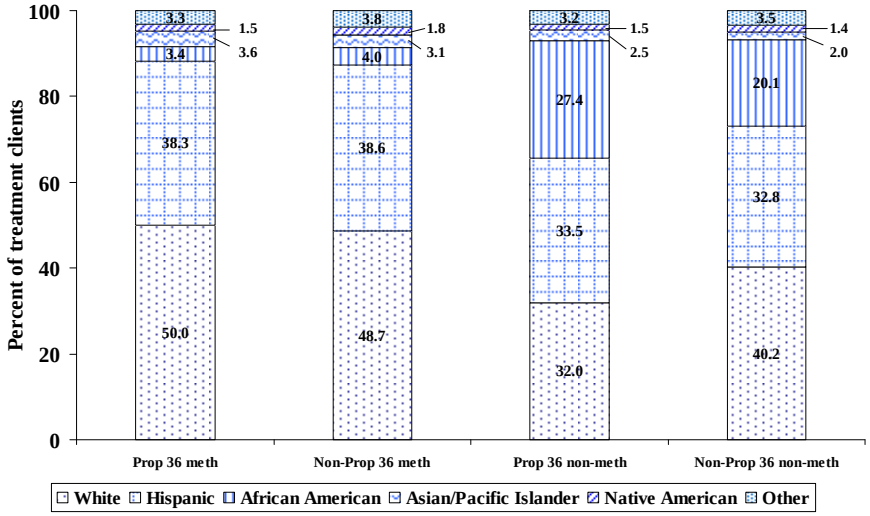
[28] Note that Prop 36 is for clients 18 years and older. Clients younger than 18 are included in the "25 & younger" category for non-Prop 36 clients.

Figure 4.1
Age of Treatment Clients
for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS, 7/1/06 – 6/30/07 (N =172,400)



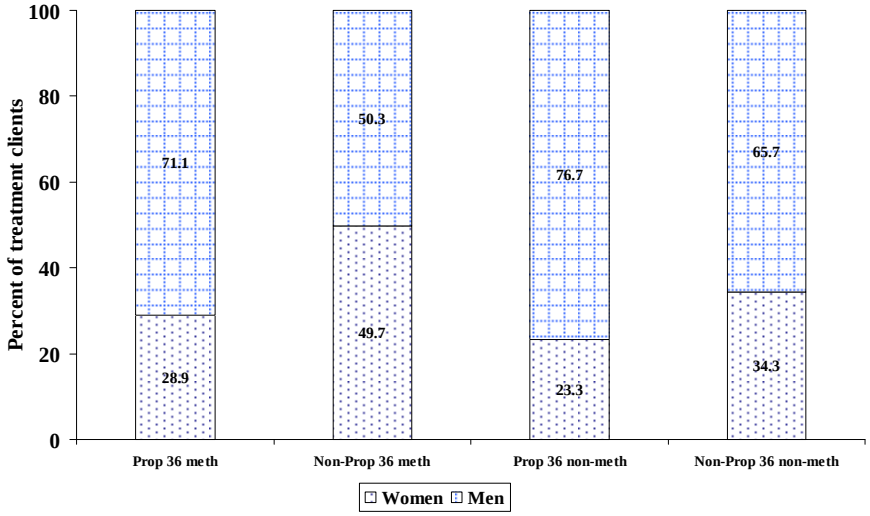
Half of Prop 36 meth users were White; 38.3% were Hispanic; 3.4% were Black; 3.6% were Asian American/Pacific Islander; and 3.3% were of other race/ethnicity (Figure 4.2). This resembled quite closely the distribution for non-Prop 36 meth users. To summarize, meth users were predominantly White or Hispanic, with the total across these two race/ethnicity categories of 88.3% for Prop 36 meth users and 87.3% for non-Prop 36 meth users. Compared to meth users, users of other drugs had lower proportions of Whites and Hispanics (totaling 65.5% for Prop 36 non-meth users and 73.0% for non-Prop 36 non-meth users).

Figure 4.2
Race/Ethnicity of Treatment Clients
for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS, 7/1/06 – 6/30/07 (N =172,400)



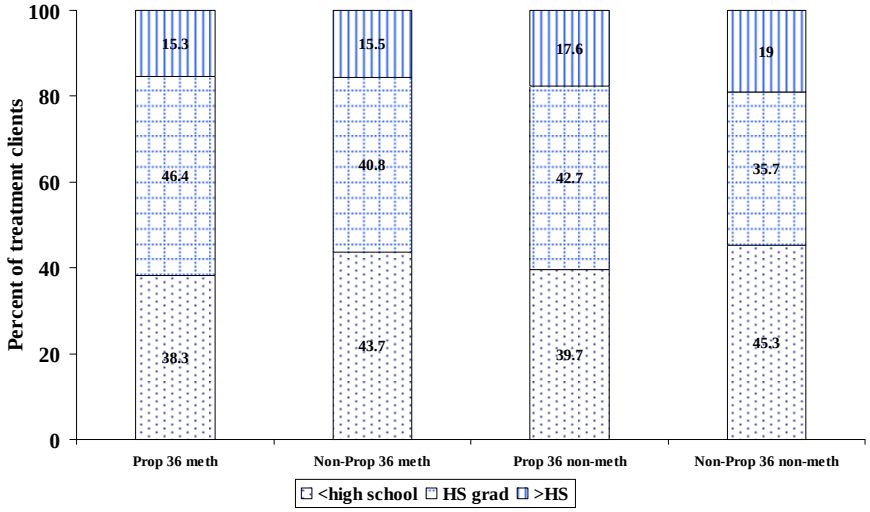
Women were disproportionately represented among meth users compared to users of other drugs (Figure 4.3). This was most notable among non-Prop 36 clients where 49.7% of non-Prop 36 meth users were women compared to 34.3% of non-Prop 36 non-meth users. While the proportion of women among Prop 36 users was low overall (26.4% of all Prop 36 clients), women's representation among Prop 36 meth users was also relatively higher (28.9%) compared to Prop 36 users of other drugs (23.3%).

Figure 4.3
Gender of Treatment Clients
for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS, 7/1/06 – 6/30/07 (N =172,400)



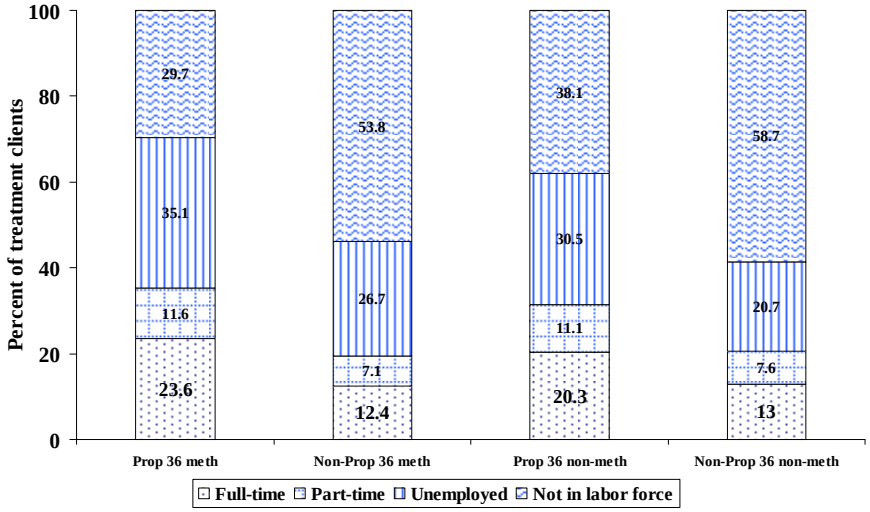
Prop 36 meth users had the highest percentage of clients with high school or greater education (a total of 61.7%), only slightly higher than the 60.3% for Prop 36 non-meth users, compared to a range of 54.7% to 56.3% for the two non-Prop 36 groups (Figure 4.4). Note that the non-Prop 36 groups also included admissions for clients under 18 years of age; and this could have influenced the proportion with less than high school educational levels.

Figure 4.4
Education Level of Treatment Clients
for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS, 7/1/06 – 6/30/07 (N =172,400)



More than one-third (35.2%) of Prop 36 meth users were employed either part- or full-time (11.6% and 23.6%, respectively); another 35.1% were unemployed; and 29.7% were not in the labor force (Figure 4.5). This distribution resembled that of Prop 36 non-meth users and was quite different from those of the two non-Prop 36 groups. The two non-Prop 36 groups had substantially higher percentages of clients not in the labor force (53.8% and 58.7% for meth and non-meth subgroups, respectively) and smaller percentages employed (combining part- and full-time, 19.8% and 20.6% for meth and non-meth subgroups). These results may also reflect the higher percentage of women and younger users in the non-Prop 36 groups (who tend to have lower employment rates) than in the Prop 36 groups.

Figure 4.5
Employment Status of Treatment Clients
for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS, 7/1/06 – 6/30/07 (N =172,400)



Substance use history

Prop 36 meth users (at 13.4 years), like other meth users (at 12.2 years), had substantially shorter primary substance use histories prior to treatment compared to users of other substances (17.6 years for Prop 36 non-meth users and 16.9 years for non-Prop 36 non-meth users). (See Figure 4.6.) Among Prop 36 meth users, 59.3% reported a secondary substance (Figure 4.7). A lower percentage (53.7%) of non-Prop 36 non-meth users reported secondary substance use, while higher percentages (63.9% and 68.8%) were reported by non-Prop 36 meth users and Prop 36 non-meth users. Past year injection use was reported by 12.2% of Prop 36 meth users, slightly below the 15.0% of other meth users, and well below the 17.2%-22.8% for users of other substances (Figure 4.8). Injection use differences would be expected since the non-meth groups include primary heroin users who typically have higher rates of injection use.

Figure 4.6
Average Years Since First Use of Primary Drug
for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS, 7/1/06 – 6/30/07 (N =172,400)

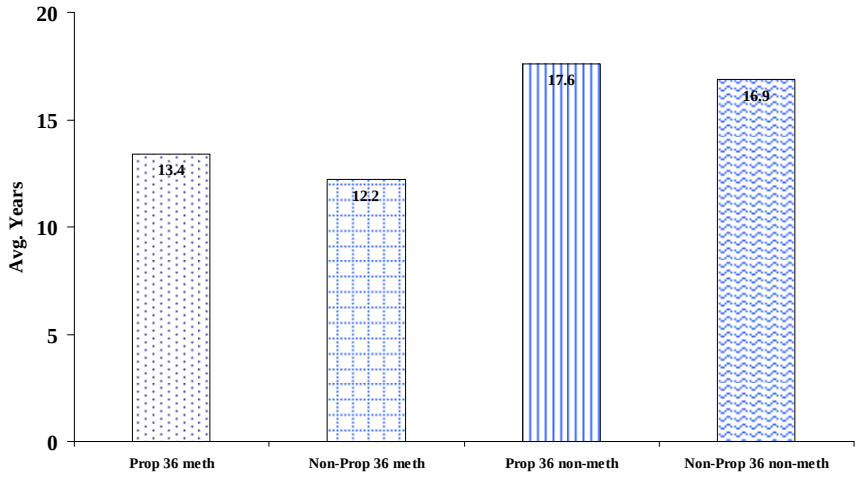


Figure 4.7
Percentage of Treatment Clients Reporting Secondary Drug
for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS, 7/1/06 – 6/30/07 (N =172,400)

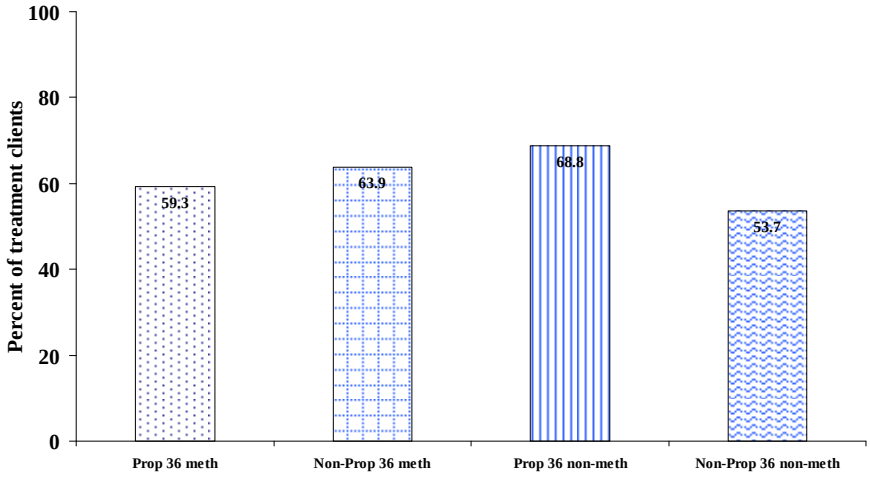
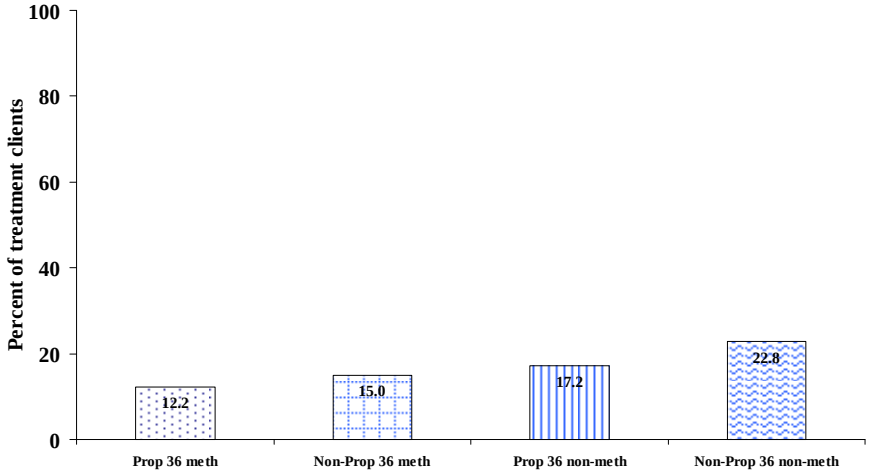


Figure 4.8
Percentage of Treatment Clients with Injection Use in Past Year for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS, 7/1/06 – 6/30/07 (N =172,400)



Treatment characteristics

Slightly higher percentages of prior substance abuse treatment were reported by the two Prop 36 subgroups (53.7% for meth users and 52.1% for non-meth users) than by the two non-Prop 36 groups (50.7% for the meth subgroup and 48.7% for the non-meth subgroup). (See Figure 4.9.) Most Prop 36 meth users (84.5%) were referred through Prop 36 probation, a percentage almost identical to the Prop 36 non-meth users (84.3%).

Most Prop 36 meth users (84.7%) were admitted to outpatient treatment, at a slightly greater rate than for Prop 36 non-meth users (81.7%).[29] (See Figure 4.10.) The two Prop 36 groups had similar percentages (12.6% and 12.9%) admitted to residential treatment ≥ 30 days. The general patterns for the two Prop 36 groups were quite different from the two non-Prop 36 groups. The non-Prop 36 meth users were twice as likely as the Prop 36 groups to enter residential treatment ≥ 30 days (27.1%). The non-Prop non-meth group had the highest rates for detox (12.4%), NTP detox (6.1%), and NTP maintenance (11.4%) consistent with its inclusion of heroin users.

[29] Detoxification by itself is typically not considered to be complete substance abuse treatment, but with its success partially determined by whether a client remains in some type of substance abuse treatment following detoxification. The CalOMS Evaluation (Rawson et al., 2008) found that about 3/4 of episodes beginning with detox did not include subsequent treatment service. However, we have included episodes consisting of detox or beginning with detox in the current analyses in order to retain a more complete picture of the range of services in the CA alcohol and drug treatment system.

Figure 4.9
Percentage of Treatment Clients with Prior Treatment
for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS, 7/1/06 – 6/30/07 (N =172,400)

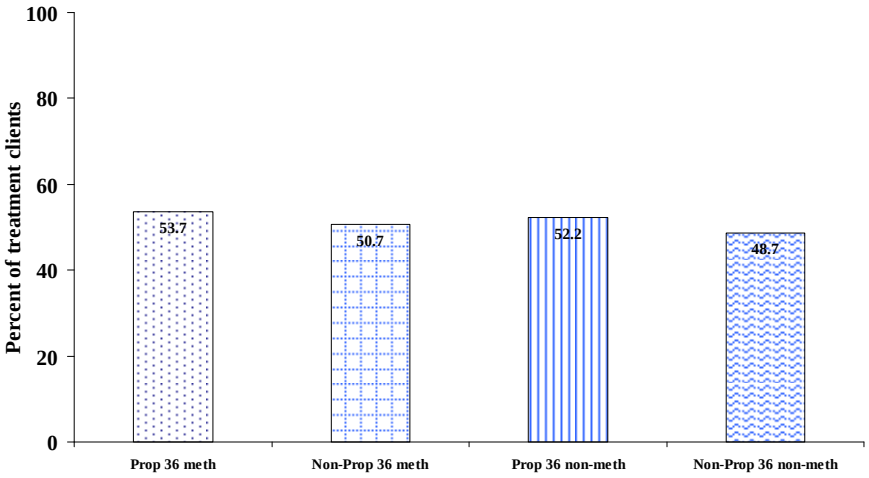
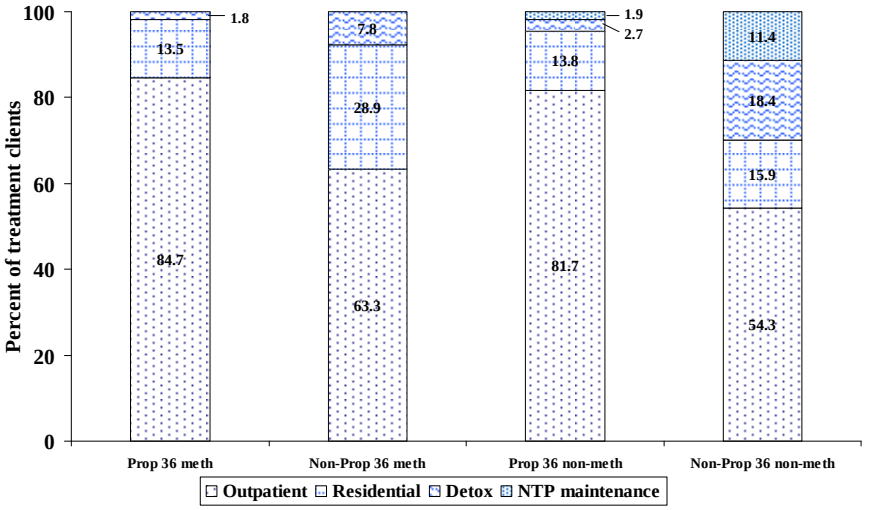


Figure 4.10
Modality of Treatment Clients
for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS Admissions, 7/1/06 – 6/30/07 (N =172,400)



Summary

Interestingly, the Prop 36 meth users most closely resembled non-Prop 36 meth users on some characteristics and Prop 36 non-meth users on other characteristics. On age, ethnicity, length of primary drug use history, and past year injection use, the meth vs. non-meth distinction took precedence. In general, meth users were older and more likely

to be White or Hispanic, with shorter primary drug history and lower rates of injection drug use than non-meth users. On gender, education, and employment, the Prop 36 vs. non-Prop 36 distinction was dominant, with Prop 36 meth users more similar to Prop 36 non-meth users than to non-Prop 36 clients. In general, Prop 36 client groups had lower percentages of women, higher educational level, and higher rates of employment than did non-Prop 36 groups. And, on modality, the Prop 36 vs. non-Prop 36 distinction strongly outstripped any meth vs. non-meth distinction, with Prop 36 clients (both meth and non-meth) more likely to be admitted to outpatient treatment than were non-Prop 36 groups.

Results: Treatment Performance/Outcomes

Performance Measures

Results for treatment performance measures (for treatment *episodes*) appear in Table 4.3. Prop 36 meth users had a completion rate for episodes of treatment (37.2%) only very slightly lower than other Prop 36 clients (38.5%), but higher than non-Prop 36 clients (34.5% for meth users and 35.9% for clients with other primary drugs (Figure 4.11).

Table 4.3. CalOMS Performance Measures for Prop 36 Primary Methamphetamine Users and Comparison to Prop 36 Users of Other Primary Substances, Non-Prop 36 Meth and Other Primary Drug Users[a]

	Methamphetamine		Other Primary Drug	
	Prop36 n=21,449	Non-Prop36 n=31,572	Prop36 n=16,423	Non-Prop36 n=76,563
Completed treatment, %	37.2	34.5	38.5	35.9
Retention (across all types of treatment)				
Avg. no. days in treatment	117.0	94.2	115.1	87.4
Median no. days in treatment	90	62	87	51
% with retention >=60 days	61.0	51.3	59.9	46.6
% with retention >= 90 days	50.3	40.6	48.9	36.5
Retention (avg. days) by admission modality[b]				
Outpatient[c]	120.1	109.1	119.5	111.8
Residential<=30 days	68.4	39.1	56.8	30.1
Residential>30 days	112.5	93.3	105.5	81.4
Detox	50.9	24.8	43.8	21.8
% with Retention>=60 days by admission modality[b]				
Outpatient[c]	61.9	57.9	61.8	61.6

Table 4.3. CalOMS Performance Measures for Prop 36 Primary Methamphetamine Users and Comparison to Prop 36 Users of Other Primary Substances, Non-Prop 36 Meth and Other Primary Drug Users[a]

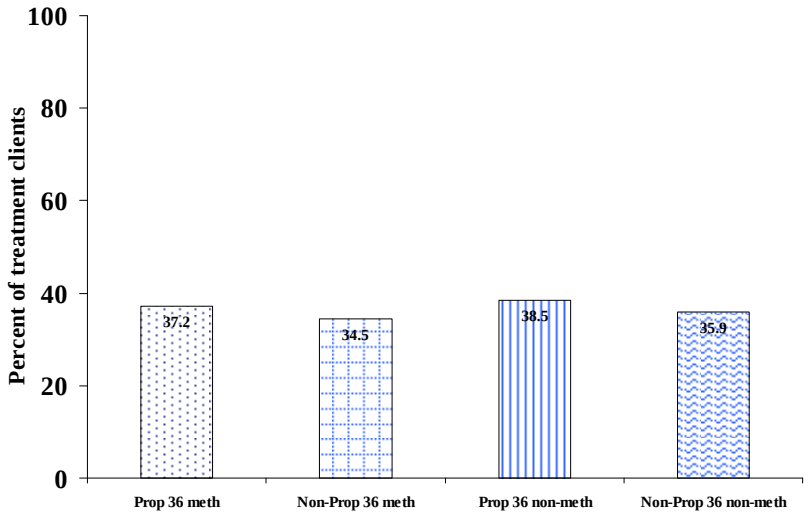
	Methamphetamine		Other Primary Drug	
	Prop36 n=21,449	Non-Prop36 n=31,572	Prop36 n=16,423	Non-Prop36 n=76,563
Residential>30 days	63.5	54.4	59.2	49.7
Detox	27.3	12.5	22.9	9.2

[a] Total n=145,947. Of the 145,947, a few had missing or invalid data for discharge status (n=1,713) or retention (n=1,494).

[b] Residential<=30 days, NTP detox, and NTP maintenance are not shown in these sections because the Prop36 groups were too small for reasonable comparison.

[c] Outpatient treatment was the most common for all groups: 83% of Prop36 meth group, 58% of non-Prop3 meth group, 80% of Prop36 non-meth, and 50% of non-Prop36 non-meth.

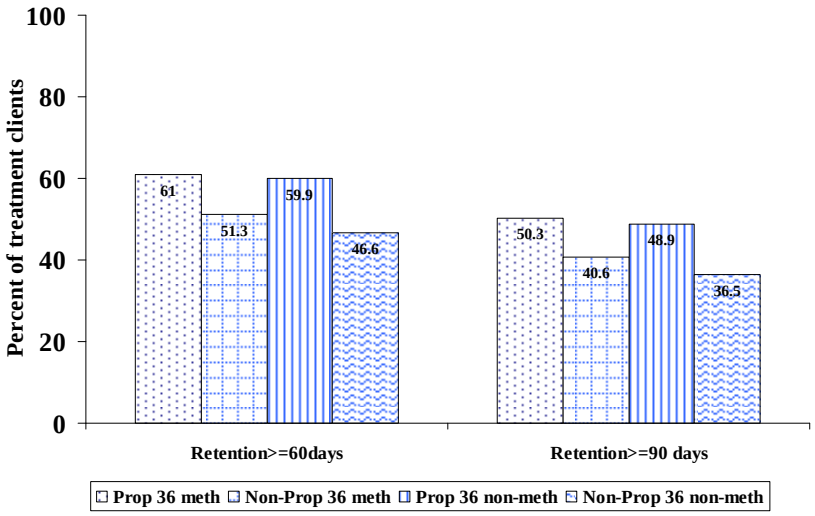
Figure 4.11
Percentage Completing Treatment
for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS Episodes, beginning 7/1/06 – 6/30/07 (N =145,947)



In terms of treatment retention, Prop 36 meth users (average of 117 days) were similar to other Prop 36 clients (average of 115 days) with longer retention than for the non-Prop 36 groups (94 days for non-Prop 36 meth users and 87 for non-meth users). Considering a 60-day retention threshold, results showed similar proportions for Prop 36 meth and non-meth users, at 61.0% and 59.9%, respectively, achieving retention in treatment episodes of at least 60 days. This rate was substantially higher than 60-day retention rates for non-Prop 36 groups (51.3% for non-Prop 36 meth users and 46.6% for non-meth users). A similar relative pattern across groups was seen for 90-day retention, but with lower

percentages across all groups than for 60-day retention. Half of the Prop 36 meth group (50.3%) achieved retention of at least 90 days, while 48.9% of the Prop 36 non-meth group had retention of at least 90 days. Non-Prop 36 groups had 90-day retention rates of 40.6% (meth) and 36.5% (non-meth).

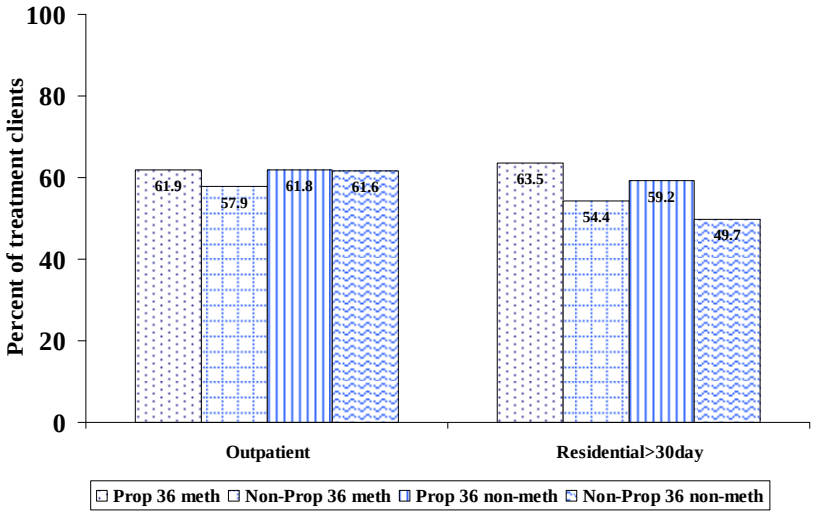
Figure 4.12
Percentage with 60- and 90-Day Retention
for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS Episodes, beginning 7/1/06 – 6/30/07 (N =145,947)



Because expected retention can differ by type of treatment and because Prop 36 clients (both meth and non-meth users) were more likely than non-Prop 36 clients to be admitted to outpatient treatment, we also examined retention for each group by type of treatment at episode admission[30]. Similar patterns to that described above of longer retention for Prop 36 clients (both meth and non-meth) compared to non-Prop 36 clients was seen for each modality, considering either average retention or 60-day retention rates. Results for 60-day retention are also shown in Figure 4.13 for outpatient and residential (>30 day) modalities. Differences across groups in 60-day retention rates are somewhat more pronounced for residential treatment as compared to outpatient.

[30] The CalOMS Evaluation (Rawson et al., 2008) found that approximately 85% of episodes ending in FY06-07 contained only one service set (and thus one type of service). Of those with more than one service set, about 1/3 still had only one type of service modality across the multiple service sets. For our analyses, episodes with more than one service set were categorized by the type of treatment in the first service set within the episode.

Figure 4.13
Percentage with 60- Retention by Selected Modalities
for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS Episodes, beginning 7/1/06 – 6/30/07 (N =145,947)



Outcome Domains

Prop 36 meth users, similar to other groups, demonstrated substantial improvement in all outcome domains (Table 4.4). (See also Technical Notes 2 and 3.) In terms of number of days of primary substance use in the past 30 days, the average at discharge (across all episodes) had declined to less than half that at admission for Prop 36 meth users (from 4.8 to 2.0 days [Figure 4.14]). Considering only episodes in which the client reported some days of primary substance use in the 30-days prior to admission, the decrease was even more substantial, from an average of 9.4 days at admission to 3.2 days at discharge for Prop 36 meth users. The percentage with any primary substance use in the past 30 days at discharge also declined to less than half the percentage at admission (from 50.9% to 24.8% [Figure 4.15]). (See Technical Notes 4 and 5.) These relative declines were quite similar to those of Prop 36 non-meth users (declines from an average across all episodes of 6.5 to 3.0 days and from 54.2% to 26.7% with any primary substance use). Non-Prop 36 meth users had only very slightly lower proportional declines in primary substance use (from an average across all episodes of 7.3 to 3.4 days and from 55.0% to 27.9% with any primary substance use). The non-Prop 36 non-meth group demonstrated slightly smaller proportional decreases (from an average across all episodes of 13.4 to 7.2 days and from 73.0% to 45.5%).[31]

[31] Note that the non-Prop 36 non-meth users had higher levels of substance use than other groups at both admission and discharge, with greater decreases if measured as simple differences between admission and discharge. However, relative proportional decreases were not as great as for the other groups. (See also Technical Note 4.)

Table 4.4. CalOMS Outcomes for Prop 36 Primary Methamphetamine Users and Comparison to Prop 36 Users of Other Primary Substances, Non-Prop 36 Meth and Other Primary Drug Users [a]

		Methamphetamine		Other Primary Drug	
		Prop36 n=11,345	Non-Prop36 n=16,118	Prop36 n=8,184	Non-Prop36 n=38,158
Primary Drug Use					
Any use in past 30 days, %	Adm[b]	50.9	55.0	54.2	73.0
	Dischg	24.8	27.9	26.7	45.5
Average days of use in past 30 days (across all episodes)	Adm	4.8	7.3	6.5	13.4
	Dischg	2.0	3.4	3.0	7.2
Median days of use in past 30 days (across all episodes)	Adm	1	1	1	9
	Dischg	0	0	0	0
Average days of use in past 30 days (for episodes with any use at admission)	Adm	9.4	13.3	12.0	18.3
	Dischg	3.2	5.7	4.8	9.6
Median days of use in past 30 days (for episodes with any use at admission)	Adm	5.0	10.0	7.0	20.0
	Dischg	0	0	0	2.0
CJS involvement (any arrests, jail or prison days) in past 30 days, %	Adm	32.3	23.8	31.2	14.5
	Dischg	7.7	6.2	7.9	5.3
Employed (current), %	Adm	35.0	18.0	32.5	21.0
	Dischg	46.0	28.0	42.1	25.1
Employed or enrolled in school or training (current), %	Adm	38.33	25.9	39.3	36.7
	Dischg	50.9	38.0	50.1	40.8
Living situation (primary status in past 30 days), %					
Homeless	Adm	10.7	24.6	14.6	24.3
	Dischg	8.3	19.7	12.3	21.0
Dependent living	Adm	43.6	41.3	40.8	40.4

Table 4.4. CalOMS Outcomes for Prop 36 Primary Methamphetamine Users and Comparison to Prop 36 Users of Other Primary Substances, Non-Prop 36 Meth and Other Primary Drug Users [a]

		Methamphetamine		Other Primary Drug	
		Prop36 n=11,345	Non-Prop36 n=16,118	Prop36 n=8,184	Non-Prop36 n=38,158
	Dischg	41.8	41.4	38.7	41.7
Independent living	Adm	45.6	34.1	44.7	35.3
	Dischg	49.9	38.9	49.1	37.4
Family conflict (any days in past 30 days), %	Adm	8.2	14.2	7.8	14.1
	Dischg	5.4	6.5	5.5	7.5
Any days with social support recovery activities (in past 30 days), %	Adm	49.0	43.6	44.2	29.7
	Dischg	69.8	74.6	65.2	57.1

a Total n=73,805. Results are reported for episodes which had valid data at both admission and discharge for specific outcome measure. Number of episodes with missing data: criminal justice involvement (22), family conflict (20,852), all other outcomes (0).

b Adm = admission; Dischg = discharge

Figure 4.14
Average Days of Primary Drug in Past 30 Days at Admission/Discharge for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS Episodes, beginning 7/1/06 – 6/30/07 (N =73,805)

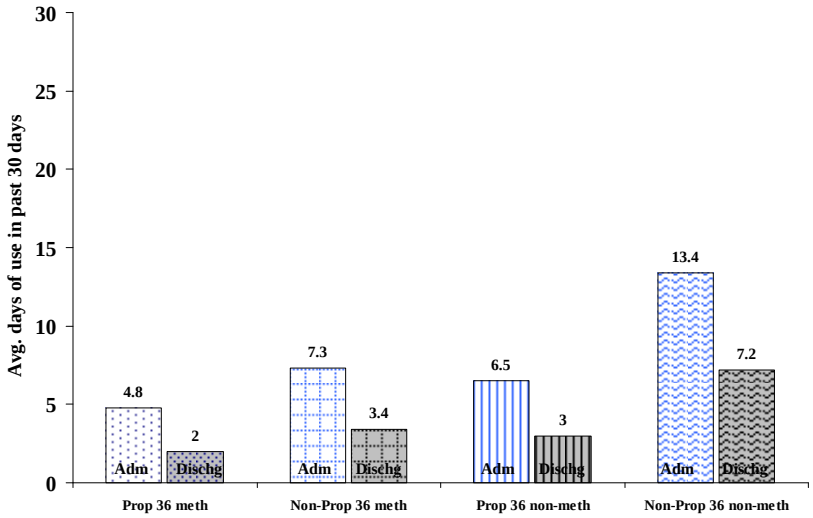
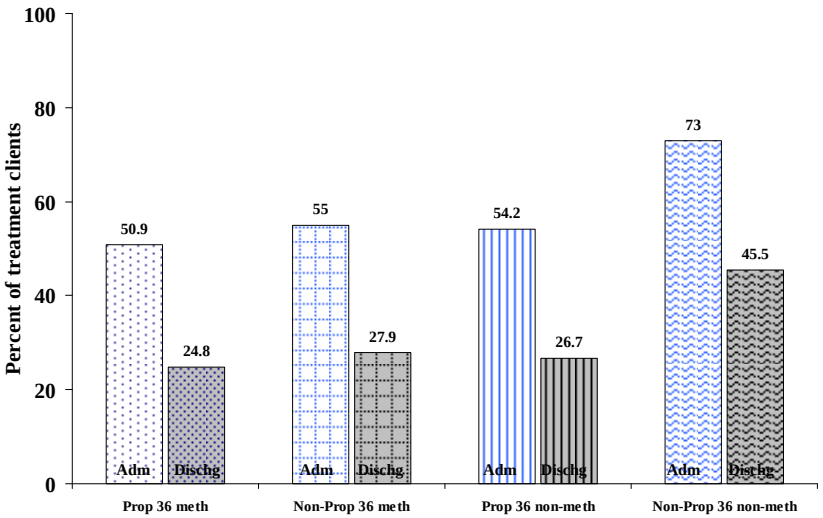
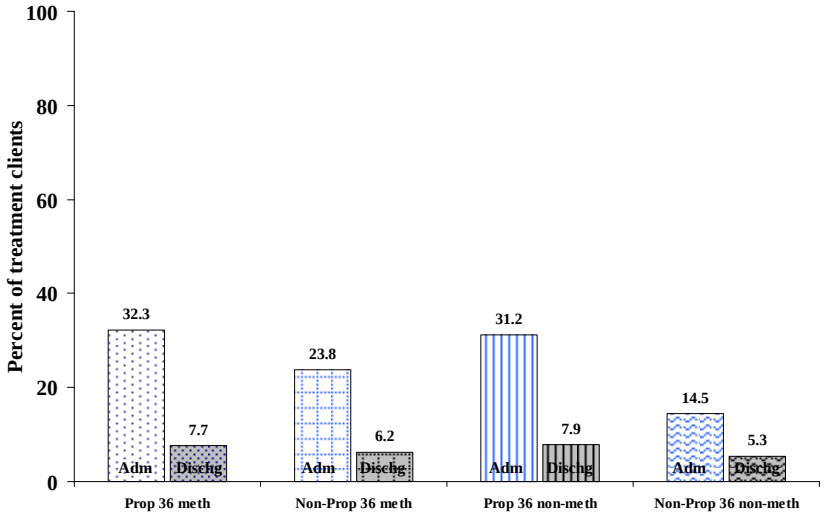


Figure 4.15
Percentage with Any Use of Primary Drug in Past 30 Days at Admission/Discharge for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS Episodes, beginning 7/1/06 – 6/30/07 (N =73,805)



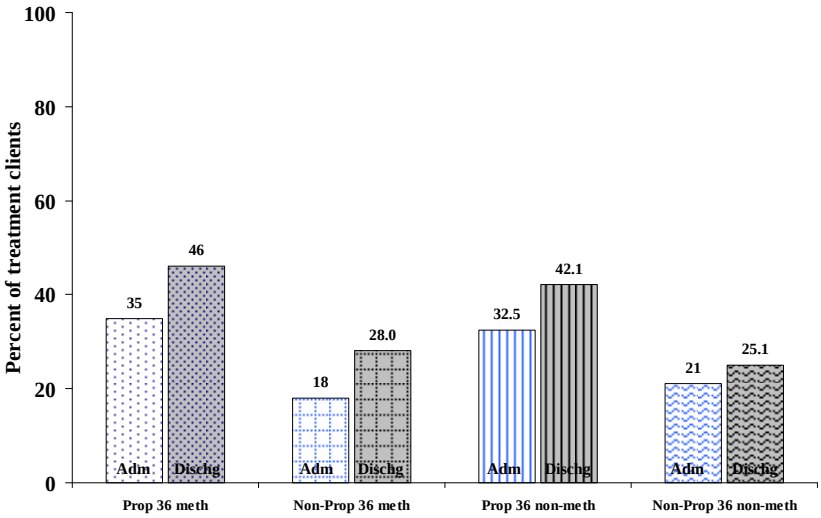
Prop 36 meth users experienced decreases in self-reported CJS involvement (any arrests, jail or prison days in past 30 days) similar to other Prop 36 clients, with proportional decreases for both Prop 36 groups slightly greater than for non-Prop 36 meth users and substantially greater than for non-Prop 36 non-meth users (Figure 4.16). The CJS involvement rate decreased from 32.3% to 7.7% for Prop 36 meth users and from 31.2% to 7.9% for other Prop 36 clients.

Figure 4.16
Percentage with Any CJS Activity in Past 30 Days at Admission/Discharge for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS Episodes, beginning 7/1/06 – 6/30/07 (N =73,805)



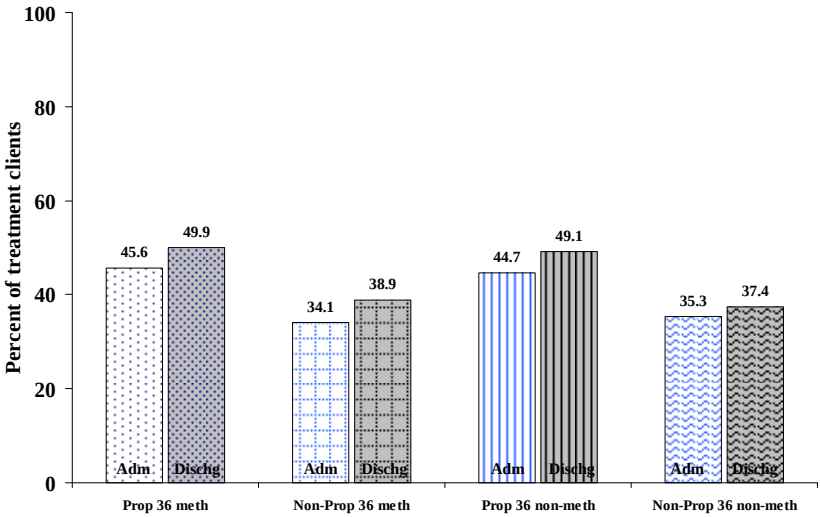
Employment rates increased for Prop 36 meth users (from 35.0% to 46.0%) similar to proportional increases for other Prop 36 clients (from 32.5% to 42.1%). (See Figure 4.17. This level of proportional increase for the Prop 36 groups was smaller than that for the non-Prop 36 meth group, which had lower rates of employment overall but a larger proportional increase (from 18% to 28%); but it was larger than for the non-Prop 36 non-meth group (from 21.0% to 25.1%). A similar pattern was seen when considering the outcome measure of employment and/or enrollment in school or training.

Figure 4.17
Percentage Employed at Admission/Discharge
for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS Episodes, beginning 7/1/06 – 6/30/07 (N =73,805)



Stability in housing increased for all groups from episode admission to discharge, reflective of decreases in homelessness for all groups and decreases in dependent living for Prop 36 groups. The largest proportional decreases in homelessness were for the meth user groups (from 10.7% to 8.3% for Prop 36 meth users and from 24.6% to 19.7% for non-Prop 36 meth users). Increases in independent living (shown also in Figure 4.18) were quite similar for the two Prop 36 groups (from 45.6% to 49.9% for meth users and from 44.7% to 49.1% for non-meth users).

Figure 4.18
Percentage Living Independently at Admission/Discharge
for Prop 36 Primary Methamphetamine Users and Comparison Groups
CalOMS Episodes, beginning 7/1/06 – 6/30/07 (N =73,805)



Improvement was seen for Prop 36 meth users as well as all other groups in the two measures of social connectedness. Both levels of and decreases in family conflict were similar for the two Prop 36 groups (from 8.2% to 5.4% for meth users and from 7.8% to 5.5% for non-meth users). (See Figure 4.19.) But these Prop 36 groups started at lower rates and had smaller decreases than did the non-Prop 36 groups, which declined from 14.2% to 6.5% (meth) and 14.1% to 7.5% (non-meth).

Rates of participation in social support recovery activities also improved for all groups (Figure 4.20). The Prop 36 meth group increased any participation from 49.0% to 69.8%, most similar to Prop 36 non-meth users (increased from 44.2% to 65.2%). But these increases for the Prop 36 groups were proportionally smaller than for the non-Prop 36 groups (from 43.6% to 74.6% for non-Prop 36 meth users and from 29.7% to 47.1% for non-meth users).

Figure 4.19
Percentage with Any Days of Family Conflict in Past 30 Days at Admission/Discharge for Prop 36 Primary Methamphetamine Users and Comparison Groups CalOMS Episodes, beginning 7/1/06 – 6/30/07 (N =73,805)

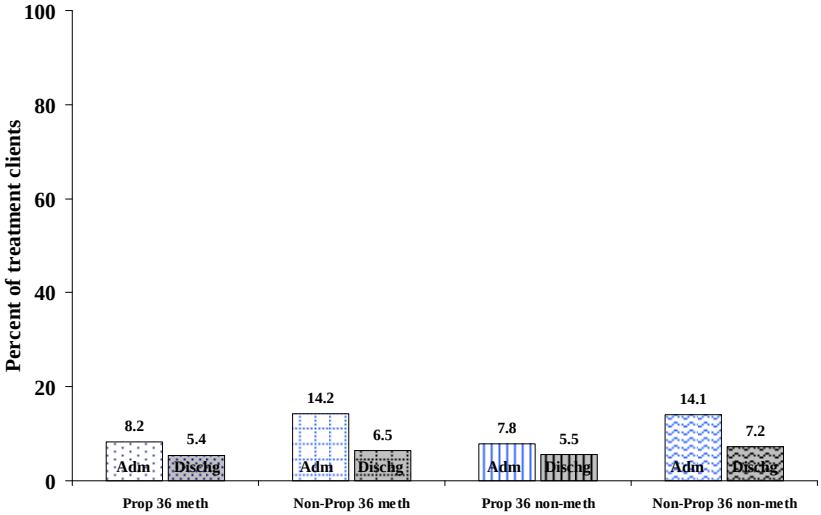
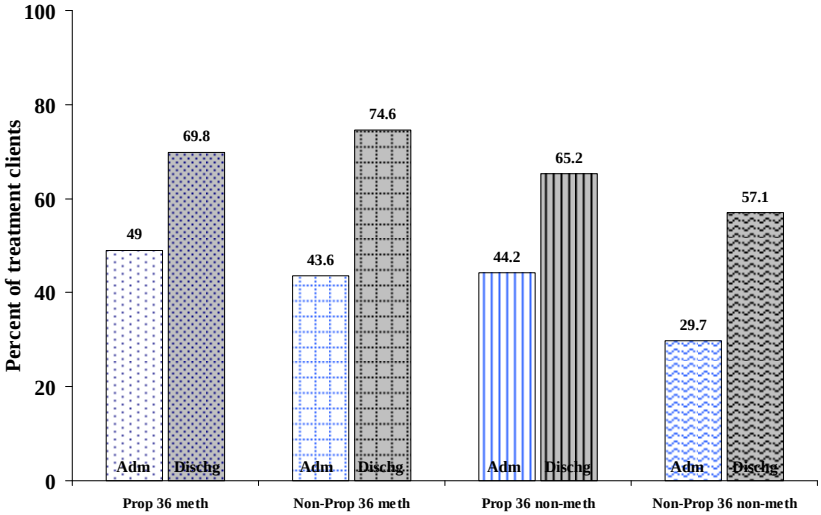


Figure 4.20
Percentage with Any Days of Social Support Recovery Activities in Past 30 Days at Admission/Discharge for Prop 36 Primary Methamphetamine Users and Comparison Groups CalOMS Episodes, beginning 7/1/06 – 6/30/07 (N =73,805)



Summary

In terms of performance measures, Prop 36 meth users had similar completion rates (37.2%) and 60-day retention rates (61.0%) to Prop 36 non-meth users (38.5% and 59.9% for completion and 60-day retention, respectively). 90-day retention followed a similar

pattern. These rates for both Prop 36 groups were higher than those for the non-Prop 36 groups (with completion at 34.5%-35.9% and 60-day retention at 46.6%-51.3%).

Prop 36 meth users showed improvement in all CalOMS outcomes domains (primary substance use, self-reported CJS involvement, employment, stability in housing, and social connectedness). The percentage of Prop 36 meth users with any primary substance abuse decreased from 50.9% in the 30 days preceding episode admission to 24.8% at discharge; this relative decrease was similar to that of Prop 36 non-meth users and non-Prop 36 meth users. For other measures, Prop 36 meth users had patterns of improvement most similar to those of Prop 36 non-meth users.

Results: Re-Offending

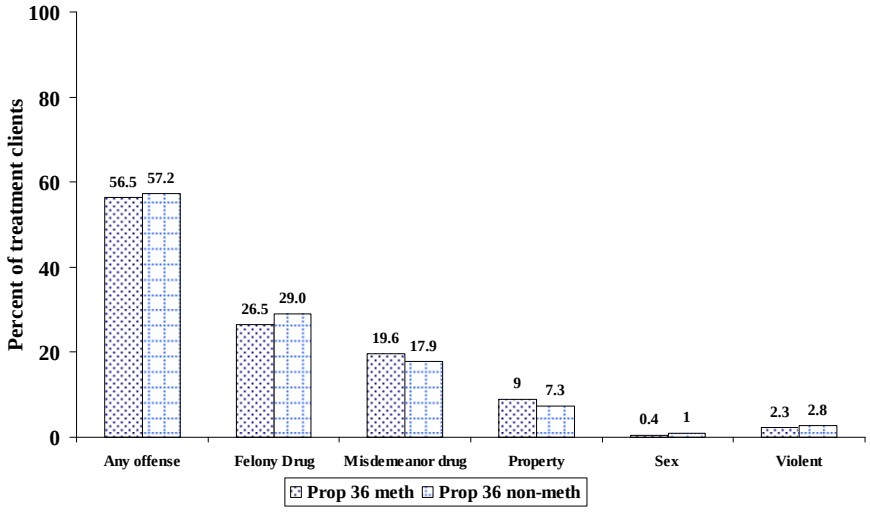
Results from the preliminary analysis of re-offending outcomes are given in Table 4.5 and Figure 4.21. Re-offending rates for the Prop 36 (treated) meth user group were 56.5% for any type of non-technical violation, with an approximately equal distribution between felony and misdemeanor arrest rates.[32] Drug arrest rates for Prop 36 meth users were 40.8%, with felony drug arrests at a somewhat higher level (26.5%) than misdemeanor rates (19.6%). Prop 36 meth user re-offense rates for other types of offenses were 9.0% for property offenses, 0.4% for sex offenses, and 2.3% for violent offenses. Differences between treated Prop 36 meth and non-meth user groups were negligible for most types of offenses. However, Prop 36 meth users had slightly lower rates for felony drug offenses (26.5% vs. 29.0% for non-meth users) and slightly higher rates for property offenses (9.0% vs. 7.3% for non-meth users).

Table 4.5. Re-Offending Outcomes for Treated Prop 36 Primary Methamphetamine Users and Comparison to Prop 36 Users of Other Primary Substances [a]

	Prop36 Meth n=6,459	Prop36 Non-meth n=3,667
Any arrest (non-technical violation)	56.5	57.2
Felony arrest	37.2	38.9
Misdemeanor arrest	28.5	28.3
Drug arrest	40.8	41.0
Felony drug arrest	26.5	29.0
Misdemeanor drug arrest	19.6	17.9
Property crime arrest	9.0	7.3
Sex crime arrest	0.4	1.0
Violent crime arrest	2.3	2.8

[32] Note that felony and misdemeanor rates do not add up to overall arrest rates, since a few offenders had both types.

Figure 4.21
Re-Offending Rates for Subset of Treated Prop 36 Primary Methamphetamine Users and Non-Methamphetamine Users



Discussion

The results of this study contribute evidence consistent with a growing body of evidence showing that treatment outcomes for meth users are not generally inferior to those for non-meth users across a range of performance and outcome measures. This study has shown that Prop 36 meth users experienced rates of treatment completion (37.2%) very similar to those of Prop 36 non-meth users (38.5%), and higher than for non-Prop 36 groups. Retention followed a similar pattern, both across all modalities and within specific major modalities (outpatient, residential>30 days, and detox). Sixty-one percent of Prop 36 meth users had treatment episode discharge data indicating completion, similar to the 59.9% for Prop 36 non-meth users. These results are also consistent with previous assessment of earlier cohorts of Prop 36 clients (e.g. Anglin et al., 2005; Urada et al., 2008).

Treatment outcomes as assessed through CalOMS treatment data showed improvement for Prop 36 meth users in all outcome domains, with patterns of change from admission to discharge similar to those of Prop 36 non-meth users. For substance use and self-reported criminal justice involvement, Prop 36 meth users showed a greater degree of improvement (in proportional terms) than did non-Prop 36 meth and non-meth users. Re-offending rates were also remarkably similar for Prop 36 meth and non-meth users for most types of arrests; meth users had very slightly lower rates of felony drug offenses and slightly higher rates of property offenses.

Patterns for performance and outcomes measures remained generally consistent even when results were adjusted to account for differences in client characteristics across the groups. Prop 36 meth users (similar to other non-Prop 36 meth users) tended to be somewhat older, White, have shorter histories of primary substance use, and lower rates of injection use (similar to other non-Prop 36 meth users) than non-meth users. The Prop 36 meth user group (similar to other Prop 36 clients) had a lower percentage of females, those with less than high school education, employed, and residential treatment admission than did non-Prop 36 clients.

These results should further dispel lingering notions that meth abuse cannot be treated or that treatment may not work for meth users even within the Prop 36 offender population. Studies (cited in the Introduction) suggest that meth users often exhibit mental health problems and/or cognitive deficits, which can complicate treatment. But there has been considerable effort in many counties to provide additional training related to meth dependence to treatment providers. Obtaining and coordinating appropriate services across service delivery systems (e.g. bridging drug treatment, criminal justice, and mental health service systems) remains a challenge according to some stakeholders; and this challenge may also be a barrier to optimal outcomes for meth users, as well as for other drug users.

On the other hand, a growing body of research has developed and documented the potential superiority of some treatment approaches for meth users for at least short-term outcomes. With increased evidence-based practice implementation, one would hope that treatment outcomes for meth use could improve systemwide.

Current analyses have explored characteristics of Prop 36 meth users and compared characteristics, treatment performance and outcomes to other client groups; but further analyses can explore what constellations of characteristics are associated with outcomes. Such results could help identify clients who could potentially benefit from additional intervention strategies. In addition, differential success across counties of treating meth users may facilitate the identification of promising practices.

These results should be interpreted within the context of several possible limitations. 1) Definitions of measures of performance and outcomes may not yet optimally reflect a continuing care perspective appropriate to a chronic illness model. For example, a standard definition of treatment "completion" may be elusive because clients' individual treatment/recovery plans can differ between various types of treatment/modalities and within programs, completion requirements may vary, and determining whether a client has completed those plans may be subjective. Further refinement of appropriate definitions is currently under discussion in the California treatment system. 2) CalOMS outcome measures were available for only about half the episodes, since collection of outcome information is not required for episodes with administrative discharges. The CalOMS evaluation explored potential bias in more detail (Rawson et al., 2008). 3) CalOMS performance and outcomes may be slightly under-estimated in our analyses since not all episodes had a final resolution; a small proportion was still on-going at the end of the observation period. As a longer observation of CalOMS data becomes

available, further analyses can assess fully resolved episodes as well as more complex histories of treatment utilization. 4) Comparisons of results to earlier Prop 36 analyses must be done with some caution. The current analyses utilized the CalOMS database implemented in 2006, whereas earlier analyses used CADDS. An example of a difference in definition between data systems: the current "completion" definition also includes completing program goals/with transfer, slightly different from earlier definitions. 5) Results presented for re-offending outcomes are considered preliminary. Re-offending data on a more comprehensive set of Prop 36 offenders should be explored.

References

Anglin, M. D., Urada, D., Brecht, M. L., Hawken, A., Rawson, R., & Longshore, D. (2007). Criminal Justice Treatment Admissions for Methamphetamine Use in California: A Focus on Proposition 36. *Journal of Psychoactive Drug*s, SARC Supplement 4, 367-382.

Baicy, K. & London, E. (2007). Corticolimbic dysregulation and chronic methamphetamine abuse. *Addiction, 102*, 5-15.

Brecht, M.-L. (2005). *Methamphetamine in the Workplace: Report to the California Dept. of Alcohol & Drug Programs*. Los Angeles: UCLA-ISAP. Retrieved May 27, 2009, from: http://www.adp.cahwnet.gov/oara/pdf/UCLAWhitePaperMeth.pdf.

Brecht, M.-L., Anglin, M. D., & Dylan, M. (2005a). Coerced treatment for methamphetamine abuse: differential patient characteristics and outcomes. American Journal of Drug and Alcohol Abuse, 31(2), 337-356.

Brecht, M.-L. (2008). *Los Angeles County Drug Trend Update*. Presented at the Community Epidemiology Work Group meeting June 12, Bethesda, MD.

Brecht, M.-L., Greenwell, L., & Anglin, M.D. (2005b). Methamphetamine treatment: trends and predictors of retention and completion in a large state treatment system (1992-2002). *Journal of Substance Abuse Treatment, 29*, 295-306.

Brecht, M.-L. Greenwell, L., von Mayrhauser, & Anglin, M. D. (2006). Two-year outcomes of treatment for MA use. *Journal of Psychoactive Drugs*, SARC Supplement No. 3, November, 415-426.

Brecht, M.-L., Stein, J., Evans, E., Murphy, D., & Longshore, D. (2009). Predictors of intention to change HIV sexual and injection risk behaviors among heterosexual methamphetamine-using offenders in drug treatment: A test of the AIDS Risk Reduction Model. *Journal of Behavioral Health Services Research*, *36*, 247-266.

California Dept. of Alcohol and Drug Programs (ADP). (2007) Fact Sheet: Methamphetamine Users in Treatment. Sacramento, CA: ADP. Retrieved January 27, 2009 from: http://www.adp.ca.gov/FactSheets/Methamphetamine_Users.pdf

Ernst, A., Weiss, S., Enright-Smith, S., Hilton, E. & Byrd, E. (2008). Perpetrators of intimate partner violence use significantly more methamphetamine, cocaine, and

alcohol than victims: a report by victims. *American Journal of Emergency Medicine, 26,* 592-596.

Glasner-Edwards, S., Mooney, L., Marinelli-Casey, P., Hillhouse, M., Ang, A., Rawson, R. & the Methamphetamine Treatment project Corporate Authors. (2008). Risk factors for suicide attempts in methamphetamine-dependent patients. *The American Journal on Addiction, 17*, 24-27.

Gonzales, R., Marinelli-Casey, P., Hillhouse, M., Hunter, J., Rawson, R.A., Mooney, L., & Ang, A. (2008). Hepatitis A and B infection among methamphetamine-dependent users. *Journal of Substance Abuse Treatment, 35*, 351-352.

Halkitis, P., Mukherjee, p., & Palamar, J. (2008—epub ahead of print). Longitudinal modeling of methamphetamine use and sexual risk behaviors in gay and bisexual men. *AIDS Behavior.*

Hawken, A., Anglin, M. D., & Conner, B.T. (2007). Treatment differences. In: Evaluation of the Substance Abuse and Crime Prevention Act 2005 Report. Los Angeles: UCLA Integrated Substance Abuse Programs. Retrieved April 13, 2007, from: http://www.uclaisap.org/prop36/documents/SACPAEvaluationReport.pdf

Hawken, A., Longshore, D., Urada, D., Fan, J., & Anglin, M. D. (2008). Proposition 36 Benefit-Cost Analysis. In Urada et al., *Evaluation of Proposition 36: The Substance Abuse and Crime Prevention Act of 2000. 2008 Report.* Los Angeles: UCLA Integrated Substance Abuse Programs. Retrieved January 27, 2009, from: http://www.uclaisap.org/prop36/documents/2008%20Final%20Report.pdf

Hillhouse, M., Marinelli-Casey, P., Gonzales, R., Ang, A., Rawson, R. & the Methamphetamine Treatment Project Corporate Authors. (2007) Predicting in-treatment performance and post-treatment outcomes in methamphetamine users. *Addiction, 102* (Suppl. 1), 84-95.

Hser, Y.-I., Huang, Y., Chou, C.-P., & Anglin, M. D. (in press) Longitudinal patterns of treatment utilization and outcomes among methamphetamine abusers: a growth curve modeling approach. *Journal of Drug Issues*.

Krasnova, R., & Cadet, J. (2009) Methamphetamine toxicity and messengers of death. *Brain Research Reviews*, *60*, 379-407.

Lapworth, K., Dawe, S., Davis, P., Kavanagh, D., Young, R., & Saunders, J. (2009) Impulsivity and positive psychotic symptoms influence hostility in methamphetamine users. *Addictive Behaviors, 34*, 380-385.

Lee, N. & Rawson, R. (2008) A systematic review of cognitive and behavioural therapies for methamphetamine dependence. *Drug and Alcohol Review, 27*, 309-17

London, E., Simon, S., Berman, S., Mandelkern, M., Lichtman, A., Bramen, J., Shinn, A., Miotto, K., Learn, J., Dong, Y., Matochik, J., Kurian, V., Newton, T., Woods, R., Rawson, R., & Ling, W. (2004). Mood disturbances and regional metabolic abnormalities in recently abstinent MA users. *Archives of General Psychiatry, 61,* 73-84.

London, J., Utter, G., Battistella, F., & Wisner, D. (2009) Methamphetamine use is associated with increased hospital resource consumption among minimally

injured trauma patients. *Journal of Trauma Injury, Infection, and Critical Care*, *66*, 485-490.

Luchansky, B., Krupski, A., & Stark, K. (2007). Treatment response by primary drug of abuse: does methamphetamine make a difference? *Journal of Substance Abuse Treatment, 32*, 89-96.

Maxwell, J. & Rutkowski, B. (2008). The prevalence of methamphetamine and amphetamine abuse in North America: a review of the indicators, 1992-2007. *Drug & Alcohol Review, 27*, 229-235.

McCann, U., Kuwabara, H., Kuman, A., Palermo, M., Abbey, R., Brasic, J., Ye, W., Alexander, M., Dannals, R., Wong, D., & Ricaurte, G. (2008). Persistent cognitive and dopamine transporter deficits in abstinent methamphetamine users. *Synapse, 62*, 91-100.

McKetin, R., Kelly, E., McLaren, J., & Proudfoot, H. (2008). Impaired physical health among methamphetamine users in comparison with the general population: the role of methamphetamine dependence and opioid use. *Drug & Alcohol Review, 27*, 482-489.

McKetin, R., McLaren, J., Lubman, D. & Hides, L. (2006). The prevalence of psychotic symptoms among methamphetamine users. *Addiction, 101,* 1473-1378.

Messina, N., Marinelli-Casey, P., West, K., & Rawson, R. (in press). Children exposed to methamphetamine use and manufacture. *Child Abuse & Neglect.*

National Association of Counties (2007). The Meth Epidemic: The Changing Demographics of Methamphetamine. Washington, DC: National Association of Counties, Research Division.

National Drug Intelligence Center (NDIC) (2006). *National Drug Threat Assessment*. Washington, D.C.: U.S. Department of Justice. Retrieved from the NDIC website January 27, 2009: http://www.usdoj.gov/ndic/pubs11/18862/18862p.pdf

National Drug Intelligence Center (2007). *National Methamphetamine Threat Assessment 2008*. Washington, D.C.: U.S. Department of Justice. Retrieved from the NDIC website January 27, 2009: http://www.usdoj.gov/ndic/pubs26/26594/26594p.pdf

National Drug Intelligence Center (2009). *National Drug Threat Assessment 2009*. Washington, D.C.: U.S. Department of Justice. Retrieved from the NDIC website January 27, 2009: http://www.usdoj.gov/ndic/pubs31/31379/31379p.pdf

Nicosia, N., Pacula, R., Kilmer, B., Lundberg, R., & Chiesa, J. (2009) *The Economic Cost of Methamphetamine Use in the United States, 2005*. Santa Monica, CA: The Rand Corp.

Nordahl, T., Salo, R. & Leamon, N. (2003). Neuropsychological effects of chronic MA use on neurotransmitters and cognition: A review. *Journal of Neuropsychiatry & Clinical Neuroscience*, 15(3), 317-325.

(ONDCP) Office of National Drug Control Policy. (2004). *The Economic Costs of Drug Abuse in the United States: 1992–2002*. Washington, DC: The White House.

Ostler, T., Haight, W., Black, J., Choi, G. Y., Kingery, L., & Sheridan, K. (2007). Case series: mental health needs and perspectives of rural children reared by parents who abuse methamphetamine. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*, 500-507.

Rawson, R., Huber, A., Brethen, P., Obert, J., Gulati, V, Shoptaw, S., & Ling, W. (2002). Status of methamphetamine users 2-5 years after outpatient treatment. *Journal of Addictive Diseases*, *21*, 107-119.

Rawson, R., Gonzales, R., Brecht, M.-L., & Crèvecoeur-MacPhail, D. (2008). Evaluation of the California Outcomes Measurement System. Los Angeles: UCLA-ISAP.

Roll, J., Petry, N., Stitzer, M., Brecht, M.-L., Peirce, J., McCann, M., & Blaine, J. (2006) Contingency management for the treatment of methamphetamine use disorders. American Journal of Psychiatry, 163(11), 1993-1999.

(SAMHSA) Substance Abuse and Mental Health Administration, Office of Applied Studies. (2008a). *Results from the 2007 National Survey on Drug Use and Health: National Findings*. Rockville, MD: SAMHSA. Retrieved January 27, 2009, from: http://oas.samhsa.gov/nsduhLatest.htm

(SAMHSA) Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008b). *Treatment Episode Data Set (TEDS). Highlights - 2006. National Admissions to Substance Abuse Treatment Services*, DASIS Series: S-40, DHHS Publication No. (SMA) 08-4313, Rockville, MD. Retrieved January 27, 2009, from: http://oas.samhsa.gov/teds2k6highlights/teds2k6highWeb.pdf

(SAMHSA)_Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. (2006). *Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 45*. DHHS Publication No. (SMA) 06-4131. Rockville, MD: SAMHSA . Retrieved May 27, 2009, from: http://download.ncadi.samhsa.gov/prevline/pdfs/DTXTIP45(3-30-06).PDF

(SAMHSA) Substance Abuse and Mental Health Administration, Office of Applied Studies. (1996). *National Survey on Drug Use and Health Advance Report [for 1995]*. Rockville, MD: SAMHSA. Retrieved January 27, 2009, from: http://oas.samhsa.gov/nhsda/ar18ttoc.htm

Scott, J., Woods, S., Matt, G., Meyer, R., Heaton, R., Atkinson, J., & Grant, I. (2007). Neurocognitive effects of methamphetamine: a critical review and meta-analysis. *Neuropsychology Review, 17*, 275-297.

Semple, S. J., Patterson, T., & Grant, I. (2004). The context of sexual risk behaviour among heterosexual methamphetamine users. *Addictive Behavior, 29*, 807-810.

Shoptaw, S. & Reback, C. (2007). Methamphetamine use and infectious disease-related behaviors in men who have sex with men: implications for interventions. *Addiction, 102*(Supplement 1), 130-135.

Shoptaw, S., Reback, C., Larkins, S, Wang, P., Rotheram-Fuller, E., Dang, J., & Yang, X. (2008). Outcomes using two tailored behavioral treatments for substance abuse in urban gay and bisexual men. *Journal of Substance Abuse Treatment, 35*, 285-293.

Smith, L. M., LaGasse, L. L., Derauf, C., Grant, P., Shah, R., Arria, A., Huestis, M., Haning, W., Strauss, A., Della Grotta, S., Liu, .J, & Lester, B. M. (2006). The infant development, environment, and lifestyle study: effects of prenatal methamphetamine exposure, polydrug exposure, and poverty on intrauterine growth. *Pediatrics, 118*, 1149-1156.

Stretesky, P. (2009). National case-control study of homicide offending and methamphetamine use. *Journal of Interpersonal Violence*, *24*, 911-924.

Urada, D., & Evans, L. (2008a). Treatment. In: *Evaluation of Proposition 36: The Substance Abuse and Crime Prevention Act 2008 Report*. Los Angeles: UCLA Integrated Substance Abuse Programs. Retrieved November 1, 2008, from: http://www.uclaisap.org/prop36/documents/2008%20Final%20Report.pdf

Urada, D., Hawken, A., Conner, B., et al. (2008b). *Evaluation of Proposition 36: The Substance Abuse and Crime Prevention Act of 2000. 2008 Report.* Los Angeles: UCLA Integrated Substance Abuse Programs. Retrieved January 27, 2009, from: http://www.uclaisap.org/prop36/documents/2008%20Final%20Report.pdf

Urada, D., Longshore, D., & Conner, B.T. (2007). Treatment. In: *Evaluation of the Substance Abuse and Crime Prevention Act: Final Report (2005 Report)*. Los Angeles: UCLA Integrated Substance Abuse Programs. Retrieved April 13, 2007 from: http://www.uclaisap.org/prop36/documents/SACPAEvaluationReport.pdf

Vik, P. (2007) Methamphetamine use by incarcerated women: comorbid mood and anxiety problems. *Women's Health Issues, 17*, 256-263.

Volkow, N., Wang, G.J., Fowler, J. et al. (2007). Stimulant-induced enhanced sexual desire as a potential contributing factor in HIV transmission. *American Journal of Psychiatry, 164*, 157-160.

Westover, A., Nakonezny, P., & Haley, R. (2008). Acute myocardial infarction in young adults who abuse amphetamine. *Drug & Alcohol Dependence, 96*, 49-56.

Technical Notes

1. A few (less than 5%) of the identified episodes with multiple types of service within the episode may not have been fully represented from initial admission to final discharge because of the time limitations imposed in the selection process. Sequences of services (each service set with an admission and discharge record) can count as part of an episode if the subsequent admission is within 30 days of the previous discharge. Thus, some episodes containing sequences of services may have begun prior to FY2006-07, but with changes in type of service (with an admission record) occurring in FY2006-07; this FY2006-07 record would have been identified for our analyses as the beginning of the defined episode. Alternatively, some episodes may have had continuing service beyond the discharge record identified as the ending date used in analysis, but not yet (as of the data file date) have been discharged from that continuing service. These limitations may potentially have some small impact on performance and outcomes results; for example, reported retention may be very slightly lower than would be found if fully comprehensive episodes were identified. However, analyses suggested that fewer than 5% of episodes were affected, so potential bias is considered minimal. See also the CalOMS Evaluation (Rawson et al., 2008) for additional discussion of episodes and multiple services within episodes.

Retention was calculated from the first admission to the last available discharge in the episode. In our analyses, no adjustment was made for time between services within an episode. Sequences of multiple services were considered part of a continuing episode if 30 days or less elapsed between a discharge from one service and the subsequent admission to another service. Thus, for the approximately 15% of clients with sequences

of two or more services within an episode, the retention calculation may slightly overestimate actual time in treatment. But also note that *exact* time in treatment is not available from CalOMS, since attendance patterns and frequency/intensity of treatment are not recorded.

2. As exploratory analyses, we also applied generalized linear models for binary performance and outcome measures and specific a priori pairwise contrasts to compare groups. Note that even small differences can be statistically significant and not all small differences were considered of clinical or policy importance and may not have been discussed in this chapter. Results for selected performance measures (completion, 60-day retention, and 90-day retention) showed significant at $p<.01$ overall differences among groups for all three measures. More specifically, while differences between the Prop 36 meth group and the Prop 36 non-meth group were small, they were significant for completion and 90-day retention. The Prop 36 meth group was also significantly different from each of the non-Prop 36 groups were significant for all three measures.

For CalOMS outcome measures, the approach was extended to repeated measures, with generalized estimating equations [GEE] (e.g. Fitzmaurice et al., 2004; Preiser & Koch, 1997). This approach summarizes overall change and also allows assessment of differential change across the 4 comparison groups (time-by-group interaction and contrasts comparing change for the Prop 36 meth group to change for each of the other groups). Results showed significant overall change from admission to discharge for all outcomes. Results also showed that for all outcome measures the Prop 36 meth was not significantly different (at $p<.01$) from the Prop 36 non-meth group in terms of change from episode admission to discharge. Change for the Prop 36 meth group was significantly different from the non-Prop 36 non-meth group for all outcomes and different from the non-Prop 36 meth group for criminal justice system activity, employment, living status, family conflict, and social/recovery support.

For re-offending measures comparing meth vs. non-meth Prop 36 clients, arrest rates differed statistically only for felony drug, property, and sex offenses; but the magnitude of differences was particularly small.

3. Because groups differed on several client characteristics, further exploratory analyses extended the generalized linear models to include covariates to control for pre-existing group differences. Covariates were constructed to capture major sources of group differences and included gender, age (older vs. younger age [<35 vs. 36 or older]), race/ethnicity (Black vs. Hispanic vs. all others), injection use, and years since first use of primary drug. For performance measures, inclusion of covariates reduced the Prop 36 meth vs. Prop 36 non-meth adjusted differences to non-significant, but did not substantively change any other results. For CalOMS outcome measures, results showed that inclusion of covariates did not appreciably affect results summarized in Note 2 above. For re-offending outcomes, results showed that inclusion of covariates reduced the Prop 36 meth vs. non-meth difference in felony drug arrests to non-significant; other results remained consistent.

4. In the chapter (Table 4.4), we have reported percentages at admission and at discharge so that the reader can see both the level at admission and discharge and the change from

admission to discharge. In addition, we sometimes refer to *proportional* (or relative) change as a convenient way of comparing groups; the proportional change is a ratio comparing the simple difference between admission and discharge percentages to the admission level. Specific proportional change values are given in the table below.

Table Note 4. Proportional Change in CalOMS Outcomes for Prop 36 Primary Methamphetamine Users and Comparison to Prop 36 Users of Other Primary Substances, Non-Prop 36 Meth and Other Primary Drug Users [a]

	Methamphetamine		Other Primary Drug	
	Prop36 n=11,345	Non-Prop36 n=16,118	Prop36 n=8,184	Non-Prop36 n=38,158
Primary Drug Use				
Average days of use in past 30 days	-58.3	-53.4	-53.8	-46.3
Any use in past 30 days	-51.3	-49.3	-50.7	-37.7
CJS activity (any arrests, jail or prison days) in past 30 days	-76.2	-73.9	-74.7	-63.4
Employed (current)	31.4	55.6	29.5	19.5
Employed or enrolled in school/training (current)	32.8	46.7	27.5	11.2
Living situation (primary status in past 30 days)				
Homeless	-22.4	-19.9	-15.8	-13.6
Dependent living	-4.1	0.2	-5.1	3.2
Independent living	9.4	14.1	9.8	5.9
Family conflict (any days in past 30 days)	-34.1	-54.2	-29.5	-46.8
Any days with social support recovery activities (in past 30 days)	42.4	71.1	47.5	92.3

[a] Change given as percentage: 100*((admission-discharge)/admission). Negative values indicate a decrease from admission to discharge, positive values indicate an increase.

5. It is important to remember that percentages at admission and discharge and change represent the group as a whole and do not take into consideration individuals' specific patterns. For example, several different possible patterns of change are aggregated into the summary statistics: 1) a subgroup of clients who had the problem at admission but not

at discharge (e.g. no longer using drugs, not having serious family conflicts); 2) a subgroup who had the problem at admission and discharge; 3) a subgroup who did not have the problem at admission but did at discharge; and 4) a subgroup who did not have the problem at either admission or discharge. As an example, we found that for any past 30-day use of primary drug, 30.9% of the Prop 36 meth users showed improvement (pattern 1 above, improving from use in the 30 days prior to admission to no use in the 30 days prior to discharge); 20.0% reported continuing use at both admission and discharge (pattern 2); 4.8% reported no use at admission but use at discharge (pattern 3); and 44.4% reported no use in the 30 days prior to either admission or discharge (pattern 4). Further studies could explore characteristics of these specific change subgroups in order to identify barriers and facilitators of treatment outcomes.

Chapter 5: Parolees in Prop 36: Barriers to Participation and Future Trends

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Parolees from the California Department of Corrections and Rehabilitation (CDCR) may become eligible for Prop 36 if they commit a Prop 36 eligible parole violation or are subject to new local court charges that are Prop 36 eligible. The current chapter presents information on barriers to Prop 36 participation among parolees, the use of specialized (Prop 36-only) parole agents versus parole agents with mixed caseloads, treatment needs of parolees in Prop 36, and treatment outcomes for parolees in Prop 36. We conclude this chapter with a discussion of recent CDCR changes that may impact parolee participation in Prop 36.

Key barriers to participation among parolees in Prop 36 included transportation, employment/treatment time conflicts, unstable housing, lack of interest in treatment, and lack of family support. Parole agents also believed that motivation for treatment and criminal sophistication were factors related to parolee performance in Prop 36.

Specialized parole agents reported that they had more time to "work" their cases because they had a caseload of only 50 individuals as compared to the typical 70 to 100 individuals in a standard mixed caseload. It was also felt that specialization allowed agents to develop more knowledge of the resources that are available to help P36 parolees be successful. Preliminary analyses of administrative data suggest that parolees on specialized caseloads may have better results than those on mixed caseloads. Analyses are continuing.

Overall, parolees reported less education, were more frequently homeless, were more likely to report use of heroin or cocaine/crack, and were more likely to report injection drug use. Compared to probationers, more parolees were referred to residential treatment greater than 30 days and they waited significantly less time to enter such treatment than probationers. Tuberculosis was more common among parolees than among probationers. Parolees had shorter treatment stays in both outpatient and residential treatment than probationers.

Discharge outcomes are presented for parolees versus probationers overall and by outpatient or residential treatment modalities. Improvements were seen relative to intake on discharge outcomes for both probationers and parolees; however, in some cases, the improvement was greater for probationers.

INTRODUCTION

As of January 1, 2008, the estimated national incarceration rate was 1 in every 99.1 adult persons in the United States, for a total inmate population in jail and prison of 2,319,258 (Pew Center on the States, 2008). The national picture from a review of Bureau of Justice Statistics for 2005 (Harrison & Beck, 2006) suggests that large increases have occurred in the prison population since the 1990s, particularly for women, and that a significant portion of the increase is due to individuals in state and federal prisons who are incarcerated on drug-related offenses.

Nearly all of these incarcerated individuals will return to the community at some point in the future. For example, Petersilia (2005) notes that in 2003, some 600,000 individuals were released from prison nationwide and 93% of all inmates will be released upon completion of their terms. Petersilia (2005) also notes that the inmates being released are characterized by severe educational deficits, are unlikely to have participated in rehabilitative programming during incarceration, and approximately 75% have a history of drug or alcohol abuse. Further, despite high need among incarcerated populations, relatively few inmates receive substance abuse services in prison (Chandler, Fletcher & Volkow, 2009; McCaffrey, 1998; Petersilia, 2005).

At the end of 2008, there were 120,281 individuals on parole in California's four parole regions (CDCR Offender Information Services Branch, 2008). In calendar year 2007, the return-to-custody rates for male felon parolees on a parole violation, pending review for revocation, and/or returned to a substance abuse treatment program without a parole revocation was 52.5%; for females this rate was 37.7% (CDCR Offender Information and Services Branch, 2007). Whereas these numbers are not recidivism rates, they suggest that a large segment of the parole population will return to CDCR custody for relatively short duration stays as the average length of stay for a parolee returned to custody is approximately four months.

Recent years have seen a re-evaluation of the effectiveness of the "get tough", incarceration-oriented approach to crime characteristic of the 1970s, 1980s, and 1990s, motivated in part by the costs associated with incarceration, and in part by overcrowding in prisons and jails. In California, the trends in voter sentiment towards more selective use of incarceration in offending populations, particularly for non-violent drug offenders, resulted in the passage of Proposition 36 in 2000. Known as the Substance Abuse and Crime Prevention Act and hereafter referred to as Prop 36, the act provided for the diversion of non-violent drug offenders from prison to substance abuse treatment, and the elimination of the use of parole revocation and re-incarceration for drug-related, non-violent parole violations.

Although there are a number of control level designations for parole (e.g., Minimum Supervision, Control Services, High Control, and Specialized Caseloads), the majority of Prop 36 cases are designated as Control Services (CS) cases. Minimum specification for

CS caseloads include the following Every 30 days a face-to-face contact, at least one of which each quarter will be at the parolee's residence, another in the field, and a third at a location of the agent's choice, including the office. Each parolee who completes 180 days of satisfactory parole under control/services supervision, absent a case review, is generally assigned to minimum level supervision but may be maintained at the control services level or reduced to minimum supervision prior to six months on parole by case review (CDCR, 2009).

CDCR Community-Based Substance Abuse Treatment

Currently, CDCR has a number of programs for parolees to decrease substance-related problems and recidivism The general conclusions regarding these in-prison, drug treatment programs have been that CDCR substance abuse treatment programs either lack formal evaluations and outcomes data or were found to be largely ineffective when evaluated (references). It is unclear whether program reform since that time has resulted in an increase in effectiveness for these TC programs. Below are programs that are currently available to parolees; however, one should note that, according to parole agents and CDCR staff, if a parolee is determined to be Prop 36 eligible prior to his/her release, Prop 36 is offered as the first option upon the commission of a Prop 36 eligible parole violation or new offense. Some of the options below are open to all parolees, whereas others are open only to those who have waived Prop 36 or who are no longer Prop 36 eligible. In addition, some programs, such as SASCA, represent the continuation of in-prison drug treatment programs.

Drug Treatment Furlough (DTF): DTF is a therapeutic community targeting substance abuse which provides case management, life skills, vocational, and parenting programming to offenders in Fresno, Kern, Los Angeles, Orange, San Joaquin, and San Diego Counties. Individuals in an in-custody substance abuse program with less than 120 days to parole who do not have a history of sex offenses, violence, arson, or a co-occurring mental health disorder are eligible for DTF. Current program capacity is 807 offenders and program duration is 120 days.

Parolee Substance Abuse Program (PSAP): PSAP operates in Folsom state prison and serves parolees from Sacramento, Yolo, Butte, San Joaquin, Alpine, Amador, Sutter, Yuba, and Stanislaus counties. Capacity is 200 offenders and all parole violators with a history of substance abuse who are not violent offenders, sex offenders, gang members or associates, or parolees housed in a secure housing unit within six months of their release are eligible to participate in PSAP. Program duration is 90 days and includes in-custody cognitive-behavioral substance abuse treatment supplemented with employability and life skills courses and voluntary continuing care.

Parolee Service Center (PSC): PSC utilizes former Halfway-Back facilities. They provide residential services focusing on employment needs, substance abuse control, stress management, victim awareness, computer-assisted literacy education, life skills training, and job search and placement assistance. The PSCs provide non-sanctioned, voluntary services and have a total of 685 beds statewide. Offenders needing to stabilize

under parole supervision and who are not sex offenders, gang members, or arsonists are eligible for the PSC program. Program duration is 3 to 12 months.

Parolee Services Network (PSN): The PSN program operates in 17 counties and has 620 residential beds statewide. It is a collaboration between the CDCR, the State Department of Alcohol and Drug Programs, and County run alcohol and drug programs. As noted in the Expert Panel report, "the PSN is a 180-day treatment program through which providers offer treatment in various modalities, to include detoxification (the social model as opposed to in-hospital medical model), residential treatment, Sober Living Environments (SLE), and outpatient services" (CDCR, 2007, pp. 158). The goal of the PSN is to reduce recidivism and revocation rates by reducing drug and alcohol use and its associated criminal activity.

Residential Multi-Service Center (RMSC): Geared specifically towards homeless parolees, the RMSCs provide shelter, food, substance abuse treatment, counseling, job readiness training, and educational services in an effort to transition parolees with housing problems to independent living without criminal involvement. Stays may last up to 180 days and may be extended a further 180 days in some facilities. Program capacity is 729 offenders. Sex offenders, violent offenders, and arsonists are not eligible for this program. Residents are required to attend outside AA/NA meetings.

Substance Abuse Treatment and Recovery (STAR): Located in parole offices in 19 counties and with a capacity of 568 offenders, STAR provides a cognitive-behavioral substance abuse curriculum in a classroom setting to all offenders on parole. Program duration is 4 weeks and upon completion, participants are expected to compose a community transition plan.

Substance Abuse Service Coordinating Agency (SASCA): With a capacity of 2,000 offenders, SASCA provides placement in substance abuse continuing care with advocacy and case management. Program duration is 180 days. SASCA contracts for services with community-based providers and is open to offenders on parole who completed an in-prison Substance Abuse Program (SAP) or a DTF. Serious and violent offenders are ineligible for SASCA. The SASCA program is in operation statewide. Parolees who have been approved for Prop 36 drug treatment may be referred by their parole agent to SASCA instead, if eligible. Such parolees are also eligible for additional Prop 36-funded treatment following their 180 day SASCA treatment if deemed necessary (Sayles-Owen, 2005).

In-Custody Drug Treatment Programs (ICDTP): ICDTP is intended for parolees who have violated parole due to the influence of drug or alcohol dependence or who need a period of confinement and treatment to stabilize and treat substance abuse issues. Parolees participating in ICDTP are housed in CDCR facilities and receive an education-based treatment program, followed by residential continuing care funded through the Substance Abuse Services Coordinating Agencies (SASCA). ICDTP participants also engage in self-help activities under the direction of the agent of record. Program capacity is 288 offenders, and services are available at the following facilities: Kern, Tulare, Del

Norte, San Francisco, and Santa Clara County Jails, and at the Chula Vista City Jail. Program duration is 150 days (60 days in custody treatment, 30 days residential continuing care, 60 days community-based treatment).

Two of the programs listed above (PSAP, ICDTP) represent in-custody treatment options to which parolees may be assigned after a parole violation. The remaining 7 programs are in-community treatment options for parolees with eligibility criteria that are similar to those of Prop 36. The exception with regards to eligibility criteria is the STAR program, which is open to all parolees, but has a relatively small capacity and short duration. The largest program for parolees is the SASCA program, which draws primarily from participants in the SAP in-custody drug treatment programs. It is notable that, despite the fact that approximately 75% of all prison inmates have substance problems, only a small percentage of them receive treatment - both in prison and upon release to the community. Specifically, capacity for the programs discussed above lags far behind a rough estimate of the total number of parolees who may need substance abuse treatment derived from multiplying the total number of parolees from the end of 2008 by Petersilia's (2005) estimate of the percentage of prisoners with substance related problems. The estimate derived by this method exceeds 90,000. By far SASCA has the greatest capacity; however, Prop 36 serves over 7,000 inmates per year. Clearly, there is a need for the expansion of treatment capacity to meet the identified need for substance abuse services among the parolee population.

This chapter begins with a discussion of barriers to Prop 36 participation among parolees, then presents information on adaptations made for parolees in Prop 36 as discussed in stakeholder focus groups. We then present data from CalOMS on treatment needs at admission for parolees, data on retention/completion for parolees by residential or outpatient treatment participation, and data on outcomes for parolees versus probationers overall, in outpatient, and in residential treatment greater than 30 days. Next we discuss important recent developments in CDCR that may impact parolee Prop 36 participation. The chapter concludes with recommendations for Prop 36 policy that may help to address the specific needs of parolees in Prop 36.

PAROLEES IN PROP 36[33]

Prop 36 is only offered to parolees upon the commission of an eligible parole violation or new offense; however, determination of eligibility for Prop 36 is made by a CDCR case classifier prior to parole. Thus, parole agents are aware of a parolees' eligibility status prior to any occurrence of a drug-related parole violation. In short, as communicated by parole agents and CDCR staff, there are three different ways that a parolee can enter the Prop 36 program: (1) the Division of Adult Parole Operations can refer the parolee to

[33] For all tables in this chapter we used either the t-tests statistic for continuous variables (e.g., age, years of education), or the chi-square statistic for categorical variables (e.g., gender, employment status) to test for differences between parolees and probationers. The p-value indicates the likelihood that the obtained statistic occurred by chance alone, with p-values < 0.05 indicating that differences observed on the test statistic are likely to have occurred by chance alone in only 5 of 100 sampling instances. Degrees of freedom [d.f.] are included because the cutoff for significance for the two statistics varies with changes in degrees of freedom.

Prop 36 after a violation report, (2) a parolee can become eligible for Prop 36 even after initially being found ineligible for Prop 36 if charges are reduced or dismissed to make a parolee eligible for Prop 36, or (3) the parolee can incur a Prop 36 eligible local charge bringing him or her back to court and the court requests that BPT drop any hold and allow the parolee to participate in Prop 36.

Barriers to Prop 36 Participation Among Parolees

One barrier to parolee participation may be ongoing CDCR parole agent practices and attitudes towards Prop 36. Data bearing on these parole-related barriers to Prop 36 participation are found in a recent dissertation (Gardiner, 2008) that has examined the impact of Prop 36 on parole agents in Orange County, CA, and the practical implementation of Prop 36 in that county.

According to interviews with Orange County parole agents presented in Gardiner (2008) parole agents believed that: parolees have too many chances in treatment under Prop 36; Prop 36 limits the discretion of the parole agent and may result in limiting treatment opportunities for parolees; and some parole agents have adopted specific strategies to circumvent aspects of Prop 36. Many parole agents reported that the writers of Prop 36 underestimated the level of criminal sophistication and addiction present in the parolee population and, therefore, parolees are a poor match for Prop 36.

Under current laws, parolees have two chances to complete Prop 36 drug treatment each time they complete a new sentence, assuming the controlling offense for that sentence does not preclude Prop 36 eligibility. Therefore if a parolee on Prop 36 fails the first time but completes a new prison term, the parolee is eligible for two new attempts. Further, if a parolee is arrested for a Prop 36 eligible offense while on parole and is convicted in a local jurisdiction he/she has additional chances to complete Prop 36 treatment through the court system, even if he/she has no further chances remaining through parole. Parole agents refer to this as having ”multiple bites at the apple” prior to revocation of parole. Thus parolees can cycle through treatment a number of times, potentially using up limited Prop 36 bed space and resources.

Parole agents in Orange County reported a number of practices that have been used to attempt to circumvent Prop 36, including encouraging parolees to waive their rights to Prop 36. Waiving rights to Prop 36 treatment may be an attractive option for parolees because they may be motivated for early release from parole supervision, may not want to report to a probation and parole agent under dual supervision, and in some cases, may find that treatment is more readily available under other funding streams. One method to circumvent Prop 36 is to Continue on parole (COP) the parolee after a drug-related violation. That is, a parolee with a Prop 36 eligible parole violation is COPed and sent to the Parole Services Network (PSN) for treatment without notifying the board of the violation. This maintains the parolee’s eligibility for early discharge, but requires that the parolee waive his/her right to Prop 36 treatment. A second practice employed to incarcerate parolees for drug-related offenses has been to arrest a parolee on a violation and then delay filing the violation. Parole agents have up to six days to file a violation, after which, they must file the violation or release the parolee (Gardiner, 2008). Thus, using this method, parole agents can implement flash incarceration for positive drug test results.

Key informant data gathered by UCLA from interviews conducted with parole agents in Southern California as part of the 2008 Prop 36 evaluation provided rich information on

parole agent perceptions of the barriers faced by parolees in participating in Prop 36 treatment. One of the first barriers mentioned for parolees participating in Prop 36 was transportation. Many parolees have difficulty getting to and from their treatment appointments. One parole agent indicated that he used to be able to give bus tokens to parolees to help them attend treatment appointments; however, given recent budget reductions, bus tokens were no longer available to issue to parolees. A second barrier to treatment participation among a subgroup of parolees was employment. Work was a barrier to treatment in cases where job hours and treatment program hours overlapped. In these cases, the parole agents believed that work was a priority because many parolees had families to support. Parole agents believed that employment/treatment conflicts may be one reason for non-completion of Prop 36 among parolees. A third barrier to Prop 36 participation among parolees was that some individuals did not want treatment. In some cases, parolees believed that being ”locked up” was easier than being in treatment. Other barriers to Prop 36 treatment completion among parolees mentioned by parole agents included lack of social support and unstable housing. In fact, parole agents believed that Prop 36 worked for those who had family support and stable housing, but was unlikely to work for parolees who had no social support and who had no stable place of residence.

Additional factors that parole agents believed were related to parolee entry into and performance during Prop 36 treatment were motivation and criminal sophistication. Parole agents referred to motivated clients as being ready for treatment and believed that those parolees who were not ready for treatment were not going to benefit from it. That is, the agents believed that those parolees who were not motivated for treatment and were criminally sophisticated were able to “work the system” to stay out of prison as long as possible, but Prop 36 eligibility only delayed the inevitable return to prison on a violation or a new charge for these individuals.

Separate focus group interviews conducted by UCLA with other county stakeholders (e.g. representatives from treatment, court, county alcohol and drug administration, public defender, probation, and district attorney offices) identified communication with parole agents as a barrier to successful parolee participation in Prop 36. Some county stakeholders noted that the large number of parole agents in their counties made it difficult to communicate with parole agents about parolees’ progress, or lack thereof, in treatment. They believed that if they had 3 or 4 specific parole agents who dealt with Prop 36 cases in their counties it would be easier to form and maintain strong working relationships with parole agents. Stakeholders believed that these working relationships were vital because the parole agent was the only person who could encourage parolees to stay “on track” in Prop 36 (except in cases of dual supervision parolees are not under any judicial supervision). Further, stakeholders stated that it was difficult to get parole to the table in Prop 36 because it was an entity independent from the county. However, the stakeholders believed that parole’s participation in Prop 36 was important because good communication and teamwork among various stakeholders in Prop 36 were vital to a successful Prop 36 program.

Parole agents[34] noted that agents with mixed caseloads may not have time to properly "work" their Prop 36 cases. One parole agent stated that mixed caseloads in his office were over 200 points, which represents approximately 70 to 100 cases. The inclusion of high-risk to reoffend parolees in a mixed caseload may require greater monitoring at the expense of non-violent drug offenders. Follow-up and communication with Prop 36 treatment providers may be difficult for parole agents with large caseloads as compared to parole agents with specialized Prop 36 caseloads. Thus, a common sentiment expressed by contacts in CDCR was that specialized Prop 36 parole agents would allow for greater familiarity on the part of parole agents with the Prop 36 population and mechanisms rather than the current situation in which many parole agents have mixed caseloads. Using specialized Prop 36 caseloads may allow for more contact with parolees by parole agents.

CDCR and UCLA are currently collaborating to determine whether parolees assigned to specialized Prop 36 agents differ from parolees assigned to parole agents assigned to mixed caseloads on measures such as show rates, time in treatment, and completion rates. While work is still underway at this writing, preliminary analyses suggest that parolees on specialized caseloads do tend to experience more positive results on these measures than parolees on mixed caseloads. Further data cleaning and analyses will be performed to more accurately measure these differences, to determine how much if any of the effect may be due to other pre-existing demographic, drug use, or criminal history differences between the groups, and to determine whether these results extend to other measures such as arrests. UCLA plans to report the results of these analyses in the next UCLA evaluation report.

Treatment Needs of Parolees in Prop 36

Chapter 1 of this report presents some information on parolees vs. probationers participating in Prop 36. We briefly summarize those data here. Parolees who commit a new offense or a parole violation made up 17% of all Prop 36 participants. Compared with probationers, parolees were more likely to be male, were older, and were slightly more likely to be unemployed or not in the labor force. Enrollment in school was lower among parolees than among probationers, but participation in job training was slightly, but not notably higher among parolees. The majority of parolees reported their primary drug to be methamphetamine (52.6%), which was not different from probationers, but much higher than individuals in drug treatment referred from drug court, other criminal justice sources, or non-criminal justice sources. Parolees had longer histories of primary drug use, with 33.1% reporting having used their primary drug for more than 20 years. A large percentage of parolees reported using their primary drug in the last 30 days prior to treatment entry (56.9%), but days of primary drug use in the last 30 did not differ between parolees and probationers and were approximately 10 days in the last 30. Similar to Prop 36 probationers and drug court clients, over half (54.5%) of Prop 36 parolees reported prior treatment experience and of those parolees reporting prior treatment

[34] UCLA individually interviewed two parole agents that were assigned to specialized Prop 36 caseloads. Both agents had previously worked on mixed caseloads, and were therefore able to compare their current and prior experiences.

experience, the mean number of prior episodes of treatment was 2.3. Homelessness was slightly more common among parolees relative to probationers, but less common than among drug court and non-criminal justice referrals sources. Social support was lower among parolees relative to probationers, fewer parolees than probationers reported being a Medi-Cal beneficiary (15.7% probationers vs. 11.2% parolees). Notably, HIV testing was higher among parolees and so was being informed of HIV test results. Mental health issues were reported at similar levels among probationers and parolees; however, underreporting may be common in the drug treatment data system (Conner & Grella, 2008). Finally, more parolees than probationers reported having children.

In order to examine the characteristic needs of parolees vs. probationers in Prop 36 data were cut from the CalOMS dataset. In some cases these data duplicate data presented in chapter 1; however, the data are presented here for ease of reference.

With regards to age at admission to treatment, parolees were significantly older than probationers, with the mean ages between groups differing by approximately 1 year. A smaller percentage of parolees reported 13 or more years of education relative to probationers (12.7% vs. 18.5%) and a larger percentage of parolees reported less than 12 years of education relative to probationers (40.5% vs. 33.3%). No differences were found between probationers and parolees for the percentage reporting employment, with just under a third of both probationers and parolees reporting employment. A larger percentage of parolees were homeless at treatment entry relative to probationers. See Table 5.1 for these data.

Table 5.1: Mean or % for Age at Admission, Education, Employment, and Admission Living Arrangments by Parole Status.

	Probation	Parole	t or χ^2[d.f.]	p-value
Age at Admission	35.0	36.1	-2.76 [770.3]	0.006
Years of Education				
< 12 years	33.3%	40.5%	24.09 [2]	0.000
12 years	48.2%	46.8%		
13 years or more	18.5%	12.7%		
Employed				
No	67.8%	70.0%	1.59 [1]	0.207
Yes	32.2%	30.0%		
Current Living Arrangements				
Homeless	11.7%	14.0%	6.54 [2]	0.038
Dependent Living	43.1%	45.0%		
Independent Living	45.2%	41.0%		

Probationers and parolees differed on a number of substance use variables. The percentage of parolees reporting Cocaine/Crack or Heroin as their primary drug was greater than the percentage of probationers reporting these drugs as their primary drugs; whereas fewer parolees reported alcohol as their primary drug than probationers (see Table 5.2 below). A significantly larger percentage of parolees reported injection as their mode of administration (16.8% vs. 9.7%), but smoking was more frequently reported among probationers (70.8% vs. 66.4%). Days of IV drug use in the last 30 prior to intake were greater among parolees relative to probationers.

Table 5.2: Mean or % for Substance Use at Admission by Parole Status.

	Probation	Parole	t or χ^2 [d.f.]	p-value
Age of First Primary Drug Use	21.5	21.2	1.06 [10561]	0.290
Primary Drug				
Alcohol	6.1%	4.4%	26.32 [5]	0.000
Cocaine/Crack	10.7%	12.4%		
Heroin	5.7%	8.9%		
Marijuana	12.4%	8.5%		
Methamphetamine	63.2%	63.6%		
Other	1.8%	2.1%		
Administration Route				
Inhalation	10.7%	9.0%	39.43 [3]	0.000
Injection	9.7%	16.8%		
Oral	8.8%	7.8%		
Smoking	70.8%	66.4%		
Days Used Primary Drug in last 30 days	5.3	5.2	0.22 [11008]	0.830
Days IV Drug Use	0.9	1.2	-1.88 [833.3]	0.060

Note: PD age of first use = age of first use of primary drug; Days Used PD = days used primary drug in the last 30 before intake; Days IV Drug Use = days of intravenous drug use.

Table 5.3 presents data on substance abuse treatment variables by parole status. Although the majority of parolees were referred to drug free outpatient treatment, this percentage was 4 percentage points lower than the percentage of probationers referred to outpatient treatment. The percentage of parolees referred to long term residential treatment (greater than 30 days) was approximately 3 percentage points higher than the percentage of

probationers referred to long term residential treatment. Fewer parolees than probationers reported Prop 36 treatment as their first treatment experience (46.7% vs. 52.7%) and the number of prior admissions was significantly higher among parolees relative to probationers. No differences were found with regards to the number of days waited to enter treatment overall.

Table 5.3: Mean or % for Substance Treatment Variables by Parole Status.

	Probation	Parole	t or χ^2 [d.f.]	p-value
Type of Treatment				
Drug Free OP	85.9%	81.9%	9.02 [1]	0.003
Residential < 30	0.4%	0.5%	0.11 [1]	0.740
Residential > 30	10.2%	13.4%	7.72 [1]	0.005
Detox	2.5%	2.9%	0.59 [1]	0.443
NTP Detox	0.3%	0.3%	0.00 [1]	0.987
First Time in Tx				
No	47.3%	53.3%	10.22 [1]	0.001
Yes	52.7%	46.7%		
# Prior Admissions	1.0	1.3	-2.47 [820.9]	0.014
Days Waited for Tx	3.9	3.8	0.351 [10878]	0.726

Note: Drug Free OP = drug free outpatient; NTP Detox = X.

With regards to days waited to enter treatment by treatment modality, parolees waited significantly fewer days to enter long term residential treatment (about 2 days fewer) than did probationers. There were no differences between probationers and parolees with regards to days waited to enter outpatient treatment. These data are presented in Table 5.4.

Table 5.4: Mean Days Waited to Enter Treatment by Modality.

	Probation	Parole	t [d.f.]	p-value
Outpatient	3.6	3.5	0.33 [9303]	0.738
Residential Treatment >30 days planned duration	5.8	3.7	2.54 [164.5]	0.012

The percentage of parolees diagnosed with tuberculosis (3.9%) was significantly higher than the number of probationers who were tuberculosis positive (1.9%). Conversely, having been tested for HIV was more commonly reported among parolees than among probationers. There was no difference between parolees and probationers with regards to the percentage of those tested for HIV who knew their HIV status. See Table 5.5.

Table 5.5: Percentages for Health-Related Variables by Parole Status.

	Probation	Parole	t or χ^2[d.f.]	p-value
Hepatitis C Positive				
No	95.4%	94.1%	2.50 [1]	0.114
Yes	4.6%	5.9%		
Tuberculosis Positive				
No	98.1%	96.1%	13.92 [1]	0.000
Yes	1.9%	3.9%		
STD Positive				
No	96.6%	97.5%	1.52 [1]	0.217
Yes	3.4%	2.5%		
Tested for HIV				
No	37.5%	27.6%	29.54 [1]	0.000
Yes	62.5%	72.4%		
Know HIV Results				
No	15.0%	14.9%	0.01 [1]	0.938
Yes	85.0%	85.1%		

Table 5.6 presents data on family variables by parole status at intake. Family conflict was significantly higher among probationers relative to parolees[35] and there was a trend for more parolees to have children at home. There were no differences in the percentage of individuals reporting children younger than 5 at home by parole versus probation status, nor were there differences in the percentage of offenders reporting termination of parental rights by parole status.

Table 5.6: Mean or % for Family Variables by Parole Status.

	Probation	Parole	t or χ^2[d.f.]	p-value
Days Family Conflict	0.8	0.5	2.58 [946.7]	0.010
Any Children at Home				
No	54.8%	51.5%	3.10 [1]	0.078
Yes	45.2%	48.5%		
Children < 5 at Home				
No	78.4%	79.1%	0.17 [1]	0.678
Yes	21.6%	20.9%		
Any Parental Rights Terminated				
No	96.5%	96.1%	0.29 [1]	0.591
Yes	3.5%	3.9%		

The mean number of days in treatment for outpatient treatment was 131.6 days for probationers and 104.4 days for parolees, which was a significant difference. Thus, on average probationers were spending nearly a month longer in outpatient treatment than were parolees. Similarly, for those initially referred to residential treatment, probationers spent an average of 111.5 days in treatment, whereas parolees spent an average of 92.4 days in treatment, again a significant difference. See Table 5.7.

[35] Parolees spent significantly more days in prison in the past month than probationers and therefore may have had fewer opportunities to interact with family, resulting in less opportunity for family conflict.

Table 5.7: Mean Time in Treatment by Treatment Modality.

	Probation	Parole	t [d.f.]	p-value
Outpatient	131.6	104.4	5.73 [614.7]	0.000
Residential Tx > 30	111.5	92.4	2.14 [123.9]	0.034

For Prop 36 Offenders in outpatient treatment, probationers were significantly more likely to reach the 60 and 90 day retention benchmarks and were also significantly more likely to reach treatment program completion (see Table 5.8).

Table 5.8: Percentage of Prop 36 Clients Reaching Three Treatment Benchmarks in Outpatient Tx.

	Probation	Parole	χ^2 [d.f.]	p-value
60 Day Retention	64.8%	55.0%	20.3 [1]	0.000
90 Day Retention	55.3%	43.1%	29.5 [1]	0.000
Tx Program Completion	35.6%	24.7%	26.0 [1]	0.000

Table 5.9 presents the percentage of individuals reaching three treatment benchmarks in residential treatment greater than 30 days. There were no differences observed between parolees and probationers for these variables.

Table 5.9: Percentage of Prop 36 Clients Reaching Three Treatment Benchmarks in Residential Tx > 30 Days.

	Probation	Parole	χ^2 [d.f.]	p-value
60 Day Retention	61.2%	60.2%	0.04 [1]	0.851
90 Day Retention	48.1%	43.0%	0.88 [1]	0.347
Program Completion	47.5%	47.3%	0.00 [1]	0.966

Qualitative data from county stakeholder focus groups indicated that some counties believed that they did not handle parolees well. In some cases counties were limited in that parolees had no court supervision and were only supervised by their parole agents. The lack of judicial oversight meant that the Prop 36 judge in that county had less knowledge of program lapses or progress towards treatment goals for parolees.

Stakeholders reported that they made some adjustments specifically for parolees. For example, one county that served parolees reported forming parolee alumni groups. Some of these groups were formed by having Prop 36 participants join alumni groups that were originally developed by parolees who completed treatment under funding streams other than Prop 36.

Incarceration Culture

Individuals with an incarceration history share a common experience and research has identified core components of prison culture that can be reliably and validly measured (e.g., Carr, Rotter, Steinbacher, Green, Dole, Garcia-Mansilla, Goldberg & Rosenfeld, 2006). Prison culture and values include such things as never showing physical or emotional weakness, doing one's own time, and interpersonal mistrust. "Prisonization" leads to the rejection of institutional values such as those of a therapeutic milieu because, "rejection of institutional values is at the heart of prison culture" (Peat & Winfree, 1992 as cited in Carr et al., 2006). Often, formerly incarcerated individuals engage in counter-therapeutic behavior and hold attitudes that are antithetical to treatment. Rotter, Larkin, Share, Massaro & Steinbacher (1999) note that inpatients with an incarceration history can be distinguished from inpatients without incarceration histories in that they are more likely to use intimidation, stonewalling of therapeutic staff, and have concerns about being open with staff while holding beliefs that the hospital experience is prison-like and that taking medication makes one vulnerable to attack.

Community-based treatment providers working with parolees should be cognizant of the impact of incarceration as it directly bears on their interpersonal behavior and willingness to engage in treatment activities. This is not merely an issue of therapeutic style as cultural competence training regarding prison culture for those serving the criminal justice involved mentally ill has been shown to increase retention and treatment engagement (Rotter et al., 2005).

TREATMENT OUTCOMES FOR PAROLEES IN PROP 36

Table 5.10 presents selected outcomes for Prop 36 participants by parole vs. probation status. Both groups showed similar reductions in drug use and criminal justice involvement at discharge relative to intake; however, there was a small difference in homelessness at discharge for parolees relative to probationers. A slightly larger percentage of parolees were not homeless at discharge (3.0%) as compared to probationers (2.4%). The change in the percentage employed by parole versus probation status was greater for probationers (-11.5%) than it was for parolees (-8.4%) (negative numbers reflect increases in employment relative to intake). Social support increased

slightly more among parolees relative to probationers as well. Family conflict was reduced to a greater extent among probationers relative to parolees.

Table 5.10: Selected Overall Outcomes for Prop 36 Offenders by Parole Status.

	Probation (N=18,023)			Parole (N=2,626)		
	I	D	Dif.	I	D	Dif.
Used Primary Drug (Past 30 days)	51.1	24.5	**-26.6**	60.1	32.9	**-27.2**
Any CJ Activity	31.9	7.3	**-24.6**	32.0	7.7	**-24.3**
Living Arrangements						
Homeless	11.6	9.2	**-2.4**	15.3	12.3	**-3.0**
Dependent Living	42.3	40.2	**-2.1**	43.4	41.4	**-2.0**
Independent Living	46.1	50.6	**4.5**	41.4	46.2	**4.8**
Employed (Full or Part-Time)	34.7	46.2	**11.5**	31.9	40.3	**8.4**
Social Support						
None	52.3	30.9	**-21.4**	58.6	35.3	**-23.3**
Some	39.5	49.3	**9.8**	32.5	42.2	**9.7**
Daily	8.2	19.8	**11.6**	8.9	22.5	**13.6**
Any	47.7	69.1	**21.4**	41.4	64.7	**23.3**
Family Conflict	8.0	5.2	**-2.8**	8.0	6.0	**-2.0**

Note: Numbers in table represent percentages; Any CJ Activity = Any criminal justice activity; I = Intake Value; D = Discharge Value; Dif. = Difference between Discharge and Intake Values.

With regards to outcomes for parolees and probationers in outpatient treatment, primary drug use reductions were similar (21.5% vs. 21.6%, respectively), but reductions in criminal justice activity dropped to a greater extent among probationers relative to parolees. Homelessness stayed relatively stable from intake to discharge among both parolees and probationers, but the change in the percentage of probationers who reported independent living at discharge was larger than what was found for parolees at discharge (-3.6 vs. -2.9). Employment also increased by a larger percentage among probationers relative to parolees. Social support gains appeared to be greater among parolees relative to probationers. Whereas family conflict was reduced among probationers, it remained somewhat stable among parolees. These data are presented in Table 5.11.

Table 5.11: Selected Outcomes for Prop 36 Offenders in Outpatient Treatment by Parole Status.

	Probation (N=14,455)			Parole (N=1,813)		
	I	D	Dif.	I	D	Dif.
Used Primary Drug (Past 30 days)	46.3	24.7	**-21.6**	58.0	36.5	**-21.5**
Any CJ Activity (Past 30 Days)	29.4	7.4	**-22.0**	26.9	8.6	**-18.3**
Living Arrangements						
Homeless	5.6	5.3	**-0.3**	5.1	5.5	**0.4**
Dependent Living	42.8	39.4	**-3.4**	46.1	42.9	**-3.2**
Independent Living	51.7	55.3	**3.6**	48.8	51.7	**2.9**
Employed (Full or Part-Time)	41.2	50.9	**9.7**	42.4	47.8	**5.4**
Social Support						
None	51.4	34.8	**-16.6**	60.7	42.0	**-18.7**
Some	40.3	51.5	**11.2**	32.3	46.7	**14.4**
Daily	8.4	13.7	**5.3**	7.0	11.3	**4.3**
Any	48.6	65.2	**16.6**	39.3	58.0	**18.7**
Family Conflict	7.5	5.6	**-1.9**	7.7	7.2	**-0.5**

Note: Numbers in table represent percentages; Any CJ Activity = Any criminal justice activity; I = Intake Value; D = Discharge Value; Dif. = Difference between Discharge and Intake Values.

Table 5.12 presents outcomes for Prop 36 offenders in residential treatment by probation versus parole status. Notably, primary drug use decreased to a greater extent from intake to discharge among probationers (50.0%) than among parolees (40.2%). Reductions in criminal justice activity were approximately comparable between parolees and probationers. Homelessness declined by 10.0% from intake to discharge for parolees. But, among probationers, homelessness decreased by 12.3% from intake to discharge. There was virtually no change in parolees reporting dependent living at discharge relative to intake. This is in contrast to probationers who showed an increase in dependent living at discharge relative to intake of -2.9%. Both parolees and probationers reported an approximate 10% increase in independent living after residential treatment. Although large gains were made in employment among both probationers and parolees, the gains among probationers were larger than those seen for parolees (-23.5% vs. -17.3%).

Similarly, increases in social support were seen for both probationers and parolees, but probationers tended to show higher gains in social support. This was true for family conflict as well. Family conflict among probationers decreased by 7.2% for probationers versus 4.6% for parolees.

Table 5.12: Selected Outcomes for Prop 36 Offenders in Residential Treatment by Parole Status.

	Probation (N=2,607)			Parole (N=612)		
	I	D	Dif.	I	D	Dif.
Used Primary Drug (Past 30 days)	63.1	13.1	**-50.0**	57.9	17.7	**-40.2**
Any CJ Activity (Past 30 Days)	48.5	5.8	**-42.7**	48.7	5.4	**-43.3**
Living Arrangements						
Homeless	38.9	26.6	**-12.3**	39.9	29.9	**-10.0**
Dependent Living	40.4	43.3	**2.9**	36.9	37.3	**0.4**
Independent Living	20.7	30.1	**9.4**	23.2	32.8	**9.6**
Employed (Full or Part-Time)	6.9	30.4	**23.5**	5.7	23.0	**17.3**
Social Support						
None	52.9	12.4	**-40.5**	51.0	18.3	**-32.7**
Some	38.5	34.2	**- 4.3**	33.7	24.7	**-9.0**
Daily	8.6	53.4	**44.8**	15.4	57.0	**41.6**
Any	47.1	87.6	**40.5**	49.0	81.7	**32.7**
Family Conflict	10.2	3.0	**-7.2**	8.0	3.4	**-4.6**

Note: Numbers in table represent percentages; Any CJ Activity = Any criminal justice activity; I = Intake Value; D = Discharge Value; Dif. = Difference between Discharge and Intake Values.

FUTURE TRENDS AND PAROLEES IN PROP 36

CDCR medical services has been under federal receivership for nearly 3 years. Currently CDCR is stretched to its limits as it is operating at nearly twice its designed inmate housing capacity. A number of commissions and expert panels have been convened to provide guidance in reforming California's prison system and have advocated significant reductions in inmate populations, major changes to the state's parole system, and

redesigning of in-prison treatment programming. Below we describe the major developments, reports, and panel recommendations that, if adopted, may impact Prop 36.

CDCR Receivership and Rulings from the United States District Court

After a failure to remedy conditions under a Special Master, on June 30th, 2005, the United States District Court ruled to establish a receivership for CDCR medical services due to unconstitutional conditions regarding physical and mental health care. This receivership is ongoing and subsequent to the placement of CDCR medical services under receivership, a number of additional rulings have been made. Most recently (02/09/09), in a tentative ruling by a three judge panel of the United States District Courts in Coleman et al. v. Schwarzenegger et al. and Plata et al. v. Schwarzenegger, the court found that overcrowding was the primary reason for the failure to provide constitutionally adequate physical and mental health care. Further, the court found that there was no other remedy than to issue a prisoner release order. This decision was based in part on the fact that as of August 2008, prisons in California were operating at twice the design capacity. A series of experts have recommended that the outside limit for capacity at which California's prisons can operate and meet constitutional requirements for adequate physical and mental health care is between 120% and 145%. Of note was the testimony that specialized clinical programs should operate at or below 100% capacity. Meeting the constitutional right for physical and mental health care is the minimum standard of operation required of CDCR; however, CDCR has redefined its role in recent years to include that of rehabilitation of inmates. It is unclear that operations at 120%-145% of capacity would allow CDCR to achieve its goal of effective rehabilitation of those inmates motivated for change. What is clear is that current capacity precludes effective rehabilitative programming.

A key element of reform relevant to Prop 36 under the U.S. District Court rulings is the revamping of the parole system. California's parole population has increased significantly in past years, growing at 8% in 2007 as compared to 0.4% for prisons (Petersilia, 2007). Given that nearly two-thirds of all parolees are returned to prison within three years and California has the highest rate of absconding (17%) from parole of any State, the parole system is not functioning in a rehabilitative capacity. The utilization of Prop 36 as an intermediate sanction for parolees committing a drug-related, Prop 36 eligible parole violation or new offense reduces the number of parolees returned to prison as it specifically eliminates the use of incarceration for non-violent, drug-related parole violations. Further, Prop 36 offers additional bed space for substance abuse treatment of parolees, which helps to meet the need for such services among the parolee population.

CDCR Expert Panel on Adult Offender and Recidivism Reduction Programming

Under Provision 18 of the California Budget Act for FY 2006-07, funds were provided for an expert panel review of adult offender reentry and recidivism reduction programs in an effort to provide a framework for modification of existing program practices and development and implementation of new program practices to reduce recidivism among California Parolees. The findings and recommendations of the expert panel are presented

in a report to the California State Legislature (CDCR, 2007). In general, the report's conclusions were that institutional environment factors and programming factors have contributed to California's high rate of parolee recidivism. Specifically, the expert panel found that California's prisons were extremely overcrowded and that this overcrowding has created barriers to rehabilitative programming including reduced programming space and interruptions in rehabilitative programming due to institution lockdowns. With regards to programming factors, the expert panel noted that little data are collected on outcomes for individuals receiving rehabilitative services and that little formal program evaluation has been done on existing CDCR programs. What data exist with regards to CDCR prison-based substance abuse treatment programs has indicated that they are largely ineffective (Cate, 2007).

AB 900

Signed into law by Governor Arnold Schwarzenegger in May of 2007, AB 900 provides for a major prison bed expansion (up to 40,000 new beds) in two phases with the stipulation that the construction funding is tied to the development and implementation of rehabilitative programming and the provision of adequate treatment space for such programming. As part of Phase I, CDCR will establish 2,000 substance abuse treatment slots at the following institutions: California Correctional Institution, level I (50 beds), California Institution for Men, level I (250 beds), Valley State Prison for Women, level I/IV (250 beds), Central California Women's Facility, level I/IV (250 beds), California State Prison, Solano, level II (500 beds), Sierra Conservation Center, level I (250 beds), Avenal State Prison, level II (250 beds), and the Leo Chesney Community Correctional Facility (200 beds). This expansion will increase the number of inmates receiving in-custody drug treatment and will be accompanied by the funding of an additional 1,000 slots for community-based substance abuse continuing care. The CDCR, under AB 900, is developing a "prison to employment" program modeled after Texas' Re-Integration of Offenders program to aid in reintegrating parolees into the community. A review of current academic and vocational programs is being conducted with an emphasis on aligning existing programs with "real-world" employment skills. Finally, mentally ill parolee services are being expanded and currently 300 parolees are receiving services in their communities utilizing funds from the Recidivism Reduction program.

In addition to expansion of in-prison programming space, CDCR has completed a review of existing parole policies and procedures and has attempted to improve the consistency of discharge recommendations for non-violent, non-serious offenders and offenders who have demonstrated good behavior and are violation free. Non-violent, non-serious offenders may receive discharge at 12 months and offenders demonstrating good behavior who are free of violations may receive parole discharge at 24 months. With regards to handling violations or commission of new crimes by parolees, a decision matrix has been developed to guide parole agents and supervisors' decisions regarding sanctions and programming options. The decision matrix was due for field training and testing beginning in April of 2008. Finally, a process for potential parolee review for discharge by the Board of Parole for non-violent, non-serious parolees under an incentives program that rewards positive, violation-free behavior has been created.

Included in the development of this program was the creation and validation of a measure to assess risk for violent re-offense, which is currently in field trials.

The major Prop 36 relevant component of Phase II is the building of some 10,000 re-entry beds located in communities throughout the state. These community re-entry facilities will be designed to house inmates in the final 12 months of their sentence and will provide programming and treatment services to aid in the transition to pro-social, non-criminal community living.

Little Hoover Commission Report

Released in January of 2007, the Little Hoover Commission Report emphasizes the need for immediate CDCR reform. The commission noted that the corrections policies of the last 30 years have lead to the release of many violent offenders without regard to the danger they pose to the public. Further, the report stated that current policies have provided little incentive for inmates to work towards change while incarcerated or while on parole. The commission made three sets of recommendations.

First, they proposed the immediate implementation, by the Governor and legislature or an appointed board of directors, of reforms to reduce prison overcrowding including revamping parole, increasing educational, vocational, and substance abuse programming, providing community-based punishment alternatives, and expanding judicial discretion. They cite the need for partnerships between CDCR and any other governmental agencies that could help advance evidence-based programming in prison and during prisoner reentry.

Second, they proposed parole reform including basing supervision decisions on a validated risk/needs assessment instrument. Such a practice would allow for the allocation of the most supervision resources to those who are in need of higher levels of supervision and reducing or eliminating supervision for those who are at low risk to reoffend. Under this recommendation, the commission also suggested shifting supervision from the State to the community level, trying offenders and sentencing them to new terms if they commit new crimes while on parole, expanding treatment programs that inmates have some form of incentive to complete, expanding local treatment and jail capacity including local intensive probation capabilities, and finally, expanding the ability of judges to set goals that offenders must achieve if they are sentenced to prison or probation.

Third, the commission recommended that California establish a sentencing commission whose primary goal is to enhance public safety and manage public resources effectively.

Legislative Analysts Office (LAO) Criminal Justice Realignment Proposal

In January of 2009, the LAO issued a report (Taylor, 2009) recommending the transfer of responsibility for punishment and treatment of drug possession offenses from the state level to the county level. This would be accomplished through the reclassification of drug

possession offenses, driving under the influence without bodily injury to others, and civil narcotics addict designation as misdemeanor offenses, precluding the imposition of a prison sentence for these offenses. Under county jurisdiction, those convicted of these offenses would be subject to probation, mandated substance abuse treatment, county jail, or any combination of these options. The LAO report estimates that there are some 11,600 inmates in state prison for drug possession, 1,700 for driving under the influence, and 700 civil narcotics addicts. These individuals would be released to county supervision

Economy

The recent recession and its effect on the California budget is likely to have a substantial effect on the flow and treatment of Prop 36 parolees, though the specific consequences will depend on a number of funding and policy decisions that cannot be accurately predicted at this time. One plausible outcome is that budget cuts will result efforts to reduce the prison population which would logically result in more parolees, and therefore more parolee admissions to Prop 36. However, at the same time Prop 36 funding has also been shrinking. A likely scenario would therefore be more Prop 36 parolees being referred to a system with shrinking resources. If Prop 36 funding is not increased, parolee outcomes will decline. Given that parolees already tend to drop out of treatment at rates substantially higher than those of other clients (see Chapter 2), this possibility is cause for great concern.

Summary of Future Trends

One possible scenario for coming years, given the current overcrowded conditions in CDCR prisons and the legal, political, and economic pressures CDCR faces, is the release of a sizeable number of offenders from prison. In addition to prisoner release, prison capacity expansion measures are being implemented. While these measures will alleviate some of the burden of overcrowding in California prisons, they may also place a great deal of strain on parole services, particularly if expansion of prison capacity lags. That is, if a large number of parolees enter the system at the same time with no change in parole practices there will be further increases in caseloads. One proposed change to parole policies that may impact Prop 36 is the increased use of ”banked” parole. Banked parole is a summary parole condition in which supervision of parolees would not involve monthly contact with parole agents. This would most likely be done for non-violent drug offenders and one parole agent believed that this would potentially significantly reduce or eliminate his Prop 36 caseload. The minimal to non-existent supervision offered under banked parole would reduce the detection of drug use through monthly drug testing and would mean that only those parolees who were arrested by police on drug-related, Prop 36 eligible charges would enter the Prop 36 system.

Based on recommendations from a number of sources, CDCR is implementing major changes in its prisoner rehabilitation efforts in an attempt to reduce California parolees' high recidivism rate. It appears that what is required is a total rebuilding of in-prison rehabilitative programming based on formal, independent evaluation of existing programs

and the implementation of evidence-based programming practices from other states and jurisdictions. Assuming the successful revision of existing programs and the implementation of evidence-based programming to reduce recidivism, it is likely that inmates will have access to a wider range of effective programming options; however, as suggested by other authors, there is a need to provide incentives for participation in these programming options. The expansion of prison-based substance abuse treatment programming may have direct bearing on Prop 36. Existing legislation will expand the capacity of in-prison drug treatment programs at a number of CDCR institutions and may result in more parolees entering post-incarceration drug treatment under SASCA funding, since in-prison treatment is an eligibility requirement for SASCA, and this may result in more Prop 36 treatment since SASCA funnels clients into Prop 36. A proposal to shift jurisdiction for non-violent drug offenders to the county level could result in increases in Prop 36 participation overall, but would mean that fewer non-violent drug offenders would enter CDCR's system, eventually resulting in fewer Prop 36 eligible parolees.

CONCLUSIONS AND RECOMMENDATIONS

5.1 The issue of specialized Prop 36 parole agents appears to have merit based on input from stakeholders and parole agents. Specifically, stakeholders believed that communication between treatment providers and parole agents would be much easier if the number of parole agents handling Prop 36 cases in a given county were reduced. Parole agents believed that specialized Prop 36 caseloads were beneficial because parole agents with smaller, specialized caseloads would have more time to "work" their cases. Preliminary analyses suggest that parolees do better under specialized agents than on mixed caseloads, but further analysis and research is necessary to confirm this.

5.2 A larger percentage of parolees reported having less than 12 years of education. Interventions to help parolees obtain G.E.Ds and/or get technical job skills training are important for efforst to reduce recidivism. Such programs are available in prison; however, there currently is no incentive for prisoners to access those services while incarcerated. Adopting incentives for participation in schooling or technical training while incarcerated or while participating in Prop 36 may be beneficial for parolees.

5.3 At intake homelessness was more prevalent among parolees than probationers. Residential drug treatment greater than 30 days resulted in a 10% reduction in homelessness among parolees; however, the percentage of parolees reporting homelessness at discharge after residential treatment was still high (approximately 30%). After outpatient treatment the percentage of parolees reporting homelessness was, for the most part, unchanged. The percentage change in homelessness after outpatient treatment was -0.4%. Notably, parole agents believed that stable housing was one factor that was related to good performance in Prop 36 among parolees. Efforts to establish and maintain housing for parolees may further improve outcomes among parolees in Prop 36.

5.4 Increases from intake to discharge in social support for parolees were smaller than those seen for probationers. Social support was cited as one factor that parole agents believed differentiated those parolees who did well in Prop 36 from those who fared poorly. Efforts to expand social support systems among parolees may help in improving outcomes among parolees in Prop 36. One stakeholder group reported the establishment of alumni groups among parolees in an effort to increase social support after treatment. Future research should examine participation in alumni groups for parolees to determine its impact on treatment outcomes for parolees. Should alumni groups prove efficacious for parolees in Prop 36, they should be considered for statewide use.

5.5 Parolees in outpatient treatment fared consistently worse than probationers in terms of reaching the 60 and 90 day retention benchmarks. Further, completion rates for parolees in outpatient treatment were lower than those for probationers. These differences were not found between probationers and parolees for residential treatment. These findings suggest that residential treatment may be a better option for some parolees. There was some indication of greater substance abuse severity among parolees at intake in that a greater percentage had previous treatment episodes, they were more likely to report cocaine/crack or heroin as their primary drug, and were more likely to report injection drug use than probationers. Care should be taken to assess drug use severity, social support, and housing stability for parolees prior to referring to outpatient treatment.

5.6 The impending changes at CDCR may have impacts on Prop 36. If large-scale release of prisoners who are non-violent drug offenders occurs with no change in parole policies one might expect an increase in the number of parolees entering Prop 36. However, if a large scale release of inmates occurs without an adequate increase in resources for parole supervision, one possible outcome would be increased use of "banked" parole with minimal to no supervision of non-violent, drug offending parolees. This lack of supervision may decrease the detection of drug-related violations among parolees, resulting in the opposite effect: fewer Prop 36 eligible parolees entering the Prop 36 system. Changes in policies and the resulting flow of Prop 36 parolee participants will need to be monitored closely.

References

California Department of Alcohol and Drug Programs. (2002). Proceedings of Proposition 36 'Making It Work!' 2002: A Statewide Technical Assistance Conference. Sacramento, CA: Author.

California Department of Alcohol and Drug Programs (2003). Proceedings of Proposition 36 'Making It Work' 2003 Building on Success: A Statewide Technical Assistance Conference. Sacramento, CA: Author.

California Department of Corrections and Rehabilitation (2009). Chapter 8: Adult Parole Operations, Control Services Supervision Procedures, Operations Manual, 620. Accessed online (8/17/2009) at:

http://www.cdcr.ca.gov/Regulations/Adult_Operations/docs/DOM/DOM%20Ch%208-Printed%20Final.pdf
California Department of Corrections and Rehabilitation, Offender Information Services Branch. (2008). Parole. Sacramento, CA: Author.
California Department of Corrections and Rehabilitation, Offender Information Services Branch. (2007). California Prisoners and Parolees 2007. Sacramento, CA: Author.
California Department of Corrections and Rehabilitation, Office of Public and Employee Communications. (2008). Prison Reforms: Achieving Results. Sacramento, CA: Author.
California Department of Corrections and Rehabilitation, Population Projections Unit. (2008). Fall 2008 Adult Population Projections: 2009 – 2014. Sacramento, CA: Author.
California Department of Justice, Criminal Justice Statistics Center. (2009a). Total felony arrests by gender, offense, and arrest rate statewide. Accessed online (01/06/09) at: http://stats.doj.ca.gov/cjsc_stats/prof06/00/3A.htm.
California Department of Justice, Criminal Justice Statistics Center. (2009b). Final law enforcement, prosecution and court dispositions of adult felony arrests by type of disposition statewide. Accessed online (01/06/09) at: http://stats.doj.ca.gov/cjsc_stats/prof06/00/6.htm.
Carr, W. A., Rotter, M., Steinbacher, M., Green, D., Dole, T., Garcia-Mansilla, A., Golderg, S. & Rosenfeld, B. (2006). Structured Assessment of Correctional Adaptation (SACA): A measure of the impact of incarceration on the mentally ill in a therapeutic setting. International Journal of Offender Therapy and Comparative Criminology, 50(5), 570-581.
Cate, M. L. (2007). Special Review into in-prison substance abuse programs managed by the California Department of Corrections and Rehabilitation. Sacramento, CA: Office of the Inspector General.
Chandler, R. K., Fletcher, B. W. & Volkow, N. D. (2009). Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. Journal of the American Medical Association, 301(2), 183-190.
Conner, B., & Grella, C. (2008). "The homeless mentally ill in Proposition 36" in *Evaluation of the Substance Abuse and Crime Prevention Act: 2008 Report.* (Prepared for the California Department of Alcohol and Drug Programs). Los Angeles, CA: UCLA Integrated Substance Abuse Programs.
Expert Panel on Adult Offender and Recidivism Reduction Programs. (2007) Report to the California State Legislature: A Roadmap for Effective Offender Programming in California. Sacramento, CA: California Department of Corrections and Rehabilitation.
Gardiner, C. L. (2008). From inception to implementation: How SACPA has affected the case processing and sentencing of drug offenders in one California county. Unpublished doctoral dissertation, University of California, Irvine.
Igneizi, J., Stinson, B., Raia, J., Ostrowski, L. & Schwirian, J. (2007). Utilizing risk-of-violence findings for continuity of care. Psychiatric Services, 58(4), 452-454.
Little, G. L. & Robinson, K. D. (1988). Moral reconation therapy: A systematic step-by-step treatment system for treatment-resistant clients. Psychological Reports, 62, 135-151.

Longshore, D., Evans, E., Urada, D., Teruya, C., Hardy, M., Hser, Y., Prendergast, M. & Ettner, S. (2003). Evaluation of the Substance Abuse and Crime Prevention Act 2002 Report. Los Angeles, CA: Integrated Substance Abuse Programs.

McCaffrey, B. (1998). Drug treatment in the criminal justice system. Washington, D.C.: Office of National Drug Control Policy.

Petersilia, J. (April 1, 2005). Hard time: Ex-offenders returning home after prison. Correcations Today. American Correctional Association.

Petersilia, J. (December, 2007). Meeting the Challenges of Rehabilitation in California's Prison and Parole System. Sacramento, CA: California Department of Corrections.

Pew Center on the States. (2008). One in 100: Behind Bars in America 2008. Washington, D.C.: Author.

Ross, R. R. & Fabiano, E. A. (1985). Time to think: A cognitive model of delinquency prevention and offender rehabilitation. Johnson City, TN: Institute of the Social Sciences and Arts, Inc.

Rothfield, M. (2009). Arnold Schwarzenegger, Jerry Brown will ask U.S. to end oversight of California prisons. Accessed online (02/24/09) at: http://www.latimes.com/news/local/la-me-prison28-2009jan28,0,2645570.story.

Rotter, M., McQuistion, H. L., Broner, N., Steinbacher, M. (2005). The impact of the 'incarceration culture' on reentry for adults with mental illness: A training and group treatment model. Psychiatric Services, 56(3), 265-267.

Sayles-Owen, D. (2005). All County Lead Agencies Letter 05-01. Accessed online (04/30/09) at: http://www.adp.state.ca.us/SACPA/PDF/ACLA_Letter_05-01.pdf

Taylor, M. (2009). 2009-2010 Budget Analysis Series: Criminal Justice Realignment. Sacramento, CA: Author.

Travis, J. (2000). But they all come back: Rethinking prisoner reentry. U.S. Department of Justice, Office of Justice Programs, National Institute of Justice. Accessed online (02/05/08) at: http://www.ojp.usdoj.gov/nij.

Wilson, D. B., Bouffard, L. A., Mackenzie, D. L. (2005). A quantitative review of structured, group-oriented, cognitive-behavioral programs for offenders. Criminal Justice and Behavior, 32(2), 172-204.

Chapter 6. Proposition 36 Special Populations: Hispanic Men Under 26

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Since its inception, the number of Hispanics in Prop 36 has been growing and Hispanics currently represent the second largest race/ethnic group in Prop 36, with Non Hispanic Whites being the first. To ensure the health and prosperity of this growing segment of the population, the health services sector must adapt to the needs, values, and culture of the Hispanic population, particularly as they relate to health behaviors.

Analyses presented in this chapter indicated that, despite the fact that there are some highly culturally responsive programs for Hispanics in Prop 36, the overall treatment system may be low in cultural responsiveness. Prop 36 treatment providers reported a number of specific measures they have taken to increase cultural responsiveness for Hispanics. These include employing ethnic/cultural matching, providing bilingual treatment information to clients, and employing Spanish speaking counselors. However, data indicate that there is a paucity of drug treatment services offered in Spanish relative to services offered in English.

The most frequently cited barrier to treatment entry was drug using peer groups, followed by language barriers and work obligations. Two of these barriers emerged as themes in our focus group data (drug using peer groups and work obligations) and one was a theme identified from key informant interviews (language barriers). Using data from CalOMS, we identified some of the specific needs of Hispanics in Prop 36 and examined outcomes for Hispanic males under 26 relative to Non Hispanic White males under 26. With regards to outcomes, all participants showed gains across a wide range of domains at treatment discharge relative to intake.

Key recommendations made include the following: (a) increased emphasis on cultural responsiveness (CR) among Prop 36 treatment providers including increasing CR residential treatment programs, continued CR training for providers, and systematic incorporation of CR practices among treatment providers serving a high number of Hispanic clients; (b) there is a clear need to attract, train, and retain Spanish speaking treatment providers for Prop 36 providers as language barriers were the second most commonly cited barrier to treatment entry for Hispanics; (c) educational interventions are necessary as education was lower among Hispanics relative to Non-Hispanic Whites and education may reduce the impact of acculturation stress as it relates to problematic substance use; (d) employment and economic considerations may need to be addressed to increase access to residential treatment services for Hispanics in Prop 36; (e) family interventions, including parenting training, may be helpful for Hispanic males under 26 as many reported having young children at home; (f) there is a need for increased emphasis on HIV testing and prevention among Hispanics as they are at greater risk than the general population for HIV; (g) economic barriers to participation in treatment are particularly problematic early in treatment and income sensitive payment plans for drug testing and court imposed fines may help to facilitate retention early in treatment.

INTRODUCTION

Hispanics[36] represent a significant percentage of the population nationwide and in California. It is expected that the Hispanic population will grow significantly in coming decades and by 2040 Hispanics will comprise the largest ethnic group in California. In order to respond to shifting demographics and to ensure the health and prosperity of this growing segment of the population the health services sector must better understand the needs, values, and health behaviors of Hispanics. In addition, existing policies and programs will require adaptation to serve a new Californian populace. In 2008, the California Alcohol and Drug Programs (ADP) identified a number of special populations of interest, of which Hispanic males younger than 26 were one, for more intensive study in the 2008 Prop 36 evaluation. This chapter addresses the questions posed regarding Prop 36 treatment outcomes for Hispanic males younger than 26. Key questions asked regarding this population were the following:

- What practice changes did providers implement to improve outcomes for Prop 36 clients who are Hispanic males under 26?
- Did any of these practices result in higher show rates, higher completion rates, or other performance improvements for Hispanic males under 26?
- What are the characteristics and needs of Hispanic males under 26, and what promising treatment strategies are recommended for these groups?
- Were OTP expenditures associated with better performance or outcomes for Prop 36 clients who are Hispanic males under 26?
- How do providers and counties address the needs of clients who are Hispanic males under 26?

Prior to addressing these questions on page 174, we review: (a) socio-demographic characteristics of the Hispanic population in the United States (U.S.); (b) substance use among Hispanics; (c) heterogeneity in substance use patterns within the Hispanic population; (d) previous work on Hispanics in Prop 36; (e) HIV/AIDS and Hispanics; and (f) Hispanic cultural responsiveness among Prop 36 treatment providers.

BACKGROUND

Hispanics in the United States

[36] For the purposes of clarity and consistency, we use the term Hispanic in this report to refer to individuals of origin from or who trace their heritage to Spain, Mexico, Cuba, Puerto Rico, Central America, or South America; however, this categorization is a gross oversimplification of the heterogeneity of populations with diverse histories, cultures, languages, and personal experiences. Further, Hispanic ethnic identity may include individuals of any race, whereas the Non-Hispanic White comparison group included in this chapter is comprised of individuals of Caucasian race who did not identify as being of Hispanic ethnicity.

The United States (U.S.) Census of 2000 defined Hispanic ethnicity as being of Mexican, Mexican-American, Chicano, Puerto Rican, Cuban, or other Spanish/Hispanic origin or heritage (Greico & Cassidy, 2001). Hispanics are a significant minority group in the U.S. population and are a particularly large component of the population in Western States. Data from the 2000 Census (Guzman, 2001) indicated that: (a) 35.3 million residents in the U.S. (excluding the Commonwealth of Puerto Rico and the U.S. Island areas) were Hispanic, which constitutes 12.5% of the total population; (b) the majority of Hispanics in the U.S. were of Mexican origin or heritage (7.3% of the total population) followed by Puerto Ricans (1.2%), Cubans (0.4%), and other Hispanics (3.6%); (c) approximately 44% of Hispanics in the U.S. lived in the West[37] and South[38]; (d) three Western States (Arizona, California, and New Mexico) and one Southern State (Texas) have Hispanic populations that are 25% or more of the total State population; (e) within California, two counties are 50% or more Hispanic, 20 counties are 25% to 49.9% Hispanic, 15 counties are 12.5% to 24.9% Hispanic, and 12 counties are 6% to 12.4% Hispanic. A total of 10,966,556 Hispanic individuals live in California. This constitutes just over 32% of the total population in the State of California and nearly one-third of all Hispanics in the U.S. Hispanics represent at least one quarter of the entire county population in 22 of the 53 California counties, with Los Angeles County having the highest number (4,242,214 individuals).

Socio-demographic data from the 2000 Census on Hispanics are presented in a report from the U.S. Census Bureau entitled 'We the People: Hispanics in the United States' (Ramirez, 2004) and major findings from this report are summarized here. The proportion of male and female Hispanics under age 35 exceeds the proportion of the total population under 35; the median age for Hispanics was nearly a decade younger than the total population, with Mexican origin or heritage individuals having the youngest median age (24.4 years). The majority of Hispanics (approximately 60%) were born in the U.S., 11.2% were naturalized citizens, and 29% were not citizens. Over half of all Hispanic individuals were married as of the year 2000, 55.1% lived in family households, and over 77% spoke a language other than English at home. Educational attainment was lower among Hispanics 25 and older relative to the total population 25 and older. The majority of Hispanics 16 and older were in the labor force (males = 69.4; females = 53.0), but these rates were slightly lower than those for the general population (males = 70.7; females = 57.5). Hispanic males, were underrepresented in the managerial, professional, and related occupations and over represented in construction, extraction, maintenance, production, transportation, and material moving occupations; however, despite still being underrepresented, a larger percentage of female than male Hispanics were employed in managerial, professional, and related occupations. Hispanic females were overrepresented in service, sales, and office occupations. Median income for Hispanic families was $34,397, whereas, the median income for all families was $50,046. The poverty rate for all Hispanics was nearly twice that of the total population (total

[37] Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Washington, and Wyoming

[38] Alabama, Arkansas, Delaware, The District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia

population = 12.4%, Hispanics = 22.6%), with 27.8% of those under 18 and 19.6% of those 65 and older living in poverty. For the total population these numbers were 16.6% and 9.9%, respectively.

Heterogeneity of Substance Use Patterns Among Hispanics

Substance problems are relatively less prevalent among Hispanic women relative to men (Karno et al., 1987; Vega et al., 1998). Vega et al (1998) found differential rates of substance use for men and women in a sample of Mexican-origin individuals in Fresno County California. The rate of marijuana use, collapsing the sample across urban, rural, and town residents, was 23.7% for females, 45.7% for males. Cocaine use prevalence was 9.0% for females and 25.9% for males. Hallucinogen use rates were 5.9% for females and 12.5% for males. Inhalant use was 3.5% for females and 8.8% for males. Rates of heroin use were 0.8% for females and 4.0% for males. Approximately 43.2% of females reported using more than one drug; whereas, 54.5% of males reported using more than one drug.

Amaro et al. (1990), using data from the Hispanic Health and Nutrition Evaluation Survey (HHANES), found gender differences in marijuana use among Hispanics. Fifty percent of Mexican-American and 50% of Puerto Rican men reported lifetime marijuana use, relative to 30% and 20% of Puerto Rican and Mexican women. One fourth of Puerto Rican men and 1/5 of Mexican-American men reported using marijuana in the prior year; whereas, 13% and 7% of Puerto Rican and Mexican women reported marijuana use.

Nativity is an important factor in substance use behavior among Hispanics. For example, Amaro et al. (1990), using data form the HHANES, found that U.S. born Hispanic individuals of Mexican, Puerto Rican, and Cuban descent were more likely to report use of marijuana in the last year relative to Hispanics born in Mexico, Puerto Rico, or Cuba, regardless of gender. For both males and females, the percentage of individual reporting marijuana use in the last year was greater among Puerto Ricans relative to Mexicans and Cubans independent of nativity. These patterns hold for cocaine use as well in the HHANES data (Amaro et al., 1990), with the exception that a larger percentage of U.S. born Cubans report prior year use of cocaine relative to U.S. born Mexicans and Puerto Ricans.

Among a sample of 3,012 Mexican-origin individuals in Fresno County, CA, 37.9% reported use of any illicit drug and, for those reporting drug use, 51% reported use of more than one drug (Vega, Alderete, Kolody & Aguilar-Gaxiola, 1998); however, rates of DSM-III substance disorders have been found to be lower among Hispanics from Mexico. For example, in the Los Angeles Epidemiologic Catchment Area Project (LAECA; Karno, Hough, Burnam et al., 1987), data indicate that lifetime DIS/DSM-III drug abuse/dependence rates were higher among Non-Hispanic Whites relative to Mexican Americans (13.2 vs. 3.7). Hispanic women and Hispanic men over 40 had the lowest rates of substance abuse/dependence. For Mexican men ages 18-39 years old, the rate was 9.0%, whereas for Mexican men ages 40 and above the rate was 0.5. For

Mexican women ages 18-39, the rate of substance abuse/dependence was 3.7%, and for Mexican women over age 40 the rate was 1.1%.

Findings about substance abuse among Hispanic populations suggest that low U.S. acculturation may be a protective factor with regards to risk for substance problems. For example, Burnam, Hough, Karno, Escobar & Telles (1987) found that as degree of U.S. acculturation increased, so did the rates of drug abuse/dependence. These authors employed a multidimensional measure of acculturation (i.e., language preference, ethnic background, identification with ethnic activities). For those with low levels of U.S. acculturation, the life-time prevalence rate for drug abuse/dependence was 0.4%. For those with medium levels of U.S. acculturation the rate of drug abuse/dependence was 4.3%. For those with high levels of U.S. acculturation, the rate was 8.3%.

Language preference as a measure of U.S. acculturation is significantly associated with marijuana and cocaine use regardless of gender (Amaro et al., 1990). In an interesting study of the impact of U.S. acculturation in adolescents on marijuana use, Epstein et al. (2001) found that adolescents who spoke English with their parents at home smoked marijuana more frequently than adolescents who spoke Spanish to their parents at home. Further, adolescents who spoke English with their parents or who were bilingual engaged in more poly-drug use.

Age appears to moderate the relationship between U.S. acculturation and alcohol use among women. Markides et al. (1990) found that U.S. acculturation was positively associated with drinking among younger women, but had no association among middle aged women. Poverty and marital stress were more related to drinking by middle aged women. Some authors have found that the affects of U.S. acculturation level may also be moderated by education (e.g., Amaro, Whitaker, Coffman & Heeren, 1990), with U.S. acculturation effects on drug use being greatest on the least educated: highly U.S. acculturated Hispanics with low levels of education were more likely to report marijuana and cocaine use than highly U.S. acculturated Hispanics with high levels of education.

Previous Prop 36 Work Related to Hispanics

The percentage of Prop 36 clients who are Hispanic has increased slightly each year. (Urada & Evans, 2008). Data from the 2008 Evaluation of Proposition 36 indicate that from July 1, 2001 to June 30, 2002 30.7% of Prop 36 treatment clients were Hispanic. As of the period from July 1, 2005 to June 30, 2006 the percentage of Hispanic clients increased approximately 5% to 35.9% Hispanic treatment clients enrolled in Prop 36. Thus, Hispanics comprise the second largest ethnic group among Prop 36 participants (the first is Non-Hispanic White at 43.9% of Prop 36 treatment clients between July 1, 2005 and June 30, 2006) and their overall representation among Prop 36 clients is similar to their representation in the general population. However, more Hispanics are entering treatment for the first time under Prop 36: clients with no prior experience were more likely to be Hispanic than clients with prior experience (37.1% vs. 30.7%) (Urada & Longshore, 2007). Also, in the first three years of Prop 36, the percentage of opiate-using Prop 36 NRT clients increased steadily for Hispanics and African-Americans.

Treatment completion rates have been consistently lower, and treatment duration shorter, for African Americans and Hispanics than for Non Hispanic Whites, Asians and Pacific Islanders, and Native Americans. (Urada, Longshore, & Conner, 2007; Urada & Evans, 2008). The percentage of Prop 36 clients who reached 90 days was slightly lower among African-Americans, Hispanics, and Native Americans than among Non Hispanic Whites, Asian-Americans, and Pacific Islanders (Urada, Longshore, & Conner, 2007). The adjusted odds ratios (O.R.) for treatment completion were lower for African-Americans (O.R. = 0.64) and Hispanics (O.R. = 0.82) than for Non Hispanic Whites (treated as the reference category, O.R. = 1.00) and Asian-Americans and Pacific Islanders (O.R. = 1.03). Thus, after adjustment for other characteristics, African-Americans were 36% less likely to complete treatment (1.00-0.64 = 0.36), and Hispanics were 18% less likely to complete treatment (1.00-0.82 = 0.18). (Urada, Anglin, & Conner, 2007).

Young Hispanic males referred to treatment through Prop 36 were less likely to be placed into long-term residential treatment than similar drug-severity Non Hispanic White males, even after controlling for factors related to treatment placement (these included age, primary drug, frequency of use, age at first use, education, labor force participation status on entry into treatment, and homelessness). Among young men, Prop 36 referrals had larger treatment disparities for Hispanics than did non-Prop 36 criminal justice referrals and self-referrals. Young Hispanic males referred through Prop 36 were only two-thirds as likely to receive a residential treatment slot as similar young Non Hispanic White males (Hawken, 2008). The difference between rates of residential placement for male Hispanic and Non Hispanic White non-Prop 36 criminal justice referrals was not statistically significant. Self-referred Hispanic males were less likely to be placed into residential treatment but the magnitude of the treatment difference by ethnicity was smaller than for Prop 36 clients. This treatment placement disparity observed among Prop 36 referrals diminished for older offenders. There was no meaningful difference in the likelihood of receiving a residential treatment placement across race/ethnicity for clients over 35 years. (Hawken, Anglin, & Conner, 2007).

The likelihood of being employed one year after Prop 36 treatment assessment was increased by treatment completion or by retention of > 90 days and Hispanic race/ethnicity, and decreased by older age, residing in particular counties, a higher ASI Employment Composite Score indicating greater severity, and receipt of "other" services and public assistance (i.e., Medi-Cal, general relief, food stamps, public assistance, etc., and also assistance with housing, transportation, and other basic needs). The greater likelihood of positive employment outcomes among Hispanic groups may be explained, in part, due to better access and motivation for work because of cultural and family obligations, and Hispanics may also exhibit a greater willingness than other racial/ethnic groups to perform unskilled work. Additional information is needed to better understand contextual factors that predict employment (Evans, 2008).

As noted above, in Prop 36, treatment completion rates were lower and 90-day treatment duration less common for African-Americans and Hispanics, than for Non Hispanic Whites, Asian-Americans, Pacific Islanders, and Native Americans. The same was true in

Prop 36's earlier years. Disparities in completion rates may reflect entrenched societal conditions. Nevertheless, these disparities are cause for concern. It may be important to explore opportunities to improve cultural competence in assessment and treatment of Prop 36 clients. Cultural competence reflects an "awareness of cultural differences and the development of skills to work in multicultural situations" (Campbell et al., 2002, page 110; see also Betancourt et al., 2003) and is believed to have a positive impact on health service utilization, sustained participation, satisfaction with services, and outcomes (Campbell et al., 2002; Paniagua, 1994; Resnicow & Braithwaite, 2001; Smedley et al., 2003). Alternatives for promoting cultural competence include racial/ethnic matching between staff and clients, offering clients the opportunity to choose a counselor of the same race/ethnicity, offering single-race group counseling sessions or self-help support groups, hiring personnel who are bilingual, and training staff in cross-cultural awareness and skills (Urada & Evans, 2008).

HIV/AIDS and Hispanics

One potential complication attendant substance-related disorders is HIV/AIDS infection. Individuals with substance-related disorders are at risk either directly through substance use behaviors (e.g., needle use, needle sharing) or through the co-occurrence of sexual risk taking associated with substance use. Data indicate that Hispanics are disproportionately impacted by HIV/AIDS, therefore, it is important that substance abuse treatment programs address HIV/AIDS issues in the Hispanic population.

Center for Disease Control data (CDC AIDS/HIV Fact Sheet: HIV/AIDS Among Hispanics, 2006) show that: (1) although Hispanics comprise 14% of the non-institutionalized population in the United States and Puerto Rico, they have accounted for 18% of identified AIDS cases since the start of the epidemic; (2) in 2002, HIV/AIDS was the third leading cause of death among Hispanic men aged 35-44 and the fourth leading cause of death for Hispanic women in the same age group; (3) the primary mode of HIV transmission among Hispanic men was through sexual contact with other men (59%), followed by injection drug use (19%), and heterosexual contact (17%); and (4) for Hispanic women, the primary route of HIV transmission was heterosexual contact (73%), followed by injection drug use (23%). Heterosexual transmission of HIV appears to be a growing problem in the Hispanic community because from 1999 to 2004 the rate of heterosexually acquired HIV infection has increased significantly among Hispanics (6.1% for males, 4.5% for females; Espinoza, Hall, Hardnett, Selik, Ling, & Lee, 2007). Even with recent advances in chemotherapy for HIV/AIDS, this disease is the third leading cause of disparity in years of potential life lost before age 75 for Hispanic women (49 years per 1,000 persons), and the fourth leading cause of disparity in years of potential life lost before age 75 for Hispanic men (113 years per 1,000 persons) relative to non-Hispanic Whites (Wong, Tagawa, Hsieh, Shapiro, Boscardin, & Ettner, 2005).

Research into the correlates and of HIV risk and protective behaviors among Hispanics is vital to the development of interventions to reduce the transmission of HIV/AIDS in the Hispanic community and thereby to attempt to reduce health disparities observed between Hispanics and non-Hispanic Whites. Highly acculturated Hispanics are likely

more at risk for HIV infection through injection drug use because high acculturation, although moderated by age, education and gender (Amaro, Whitaker, Coffman, & Heeren, 1990; Markides et al., 1990), is associated with increased risk for substance use (Amaro et al., 1990; Burnam, Hough, Karno, Escobar, & Telles, 1987; Epstein et al., 2001; Vega et al., 1998) and may be associated with more permissive attitudes towards sex (Sabogal, Faigeles, & Catania, 1993). Low acculturation may be a risk factor for HIV as well in that traditional culture-based gender roles may contribute to HIV risk in that traditions of machismo, sexual silence, presumptions of the value female sexual inexperience, and differential power roles may all impact HIV-related behavior (VanOss Marin, 2003). These cultural values may contribute indirectly to the increased incidence of HIV/AIDS among Hispanic females through unprotected heterosexual contact with high-risk males, many of whom may be their long-term partners (Amaro & Raj, 2000).

Despite the over representation of Hispanics in the HIV/AIDS epidemic, HIV/AIDS testing may be lower than among another high HIV/AIDS risk group: African Americans (Taylor et al., 2006). Data from early studies on HIV testing indicate that HIV/AIDS testing behavior among Hispanics is influenced primarily by self-perceived risk for being infected with HIV and self-perceived knowledge of HIV, rather than by other variables such as membership in a high risk group, gender, age, or residence (Phillips, 1993). Past work by Sabogal and Catania (1996) suggested that, among heterosexual Hispanics in the United States, over 15% reported an HIV risk factor (e.g., multiple sex partners in the last 12 months, risky main sex partner, transfusion between 1978 and 1985, and intravenous drug use in the past 5 years), and of those, 35% reported having been tested for HIV. Males and those from the middle income group were more likely to have tested for HIV. Despite the CDC data suggesting high risk for HIV infection through heterosexual contact (see above paragraph), Hispanic females may be less likely to test for HIV. Mixed results for the effect of acculturation on HIV testing have been found with some studies suggesting that higher acculturation is associated with lower intention to test for HIV (Cuadra, 2004), whereas others suggest that, among high acculturated Hispanics, but not lower acculturated Hispanics, higher education is associated with a greater likelihood of having tested for HIV (Sabogal & Catania, 1996).

Drug Treatment Retention and Hispanics

Examination of factors associated with retention in substance abuse treatment among Hispanics in culturally responsive (CR) treatment are similar to those found to predict treatment retention in the general substance abuse treatment population (e.g., Amodeo, Chassler, Oettinger, Labiosa, & Lundgren, 2008). These factors are detailed below:

- More severe substance use problems are associated with shorter stays in treatment and poorer outcomes.
- More criminal involvement, unemployment, and more medical problems at intake are associated with shorter treatment stay and poorer treatment outcomes.
- Legal pressure is associated with longer treatment stays.

- Greater matching of treatment to clients' expressed needs associated with longer treatment stays.
- Higher client motivation associated with longer treatment stays.
- Stronger client-counselor therapeutic alliance, as rated by the counselor, is associated with longer treatment stays.

Further, Amodeo et al. (2008), in a study of 164 Hispanic individuals who were primarily Puerto Rican and were treated in a CR residential drug treatment program found that co-occurring mental illness and substance use in the three months prior to treatment entry were associated with shorter stays in treatment and having lived in an institutional setting prior to treatment entry was associated with longer stays in treatment.

Niv and Hser (2006) examined service utilization and outcomes using data from 128 Hispanic and 371 Non Hispanic White methamphetamine abusers admitted to treatment in 2000-2001 in 43 drug treatment programs in 13 counties in California. Key findings from this study were that: (a) despite similar severity across substance use, legal, medical, psychiatric, and family/social domains, Hispanics were less likely than Non Hispanic Whites to be treated in residential programs; (b) more Non Hispanic Whites than Hispanics received psychiatric services; (c) Non Hispanic Whites reported receiving a greater number of total services and those services addressing alcohol and psychiatric problems; (d) treatment satisfaction was similar for Non Hispanic Whites and Hispanics; (e) Hispanics demonstrated better family/social outcomes than Non Hispanic Whites. Niv and Hser (2006) note the need for more detailed study of the potential disparity in placement in residential versus outpatient treatment between Non Hispanic Whites and Hispanics.

Cultural Responsiveness Among Prop 36 Providers

Hispanic cultural responsiveness, or the extent to which drug treatment programs providing services under Prop 36 funding adjust to the values, needs, and culture of Hispanics, was assessed in the 2008-09 Treatment Provider survey. Items were added to the Program Characteristics section, the Treatment and Ancillary Services section, and a new section was added specifically to address cultural responsiveness. Items in the Program Characteristics section asked specifically about the number of treatment providers, including drug treatment counselors, case managers, nurses, physicians, psychiatrists, psychologists, clinical social workers, and other employees who were Spanish speaking. Items in the Treatment and Ancillary Services section asked providers to report the specific services offered on-site and off-site in the Spanish language. The new section on cultural responsiveness included 15 questions designed to assess the extent to which Prop 36 programs demonstrate CR practices, determine the relative caseload of treatment personnel who reported being bilingual versus those who were English speaking only, assess the extent of cultural responsiveness training among Prop 36 providers, and identify the key barriers to treatment entry among Hispanics receiving drug treatment services under Prop 36 funding. A copy of the treatment program survey and a description of the survey methods used can be found in Appendix B.

In this section we discuss a composite measure constructed from items in the Cultural Responsiveness section of the UCLA Treatment Provider Survey which serves as an index of cultural responsiveness. The items incorporated into the composite measure are presented in Table 6.1.

Table 6.1

Items from the Cultural Responsiveness Section of the Treatment Provider Survey Used to Construct the Composite Cultural Responsiveness Measure.

Does your program:
Have adequate numbers of Spanish speaking counselors for the Spanish speaking Prop 36 caseload?
Use language translators from the community when necessary?
Offer treatment information materials (for example, pamphlets, videos, etc.) in both English and Spanish?
Provide health-education in both English and Spanish to increase Prop 36 clients' ability to understand, remember, and follow treatment providers' instructions?
Match Prop 36 clients with counselors on ethnicity/cultural background if they so choose?

To what extent:
Have Latino/a cultural components (for example, holiday celebrations, arts, entertainment, food, etc.) been incorporated into the treatment setting?
Were attempts made to gain support for drug treatment services among Latino/a community leaders (for example, church leaders, organization leaders) or other Latino/a community based agencies?

Has your program ever conducted a systematic assessment to:
Determine the ethnic composition of your program's Prop 36 caseload?
Identify specific counseling strategies for Prop 36 Latino/a clients?
Identify facility location and features attractive to Prop 36 Latino/a clients?
Identify reasons for early termination for Prop 36 Latino/a clients?

For each item listed in Table 1 'Yes' responses were coded 1 and 'No' responses were coded '0'. Items were then summed to create a composite score ranging from 0 to 11 (Mean = 3.3; Standard Deviation = 3.0; Median = 3.0). In order to assess the validity of the cultural responsiveness score, the correlations between this score and the following measures were examined: the ratio of Spanish speaking to English speaking registered drug counselors in a program, the reported percentage of Spanish speaking Prop 36 clients in a program, the total number of services offered in Spanish at a program (regardless of on-site or off-site location), and the report of formal cultural responsiveness training for a program. All measures were continuous except for the dichotomous report of either having or not having had cultural responsiveness training for a program, thus the correlation for this measure represents a point-biserial correlation rather than a Spearman correlation. The obtained correlations for these measures and the cultural responsiveness score are presented in Table 6.2.

Table 6.2

Correlations for Cultural Responsiveness Scale Scores and Validity Measures.

	1	2	3	4	5
1. CR Score	1.0				
2. SS Counselors	0.35*	1.0			
3. SS Services	0.60**	0.32*	1.0		
4. % SS Clients	0.06	0.25	0.14	1.0	
5. CR Training	0.33*	-0.00	0.15	-0.07	1.0

Note: CR Score = Cultural Responsiveness Score; SS Counselors = Spanish speaking registered drug counselors; SS Services = Spanish speaking treatment services; % SS Clients = Reported % of Spanish speaking clients; CR Training = Reported formal cultural responsiveness training.

* $p < 0.05$; ** $p < 0.01$

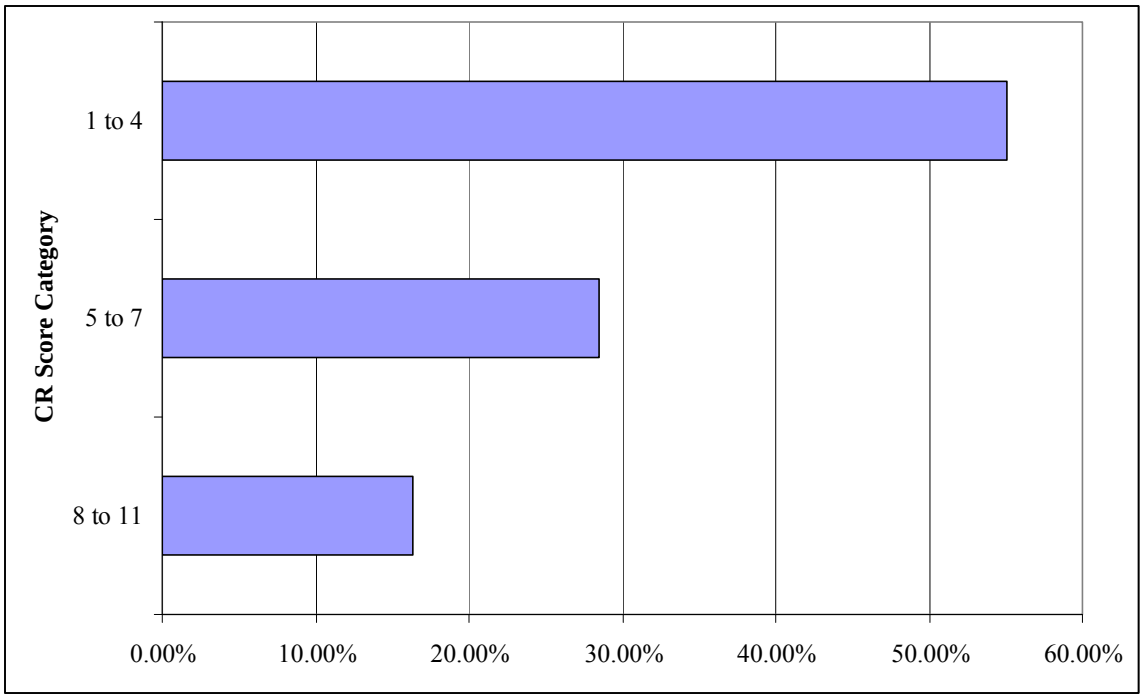
The obtained correlations provide some preliminary support for the validity of the CR measure we constructed. Significant positive correlations were obtained between the CR measure and the number of Spanish speaking counselors and the number of Spanish language services offered.

Notably, however, the correlation between the estimated percent of Spanish speaking clients served by a given program was not correlated with the CR measure. That is, there was no demonstrated relationship between Spanish speaking caseload and the cultural responsiveness of treatment providers. The CR measure did correlate significantly and positively with reports of cultural responsiveness training which may suggest that those programs receiving CR training do engage in a higher number of CR treatment practices.

In Figure 6.1 data on the number of programs, regardless of service modality, falling into one of three categories for CR scores are presented. Over 50% of current programs serving at least one Hispanic Prop 36 client in the past year scored at 4 or below on our measure of cultural responsiveness. Just under 30% scored in the 5 to 7 range, and only approximately 16% scored in the 8 to 11 range. Thus, despite the fact that Hispanics are the second largest ethnic group among Prop 36 clients, only a minority of programs have taken significant steps to provide culturally competent services to Hispanic clients in Prop 36.

Figure 6.1

Percentage of Providers Falling in Three CR Score Categories



Note: CR Score Category = Cultural Responsiveness Score Category.

An analysis of CR by service type revealed that the mean CR score for residential programs was significantly lower than that for outpatient treatment. The CR score for residential programs was approximately 1 out of 11, whereas the mean CR score for outpatient treatment programs was 4. Despite the low mean score for residential programs overall with regards to cultural responsiveness, there are residential programs high in CR, but they are few. Similarly, there were a number of outpatient programs who scored high on CR, but they were relatively less frequent than programs low in CR. Thus, there is a need to increase the CR of existing residential and outpatient treatment services and to increase capacity of CR residential treatment services for Hispanics. Analyses presented later in this chapter evaluate the relationship between CR scores and treatment outcomes. At this time, it is unclear why there are so few residential programs high in CR. One possibility is the relative lack of Spanish speaking counselors and Spanish language services in the treatment system in general.

Recently, a number of researchers have outlined areas in which the literature on Hispanic substance abuse treatment needs development (Alegria et al., 2006; Amaro, Arevalo, Gonzalez, Szapocznik, & Iguchi, 2006). Suggestions for improvement were made in four priority areas in Alegria et al. (2006):

- Understanding the community context.
- Service models for Hispanic drug abusers.
- Barriers to service utilization by Hispanic drug users.
- Hispanic drug users' linkage with other service sectors.

The information provided in this chapter addresses at least two of these areas directly: understanding the community context and identifying barriers to service utilization by Hispanic drug users.

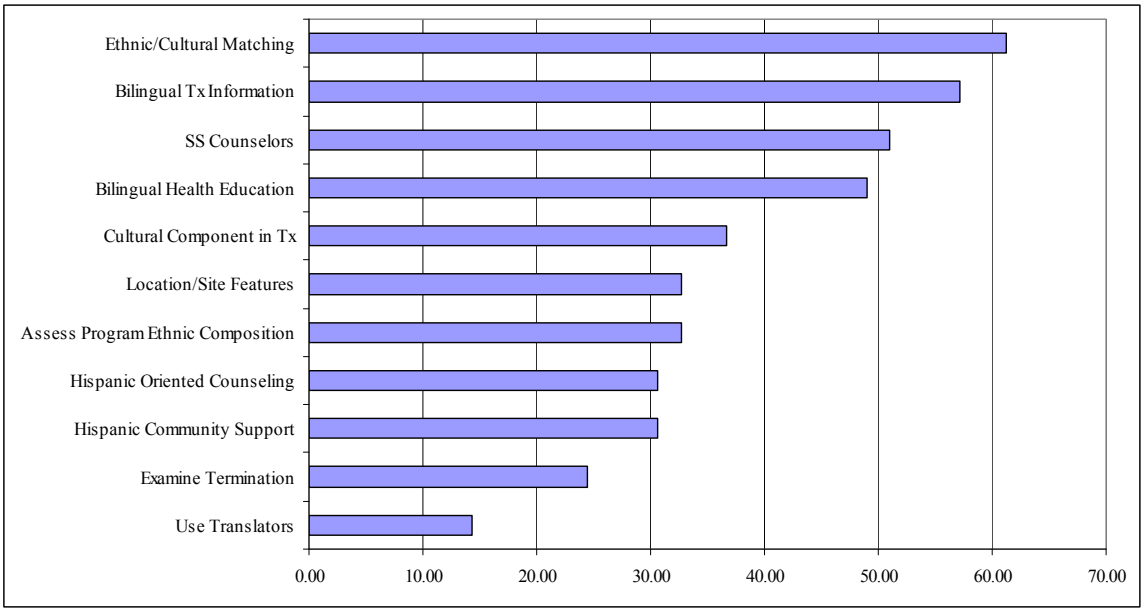
HISPANIC MALES UNDER 26 IN PROP 36

This section provides data bearing on the questions posed by ADP regarding Hispanics in Prop 36, and where possible Hispanic males under 26 in particular. Data sources used to generate responses to these questions included CalOMS, the UCLA ISAP Treatment Provider Survey, key informant interviews, and focus groups conducted with treatment participants.

One question of interest was whether treatment providers implemented practice changes to improve outcomes that might affect this special population. Figure 6.2 presents data on measures taken to improve CR for Hispanics in Prop 36 among programs reporting having served at least one Hispanic client in the past year. The most frequently reported program action was using ethnic/cultural matching for clients and counselors. The least frequently employed action to increase CR for Hispanics was to use Spanish language translators. Over half of all programs reported providing treatment information in both English and Spanish and just under half of all programs reported providing bilingual health education. Approximately 30% of all programs reported having identified specific counseling strategies for Hispanic clients. Approximately one quarter reported having systematically examined reasons for early termination among Hispanic Prop 36 clients.

Figure 6.2

CR Measures for Hispanics Among Prop 36 Treatment Providers.



Note: SS Counselors = Spanish speaking counselors.

Another question of interest was whether any of these practices resulted in higher completion rates or other improvements for Hispanic males under 26. In order to track such measures by level of cultural responsiveness, a match was made between client data and CR score. Because not all programs completed the treatment provider survey, only a subset of programs could be assigned a CR score. The CR scores for all programs reporting having served at least 1 Hispanic client in the past year were divided using a median split (Median = 4), with programs scoring below the median labeled as low CR and those scoring above the median as high CR. The data presented here is limited to only those Hispanic male clients under 26 who participated in a program that completed the treatment provider survey. The number of residential clients for whom treatment program CR scores could be matched was too low for analyses as there was only one Hispanic client identified who was in a program with an above median score on the CR measure.

Table 6.3

Outpatient Outcomes for Hispanic Males Under 26 by Level of Cultural Responsiveness.

	Low CR	High CR	$\chi 2$ [d.f.]	p-value
60 Day Retention	35 (30.2)	43 (37.1)	1.73 [1]	0.188
90 Day Retention	27 (23.3)	38 (32.8)	3.42 [1]	0.065
Program Completion	15 (12.9)	16 (13.8)	0.01 [1]	0.922

Results of analyses presented in Table 6.3 indicate a trend for a greater percentage of Hispanic males under 26 who were treated in high CR outpatient programs to reach the 90-day retention benchmark. However, program completion was not much different. These analyses should be interpreted with great caution as the total sample identified for these analyses is a very small percentage of all Non Hispanic White or Hispanic males under 26 Prop 36 participants with CalOMS data. What these data may indicate is the need for formal analysis of CR among treatment providers statewide, and more thorough analysis of its impact on retention. We speculate that high CR programs may address one of the primary barriers to treatment entry and retention: language barriers. In addition, we speculate that high CR programs may be more likely to employ counselors who themselves are high in CR and therefore are more likely to develop good working alliances with clients in treatment.

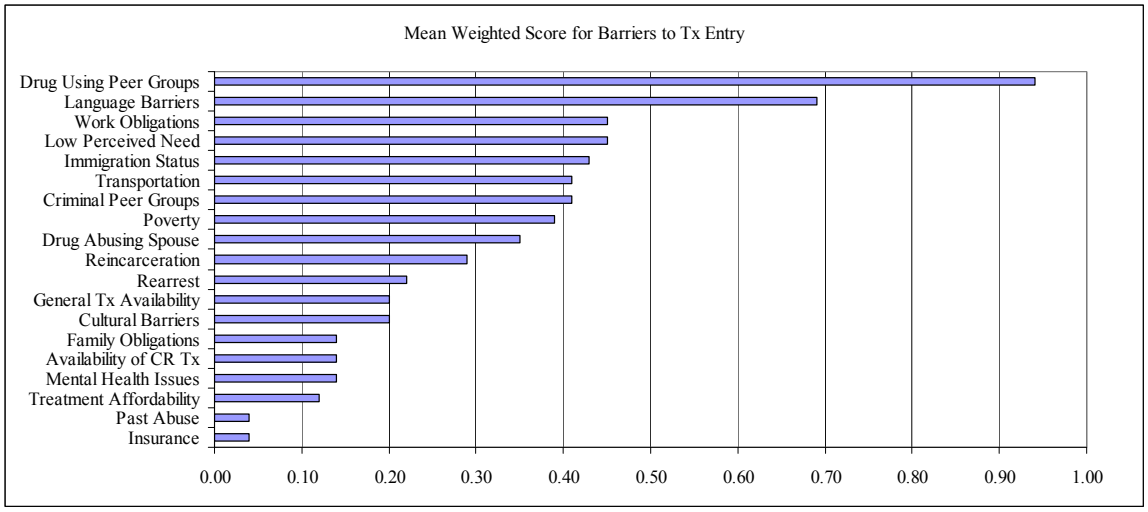
Barriers to Treatment Entry Among Hispanics

Another question of interest is what the characteristics and needs are among Hispanics. As part of UCLA's survey of treatment providers, programs were asked to report what

they believed were the top three barriers to treatment entry for young Hispanic males. Data on the barriers reported are presented in Figure 6.3. Data are reported as weighted mean scores for all responses with means greater than 0. Weighting was done by assigning a score of 3 for barriers reported as the primary barrier to treatment entry, a score of 2 for barriers reported as the second most important barrier to treatment entry, and a score of 1 for barriers reported as the third most important barrier to treatment entry. If a barrier was not cited as one the top three barriers by a program, it was assigned a score of 0. Forty-nine programs were used for this analysis as they reported serving at least one Hispanic Prop 36 client in the past year.

Figure 6.3

Barriers to Treatment Entry Among Hispanic Males Under 26 as Reported by Treatment Providers.



Note: Low Perceived Need = Client does not feel the need for treatment; Availability of CR Tx = Availability of culturally responsive treatment; Past Abuse = History of past physical or sexual abuse..

The top 5 barriers with the highest mean scores were as follows: drug using peer groups, language barriers, work obligations, no perceived need for treatment, and immigration status. The availability of CR treatment was the 15th most pressing barrier for young Hispanic males; however, the pragmatic issue of language barriers was the second most cited barrier to treatment entry. These data are consistent with the data presented in this chapter in Figures 6.4 through 6.6. Overall, the figures indicate a general underdevelopment of Spanish language services among Prop 36 treatment providers. Examination of data from the treatment provider survey indicated that approximately 60% of all programs responding to the survey reported serving clients who were Spanish speaking. The mean percentage of Spanish speaking clients across all programs was nearly 7%; however, approximately 10% of treatment programs reported that 20% or more of their past-year clients from Prop 36 were Spanish speaking.

In the earlier section of this chapter on CR scores, there was a relationship between the number of Spanish speaking counselors and overall levels of cultural responsiveness. In

order to overcome language barriers in drug treatment for Prop 36 participants, and Hispanics in drug treatment in general, there is an urgent need to recruit, train, and retain qualified Hispanic counselors and treatment staff. A stop-gap measure may be to train the existing workforce in Spanish; however, such language training would require additional experience in working in Hispanic communities in order to gain experiences and insight into the cultural nuances relevant to drug treatment among Hispanics.

With regards to perceived need for treatment, some data suggest ethnic differences in perceived need for substance disorder treatment. Longshore et al. (1993) examined the issue of perceived need for treatment among a sample of Los Angeles County arrestees who participated in the Drug Use Forecasting Project (DUF). This study found that the predisposing factors of self-reported drug dependence, attitudes toward treatment for drug use, and occurrence of drug related problems other than dependence were related to perceived need for treatment. Also, the perception of need for drug treatment was higher among females. Hispanics were less likely to perceive a need for treatment, even among daily drug users. In addition, it appears that Hispanics are less likely to hold positive attitudes towards professional help for drug problems (Longshore et al., 1993)

Some of the reported barriers to treatment were echoed in qualitative data gathered from focus groups conducted with young Hispanic males in Prop 36. One theme that emerged from these focus groups was that returning to the 'old neighborhood' and seeing former peers who were still using was a difficult experience and served as a trigger for substance use. This is a problem common to individuals in recovery of all races and ethnicities. Key informant interviews with Prop 36 providers indicated that a major barrier to treatment entry for young Hispanic males was the fact that they often worked as laborers 'under the table' and any time away from work represented an economic loss for them and their families. This factor may particularly contribute to willingness to participate in residential treatment because such treatment would preclude work.

Treatment Needs of Hispanic Males Under 26[39]

Data bearing on the treatment needs of Hispanic males under 26 come from a subset of data from the CalOMS dataset. This data included all males under 26 in all California counties who were admitted to Prop 36 treatment in FY 2006-07. Due to small sample sizes for other ethnic categories, comparisons are made between Hispanic males under 26 and Non Hispanic White males under 26.

Table 6.4 presents demographic and background information by ethnicity for Non Hispanic White males under 26 and Hispanic males under 26. Mean age at admission to treatment for this subsample did not differ, but a number of significant differences were

[39] For all tables in this chapter we used either the t-tests statistic for continuous variables (e.g., age, years of education), or the chi-square statistic for categorical variables (e.g., gender, employment status) to test for differences between Non-Hispanic White males under 26 and Hispanic males under 26. The p-value indicates the likelihood that the obtained statistic occurred by chance alone, with p-values < 0.05 indicating that differences observed on the test statistic are likely to have occurred by chance alone in only 5 of 100 sampling instances. Degrees of freedom [d.f.] are included because the cutoff for significance for the two statistics varies with changes in degrees of freedom.

found with regards to other background and demographic variables. Relative to Non Hispanic White males under 26, a larger percentage of Hispanic males under 26 reported having less than 12 years of education (24.4% vs. 14.9%). This finding suggests that Hispanic males under 26 require help in obtaining a G.E.D. The percentage of Hispanic males with 13 years or more of education was nearly half that of Non-Hispanic White males under 26 (3.6% vs. 6.2%). Thus, interventions to increase college education among Hispanic males under 26 are warranted. There were no differences found between Non-Hispanic Whites and Hispanics with regards to employment. We did, however, find that a significantly larger percentage of Hispanic males under 26 were felons and fewer were misdemeanants than Non Hispanic Whites in Prop 36. The felon and misdemeanant categories, although analyzed separately, were not mutually exclusive, so some segment of the population could have had both a felony and a misdemeanor conviction. It is unclear at this time why more young Hispanic males had felony convictions than young Non Hispanic White males.

Table 6.4

Mean (SD) or N (%) for Demographic and Background Information by Ethnicity for

Males Under 26 in Prop 36 from FY 2006-07.

	NH White	Hispanic	t or χ^2[d.f.]	p-value
Age at Admission	22.7 (2.3)	22.8 (2.2)	-0.64 [2,064]	0.524
Years of Education				
< 12 years	307 (14.9)	503 (24.4)	59.39 [2]	0.000
12 years	547 (26.6)	498 (24.2)		
13 years or more	128 (6.2)	75 (3.6)		
Employed				
No	663 (32.1)	705 (34.1)	0.67 [1]	0.413
Yes	325 (15.7)	373 (18.1)		
Prop 36 Felony				
No	478 (23.1)	450 (21.8)	9.12 [1]	0.002
Yes	510 (24.7)	628 (30.4)		
Prop 36 Misdemeanor				
No	378 (18.3)	498 (24.1)	13.30 [1]	0.000
Yes	610 (29.5)	580 (28.1)		

Note: NH White = Non Hispanic White.

For substance use variables a number of differences were found between Non Hispanic White males and Hispanic males under 26. Hispanic males reported being older at the age of first use of their primary drug (17.0 vs. 16.6). Hispanic males were more likely to report their primary drug as methamphetamine (32.6% vs. 27.7%) or cocaine/crack (3.2% vs. 1.3%), but were less likely to report heroin (1.9% vs. 4.6%) or other drugs (0.5% vs. 1.4%) as their primary drug. Injection as a mode of administration was more common among Non Hispanic White males under 26 (6.8%) than among Hispanic males under 26 (2.0%). More Hispanic males under 26 reported smoking as their primary route of administration (42.5%) than Non Hispanic White males under 26 (33.8%). The mean number of days in the last 30 of primary drug use prior to admission for Hispanics was lower (4.8) than that reported by Non Hispanic Whites (7.0). As expected due to the higher rates of IV drug use among Non Hispanic Whites relative to Hispanics, the number of IV drug use days in the last 30 among Hispanics was lower (0.5) than that reported by Non Hispanic Whites (1.3). See Table 6.5.

Table 6.5

Mean (SD) or N (%) for Substance Use Variables by Ethnicity.

	NH White	Hispanic	t or χ^2 [d.f.]	p-value
PD Age First Use	16.6 (2.9)	17.0 (3.0)	-3.00 [1927]	0.003
Primary Drug				
Alcohol	58 (2.8)	59 (2.9)	53.61 [5]	0.000
Cocaine/Crack	27 (1.3)	66 (3.2)		
Heroin	95 (4.6)	40 (1.9)		
Marijuana	206 (10.0)	229 (11.1)		
Methamphetamine	573 (27.7)	674 (32.6)		
Other	29 (1.4)	10 (0.5)		
Administration Route				
Inhalation	63 (3.1)	80 (3.9)	73.23 [3]	0.000
Injection	140 (6.8)	42 (2.0)		
Oral	88 (4.3)	74 (3.6)		
Smoking	696 (33.8)	876 (42.5)		
Days Used PD	7.03 (10.2)	4.8 (8.4)	5.38 [1921.9]	0.000
Days IV Drug Use	1.27 (5.4)	0.54 (3.8)	3.52 [1734.9]	0.000

Note: NH White = Non Hispanic White; PD Age First Use = Age of first use of primary drug; Days used PD = Days used primary drug in the last 30; Days IV Drug Use = Days intravenous drug use in the last 30.

Table 6.6 presents data on treatment variables by ethnicity. As found in previous work, more Non Hispanic White males under 26 were in lont-term residential treatment (greater than 30 days) relative to Hispanic males under 26. Approximately 34% of Hispanic males under 26 reported that they had no prior drug treatment experience, but among Non Hispanic White males under 26, the percentage with no prior treatment experience was 26.4%. There were no differences between Non Hispanic Whites and Hispanics with regards to the number of days waited to enter treatment.

Table 6.6

Mean (SD) or N (%) for Substance Treatment Variables by Ethnicity.

	NH White	Hispanic	t or χ^2 [d.f.]	p-value
Type of Treatment				
Drug Free OP	728 (38.2)	892 (46.8)	11.45 [1]	0.001
Residential	160 (8.4)	127 (6.7)		
First Time in Tx				
No	441 (21.5)	368 (18.0)	23.23 [1]	0.000
Yes	541 (26.4)	699 (34.1)		
N Prior Admissions	0.86 (1.4)	0.56 (1.1)	5.38 [1,890.3]	0.000
Days Waited for Tx	4.95 (14.8)	4.99 (13.2)	-0.07 [2045]	0.942

Note: NH White = Non Hispanic White; Drug Free OP = drug free outpatient treatment.

Table 6.7 presents data on health-related variables by ethnicity. Although there were no significant differences between Non Hispanic Whites and Hispanics with regards to the percentages reporting being Hepatitis C or Tuberculosis positive, or for the incidence of sexually transmitted diseases, fewer Hispanic males reported having been tested for HIV (24.4% vs. 27.3%). For those who were tested for HIV, fewer Hispanics were aware of the results of their test (38.0%) than were Non Hispanic Whites (45.6%).

Table 6.7

Mean (SD) or N (%) for Health-Related Variables by Ethnicity.

	NH White	Hispanic	t or χ^2[d.f.]	p-value
Hepatitis C Positive				
No	967 (47.0)	1064 (51.7)	3.08 [1]	0.079
Yes	18 (0.9)	10 (0.5)		
Tuberculosis Positive				
No	975 (47.3)	1057 (51.3)	1.16 [1]	0.282
Yes	11 (0.5)	18 (0.9)		
STD Positive				
No	963 (46.7)	1057 (51.3)	1.52 [1]	0.218
Yes	23 (1.1)	17 (0.8)		
Tested for HIV				
No	421 (20.5)	569 (27.8)	21.59 [1]	0.000
Yes	559 (27.3)	500 (24.4)		
Know HIV Results				
No	74 (7.0)	99 (9.4)	8.10 [1]	0.004
Yes	482 (45.6)	401 (38.0)		

Note: NH White = Non Hispanic White.

Table 6.8 presents data on family variables by ethnicity. A larger percentage of Hispanic males under 26 reported having any children at home (20.5% vs. 11.2%), and having children younger than age 5 at home (17.7% vs. 10.2%).

Table 6.8

Mean (SD) or N (%) for Family Variables by Ethnicity

	NH White	Hispanic	t or χ^2[d.f.]	p-value
Days Family Conflict	1.01 (4.9)	0.91 (4.5)	0.479 [2002.6]	0.632
Any Children at Home				
No	388 (37.6)	317 (30.7)	34.84 [1]	0.000
Yes	115 (11.2)	211 (20.5)		
Children < 5 at Home				
No	398 (38.6)	346 (33.6)	23.70 [1]	0.000
Yes	105 (10.2)	182 (17.7)		
Any Parental Rights Terminated				
No	973 (47.1)	1057 (51.2)	0.556 [1]	0.456
Yes	15 (0.7)	21 (1.0)		

Note: NH White = Non Hispanic White.

Focus Group Qualitative Data

Main themes emerging from two focus groups with Hispanic Prop 36 participants are reported below. The majority of themes emerging were related to barriers to treatment; however, some facilitators of treatment progress also emerged as themes.

Economic Barriers: Costs associated with drug testing requirements were noted as prohibitive, particularly early in treatment. Costs associated with probation, including fines, were prohibitive as well. In particular, individuals with higher probation fines reported greater difficulty making payments towards these fines. One of the key reasons that these costs were prohibitive, according to focus group members, was the difficulty they experience in finding employment with a conviction on their records. Many reported that they had little success applying for employment because they could not apply to jobs that exclude felons. In addition, focus group participants reported that they could not ask their parents for money to pay for requirements such as testing and probation fines because their families no longer had trust in their intentions for the money.

Logistical Barriers: Transportation was a second barrier commonly reported as a problem by focus group participants. Many did not have transportation and were using public transportation to get to and from treatment, probation, and drug testing sites. As a result

of public transportation usage, many treatment and probation tasks required a full day to complete.

Neighborhood Conditions: Many focus group participants reported great difficulty in dealing with triggers for drug use when they returned to their neighborhoods. They reported that many of their peers continued to engage in drug use and criminal lifestyles and that the perceived little other economic options in their neighborhoods of origin.

Social Support/Family Issues: Focus group respondents reported that supportive relationships were important in their recovery. In particular, having a significant other who was not using and who was disapproving of substance use and set limits regarding nicotine and alcohol use helped in maintaining sobriety. In addition to spouses or girlfriends, having children who required support provided a sense of responsibility and desire to stay clean among focus group participants. These motivations were different than focus group participants' reported initial motivations for taking Prop 36: to avoid jail or prison time. Key themes related to assuming the role of a provider for the family were cited as rewarding and sustaining of participants sobriety, and the provider role was reported as being in line with participants perceptions of manhood.

Counseling: Focus group participants reported counseling as being very important in their recovery. Participants valued the sense of community and family which was fostered as part of group therapy. A second aspect of counseling that was important to clients was the feeling that counselors treated clients with respect. Focus group participants reported feeling respected because counselors took the time to ask them if they had any problems they wanted to discuss, but also held Prop 36 participants accountable for program lapses and responsible for seeking employment and accountable for program lapses. A second aspect related to feeling respected was that the counselors demonstrated flexibility when legitimate barriers to program participation (e.g., child care issues) arose. A third aspect of counseling that focus group participants reported as helpful was the problem solving that occurred in both the group setting and in individual sessions. Focus group participants reported that they could bring issues to the group and to individual counseling and get real solutions to those problems. This was the case even when clients faced the group and counselors after having received dirty tests.

Probation: Respondents reported that probation was helpful to them. They reported that being called in to court on violations required them to reconsider their actions.

Key Informant Qualitative Data

The major themes from key informant interviews are presented below. The data come primarily from an urban treatment setting and questions for the key informant interview were directed at understanding issues faced by the Hispanic population served under Prop 36, with special emphasis on factors related to participation in residential treatment programming.

Language Barriers: Key informant data suggested that the lack of Spanish speaking counselors was a significant problem for monolingual Spanish speaking clients. The lack of Spanish speaking counselors was a problem for some bilingual Spanish/English clients who expressed themselves better in Spanish. The lack of Spanish language assessors was also noted as a problem and one key informant reported that existing services did not match the needs of the Hispanic population.

Diversity of Hispanic Subgroups: As noted in the introduction, the term Hispanic is an oversimplification of the diversity of Spanish speaking individuals. One point made by key informants related to the need to understand the diversity of Hispanic subgroups was that Black Hispanics often had difficulties in Prop 36 treatment because assessors sometimes assumed that they were English speakers and assumed that the cultural experiences most relevant to them were those of U.S. African American culture. Key informants felt that the impacts of this misunderstanding included difficulties in accurate assessment which could lead to over diagnosis of mental health problems.

Work as a Barrier to Treatment: Key informants indicated that many Hispanic Prop 36 clients do not want to do residential treatment because they would rather be out working. In addition to treatment entry, employment was reported as a barrier to continued treatment in that work schedules made it difficult for them to come back for treatment. Further, key informants reported that many Hispanic Prop 36 clients were working 'under the table' jobs. Absence from these jobs is uncompensated and represents a serious financial hardship. One solution to this problem proposed by a key informant was to increase the availability of late afternoon and evening programming at Prop 36 treatment programs.

Assessor Approach to Residential Treatment for Hispanics: Key informants indicated that they did not push residential treatment for Hispanics unless they specifically requested it due to the barriers to residential treatment noted above (i.e., employment situations). Key informants also indicated that some Hispanics who entered residential treatment faced the prospect of homelessness upon treatment completion. Residential treatment for Hispanics was considered on a case-by-case basis, based on what the clients' desires were.

Offender Treatment Program Augmentations for Hispanics in Four Selected Counties

Beginning in FY 2006-2007, California Alcohol and Drug Programs offered funding to county Prop 36 programs on a competitive basis under the Offender Treatment Program (OTP). In order to receive State funding, counties were required to provide matching funds. The goal of the OTP program was to enhance outcomes and accountability. The current chapter focuses on evaluating OTP funded CR services for Hispanics younger than 26 in counties that reported full implementation of those services as of the treatment provider survey administration of 2006-2007.

Four counties were identified that had applied for OTP funding for Hispanic-oriented culturally relevant services augmentation and reported full implementation of program augmentations in FY 2006-2007. The augmentations proposed under these funds were

varied and included the following: 1) CR outreach for clients who failed to show for probation and treatment; 2) providing additional outpatient services for monolingual Spanish speakers; 3) expanding Spanish language, culturally competent service to include intensive outpatient services and outreach services; and 4) addition of a Spanish-speaking therapist.

In order to examine outcomes for counties receiving OTP funds for program augmentations for Hispanics, we divided the CalOMS sample into two groups: those clients in counties receiving OTP funds for program augmentations for Hispanics, and those clients in counties not receiving OTP funds for program augmentations for Hispanics. Analyses were restricted to Hispanic males under 26 and are presented in Table 6.9

Table 6.9

N(%) for Hispanic Males Under 26 Reaching Three Treatment Benchmarks by OTP Funding for Hispanic-Specific Program Augmentation.

	Non-OTP	OTP	$\chi 2$ [d.f.]	p-value
60 Day Retention	390 (42.2)	151 (16.3)	2.85 [1]	0.092
90 Day Retention	335 (36.2)	120 (13.0)	5.77 [1]	0.016
Program Completion	207 (22.4)	62 (6.7)	8.76 [1]	0.003

Note: Non-OTP = Non Offender Treatment Program recipient; OTP = Offender Treatment Program Recipient.

Findings from the analysis of 60- and 90-day retention and program completion for Hispanic males under 26 in Non-OTP vs. OTP counties suggested that fewer Hispanics made the 60- and 90-day benchmarks and fewer Hispanics completed the Prop 36 program in OTP counties. One possible explanation for these findings may be that, despite specifically addressing the needs of the Hispanic populations in these counties, the services offered may represent too little to impact outcomes among Hispanics in the OTP counties. Future OTP augmentations may require a larger scope and may best be directed at language barriers and other barriers to treatment participation identified in this chapter.

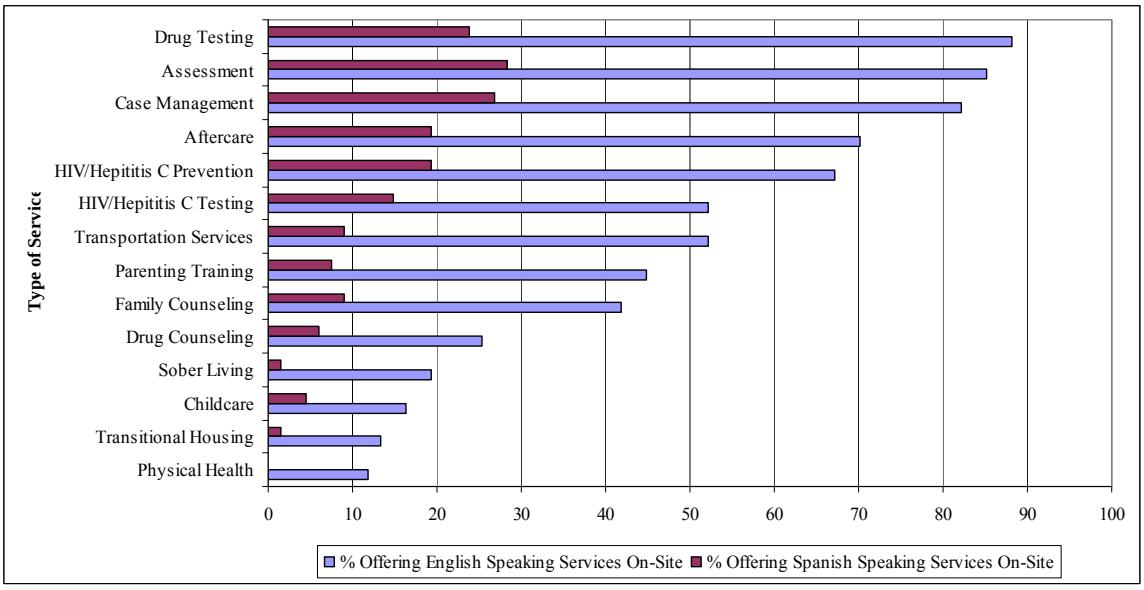
Another question of interest is how providers and counties address the needs of Hispanic clients. Perhaps the first step in providing CR drug treatment to Hispanics in Prop 36 is the recognition of the need for multilingual treatment delivery. English language fluency may be problematic for some Hispanics which requires the delivery of services in

Spanish. In addition, some Hispanics who are proficient in English may prefer Spanish language treatment services.

Data from the 2008 Treatment Provider Survey provides an indication of percentage of programs offering various services in the Spanish language (see Figure 6.4). The two most frequently reported services offered in Spanish were assessment and case management. Just over one quarter of all treatment providers reported assessment in Spanish or Spanish language case management. Just over one fifth of treatment providers reported drug testing services in Spanish. Approximately one fifth of treatment providers reported providing Hepatitis C/HIV prevention programming in Spanish, but fewer (approximately 15%) reported Hepatitis C/HIV testing in Spanish. Spanish language continuing care services were offered by nearly 20% of all treatment programs. Services such as sober living, transitional housing, childcare, parenting training, drug counseling, and family counseling were offered in Spanish by under 10% of all programs. Notably, no programs reported offering physical health services in Spanish.

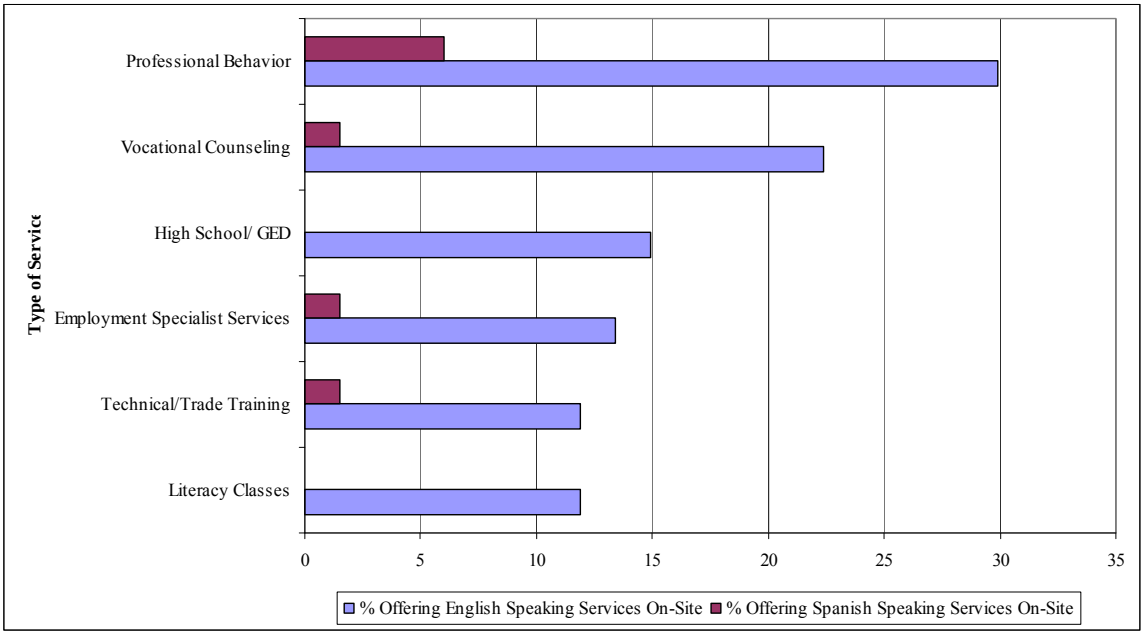
Figure 6.4

Drug Treatment Services Offered by Language for Prop 36 Treatment Providers.



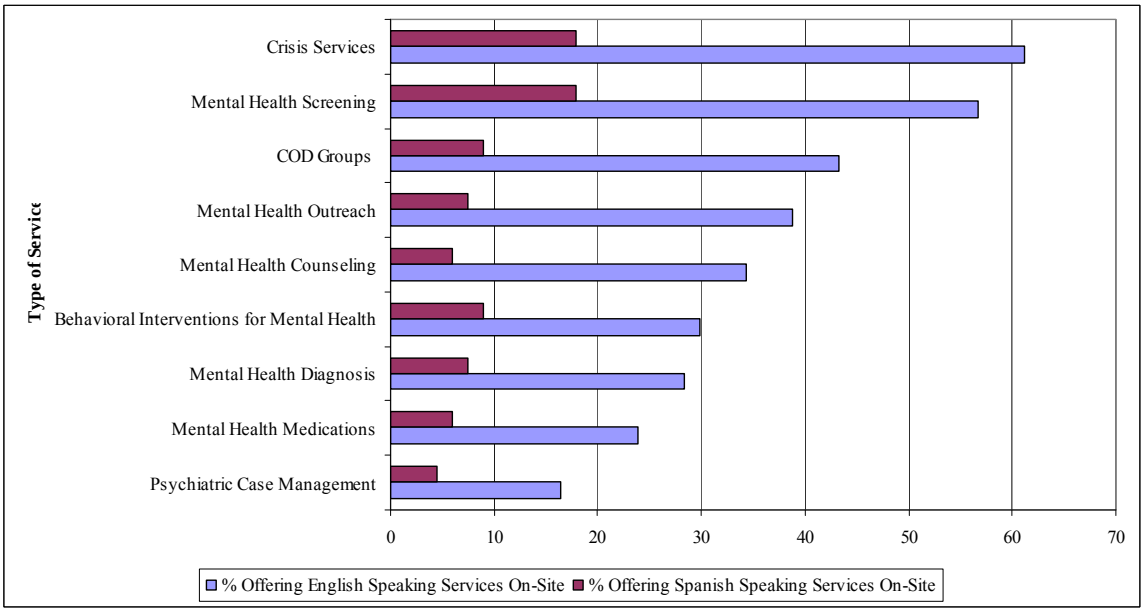
With regards to services for employment, less than 10% of treatment providers reported offering the services of an employment specialist, vocational counseling, or technical/trade training in Spanish. No programs reported offering Spanish language literacy or G.E.D. classes. The most frequently offered Spanish language service offered, although offered by less than 20% of programs, was life-skills training. In general, there appears to be a paucity of Spanish language employment services offered by treatment providers (see Figure 6.5).

Figure 6.5: Employment Services Offered by Prop 36 Treatment Providers by Language.



Mental health screening and crisis services were the two most frequently offered Spanish language mental health services offered, but both were offered by just under 20% of all treatment providers. Less than 10% of all treatment providers offered mental health outreach, behavioral interventions for mental health problems, psychiatric case management, co-occurring disorders groups, mental health medications, mental health counseling, or mental health diagnosis. In general, mental health services in Spanish were much less frequent than mental health services in English. See Figure 6.6.

Figure 6.6: Mental Health Services Offered by Prop 36 Providers by Language.



Note: COD Groups = Co-occurring disorders groups.

TREATMENT OUTCOMES FOR HISPANIC MALES UNDER 26 IN PROP 36

Table 6.10 presents selected treatment outcomes for Hispanic males under 26 as compared to Non Hispanic White males under 26 regardless of service modality at intake. The domains included in these tables are primary drug use, criminal justice contact, living arrangements, employment, social support, and family conflict.

Overall, the pattern of outcomes, regardless of service modality, for Hispanic males under 26 was similar to that seen for Non Hispanic White males under 26 in that, across nearly all domains, improvements were made. The two exceptions were in the domains of housing and social support. Homelessness was less frequent among Hispanic males under 26 (4.5%) relative to Non Hispanic White males under 26 (7.7%) at intake; however, homelessness among Hispanic males under 26 remained nearly constant at discharge with reductions of only 0.3% relative to intake as compared to a reduction of 2.5% among Non Hispanic White males under 26 in Prop 36. Gains in social support were somewhat higher among Hispanic males under 26 relative to Non Hispanic White males under 26.

Table 6.10: Selected Outcomes, Prop 36 Offenders by Ethnicity All Service Modalities.

	NH White (N=1,024)			Hispanic (N=1,455)		
	I	D	Dif.	I	D	Dif.
Used Primary Drug	55.5	26.7	**-28.8**	48.9	23.6	**-25.3**
Any CJ Activity	30.7	10.2	**-20.5**	31.0	7.6	**-23.4**
Living Arrangements						
Homeless	7.7	5.2	**-2.5**	4.5	4.2	**- 0.3**
Dependent Living	55.1	52.7	**-2.4**	57.4	53.7	**-3.7**
Independent Living	37.2	42.1	**4.9**	38.1	42.1	**4.0**
Employed (Full or Part-Time)	36.2	49.8	**13.6**	40.3	51.6	**11.3**
Social Support						
None	55.9	36.7	**-19.2**	63.4	39.3	**-24.1**
Some	38.3	47.1	**8.8**	30.9	45.3	**14.4**
Daily	5.9	16.2	**10.3**	5.7	15.4	**9.7**
Any	44.1	63.3	**19.2**	36.6	60.7	**24.1**
Family Conflict	7.8	5.4	**-2.4**	6.2	4.0	**-2.2**

Note: NH White = Non Hispanic White; Any CJ Activity = Any criminal justice activity; I = Intake Value; D = Discharge Value; Dif. = Difference between Discharge and Intake Values.

Table 6.11 presents outcomes for Hispanic males under 26 relative to Non Hispanic White males under 26, all of whom were in Prop 36 outpatient treatment. Overall, the pattern was similar for most outcomes between Hispanic males under 26 and Non-Hispanic White males under 26 in that all clients showed improvement, but Hispanic males under 26 had greater reductions in criminal justice contacts, had slightly less reduction in drug use, and greater improvement in social support relative to Non Hispanic Whites under 26.

Table 6.11

Selected Outcomes for Prop 36 Offenders by Ethnicity for Outpatient Service Modality.

	NH White (N=825)			Hispanic (N=1,234)		
	I	D	Dif.	I	D	Dif.
Used Primary Drug	52.5	27.4	**-25.1**	45.7	24.1	**-21.6**
Any CJ Activity	28.7	10.9	**-17.8**	28.8	7.4	**-21.4**
Living Arrangements						
Homeless	2.2	2.9	**-0.7**	1.6	1.5	**-0.1**
Dependent Living	57.1	52.5	**-4.6**	56.9	52.7	**-4.2**
Independent Living	40.7	44.6	**3.9**	41.5	45.9	**4.4**
Employed (Full or Part-Time)	43.5	53.7	**10.2**	45.2	55.4	**10.2**
Social Support						
None	55.3	41.7	**-13.6**	63.5	43.8	**-19.7**
Some	39.3	48.9	**9.6**	30.7	46.3	**15.6**
Daily	5.5	9.5	**4.0**	5.8	9.9	**4.1**
Any	44.7	58.3	**13.6**	36.6	56.2	**19.6**
Family Conflict	7.1	5.7	**-1.4**	5.7	4.2	**-1.5**

Note: NH White = Non Hispanic White; Any CJ Activity = Any criminal justice activity; I = Intake Value; D = Discharge Value; Dif. = Difference between Discharge and Intake Values.

Table 6.12 presents data on residential treatment outcomes for Hispanic males under 26 and Non Hispanic White males under 26. Most notable in this table is the relatively worse housing outcomes for Hispanic males under 26 in residential treatment. Although the rate of homelessness was lower among Hispanic males under 26 at intake (22.0%) relative to

Non Hispanic White males under 26 (31.7%), the rate of homelessness at discharge was greater for young Hispanic males (20.3%) relative to Non Hispanic White males (14.5%). Whereas Non Hispanic White males under 26 had a 17.2% reduction in homelessness after residential treatment, Hispanic males under 26 had only a 1.7% reduction in homelessness. This disparity in housing outcomes suggests that housing problems are more chronic and resistant to intervention among young Hispanic males referred to residential treatment. There was an indication of better social support outcomes among young Hispanic males relative to Non Hispanic Whites in that the daily social support was higher among Hispanic males under 26 relative to Non Hispanic Whites under 26. In addition, greater reductions occurred in family conflict for Hispanic males relative to Non Hispanic White males.

Table 6.12: Selected Outcomes for Prop 36 Offenders by Ethnicity for Residential > 30 Days Service Modality.

	NH White (N=138)			Hispanic (N=175)		
	I	D	Dif.	I	D	Dif.
Used Primary Drug	58.7	11.3	**-47.4**	63.8	13.5	**-50.3**
Any CJ Activity	42.8	5.5	**-37.3**	47.5	6.2	**-41.3**
Living Arrangements						
Homeless	31.7	14.5	**-17.2**	22.0	20.3	**-1.7**
Dependent Living	48.3	54.5	**6.2**	58.8	57.1	**-1.7**
Independent Living	20.0	31.0	**11.0**	19.2	22.6	**3.4**
Employed (Full or Part-Time)	8.3	37.9	**29.6**	13.6	32.2	**18.6**
Social Support						
None	60.0	11.7	**-48.3**	61.0	13.0	**-48.0**
Some	31.0	35.9	**4.9**	33.3	33.9	**0.6**
Daily	9.0	52.4	**43.4**	5.7	53.1	**47.4**
Any	40.0	88.3	**48.3**	39.0	87.0	**48.0**
Family Conflict	9.4	3.6	**-5.8**	10.3	2.3	**-8.0**

Note: NH White = Non Hispanic White; Any CJ Activity = Any criminal justice activity; I = Intake Value; D = Discharge Value; Dif. = Difference between Discharge and Intake Values.

CONCLUSIONS AND RECOMMENDATIONS

Below we present conclusions and recommendations related to providing treatment to Hispanic males under 26 based on quantitative analyses of CalOMS data, data from the UCLA Treatment Provider Survey, qualitative data gathered from focus groups with Hispanic Prop 36 clients, and interviews with key informants.

6.1 Overall, the cultural responsiveness of Prop 36 providers was low. Using a measure of cultural responsiveness derived from the treatment provider survey, we estimated that the mean cultural responsiveness score for all treatment providers was four on a scale from 0 to 11. In particular, residential treatment providers had low scores on measures of cultural responsiveness. The mean score for residential treatment providers on our measure of cultural responsiveness was one on a scale from 0 to 11. There is a need to develop more CR residential treatment programs to serve Hispanic clients in Prop 36. Continued training in CR for Prop 36 providers is warranted. There was some indication from correlations between CR training and our overall measure of CR that CR training may increase the number of CR practices employed by Prop 36 programs. We recommend the systematic incorporation of CR practices, particularly among programs serving high numbers of Hispanic individuals. In the mental health literature, "a meta-analysis of the literature found that mental health treatments were four times more effective when culturally modified for a specific group and when attentive to cultural context and values" (Añez, Silva, Paris, & Bedregal, 2008, pp. 154).

6.2 There is a need to recruit, train, and retain Spanish speaking service providers for Prop 36 participants. Overall, the data on services offered in Spanish indicated that such services lagged far behind the number of services offered in English (see Figures 6.4 to 6.6. Given the high number of Hispanics served under Prop 36 (they represent the second most common ethnic subgroup and have been growing each year). This need is underscored by the examination of barriers to treatment entry among Hispanic Prop 36 participants, which indicated that language barriers were the second most commonly cited barrier to treatment entry (see Figure 6.3). A number of studies have indicated that when language and cultural barriers to treatment are reduced, use of mental health services increases to be on par with national rates of usage (Añez, Silva, Paris & Bedregal, 2008).

6.3 Educational interventions for Hispanic males under 26 would be beneficial. Relative to Non-Hispanic Whites from the same age group, Hispanic males under 26 were less likely to have attended any college and were more likely to have fewer than 12 years of education. These discrepancies in educational attainment likely limit employment opportunities for Hispanic males under 26. Notably, education is a protective factor for substance use problems among Hispanics in that it appears to moderate the impact of acculturation to mainstream United States culture which is associated with increased substance use (Amaro et al., 1990). Notably, no Prop 36 treatment programs that responded to the treatment

provider survey offered literacy classes or High School/G.E.D. classes in Spanish and very few (less than 5%) offered technical/trade training in Spanish. This suggests a need for more CR educational programs among Prop 36 providers.

6.4 Some discrepancy was found between the number of Hispanic males under 26 who were charged with felonies (Hispanic higher) and the number of Non Hispanic White males under 26 who were charged with felonies. The reason for the discrepancy should be systematically examined in future research.

6.5 With regards to residential treatment, key informant interviews indicated that many Hispanic males under 26 did not want to enter residential treatment because they preferred to be working. According to key informants, many Hispanic males under 26 worked 'under the table' jobs that do not offer compensated time off for treatment services. Thus economic pressure may make residential treatment an unattractive option for a segment of the Hispanic population served by Prop 36. This is echoed in the data on barriers to treatment entry among Hispanics in Prop 36, in which work obligations were high on the list of barriers to treatment entry (see Figure 6.3).

6.6 A larger percentage of Hispanic males under 26 reported having any children at home and more Hispanic males under 26 reported having children under 5 at home. From a practical standpoint, there may be a greater need for childcare services or other measures to address this barrier to facilitate treatment participation among this segment of the Prop 36 population. In addition, while in treatment Hispanic males under 26 may benefit from such things as family interventions and parenting training; however, for Spanish speaking persons access to such services is limited as less than 10% of programs reported offering Spanish language family interventions or parenting training.

6.7 Previous research has indicated that Hispanics are disproportionately impacted by the HIV/AIDS epidemic. Yet, less than 20% of programs reported offering HIV/AIDS education and prevention in Spanish and less than 20% of programs reported offering Spanish language HIV testing services. In our data, we found that relative to Non-Hispanic Whites of the same age, Hispanic males under 26 were less likely to have been tested for HIV/AIDS and, if tested, were less likely to know their HIV/AIDS test result. Increased attention to HIV/AIDS issues among Hispanics in Prop 36 is warranted as a preventative measure given the fact that HIV/AIDS disproportionately impacts Hispanics.

6.8 Focus group data gathered from Hispanic males under 26 in Prop 36 treatment indicated that they experienced great difficulty in meeting the financial responsibilities attendant participation in Prop 36. Specifically, clients reported difficulty in coming up with money to pay the fines associated with probation and the costs associated with drug testing. Clients reported that this was particularly true early in treatment because few were able to maintain employment given the time commitment necessary to complete treatment tasks. One consideration may

be to create an income sensitive payment plan for treatment costs and court levied fines.

References

Alegria, M., Page, J. B., Hansen, H., Cauce, A. M., Robles, R., Blanco, C., et al. (2006). Improving drug treatment services for hispanics: Research gaps and scientific opportunities. *Drug and Alcohol Dependence, 84*((Supplement)), 76-84.

Amaro, H. & Raj, A. (2000). On the margin: Power and women's HIV risk reduction strategies. Sex Roles, 42(7/8), 723-749.

Amaro, H., Whitaker, R., Coffman, G. & Heeren, T. (1990). Acculturation and marijuana and cocaine use: Findings from HHANES 1982-84. American Journal of Public Health, 80(Suppl.), 54-60.

Amodea, M., Chassler, D., Oettinger, C., Labiosa, W., & Lundgren, L. M. (2008). Client retention in residential drug treament for Latinos. Evaluation and Program Planning, 31, 102-112.

Amaro, H., Arevalo, S., Gonzalez, G., Szapocznik, J., & Iguchi, M. (2006). Needs and scientific opportunities for research on substance abuse treatment among Hispanic adults. *Drug and Alcohol Dependence, 84S*, 64-75.

Añez, L. M., Silva, M. A., Paris, M., & Bedregal, L. E. (2008). Engaging Latinos through the integration of cultural values and motivational interviewing principles. Professional Psychology: Research and Practice, 39(2), 153-159.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, 0. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities health and healthcare. Public Health Reports, 118, 118-293.

Burnam, M. A., Hough, R. L., Karno, M., Escobar, J. I. & Telles, C. A. (1987). Acculturation and lifetime prevalence of psychiatric disorders among Mexican Americans in Los Angeles. Journal of Health and Social Behavior, 28(1), 89-102.

Campbell, C. I., & Alexander, J. A. (2002). Culturally competent treatment practices and ancillary service use in outpatient substance abuse treatment. Journal of Substance Abuse Treatment, 22, 109-119.

Center for Disease Control (June 2006). CDC HIV/AIDS Fact Sheet: HIV/AIDS among Hispanics. Accessed March 2, 2007 on the web: http://www.cdc.gov/hiv/resources/factsheets/hispanic.htm

Cuadra, A. M. (2004). Intention to test for HIV in a national sample of Latinos in the United States: The role of acculturation and attitudes. Dissertation Abstracts International: Section B: The Sciences and Engineering, 64(11-B), 5837.

Epstein, J. A., Botvin, G. J., & Diaz, T. (2001). Linguistic acculturation associated with higher marijuana use among hispanic adolescents. Substance Use and Misuse, 36(4), 477-499.

Evans, E. (2008). Employment Assistance in Proposition 36. In: Evaluation of Proposition 36: The Substance Abuse and Crime Prevention Act of 2000: Final Report. Retrieved from: http://www.uclaisap.org/Prop36/documents/2008%20Final%20Report.pdf.

Fosados, R., Evans, E., & Hser, Y. (2007). Ethnic differences in utilization of drug treatment services and outcomes among Proposition 36 offenders in California. *Journal of Substance Abuse Treatment, 33*, 391-399.

Greico, E. M., & Cassidy, R. C. (2001). *Overview of Race and Hispanic Origin*. Washington, D.C.: United States Census Bureau.

Guzman, B. (2001). *The Hispanic Population*. Washington, D.C.: United States Census Bureau.

Hawken, A. (2008). Residential Treatment. In: Evaluation of the Substance Abuse and Crime Prevention Act Final Report. 173-183. Retrieved from: http://www.uclaisap.org/prop36/documents/2008%20Final%20Report.pdf.

Hawken, A., Anglin, D., & Conner, B. (2007). Treatment Differences. In: Evaluation of the Substance Abuse and Crime Prevention Act: Final Report. Retrieved from: http://www.uclaisap.org/Prop36/documents/SACPAEvaluationReport.pdf.

Karno, M., Hough, R. L., Burnam, M. A., Escobar, J. I., et al. (1987). Lifetime prevalence of specific psychiatric disorders among Mexican-Americans and Non-Hispanic Whites in Los Angeles. Archives of General Psychiatry, 44(8), 695-701.

Markides, K. S., Ray, L. A., Stroup-Benham, C. A., & Trevino, F. (1990). Acculturation and alcohol consumption in the Mexican-American population of the Southwestern United States: Findings from HHANES 1982-84. American Journal of Public Health, 80(suppl.), 42-46.

Niv, N. & Hser, Y. I. (2006). Drug treatment service utilization and outcomes for Hispanic and White methamphetamine abusers. Health Services Research, 41(4), 1242-1257.

Peniagua, F. A. (1994). Assessing and treating culturally diverse clients: A practical guide. Thousand Oaks, CA: Sage Publications.

Phillips, K. (1993). Factors associated with voluntary HIV testing for African-Americans and Hispanics. AIDS Education and Prevention, 5(2), 95-103.

Ramirez, R. R. (2004). *We the People: Hispanics in the United States*. Washington, D.C.: United States Census Bureau.

Resnicow, K., & Braithwaite, R. L. (2001). Cultural sensitivity in public health. In Braithwaite, R. L. & Taylor, S. E. (Eds.), Health Issues in the Black Community, San Francisco: Jossey-Bass Publishers.

Sabogal, F., & Catania, J. A. (1996). HIV risk factors, condom use, and HIV antibody testing among heterosexual Hispanics: the National AIDS Behavioral Surveys (NABS). Hispanic Journal of Behavioral Sciences, 18(3), 367-391.

Sabogal, F., Faigeles, B., & Catania, J. (1993). Multiple sex partners among Hispanics in the United States, the National AIDS Behavior Surveys. Family Planning Perspectives, 25, 257-262.

Simpson, D. D. (2004). A conceptual framework for drug treament process and outcomes. Journal of Substance Abuse Treatment, 27, 99-121.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). Unequal treatment: Confronting racial and ethnic disparities in health care. Washington, DC: The National Academic Press.

Urada, D., & Evans, E. (2008). Proposition 36 Offender Characteristics. In: Evaluation of Proposition 36: The Substance Abuse and Crime Prevention Act of 2000: Final Report. Retrieved from:

http://www.uclaisap.org/Prop36/documents/2008%20Final%20Report.pdf.
Urada, D., Hawken, A., Conner, B. T., Evans, E., Anglin, M. D., Yang, J., et al. (2008). *Evaluation of Proposition 36: The Substance Abuse and Crime Prevention Act of 2000*. Los Angeles: UCLA Integrated Substance Abuse Programs.
Urada, D., & Longshore, D. (2007). SACPA Offenders. In Evaluation of the Substance Abuse and Crime Prevention Act: Final Report. Retrieved from: http://www.uclaisap.org/Prop36/documents/SACPAEvaluationReport.pdf.
Urada, D., Longshore, D., & Conner, B. (2007). Treatment. In Evaluation of the Substance Abuse and Crime Prevention Act: Final Report. Retrieved from: http://www.uclaisap.org/Prop36/documents/SACPAEvaluationReport.pdf.
VanOss Marin, B. (2003). HIV prevention in the Hispanic community: Sex, culture, and empowerment. Journal of Transcultural Nursing, 14(3), 186-192.
Vega, W. A., Alderete, E., Kolody, B. & Aguilar-Gaxiola, S. (1998). Illicit drug use among Mexicans and Mexican Americans in California: The effects of gender and acculturation. Addiction, 93(12), 1839-1850.
Wong, M. D., Tagawa, T., Hsieh, H. J., Shapiro, M. F., Boscardin, W. J., & Ettner, S. L. (2005). Differences in cause-specific mortality between Latino and White adults. Medical Care, 43(10), 1058-1062.

Chapter 7: Co-Occurring Disorders in Proposition 36

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According to the research literature, 37% to 53% of all individuals diagnosed with a substance use disorder have also been diagnosed with mental illness in their lifetimes.

Within Prop 36 only a few of the drug treatment programs surveyed reported having no clients with co-occurring drug and mental health disorders, however, the majority of drug treatment programs reported that they did not employ personnel trained to treat mental health disorders. Additionally, about 40% of Prop 36 Assessors reported that they did not conduct a mental health screening during the Prop 36 assessment process.

While individuals not appearing in Department of Mental Health databases (Comparison Group) were more likely to complete drug treatment than those located in the DMH databases (Diagnosed Group), time in treatment was equivalent between the two. Prop 36 participants diagnosed with a cognitive disorder had the lowest completion rate, followed by participants who had a substance use disorder.

The Diagnosed Group was more likely than the Comparison Group to be arrested at least once in the 30 month follow-up period for drug, property, and violent crimes. Offenders in the Diagnosed Group were more likely to have at least one misdemeanor arrest and at least one felony arrest in the 30 month follow-up period than the Comparison group. Offenders diagnosed with a substance use disorder were more likely than other diagnostic classes to have at least one misdemeanor arrest in the 30 month follow-up period. Offenders diagnosed with adjustment disorders and substance use disorders were more likely to have at least one felony arrest in the 30 month follow-up period.

Integrated Dual Diagnosis Treatment (IDDT) is an evidence-based treatment of co-occurring disorders that the Federal Substance Abuse and Mental Health Services Administration recommends as the preferred treatment for co-occurring disorders. Drug treatment programs report an increase in the use of IDDT from 2006/2007 to 2007/2008, however, there are some inconsistencies in the reporting of this information.

California has two separate departments with two separate means for funding drug and mental health treatment. ADP's funding includes Prop 36, while DMH's includes Prop 63. Data indicate the drug treatment programs have had limited success in accessing these Prop 63 funds. UCLA continues to recommend that drug treatment and mental health services find ways to integrate these funding sources to improve treatment for individuals with co-occurring disorders.

Co-occurring disorders typically include any combination of substance use disorders (e.g., alcohol abuse or dependence, cocaine abuse or dependence, polysubstance abuse or dependence), which are on Axis I of the Diagnostic and Statistical Manual of Mental Disorders–IV–Text Revision (DSM-IV-TR; American Psychiatric Association, 2000),

and mental disorders (e.g, major depression, schizophrenia, posttraumatic stress disorder, or borderline personality disorder), which may be on either Axis I or Axis II of the DSM-IV-TR. There are two ways to look at prevalence rates of co-occurring disorders: 1) determine among individuals who have been diagnosed with a mental illness what percentage have also been diagnosed with a substance use disorder, or 2) determining among individuals who have been diagnosed with a substance use disorder the percentage that have also been diagnosed with a mental illness. There are also 2 time frames that are typically reported 1) lifetime prevalence and 2) 12-month prevalence. When discussing co-occurring disorders life-time prevalence typically means the prevalence of any other disorder at any time over the lifespan of the individual with the diagnosis of interest (e.g., what is the lifetime prevalence of mental illness among individuals currently diagnosed with a substance use disorder); whereas 12-month prevalence is the co-occurrence of a secondary disorder in any 12-month period of the active diagnosis of interest (e.g., the percentage of individuals that are currently diagnosed with a substance use disorder that have also met criteria for a diagnosis of mental illness in the previous 12 months).

Epidemiological data (for example see the National Comorbidity Study and its replication and the National Epidemiologic Survey on Alcohol and Related Conditions) on the rates of co-occurring disorders indicate that 30% to 72% of individuals who have been diagnosed with a mental illness have also, at some point in their lifetime, had a diagnosis of a substance (alcohol or drug) use disorder (Merikangas et al., 1998; Watkins et al., 2004). However 12 month prevalence rates of substance use disorders co-occurring with mental illness range from 15 to 20% (Grant et al., 2004). When analyzing the data from the starting point of substance use disorders, lifetime prevalence of a diagnosed co-occurring mental illness among those currently diagnosed with a substance use disorder is estimated to be between 37% and 53% (Cacciola et al., 2001). These percentages have remained stable over time (Center of Substance Abuse Treatment, 2005).

Empirical research indicates that individuals with co-occurring disorders are more likely to be arrested, incarcerated, and spend more time incarcerated than those without mental health disorders (Drake et al., 2001; Monahan et al., 2005). Additionally, this group of individuals has more trouble getting and keeping employment or other forms of financial support, reliable transportation, or appropriate medical and mental health care (Brunette & Mueser, 2006). All of these factors combine to make it very difficult to track, study, and treat this special population.

Co-Occurring Disorders in Prop 36

Mental Disorder Assessment in Prop 36

Data presented in this chapter were derived from a number of sources including the UCLA Stakeholder and Program Surveys (completed by lead agencies, assessors, courts, probation, parole, and treatment providers across the state) and administrative databases from the California Department of Justice (DOJ), the California Department of Mental Health (DMH), and the California Department of Alcohol and Drug Programs (ADP). Data from ADP come from two different sources: the California Alcohol and Drug Data System (CADDS) and the California Outcomes Measurement System (CalOMS).

As part of the Prop 36 "pipeline" each offender that elects to participate in Prop 36 must undergo an assessment. The assessment is supposed to be used to inform treatment recommendations. On the UCLA Stakeholder Survey 75.7% of responding lead agencies (28 of 37) reported that their county employed a centralized assessment process, and an average of 96.1% of Prop 36 treatment admissions were received through these assessment centers. A separate survey asked assessors to indicate if during the assessment a mental health disorder screening[40] was either 1) routinely conducted as part of this assessment or 2) if a mental disorder screening was conducted in response to elevations on items of a typical assessment (i.e., the Addiction Severity Index or the American Society of Addiction Medicine Patient Placement Criteria) that indicates that the individual may be suffering from a mental disorder. Of the 26 county assessors that responded to the survey (see Appendix A), 19.2% (5 counties) reported routinely conducting a mental disorder screening in addition to the typical assessment instrument and 46.2% (12 counties) reported conducting a mental disorder screening in response to elevations on the typical assessment that indicated the presence of a mental disorder, meaning that 42.3% (11) of the counties reported that they did not conduct a mental health disorder screening as part of the Prop 36 assessment (2 counties reported conducting both types of mental health disorder assessment). When compared to previous years these data indicate an overall decline in mental health assessment during the Prop 36 assessment, however, this decrease could be due to two factors: 1) this is the first year that UCLA has collected data from assessors (in prior years UCLA collected this data from the lead agencies overseeing Prop 36 implementation) and 2) the response rate for the assessor survey was quite low, 26 of 58 or approximately 44.8% of counties returned the assessor portion of the survey to UCLA. As these data come directly from the assessors it is likely that it is a more accurate reflection of what actually occurs during the assessment process, however, given the low response rate, there is the possibility that this data is not an accurate representation of what is occurring statewide.

Table 7.1 details the methods used to address the presence of a mental disorder in the participant being assessed by those lead agencies that reported conducting any type of mental disorder screening.

Table 7.1: Addressing Mental Health Disorders Detected at Assessment

	N	*%*
Given a recommendation to be placed in a program specializing in the treatment of co-occurring drug and psychiatric disorders?	13	86.7%
Given a referral for mental health services at a provider other than the drug treatment program they were being referred to.	12	80.0%
Seen by a licensed mental health professional?	10	66.7%
Given a referral for psychiatric medication evaluation?	11	73.3%

Note: Percentages are based on the 15 assessors (44.8%) that reported conducting a mental disorders assessment.

[40] An assessment is typically a detailed interview for the purpose of diagnosis, classification, or service planning whereas a screening is a brief inquiry as to whether a problem exists. Typically a positive result on a screening should lead to a detailed assessment.

Treatment of those with Mental Health Disorders in Prop 36

UCLA received responses to the UCLA Program Survey from 63 drug treatment providers who held Prop 36 contracts at the time of data collection (see Appendix B). Of the 63, 53 drug treatment providers reported on the percentage of their clients that have a co-occurring mental health disorder. They reported that, on average, 23.4% (with estimates ranging from 0 to 99%) of their clients had a co-occurring mental health disorder at treatment entry. Four of the programs indicated that 0% of their clients had a co-occurring mental health disorder.

One aim of the survey was to determine how the drug use disorders treatment programs were addressing the presence of mental health disorders among their clients. The first question of interest was "*Does your program provide Co-occurring Disorders Treatment services?*". Of the 63 programs that responded, 4 programs did not answer this question. Of the remaining 59 programs, 46%, or 29 programs, indicated that they offered co-occurring disorders treatment services. Of those 29 programs, 72.4%, or 21 programs, reported using an Integrated Dual Diagnosis Treatment (IDDT) approach. IDDT is an evidence-based practice for the treatment of co-occurring disorders that the Substance Abuse and Mental Health Services Administration (SAMSHA) currently recommends as the preferred treatment for individuals diagnosed with co-occurring disorders (SAMSHA, 2003). The IDDT approach includes a performance management component that allows for oversight of these programs, referred to as fidelity measurement[41]. Of the 21 programs that reported employing an IDDT approach, 33.3%, or 7 programs, reported that the fidelity measures provided by SAMHSA were used to assess their implementation of IDDT. While the percentage of programs conducting quality control of their IDDT is very low, it is encouraging that 72.4% of the programs that reported offering mental health services were using an evidence-based treatment recognized as the gold standard in the treatment of co-occurring disorders.

The UCLA program survey also asked if the program employed mental health professionals (see Table 7.2). 34.9%, or 22 programs, reported employing some combination of psychiatrists, psychologists, and social workers. 9.5%, or 6, reported having at least one psychiatrist on staff, 17.5%, or 11, reported having at least one psychologist on staff, and similarly 17.5%, or 11, reported having at least one social worker on staff. One of the tenets of IDDT is that it be delivered by a mental health professional (SAMSHA, 2003). When looking at the 21 Prop 36 programs that indicated on the UCLA Program Survey that they offered IDDT, 42.9%, or 9, of them did not report employing any mental health professionals.

[41] Fidelity refers to the degree of an evidence-based practice (EBP) that is implemented in a system. Research suggests that use of fidelity scales provides an objective, structured way to diagnose program weaknesses and clarify strengths on implementation. Fidelity scales also provide a framework for comparing statewide trends and outliers across locations (SAMSHA 2003).

Table 7.2: Distribution of Mental Health Professionals across Treatment Programs				
Program	Psychiatrist	Psychologist	Social Worker	**Total**
1	0	1	0	**1**
2	0	1	0	**1**
3	1	0	1	**2**
4	1	0	0	**1**
5	0	1	1	**2**
6	0	10	0	**10**
7	2	1	6	**9**
8	0	1	0	**1**
9	0	0	0	**0**
10	0	0	0	**0**
11	0	0	0	**0**
12	0	1	2	**3**
13	1	2	0	**3**
14	0	0	0	**0**
15	0	0	8	**8**
16	0	3	1	**4**
17	0	0	3	**3**
18	1	0	0	**1**
19	0	0	1	**1**
20	0	0	1	**1**
21	0	0	4	**4**
22	0	0	1	**1**
Total	**6**	**21**	**29**	**56**

There are two primary implications of these findings: 1) approximately 34.9%, or 22, of the drug treatment facilities holding Prop 36 contracts have the ability to offer mental health services in an integrated fashion (i.e., receiving mental health and drug treatment at the same treatment facility) and 2) programs that do not employ mental health professionals reported offering mental health services, including IDDT, on site. As

previously reported (Conner & Grella 2008), the second implication can be explained in a number of ways. Consulting data collected through focus groups, UCLA was able to determine that drug treatment providers often came up with inventive ways to offer mental health services. In cases where the county was the primary drug treatment provider, it was not unusual to have the county mental health services located in the same or in nearby facilities. This co-location allowed providers to offer mental health services on site even when they were not employing mental health professionals, especially if the Prop 36 participant had some method to pay for the mental health services. However, UCLA also found instances where it appeared that mental health services were being provided by individuals not adequately trained to offer these services, such as dual diagnosis treatment groups run by certified substance use disorders counselors. While it is clear that some form of mental healthcare would be beneficial for the majority of Prop 36 clients, services offered by individuals not adequately trained have the potential of causing harm to the clients, and thus violate industry, state, and federal ethical and legal regulations, regardless of the intention of the provider.

The UCLA program survey also asked how drug treatment programs handled participants with co-occurring disorders (see Table 7.3). Programs were asked to indicate if they offered the services at the treatment clinic (On Site) or through a referral or a cooperative agreement (see Table 7.4).

Table 7.3: Methods for Addressing Mental Illness On Site

Services Available On Site	*N*	*%*
Brief Mental Health Screening	38	60.3
Formal diagnosis provided by a mental health professional (MHP)	19	30.2
Counseling/therapy (group or individual) provided by a MHP	23	36.5
Medication services provided by a MHP	16	25.4
Special "co-occurring disorders" groups (includes 12-step groups)	29	46.0
Psychiatric case management	11	17.5
Behavioral Interventions for Mental Health Problems	41	65.1
Crisis intervention services	20	31.7
Outreach	26	41.3

Note: N in this table represents the number of programs offering mental health services as part of their treatment programs, meaning that they provide mental health and drug treatment services simultaneously.

Table 7.4 details the responses of the programs that reported not employing mental health professionals (the remaining 65.1% of the 63 programs that completed UCLA's Program Survey) when asked what services were available for Prop 36 participants with mental health disorders. Some of these programs have referral sources, while others reported not offering or being able to refer their clients for mental health services.

Table 7.4: Programs Not Employing Mental Health Professionals

	*Offsite**	*Not Provided*
Brief Mental Health Screening	23.8%	15.9%
Formal diagnosis provided by a mental health professional (MHP)	42.9%	25.4%
Counseling/therapy (group or individual) provided by a MHP	41.3%	22.2%
Medication services provided by a MHP	38.1%	31.7%
Special "co-occurring disorders" groups (includes 12-step groups)	23.8%	33.3%
Psychiatric case management	28.6%	46.0%
Behavioral Interventions for Mental Health Problems	25.4%	15.9%
Crisis intervention services	28.6%	34.9%
Outreach	30.2%	25.4%

*Offsite was indicated if services were offered by referral or through a cooperative agreement.

Mental Disorder Frequencies in Prop 36

Analysis of the fiscal year 07/08 CalOMS data provides an indication of the prevalence of mental health disorders in the Prop 36 population who entered drug treatment, though this is likely an invalid and unreliable estimate. This is because the data are based on self-report from Prop 36 clients during their initial Prop 36 Assessment. Individuals completing a CalOMS assessment at drug treatment entry are asked to answer four questions regarding their mental health: "*Has the client ever been diagnosed with a mental illness?*" (16% in 07/08 answered yes to this item), "*How many times in the past 30 days has the client received outpatient emergency services for mental health needs?*" (1.8% in 07/08 had any data on this item), "*How many days in the past 30 days has the client stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs?*" (1.0% in 07/08 had any data on this item), and "*In the past 30 days, has the client taken prescribed medication for mental health needs.* These percentages are quite low and likely represent an under-reporting of mental health disorders among Prop 36 offenders. Under-reporting has been noted in prior Prop 36 evaluation reports (Conner & Grella, 2008). The CalOMS lifetime mental illness question likely does not yield valid and reliable data for estimating the prevalence of co-occurring disorders in Prop 36, though there appear to be efforts to correct this and improve the quality of this data in the future.

UCLA was able to access data from DMH for those clients that received mental health services in addition to treatment for their drug use disorders (drug treatment). DMH data from the first 3 years of Prop 36 have been matched to both the DOJ and CADDS

databases[42]. It should be noted that California's DMH is charged with treating only those individuals with severe and persistent mental illness, so these numbers only reflect the most severe cases. It is likely that there are many more individuals receiving drug treatment through Prop 36 who have a co-occurring mental health disorder that do not meet this criteria. For these years approximately 24% of all Prop 36 clients were located in the DMH database, however, on average only 8% received mental health services concurrently with their Prop 36 drug treatment. Individuals who are able to pay for mental health services with private insurance or out-of-pocket are likely not present in the DMH administrative data. These percentages are then an approximation of the number of Prop 36 clients who were formally diagnosed with mental health disorders and were referred and received mental health treatment through the public mental health system, both on the whole and during their participation in Prop 36. The inherent difficulties associated with matching administrative data may have limited UCLA's ability to accurately identify all clients receiving mental health and drug treatment concurrently while participating in Prop 36.

Though multiple funding sources are available, the primary mechanism used to fund the public mental health system in California is Medi-Cal. California residents may be eligible for Medi-Cal if they receive assistance from the Supplemental Security Income/State Supplemental Program (SSI/SSP), the California Work Opportunity and Responsibility to Kids (CalWORKs, previously called Aid to Families with Dependent Children or AFDC), or Refugee Assistance, if they participate in the Foster Care or Adoption Assistance Program, if they are 65 or older, blind, disabled, under the age of 21 years, pregnant, diagnosed with breast or cervical cancer, in a skilled nursing or intermediate care facility, or if they have refugee status during a limited period of eligibility. California residents are also eligible to receive Medi-Cal if they are a parent or caretaker relative of a child under 21 and the child's parent is deceased or doesn't live with the child, or the child's parent is incapacitated, or the child's parent, who is the primary wage earner, is unemployed or underemployed, meaning that the family is below the Federal Poverty Line.

Information used to identify specific Prop 36 eligible offenders in CADDS are limited to first and last initial, sex, and date of birth (Appendix A), as such only a subset of the available DMH records matched with the DOJ data. Identifying eligible offenders who had a mental health disorder was dependent on whether the participant is identified in the DMH database as having received mental health services in the 12 months following the date that they became eligible for Prop 36 participation. If they were not identified in the DMH database, the assumption was that they were not suffering from a mental health disorder in the 12 months following Prop 36 eligibility. The 12-month time-frame is the same standard used to identify Prop 36 drug treatment following the eligible conviction. While this approach is optimistic in its assumption that those with mental illness receive mental health services, given the way data are collected, it is the most conservative method for making comparisons. In this sense, the appropriate terminology for the comparisons is those that are identified as receiving mental health services (Diagnosed

[42] UCLA is currently in the process of obtaining DMH data from 04-08 to match it with DOJ and CalOMS data, however, at the time of this report those data were not yet available. As a result, data presented here-in are from participants that entered Prop 36 during its first 3 years, 7/1/2001-6/30/2004.

Group) compared to those that are identified as not receiving mental health services (Comparison Group).

Using the DMH administrative data, UCLA can detail the distribution of the most common diagnoses in the Prop 36 population. The most common diagnosis was Depressive Disorder Not Otherwise Specified (NOS), at 8.1% of those present in both the DOJ data and the DMH data. See Tables 7.5-7.7 for more information regarding the distribution of diagnoses. The majority of diagnoses were from the family of Mood Disorders (37.2%), Substance Use Disorders (22.8%), or the Schizophrenias (16.5%).

Table 7.5: Distribution of Mental Health Disorders in Prop 36

Disorder	*Frequency*	*Percent*
Depressive Disorder NOS	6,125	8.1%
Psychotic Disorder NOS	5,947	7.8%
Mood Disorder NOS	5,598	7.4%
Diagnosis Deferred	3,551	4.7%
Polysubstance Dependence	2,909	3.8%
Schizoaffective Disorder	2,385	3.0%
Schizophrenia, Paranoid Type	2,207	2.9%
Adjustment Disorder Unspecified	2,025	2.7%
Bipolar Disorder NOS	1,940	2.6%
Amphetamine Dependence	1,816	2.4%
Total	**34,503**	**45 %**

Note: Only the top 10 diagnoses are given in the table as the total list is too long to reproduce here. There are a total of 10,509 individuals represented in the table above. The disorders are based on DSM-IV-TR diagnoses.

Table 7.6: Distribution of Diagnoses by Subcategory

Subordinate Diagnostic Category	*Frequency*	*Percent*
Drug Use Disorders	15,057	19.9%
Major Depression	8,032	10.6%
Mood Disorder	6,932	9.1%
Bipolar Disorder	6,709	8.9%
Depressive Disorders	6,125	8.1%
Psychotic Disorder NOS	6,099	8.0%
Adjustment Disorders	5,810	7.7%
Diagnosis Deferred	3,551	4.7%
Schizoaffective Disorders	2,410	3.2%
Anxiety Disorders	2,329	3.1%
Schizophrenia Paranoid Type	2,291	3.0%
Alcohol Use Disorders	2,207	2.9%
Stress Disorders	1,218	1.6%
Schizophrenia Undifferentiated Type	1,192	1.6%
Conduct Disorders	877	1.2%
Total	**70,839**	**93.4**

Note: The total, 70,839, represents the number of unique diagnoses present, not individuals. There are 21,818 individuals represented in the table. The remaining 6.57% of diagnoses not present in the table represented less than 1% each of the data and were too numerous to list here. The subordinate diagnostic categories are based on the major divisions of the 16 major diagnostic classes of the DSM-IV-TR.

Table 7.7: Distribution of Diagnoses by Diagnostic Class

Superordinate Diagnostic Category	*Frequency*	*Percent*
Mood Disorders	28,202	37.2%
Substance Use Disorders	17,267	22.8%
Schizophrenia/Psychotic Disorders	12,472	16.5%
Adjustment Disorders	6,320	8.3%
Diagnosis Deferred	3,551	4.7%
Anxiety Disorders	3,052	4.0%
Disorders Usually Diagnosed in Childhood	1,517	2.0%
V Codes	1,179	1.6%
Personality Disorders	469	0.6%
Impulse Control Disorders	424	0.6%
Disorders due to a General Medical Condition	409	0.5%
Mental Disorder NOS	284	0.4%
Cognitive Disorder NOS	238	0.3%
Malingering	221	0.3%
Sleep Disorders	45	0.06%
Somatoform Disorders	31	0.04%
Eating Disorders	30	0.04%
Dissociative Disorders	28	0.04%
Sexual Disorders	25	0.03%
Problems with Physical Abuse	24	0.03%
Factitious Disorders	11	0.01%
Medication Induced Disorders	10	0.01%
Noncompliance with Treatment	8	0.01%
Total	**75817**	**100.00**

Note: The total, 75,871, represents the number of unique diagnoses present, not individuals. There are a total of 23,352 individuals represented in the above table. The superordinate diagnostic categories are based on the 16 major diagnostic classes of the DSM-IV-TR.

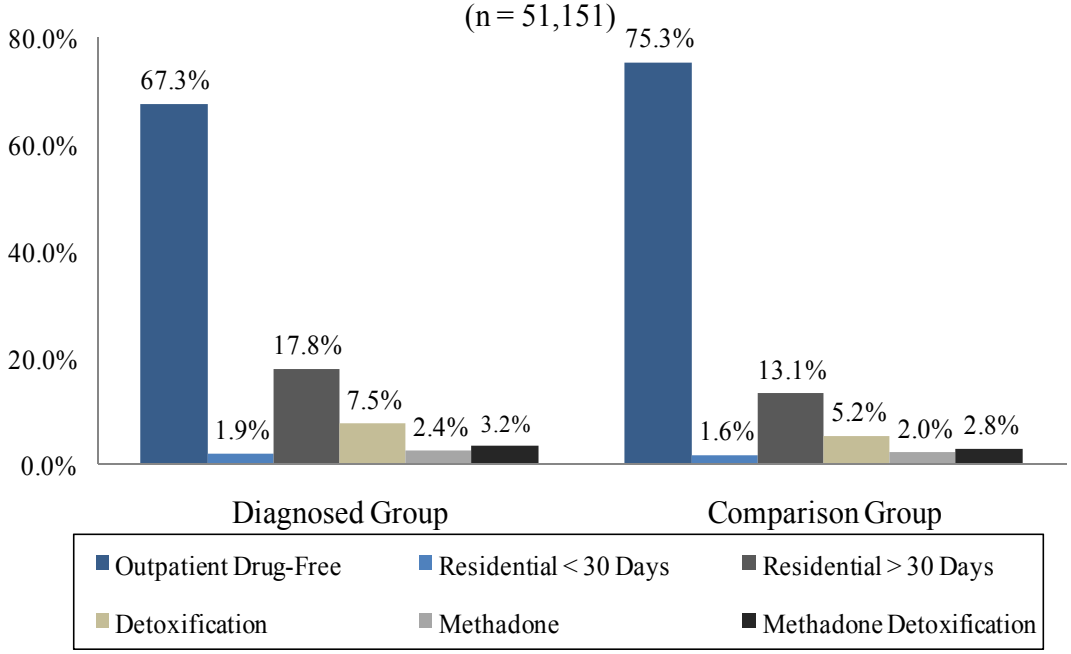
Outcomes for Prop 36 Eligible Offenders with Co-Occurring Disorders

In order to determine the effectiveness of Prop 36 for this special population, UCLA compared eligible offenders with co-occurring disorders identified and matched across the three databases (DOJ, DMH, and CADDS), referred to as the Diagnosed Group, to those who were not located in the DMH administrative database, referred to as the Comparison Group. The caveat is that the available data are not necessarily a random or representative sample of those with co-occurring disorders in the Prop 36 population, so caution should be used when interpreting them. In these analyses any one not present in the DMH database is included in the comparison group. This means that the true nature of the comparison is those that received mental health services versus those that did not or did not receive them through a DMH provider. Finally, given the amount of missing data, comparisons of treatment completion and treatment duration are based on the data available.

Treatment Placement

The first step in the comparisons was to determine if there were significant differences between the groups in the type of treatment they were placed in (see Figure 7.1). Participants in the Diagnostic Group were more likely to be in Long Term Residential Drug Treatment (Residential > 30 Days) whereas those in the Comparison Group were more likely to be in Outpatient Drug-Free Drug Treatment. This difference is likely a reflection of the difference in severity of disorders and the difficulty in treating individuals with co-occurring disorders.

Figure 7.1 Treatment Modality by Mental Health Status
(n = 51,151)



In addition to analyzing data between individuals in the Diagnosed Group and those Comparison Group, data can be broken within the Diagnosed Group across the primary diagnosis. Figures 7.2 through 7.8 present the percentage of participants in different treatment modalities by diagnostic class.

Figure 7.2 Treatment Modality within Adjustment Disorders
(n = 353)

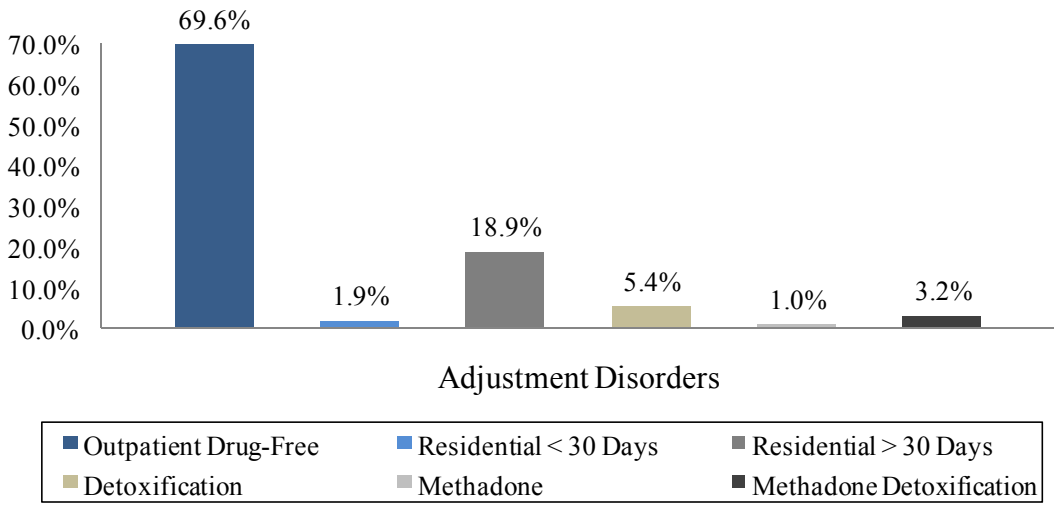
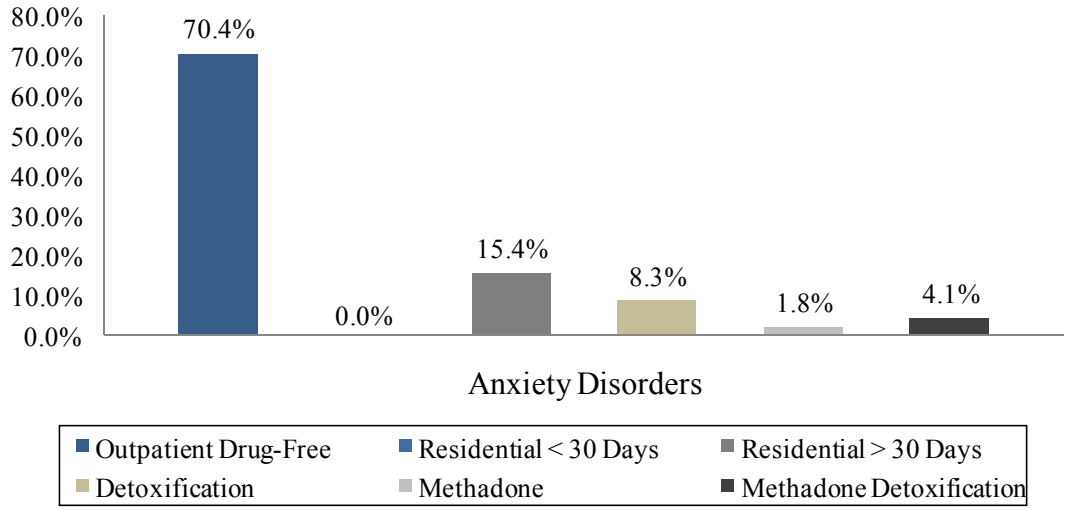


Figure 7.3 Treatment Modality within Anxiety Disorders
(n = 194)



Note: There were no participants in the Anxiety Disorders Class reported in Short-Term Residential Drug Treatment.

Figure 7.4 Treatment Modality within Cognitive Disorders
(n = 210)

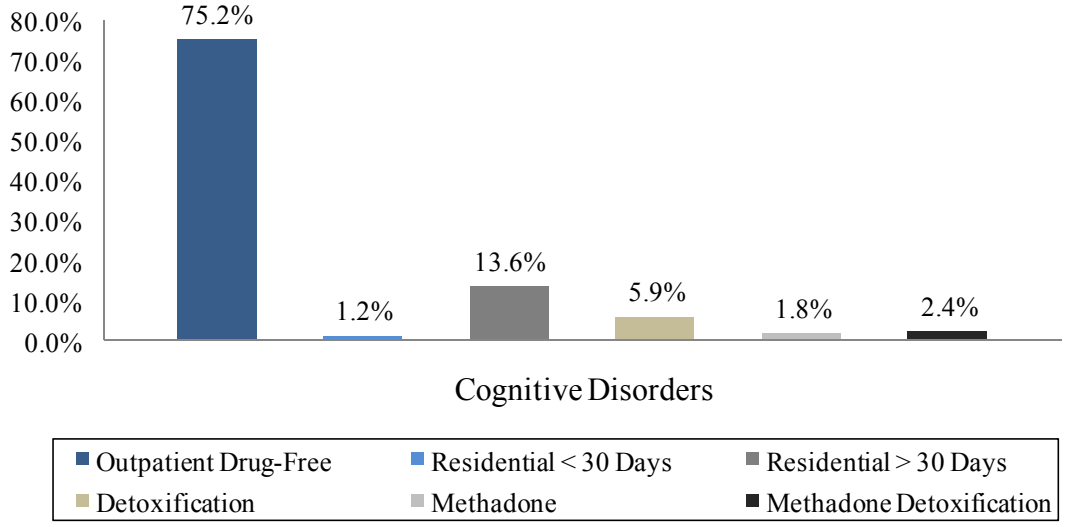


Figure 7.5 Treatment Modality within Mood Disorders
(n = 1578)

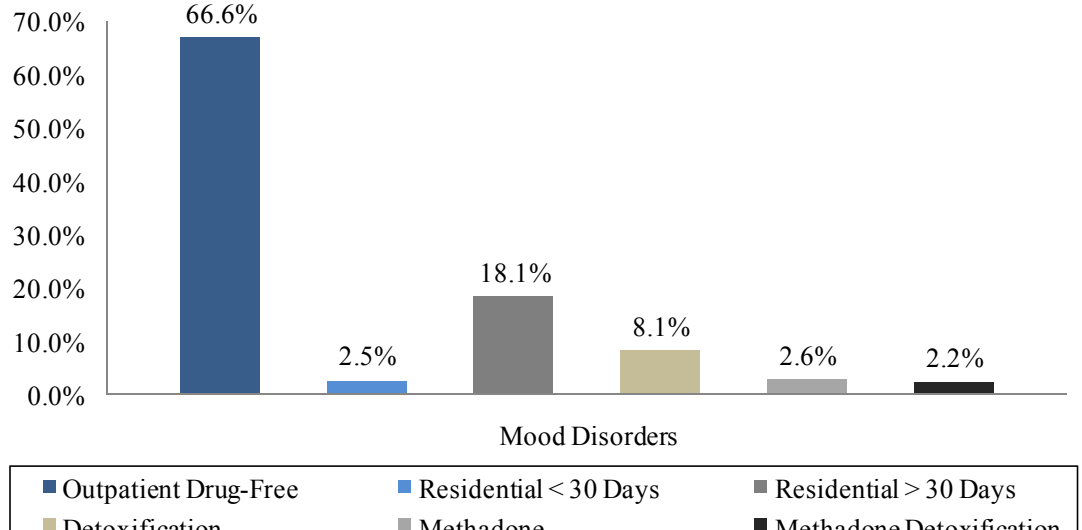


Figure 7.6 Treament Modality within Schizophrenia/Psychotic Disorders (n = 918)

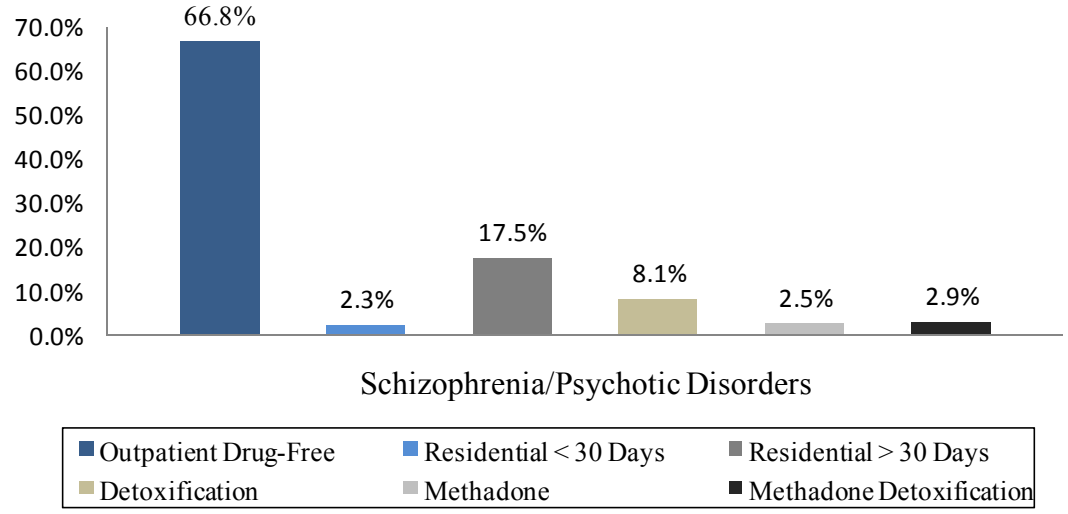
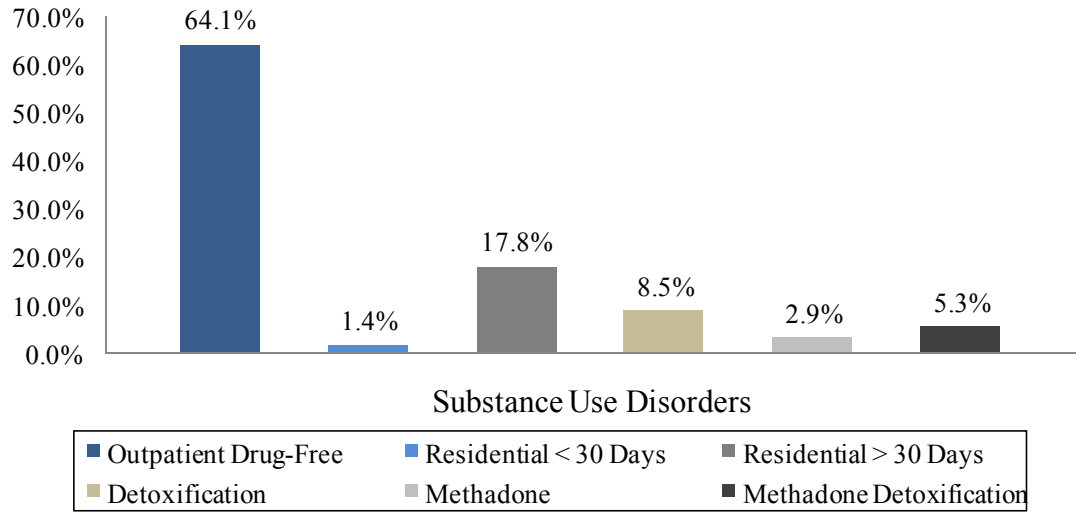
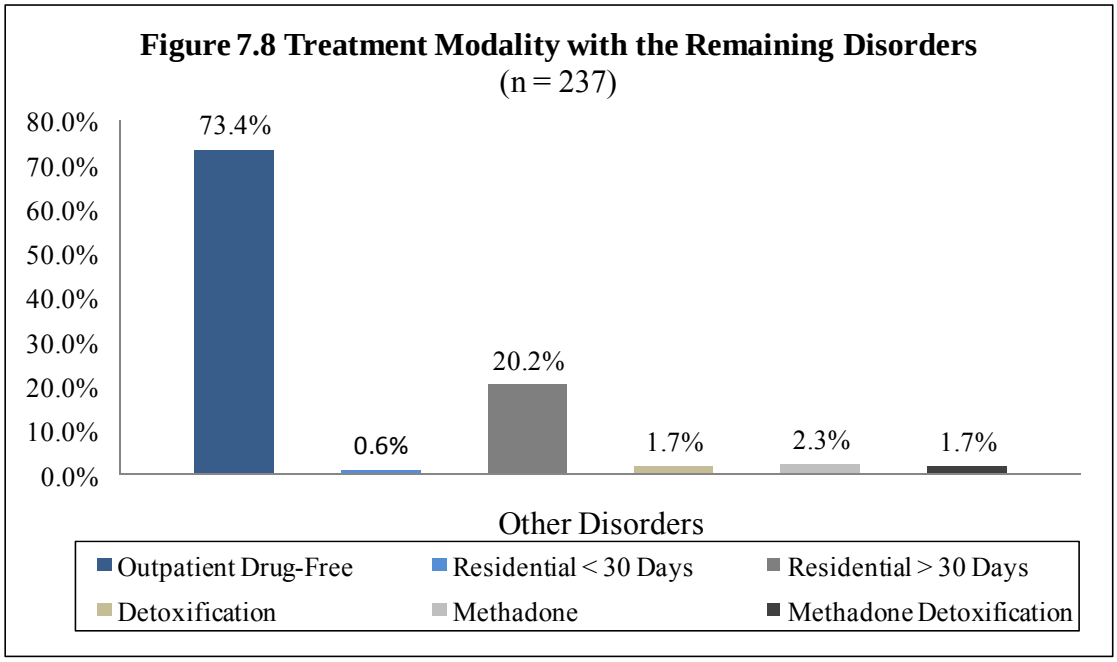


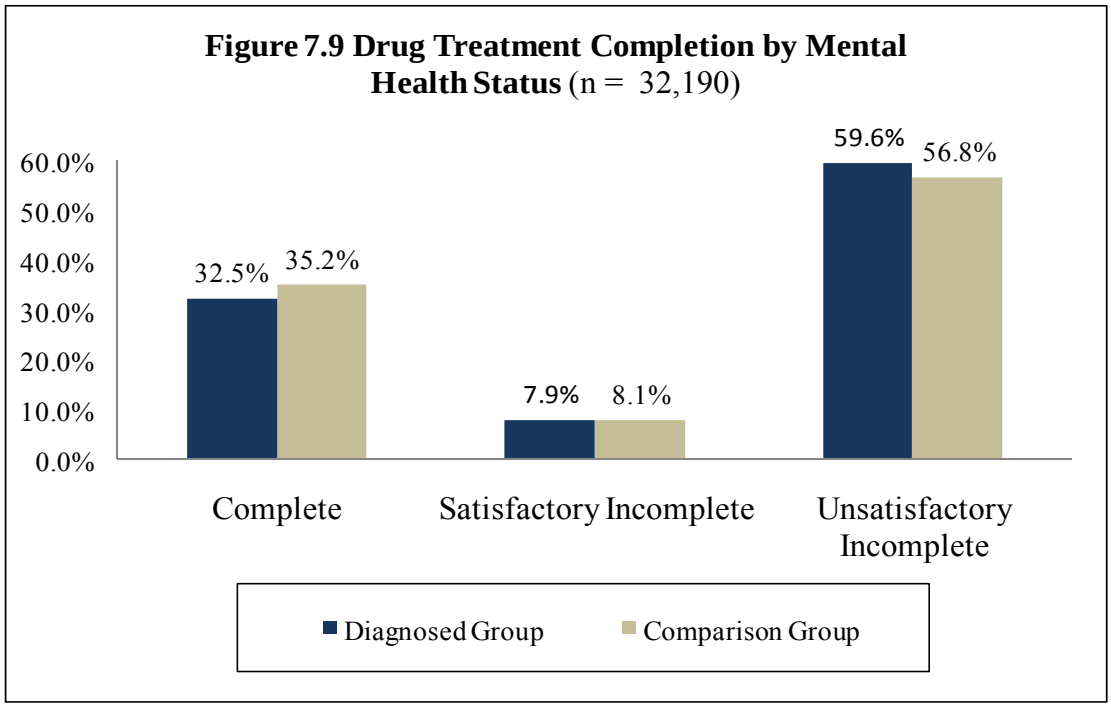
Figure 7.7 Treatment Modality within Substance Use Disorders (n = 885)





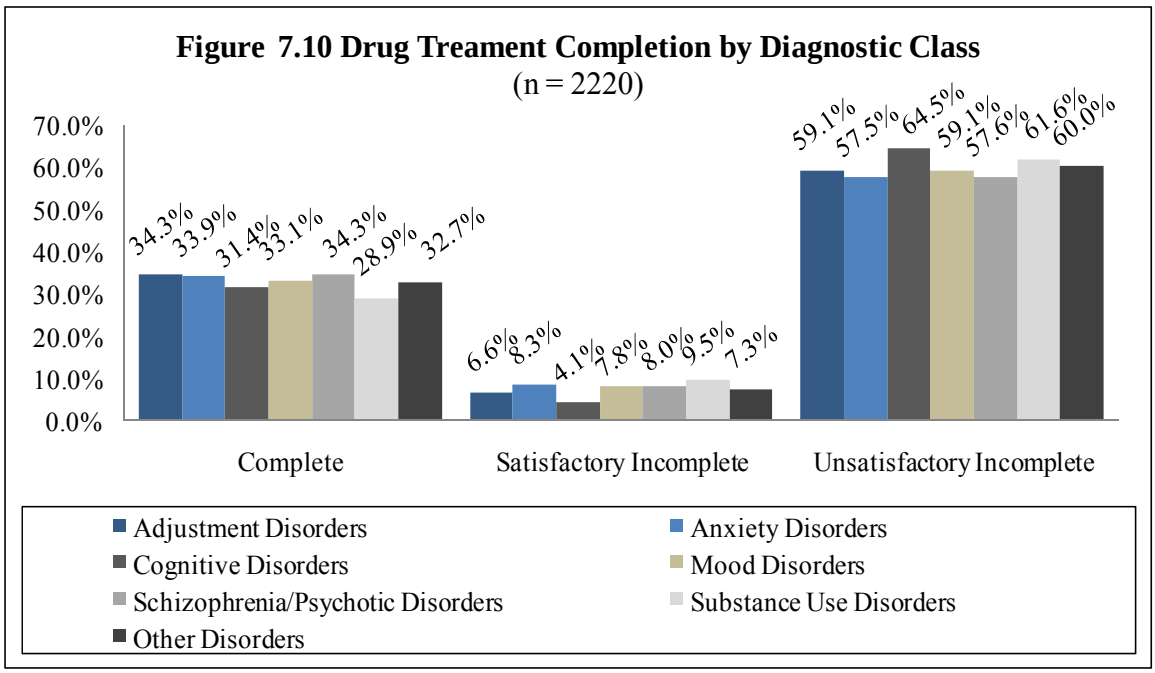
Treatment Completion

One of the primary outcome measures for the evaluation of Prop 36 is drug treatment completion. Drug treatment completion data are presented in Figure 7.9. Prop 36 participants in the Diagnosed Group were more likely to have an Unsatisfactory Incomplete status than those in the Comparison Group. Conversely the Comparison Group had a higher percentage of members who completed treatment.



Note: Percentage based on those clients that had a discharge status. Clients with no discharge status were treated as missing data.

Figure 7.10 shows the percentage of Prop 36 participants who completed treatment by their Diagnostic Class. The data is limited to those that had a completion status. Diagnostic Class categories are collapsed for those diagnoses with less than 5% of the cases. Prop 36 participants diagnosed with a Substance Use Disorder had the lowest completion rate, followed by participants who had a Cognitive Disorder (Delirium, Dementia, and Amnestic Disorders) as their primary diagnosis.



Note: Percentage based on those clients that had a discharge status. Clients with no discharge status were treated as missing data. Adjustment Disorders n = 198, Anxiety Disorders n = 109, Cognitive Disorders n = 121, Mood Disorders n = 807, Schizophrenia/Psychotic Disorders n = 401, Substance Use Disorders n = 474, Other n = 110.

Treatment Duration

In addition to completion information, using CADDS data, the length of time in treatment can be calculated for individuals that have both an intake and a discharge date. As noted in other parts of the report this is an estimate for only those people that have a discharge status. It is difficult to interpret the data given the amount of missing discharge data, however, using available data may give some indication of how long this special population remains in treatment and how that compares to other populations. Additionally, this variable does not account for the amount of actual time in treatment, just the time between intake and discharge. Table 7.8 presents data on the length of time spent in treatment by Mental Health status.

Table 7.8: Days in Drug Treatment by Mental Health Status

	N	Days in Treatment
Diagnosed Group	7942	40.7 (104.1)
Comparison Group	116,995	38.7 (101.4)

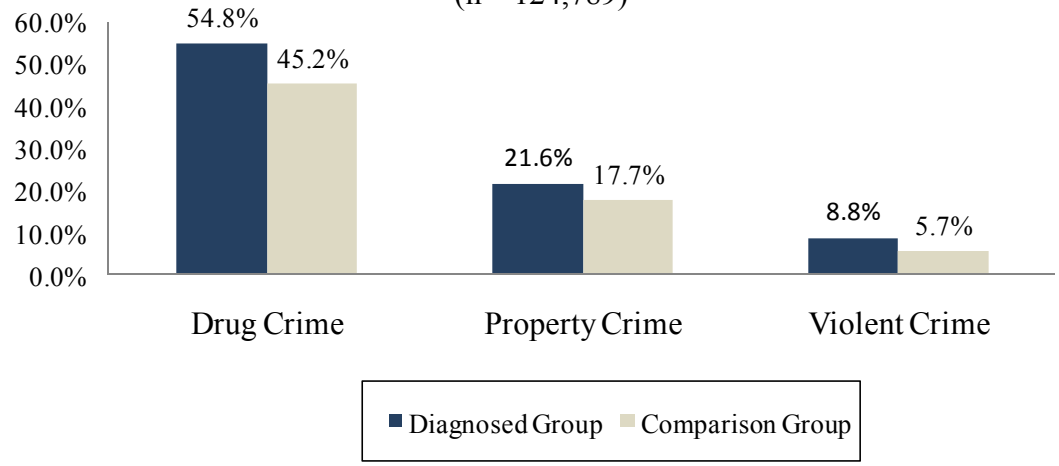
Note: Data presented are Mean and (Standard Deviation) based on those that had discharge data.

Time in treatment was equivalent between those with a mental health diagnosis and the comparison group.

Re-offending

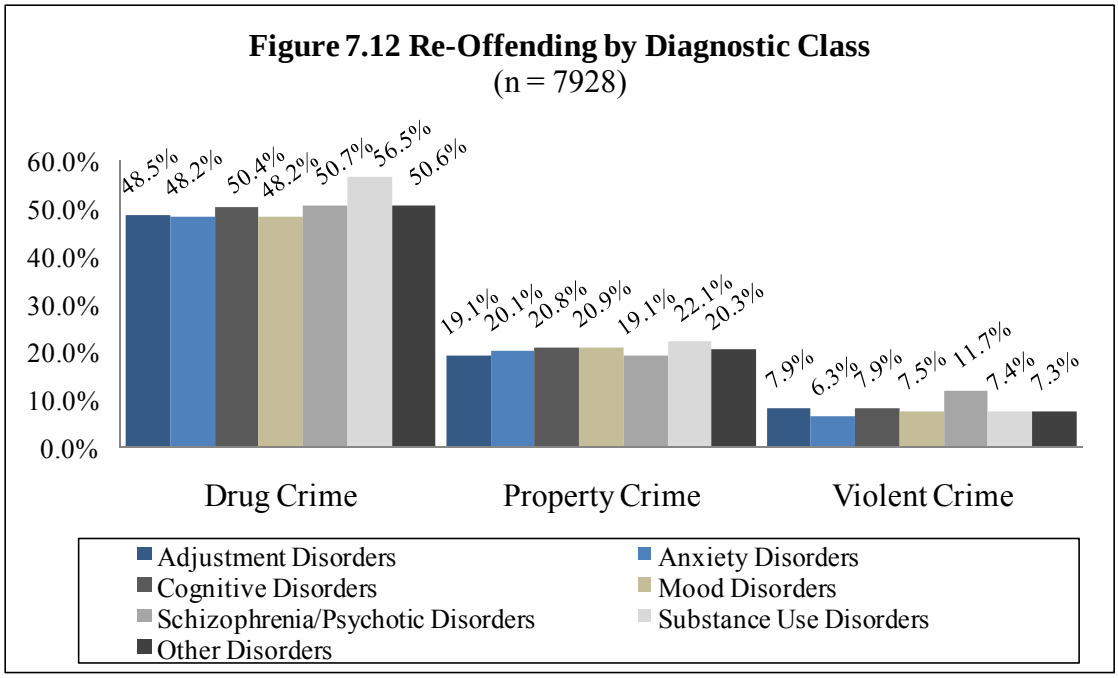
In addition to drug treatment outcome data, DOJ data were used to compare re-offending among those with co-occurring disorders and the comparison group. Figure 7.11 presents the percentage of participants from each group that was arrested at least one time in the 30 months following their Prop 36 eligible conviction. Only drug, property, and violent crime data are presented, other types were not prevalent enough for analysis.

Figure 7.11 Re-Offending by Mental Health Status
(n = 124,789)



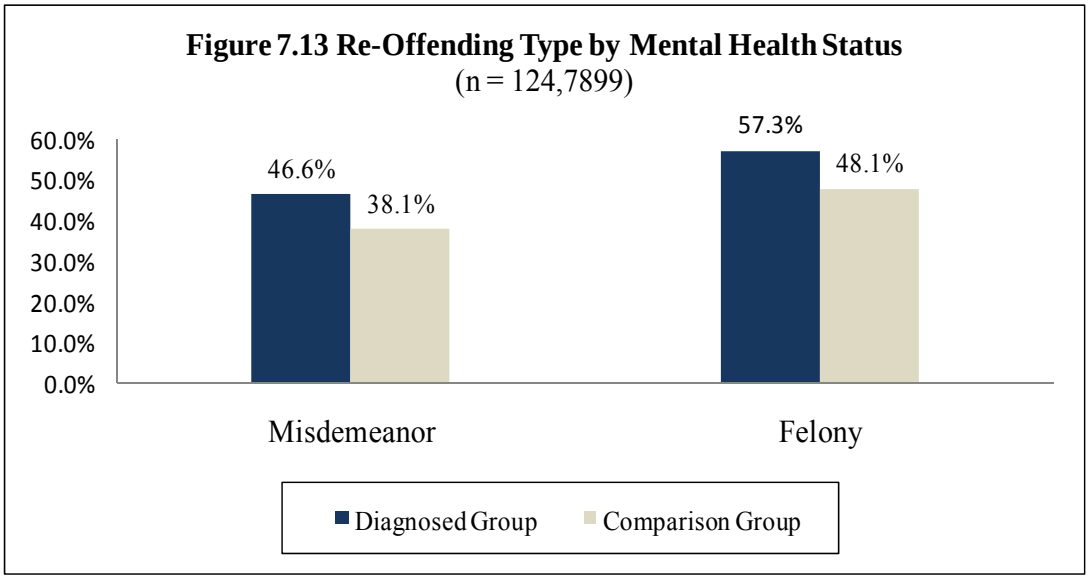
Note: Shows the percentages of the total participants per group re-arrested at least once for each type of crime. Mentally ill n = 7,927, Comparison Group = 116,862.

Across all three categories of crime individuals with co-occurring disorders were more likely to be arrested at least once in the 30 month follow-up period. This is consistent with findings from previous research that indicates that individuals with co-occurring disorders are more likely to be arrested than offenders with no evidence of mental illness. In addition to analyzing re-offending between those with mental health disorders and the comparison group, Figure 7.12 presents re-offending by diagnostic class.



Note: Shows the percentages of the participants per group re-arrested at least once for each type of crime. Adjustment Disorders n = 668, Anxiety Disorders n = 363, Cognitive Disorders n = 379, Mood Disorders n = 2892, Schizophrenia/Psychotic Disorders n = 1564, Substance Use Disorders n = 1653, Other n = 409.

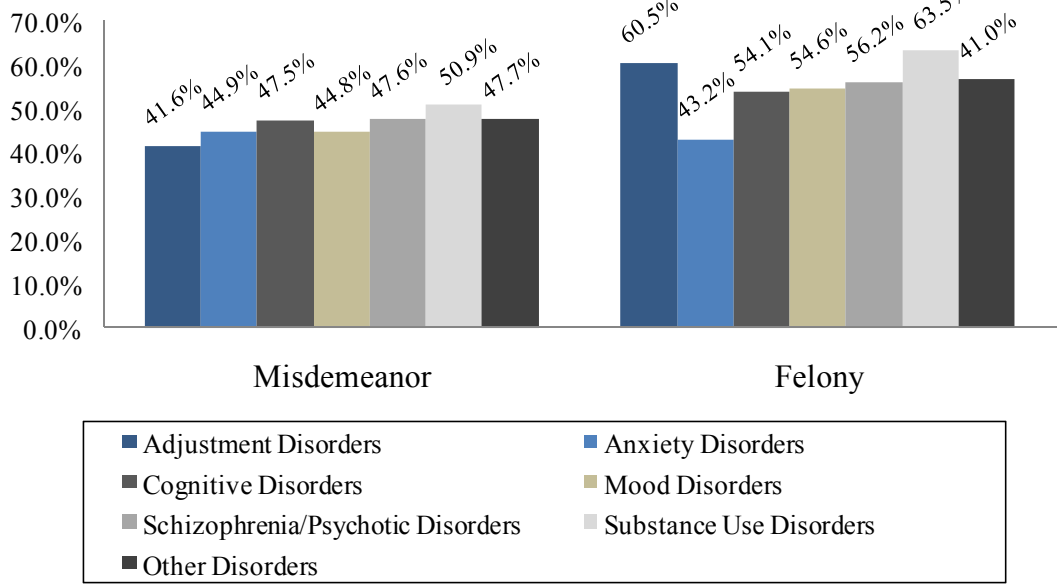
Figures 7.13 presents re-offending data by crime type, either misdemeanor or felony, between Prop 36 offenders with a co-occurring mental health disorder and the comparison group. Figure 7.14 presents re-offending data by crime type, either misdemeanor or felony, among the diagnostic classes.



Note: Shows the percentages of the total participants per group re-arrested at least once for each type of crime. Diagnosed Group n = 7,927, Comparison Group = 116,862.

Offenders diagnosed with a mental health disorder were more likely to have at least one misdemeanor arrest and at least one felony arrest in the 30 month follow-up period than the comparison group.

Figure 7.14 Re-offending Type by Diagnostic Class
(n = 7923)



Note: Shows the percentages of the participants per group re-arrested at least once for each type of crime. Adjustment Disorders n = 668, Anxiety Disorders n = 363, Cognitive Disorders n = 379, Mood Disorders n = 2891, Schizophrenia/Psychotic Disorders n = 1564, Substance Use Disorders n = 1653, Other n = 405.

Offenders diagnosed with a Substance Use Disorder as their primary diagnosis were more likely to have at least one misdemeanor arrest in the 30 month follow-up period than the other diagnostic classes. Offenders diagnosed with Adjustment Disorders and Substance Use Disorders were more likely to have at least one felony arrest in the 30 month follow-up period when compared to the other diagnostic classes.

Recommendations

Identification of Those in Need

This section represents an update to recommendations that were presented in the 2008 Prop 36 Evaluation report. There continue to be no standards for the initial Prop 36 assessment process across the state of California. Each county continues to assess Prop 36 offenders using their own methods. While most counties conduct an assessment that includes some form of the ASI or the ASAM-PPC, others use measures that they have developed. Additionally, counties still are not required to report assessment results to a centralized database. Additionally, while there is agreement that CalOMS is an improvement over CADDS, it still does not provide sufficient information to make accurate estimates of the prevalence of mental health disorders in the AOD treatment population, nor does it have the ability to distinguish between less and more severe mental health disorders. This makes identifying and tracking Prop 36 offenders with co-occurring mental health disorders in drug and mental health treatment almost impossible.

UCLA continues to recommend that a standardized assessment be either a) adopted or b) developed and then implemented statewide. This assessment tool should accurately identify individuals who have co-occurring mental health disorders that are significantly affecting their functioning according to DSM-IV-TR criteria in addition to the other areas that are typically assessed as part of the Prop 36 assessment. A standardized training should also be developed so that each person charged with assessing Prop 36 clients receives an appropriate level of training to correctly and accurately conduct the assessment. Additionally, UCLA is recommending that counties report assessment results in a standardized form to a database maintained by ADP, either as part of CalOMS or through a separate database, for research and quality assurance purposes.

Proper Treatment Placement for Individuals with Co-Occurring Disorders

In the 2008 Evaluation Report described the development of a conceptual framework for placing clients with co-occurring disorders in the level of treatment most suited to the severity of combined disorders, the "quadrant" model (National Association of State Mental Health Program Directors and National Association of State Alcohol/Drug Abuse Directors, 1998; Burnam & Watkins, 2006; Pincus et al., 2007). This model suggests that individuals who are "high" in severity on both dimensions of substance use and mental disorders require treatment in high-intensity settings, such as residential treatment, whereas those low in severity in both or either dimension can be effectively treatment in specialized mental health or substance abuse treatment programs that have cross-linkages with programs in the other treatment sector. The feasibility of using this model to classify clients with co-occurring disorders into the appropriate level of care was recently supported in a study using Medicaid claims data from 6 states (McGovern et al., 2007). UCLA continues to recommend that counties adopt a model that improves the treatment placement process taking into account both client needs and system availability in an effort to improve treatment outcomes.

Integrated Dual Disorders Treatment

UCLA previously described an evidence-based treatment for individuals with co-occurring disorders, integrated dual disorders treatment (IDDT). IDDT is an evidence-based practice for the treatment of co-occurring disorders that the Substance Abuse and Mental Health Services Administration (SAMSHA) currently recommends as the preferred treatment for individuals diagnosed with co-occurring disorders (SAMSHA, 2003). The majority of the data published to date supports improved treatment outcomes for those receiving IDDT compared to care-as-usual, such as parallel or serial treatments of the mental and substance use disorder (i.e., Boyle & Kroon, 2006; James et al., 2004; and Mangrum et al., 2006). Additionally, the IDDT approach includes a performance management component that allows for oversight of these programs.

In the 2008 Evaluation Report UCLA recommended that each county be able to offer IDDT to those who meet diagnostic criteria for co-occurring disorders. In the 2008 Program Survey 24 of 83 programs reported offering treatment for co-occurring disorders. Of those, 11 said they offered IDDT, however, 8 of the 11 did not report employing any mental health professionals (i.e., psychiatrist, psychologist, clinical social worker), which is necessary in order to correctly implement IDDT. In the 2009 Program Survey 34.9%, or 22 programs, reported employing some combination of psychiatrists,

psychologists, and social workers and 21 reported using IDDT. 42.9%, or 9, of them did not report employing any mental health professionals, and only 7 of them reported using the fidelity measures. UCLA continues to recommend that treatment programs serving individuals with co-occurring disorders properly implement and assess the fidelity of IDDT.

Alternate Funding Sources

In November 2004, California voters passed Prop 63, the Mental Health Services Act (MHSA), with 53.4% of the vote. Prop 63 was designed to provide funds to counties to expand services and develop innovative programs and integrated service plans for mentally ill children, adults and seniors (Scheffler & Adams, 2005). The new law also established the Mental Health Services Oversight and Accountability Commission (MHSOAC). This commission recently issued a report on co-occurring disorders that also listed specific recommendations (MHSOAC, 2007).

One of the primary recommendations from this report is to take a "Whatever it Takes" approach to funding and providing treatment refers to funding for a "wide array of clinical and supportive services beyond mental health care, notably including such things as housing and treatment for co-occurring [disorders]". The commission also noted that IDDT was the exception rather than the rule in California, but that integrated care is likely the best treatment setting for individuals with co-occurring disorders and that there are limited public and private funding sources for such integrated care. One of the primary recommendations from this commission was that "Public and private health plans which have programs that are funded by the Mental Health Services Act should be required to ensure integrated mental health and substance abuse services are available for all clients who need them".

In the 2008 Evaluation Report UCLA recommended that Prop 36 contracts be awarded to drug treatment facilities that employ mental health professionals and mental health treatment facilities that employ certified substance use disorders treatment personnel. Prop 36 contracts should also reimburse these programs taking into account the cost of employing these professionals. If this can be achieved, then becomes an issue of training. As noted previously, the materials needed for implementation of IDDT are available from SAMSHA at no cost.

In 2008 UCLA recommended that Prop 63 funds be awarded to drug use disorders treatment facilities that employ mental health professionals so that they can begin using an IDDT approach. This would allow the best use of available funds from both sources to create and implement the "Whatever it Takes" approach to treating those with co-occurring disorders. In the 2009 Program Survey, treatment providers were asked if they receive Prop 63 funding. 28.6%, or 8, of the programs that reported offering treatment for co-occurring disorders indicated that they received Prop 63 funding. This represents a step in the right direction, however, UCLA continues to recommend that treatment programs that employ mental health professionals continue to seek Prop 63 funding.

Data Collection

As part of this evaluation UCLA was asked to evaluate the performance and outcomes of Prop 36 clients with co-occurring disorders. It continues to be difficult to answer these questions given the nature of the data available. While progress in improving data collection has been made by ADP in moving from CADDS to CalOMS, as discussed earlier, the CalOMS data continues to fall short of acceptable data collection. CalOMS does not appear to provide reliable and valid data on co-occurring disorders in the Prop 36 population.. UCLA continues to recommend that ADP and county stakeholders work together to develop better data collection across the all of the agencies involved in treating and monitoring Prop 36 participants, especially those with co-occurring disorders.

Conclusions

Prop 36 clients who have co-occurring mental health and drug use disorders represent a special population that are often difficult to track, study, and treat. This chapter reported outcomes between individuals diagnosed with a mental health disorder (referred to as the diagnosed group) and those not located in the DMH database (referred to as the comparison group). Time in treatment was equivalent between the diagnosed and the comparison groups. Prop 36 participants diagnosed with a cognitive disorder had the lowest completion rate, followed by participants who had a substance use disorder.

When looking at re-offending data, the diagnosed group was more likely than the comparison group to be arrested at least once in the 30 month follow-up period for drug, property, and violent crimes. The rates of re-offending were fairly similar across the different diagnostic classes, however, offenders diagnosed with a substance use disorder were more likely to have been arrested for at least one drug crime and at least one property crime. Offenders diagnosed with schizophrenia or other psychotic disorders were more likely to have been arrested for at least one violent crime. The diagnosed group was more likely than the comparison group to have at least one misdemeanor arrest in the 30 month follow-up period. The percentages for felony arrests were similar across the two groups. Offenders diagnosed with a substance use disorder were more likely than the other diagnostic classes to have at least one misdemeanor arrest in the 30 month follow-up period. Offenders diagnosed with adjustment disorders and substance use disorders were more likely to have at least one felony arrest in the 30 month follow-up period when compared to the other diagnostic classes.

Identifying clients with co-occurring disorders early in the Prop 36 process, such as during assessment or sentencing, may lead to better drug and mental health treatment outcomes as well as lower recidivism. These clients will likely benefit from placement in treatment programs that are better suited to meet their needs, such as programs that offer IDDT. Data indicate that since UCLA's 2008 evaluation report there has been movement in the right direction. More programs report using IDDT in 2009 and some programs report being able to access the Prop 63 funding stream. Treatment placement and thus outcomes, will likely improve if collaboration between drug treatment and mental health professionals continues to develop.

References

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision* (DSM-IV-TR). Washington, DC: American Psychiatric Press, Inc.

Boyle, P., & Kroon, H. (2006). Integrated dual disorder treatment: comparing facilitators and challenges of implementation for Ohio and the Netherlands. *International Journal of Mental Health, 35,* 70-88.

Brunette, M.F., & Mueser, K.T. (2006). Psychosocial interventions or the long-term management of patients with severe mental illness and co-occurring substance use disorder. *Journal of Clinical Psychiatry, 67, Suppl 7,* 10.17.

Burnam, M.A., & Watkins, K.E. (2006). Substance abuse with mental disorders: Specialized public systems and integrated care. *Health Affairs, 25,* 648-658.

Center for Substance Abuse Treatment. (2005). Substance abuse treatment for persons with co-occurring disorders (Treatment Improvement Protocol TIP Series 42, DHHS Publication No. SMA 05-3992). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Conner, B.T., & Grella, C. (2008). The Homeless Mentally Ill in Proposition 36. In *Evaluation of Proposition 36: The Substance Abuse and Crime Prevention Act of 2000 2008 Report* (pp. 69-97). Los Angeles, UCLA.

Drake, R.E. et al. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services, 52,* 469-476.

Drake, R.E., et al. (2006). The challenge of treating forensic dual diagnosis clients: Comment on "integrated treatment for jail recidivists with co-occurring psychiatric and substance use disorders". *Community Mental Health Journal, 42,* 427-432.

James, W., Preston, N.J., Koh, G., Spencer, C., Kisely, S.R., & Castle, D.J. (2004). A group intervention which assists patients with dual diagnosis reduces their drug use: a randomized controlled trial. *Psychological Medicine, 34,* 983-990.

Mangrum, L., Spence, R., & Lopez, M. (2006). Integrated versus parallel treatment of co-occurring psychiatric and substance use disorders. *Journal of Substance Abuse Treatment, 30,* 79-84.

McGovern, M.P., Clark, R.E., & Samnaliev, M. (2007). Co-occurring psychiatric and substance use disorders: A multistate feasibility study of the quadrant model. *Psychiatric Services, 58,* 949-954.

Medi-Cal Eligibility Manual (2007). California Medi-Cal Eligibility Branch. Accessed at: http://www.dhs.ca.gov/mcs/mcpd/meb/Medi-CalEligibilityProceduresManual/default.htm

Mental Health Services Oversight and Accountability Commission (2007). Mental Health Services Oversight and Accountability Commission Report on Co-Occurring Disorders. Accessed at: http://www.dmh.ca.gov/MHSOAC/docs/Co-OccurringDisorders.pdf.

Monahan J., Steadman H.J., Robbins P.C., Appelbaum P., Banks S., Grisso T., Heilbrun K., Mulvey E.P., Roth L., Silver E. (2005). An actuarial model of violence risk assessment for persons with mental disorders. *Psychiatric Services, 56,* 810-815.

Mueser, K.T.; Noordsy, D.L.; Drake, R.E.; Fox, L. (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective Practice*. New York. Guilford Press. 402-405.

NASMHD &NASADAD (1998). National dialogue on co-occurring mental health and substance abuse disorders. Washington, DC: Center for Mental Health Services and the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration (SAMHSA).

National Comorbidity Study. Accessed at: http://www.hcp.med.harvard.edu/ncs/index.php.

National Comorbidity Study Replication. Accessed at: http://www.hcp.med.harvard.edu/ncs/index.php.

National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). Accessed at: http://niaaa.census.gov/.

Pincus, H.A., Watkins, K., Vilamovska, A., & Keyser, D. (2007). Models of care for co-occurring disorders: Final report to the Substance Abuse and Mental Health Administration: Center for Substance Abuse Treatment. Santa Monica, CA: RAND Corporation.

Rossi, P.H. (1989). Down and out in America: The origins of homelessness. Chicago: University of Chicago Press.

Scheffler, R.M., & Adams, N. (2005). Millionaires and mental health: Proposition 63 in California. Health Affairs. Web Exclusives: W5-212-W5-224. Accessed at: http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.212v1.

Substance Abuse and Mental Health Administration (SAMSHA; 2003). Co-Occurring disorders: Integrated Dual Disorders Treatment. Accessed at: http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/.

Watkins, K.E., Hunter, S.B., Wenzel, S.L., Tu, W., Paddock, S.M., Griffin, A., Ebener, P. (2004). Prevalence and characteristics of clients with co-occurring disorders in outpatient substance abuse treatment. *American Journal of Drug and Alcohol Abuse, 30,* 749-764.

Chapter 8: Process Improvement

Beth Rutkowski, M.P.H. and Darren Urada, Ph.D.

Statewide, awareness of NIATx and use of process improvement methods increased dramatically between 2007 and 2009.

Building upon an earlier pilot project described in the 2008 Proposition 36 Evaluation Report, in 2007-2008 a new demonstration project took place in Los Angeles County with the following goals: (1) determine whether agencies receiving minimal support and no financial assistance could adopt and use process improvement methods to improve assessment no-show rates and 30-day and 60-day continuation rates; (2) utilize data gathered by the participating agencies to determine the degree to which they were able to reduce no-shows to assessment, improve participation in individual and group counseling sessions, and increase 30- and/or 60-day continuation rates; (3) assess agency commitment to adopting and administratively supporting the process improvement methodology at the conclusion of the project; and (4) identify key attributes of the project that contribute to success, as well as components that could be improved to increase the likelihood of successful business and service improvements.

The agencies used a variety of innovative strategies, including: same-day assessments, consolidation of multiple assessment appointments into a single appointment, increased contact with prospective clients, in-house intake appointments, daily check-in calls with clients on a residential program waiting list, bus tokens, alteration of intake and assessment appointment times, reminder phone calls, and assignment of clients to a primary counselor at time of assessment to streamline the intake, assessment, and admission process; as well as distribution of weekly group and individual session appointment schedules, reminder calls, regular meetings between new clients and staff from various departments, satisfaction questionnaires, adjustment of meal, mail, and medication times to better accommodate clients' schedules, and a welcome/orientation group offered daily for the first five days of treatment to encourage continued participation in treatment.

The vast majority of agencies were able to demonstrate improvements in waiting time, intake/assessment no-show rates, group and individual session attendance rates, 30-day continuation rates, and overall number of admissions. Aggregate data from participating programs revealed a 42% reduction in wait time from initial contact to assessment/intake appointment; a 44% reduction in no-shows to intake, assessment, or admission appointments; a 19% increase in post-admission session-by-session attendance; and a 6% increase in 30-day continuation.

As discussed in prior chapters in this report, there is no single reason why Prop 36 clients do not show for scheduled appointments (Chapter 1), or drop out of treatment prematurely (Chapter 2), but both are persistent challenges. Maintaining or improving show rates and retention is also becoming more difficult in the current environment of

decreasing Prop 36 funding. Therefore, low-cost initiatives like the process improvement methods described in UCLA's 2008 Proposition 36 report (Rutkowski and Urada, 2008) and updated in this chapter are more important than ever. In the previous UCLA Prop 36 report, UCLA reported on general awareness of these methods and described a pilot project that took place in Los Angeles County in 2005 and 2006 (Rutkowski and Urada, 2008). This chapter provides the latest measures of statewide awareness and describes a second Los Angeles County pilot project that built upon the success of the first.

Process Improvement and the Network for the Improvement of Addiction Treatment (NIATx)

Process improvement is an evidence-based framework that provides a systematic problem solving approach that organizations can use to develop a deeper understanding of client needs, restructure the workflow to more effectively respond to client and staff needs, and make the most efficient use of available resources (Langley, Nolan, Nolan, Norman, & Provost, 1996).

A systematic examination of process improvement strategies and their effects in drug treatment was initiated nationally in 2003. The Network for the Improvement of Addiction Treatment (NIATx), a partnership between the Robert Wood Johnson Foundation's Paths to Recovery program and the Center for Substance Abuse Treatment's Strengthening Treatment Access and Retention (STAR) program, was formed to promote process improvement specifically in substance abuse treatment.[43] The staff of NIATx member programs learn to apply process improvement principles to improve client engagement and retention in addiction treatment, while integrating process improvement into program culture. Providers use process improvement methods to improve services and client attendance by focusing on four service delivery aims: (1) reducing waiting times from first contact to admission and receipt of first service; (2) reducing no-shows to assessment or admission interviews; (3) increasing admissions to the level of funded capacity; and (4) increasing client continuation rates. NIATx provides a set of tools designed to help treatment providers improve their programs in these areas and to attain better client outcomes.

The change processes used to achieve these goals include:

- Identify process barriers. This may be done by conducting client interviews or a program walk-through from a client's perspective to understand how current processes facilitate or inhibit treatment goals.
- Identify what is to be accomplished and define a reasonable and measurable goal.
- Establish a Change Team to select, adapt if needed, and test the potential changes identified for addressing targeting problems. The Change Team is formed by the Executive Director of the organization and a staff member designated as Change Leader. Effective Change Teams often include a client or "customer."

[43] For more information on NIATx, visit www.niatx.net.

- Use a rapid Plan-Do-Study-Act (PDSA) cycle including the collection of data before, during, and after a change to evaluate whether it resulted in improvement.
- Make adjustments to continuously improve and sustain changes.

The specific processes to be improved are identified and changed based on the identified needs and goals of individual sites. A key innovation is the use of a tested model (e.g., the PDSA cycle) to guide process improvement.

Awareness of NIATx

For the second consecutive year, to gauge current awareness and implementation of NIATx among Prop 36 substance abuse treatment providers statewide, UCLA asked treatment providers survey respondents if they had heard of NIATx, implemented procedures (for more on survey methods, see Appendix B). The results are shown below. As shown in Table 8.1, in 2007 only 14.0% of surveyed providers indicated that they had heard of NIATx, and only 5.8% reported having actually implemented NIATx procedures. The most recent survey, distributed in December 2008 with the majority of responses returned in 2009 (2009 survey), revealed that the percentage of treatment providers that had heard of NIATx had more than quadrupled. A substantial majority of providers now acknowledge having heard of NIATx. Moreover, the percentage of providers reporting that they had implemented NIATx procedures was more than seven times higher than in the prior survey.

Table 8.1: Awareness of NIATx

	% Yes: 2007 Survey	% Yes: 2009 Survey
Have you heard of the Network for the Improvement of Addiction Treatment (NIATx)?	14.0%	64.3%
Has your treatment program ever implemented NIATx Procedures?	5.8%	42.3%

The dramatic increase in awareness and implementation of NIATx methods may be attributable to many factors. One major contributor may have been a series of California Addiction Training and Education Series (CATES) workshops focused on NIATx that were held in the Fall of 2007 and Spring and Fall of 2008 in multiple locations throughout the state. These CATES trainings were well publicized, well attended (more than 1,000 California-based treatment providers attended one of nine daylong workshops), and treatment programs were encouraged to attend by county alcohol and drug program administrators. Another contributor may have been the national Adopting Changes to Improve Outcomes Now (ACTION) Campaign launched by a partnership of several national organizations in 2007 to promote promising practices derived from

NIATx.[44] A third contributor to awareness and implementation was the Los Angeles County pilot projects themselves. These pilot projects contributed both by training programs directly, and through dissemination of results from the phase I project in multiple conference presentations, newsletters, the previous UCLA Prop 36 evaluation report, and by word of mouth.

The 2007-2008 Phase II Los Angeles County Process Improvement Pilot Project

The description of the Los Angeles County Process Improvement Pilot Project procedures and outcomes included here are a condensed version of those in The Los Angeles County Process Improvement Pilot Project, Phase 2 Project Implementation Guide and Final Report (Rutkowski, 2009).[45]

In 2007-2008, the Pacific Southwest Addiction Technology Transfer Center, together with the County of Los Angeles Department of Public Health, Alcohol & Drug Program Administration and NIATx, sponsored an 13-month demonstration project with eight County-funded treatment agencies (in a total of nine outpatient programs and four residential programs) to determine if the process improvement model described in NIATx could improve treatment retention and completion rates in Los Angeles County. This project represented an enhanced continuation of a training/dissemination effort that begin in 2005-2006 with the phase I pilot project.

The pilot project aimed to: (1) determine whether agencies receiving minimal support and no financial assistance could adopt and utilize process improvement methods to improve assessment no-show rates and 30-day and 60-day continuation rates; (2) utilize data gathered by the participating agencies to determine the degree to which they were able to reduce no-shows to assessment, improve participation in individual and group counseling sessions, and increase 30- and/or 60-day continuation rates; (3) assess agency commitment to adopting and administratively supporting the process improvement methodology at the conclusion of the project; and (4) identify key attributes of the project that contribute to success, as well as components that could be improved to increase the likelihood of successful business and service improvements.

The agencies used a variety of innovative strategies, such as same-day assessments, consolidation of multiple assessment appointments into a single appointment, increased contact with prospective clients, in-house intake appointments, daily check-in calls with clients on a residential program waiting list, bus tokens, alteration of intake and assessment appointment times, reminder phone calls, and assignment of clients to a primary counselor at time of assessment to streamline the intake, assessment, and admission process; as well as weekly group and individual session appointment schedules, reminder calls, regular meetings between new clients and staff from various departments, satisfaction questionnaires, adjustment of meal, mail, and medication times

[44] For more information, see https://www.actioncampaign.org/

[45] Those interested in receiving this document, which includes greater detail, can request it from Beth Rutkowski at UCLA ISAP (brutkowski@mednet.ucla.edu).

to better accommodate clients' schedules, and a welcome/orientation group offered daily for the first five days of treatment to encourage continued participation in treatment.

Project Leadership was provided by the Pacific Southwest Addiction Technology Transfer Center (PSATTC) and the County of Los Angeles Department of Public Health, Alcohol and Drug Program Administration (LA County ADPA). The University of Wisconsin at Madison (NIATx National Program Office) provided technical assistance. The participating treatment agencies were:

- Antelope Valley Rehabilitation Center (Acton Rehabilitation Center and Warm Springs Rehabilitation Center)
- Behavioral Health Services, Inc. (American Recovery Center and Hollywood Recovery Center)
- California Hispanic Commission on Alcohol and Drug Abuse (Latino Family Center and San Gabriel Valley Center)
- Didi Hirsch Community Mental Health Center (Metro and Culver Palms)
- House of Hope
- MELA Counseling Services Center
- SHIELDS for Families, Inc.
- Tarzana Treatment Centers, Inc. (Tarzana and Lancaster)

According to admissions records from the California Department of Alcohol and Drug Programs' California Outcomes Monitoring System (CalOMS), all of these treatment providers served Prop 36 clients during FY 2007-2008.

A description of the pilot project's stages follows. A more detailed description of each stage can be found in Rutkowski (2009).

Pilot Project Stages

Stage 1: Pre-Work (September 2007 to February 2008)

Informational Meeting
In September 2007, the PSATTC and LA County ADPA convened a three-hour Informational Meeting for addiction treatment providers in Los Angeles County to introduce them to the principles of process improvement. More than 100 treatment and recovery program Executive Directors were personally invited to attend the meeting. A neutral, centrally located facility was chosen.

Orientation Meeting
Executive Sponsors who agreed to participate in the phase II process improvement project were invited to an Orientation Meeting. The goal of the meeting was to stress the importance of the CEO/agency director making a commitment to the project in terms of time and personnel. Planned activities and support services were clarified and pre-work assignments were distributed.

At this three-hour Orientation Meeting, participants were asked to do the following to prepare for project implementation:

- Assign an Executive Sponsor who will support the project by making it an agency priority, remove barriers, and participate directly when necessary;
- Assign a Change Leader who will provide daily leadership, keep the project organized, and assure that the Change Team continually worked to achieve improved results.
- Conduct an agency walk-through to identify potential improvements to existing agency procedures utilized during the assessment, admission, and active stage of the treatment process.
- Develop a baseline through the compilation of existing client data or collection of new data over two months of the following information: total number of admissions, wait-time from initial contact to admission; intake/assessment appointment no-show rates, and 30- and 60-day client continuation rates (defined as the percentage of clients participating in at least one face-to-face session per week).

Stage 2: Kick-off Workshop (late-February 2008)

The pilot project officially commenced on February 26, 2008 at an all day workshop. The goals of the workshop were to: (1) describe the concepts underlying a structured improvement process and the use of a rapid cycle change strategy; (2) explain how to identify and prioritize improvement needs based on existing data and the experience of conducting an agency walk-through; and (3) create a Quick Start Road Map to initiate service improvements, which includes the collection of and ongoing use of data in change project decision-making.

Participants were given several opportunities to network with representatives from other treatment agencies, as well as with the workshop facilitators. The site visits and monthly conference calls that would follow in future months were scheduled, and participants left the workshop with many of the tools[46] necessary to initiate change projects.

Stage 3: Change Project Implementation (March 2008 – October 2008)

Throughout the course of the pilot project, Change Teams from each participating agency conducted one or more process improvement rapid Plan-Do-Study-Act (PDSA) cycles aimed at one of the four NIATx aims (reducing wait time; reducing no-shows to assessment/intake, increasing admissions, and improving continuation rates). Most of the agencies used the month of March to finalize their Change Teams and brainstorm potential change projects. Actual implementation of initial change projects mostly occurred on or around April 1, 2008. Pilot organizations were expected to start a project

[46] Participants were provided with several handouts, including: a primer on process improvement, reprints from the NIATx website (measuring change, conducting an agency walk-through, recommended practices for no-shows and continuation, role of the executive sponsor and change leader), change project reporting form, client-specific tracking worksheet, timeline of activities, and Quick Start Road Map.

focused on one of the four aims until they achieved their target improvement. Thereafter, agencies could decide to focus their efforts on one or more additional aims (such as improving continuation rates at 30 and/or 60 days following admission).

Agency site visits were held in mid-March, just prior to the start of change project implementation. Five monthly Change Leader conference calls, two Executive Sponsor conference calls, individual data coaching conference calls, and a Change Leader Face-to-Face Meeting were held during the project implementation stage.

Stage 4: Completion Conference (October 2008)

On October 20, 2008, the Change Teams from each agency were invited to a full-day Completion Conference. The purpose of the event was two-fold: (1) to celebrate the successes of each Change Team (by reporting on a change project that led to improvements in client engagement/access and/or retention/continuation); and (2) to share ideas, strategies, and recommendations regarding the continuation of process improvement strategies within Los Angeles County and sustainability of the current change projects.

Pilot Project Data Collection

All participating agencies were asked to collect and submit a monthly Microsoft Excel client tracking spreadsheet and a Microsoft Word change project reporting form to the LA County ADPA project staff, who compiled necessary client/program information to monitor progress and to troubleshoot potential implementation issues. An emphasis was placed on ensuring data were collected consistently and that high quality data were submitted each month. In addition, technical assistance was provided at the start of the project, as well as throughout the change project implementation stage to assist Change Team Members in troubleshooting problems with the data collection tools and helping to ensure that those responsible for collecting the PDSA change cycle data had the support they needed to continually improve the quality of information submitted.

The tracking worksheet included several graphs/figures that agencies could print out and use during Change Team meetings to illustrate the impact of the changes that were being tested.

The change project reporting form was designed to assist Change Teams in keeping track of their various change projects throughout the course of the project implementation period. The form includes a series of tables that are meant to be updated and added to on an ongoing basis. The first table includes basic information on the project (title, aim addressed, level of care, Change Leader, Team members, and other unanticipated impacts). The second table includes the details of the change project including the rapid cycle number, the cycle start date, and the "plan," "do," "study," and "act" details. The third table outlines project outcomes (project stop date, what the team learned form the change effort, and financial impact) and sustainability plan, if the team decided to sustain the project (including the sustain leader, the steps being implemented to assure the

change is sustained, the monitoring system, and the point at which the team would intervene to get the project back on track).

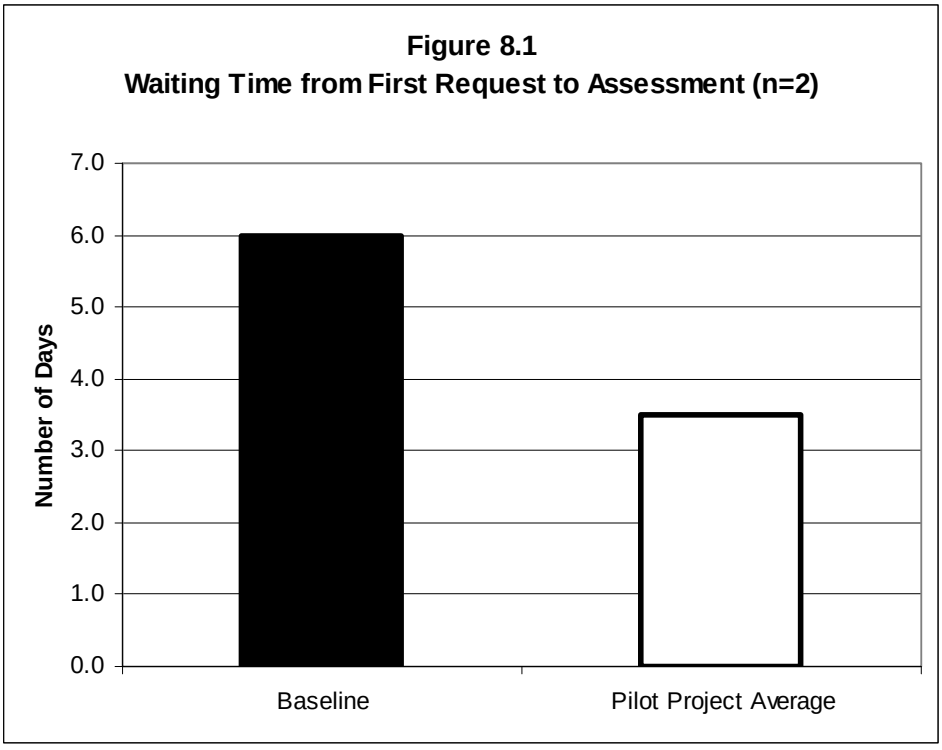
Pilot Project Aggregate Results

Over the course of the project, all teams were able to show at least a modest improvement in their chosen aim(s) according to the data they collected; more than half of the change teams either met or exceeded the target objective they set during change project planning. The following section highlights the numerous innovative strategies utilized by change team to address one or more of the four NIATx aims, and the resulting improvements in client engagement and retention. Greater detail on individual treatment-program results are reported in Rutkowski (2009) and will be detailed in a future report.

Strategies to decrease waiting time from initial contact to assessment/intake appointment

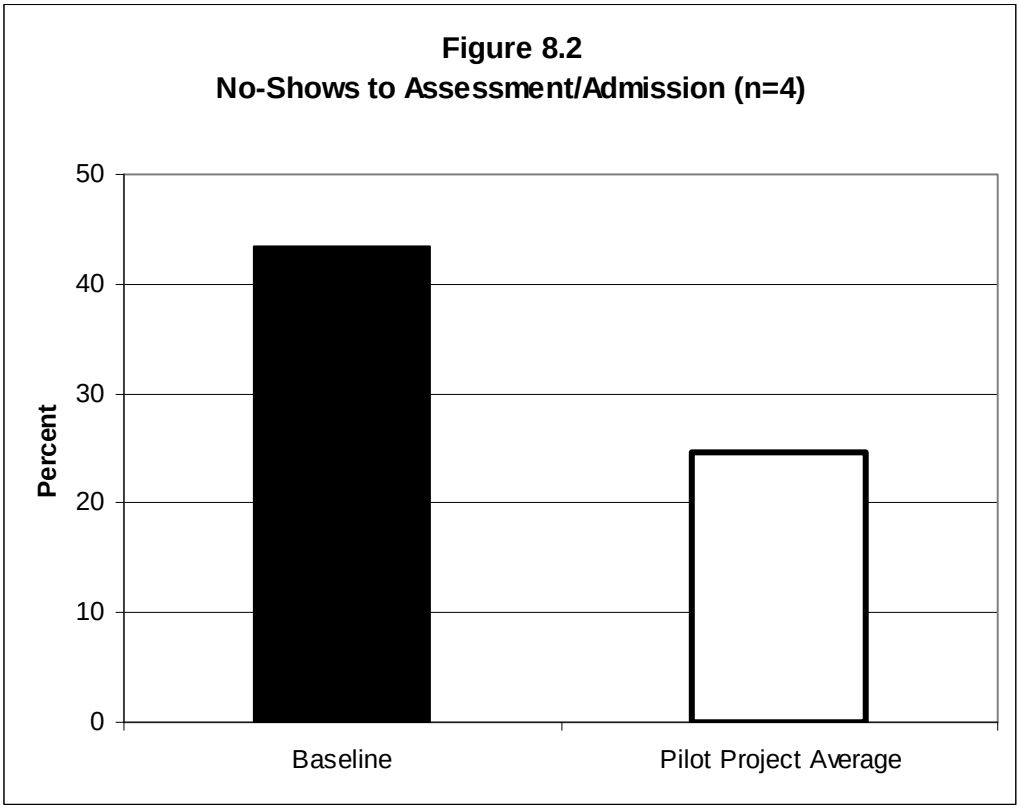
The average baseline waiting time for the two teams that chose to focus on waiting time was 6.0 days. Over the course of six months, the average waiting time decreased to 3.5 days, which represents a 42.2% improvement over baseline (Figure 8.1). The change teams implemented a variety of strategies in their pursuit of their goal, which included (1) combining two pre-assessment phone interviews into one so that a single interview could be scheduled upon first contact; (2) making in-house residential program assessments more available by opening up the program manager's schedule; (3) offering walk-in assessments; and (4) offering in-home assessment appointments (whereby a case manager would visit the prospective client's home to complete the initial assessment paperwork).

Figure 8.1
Waiting Time from First Request to Assessment (n=2)



Strategies to decrease no-shows to intake, assessment, or admission appointment

The average baseline no-show rate for the four teams that chose to focus on assessment or admission no-shows was 43.5%. Over the course of six months, the average no-show rate decreased to 24.6%, which represents a 43.5% improvement over baseline (Figure 8.2). The change teams implemented a variety of strategies, which included (1) engaging prospective residential clients while on the waiting list by making daily check-in calls; (2) making reminder calls the day before a scheduled assessment appointment and offering to reschedule, if needed; (3) offering bus tokens for clients to return home upon completion of an intake appointment; (4) implementing an open intake system whereby slots are made available three times weekly for walk-ins; (5) altering intake and assessment appointment times to allow clinicians enough time to complete all paperwork; and (6) assigning clients to a group schedule with their primary counselor at the time of intake and allowing the primary counselor to complete the assessment.

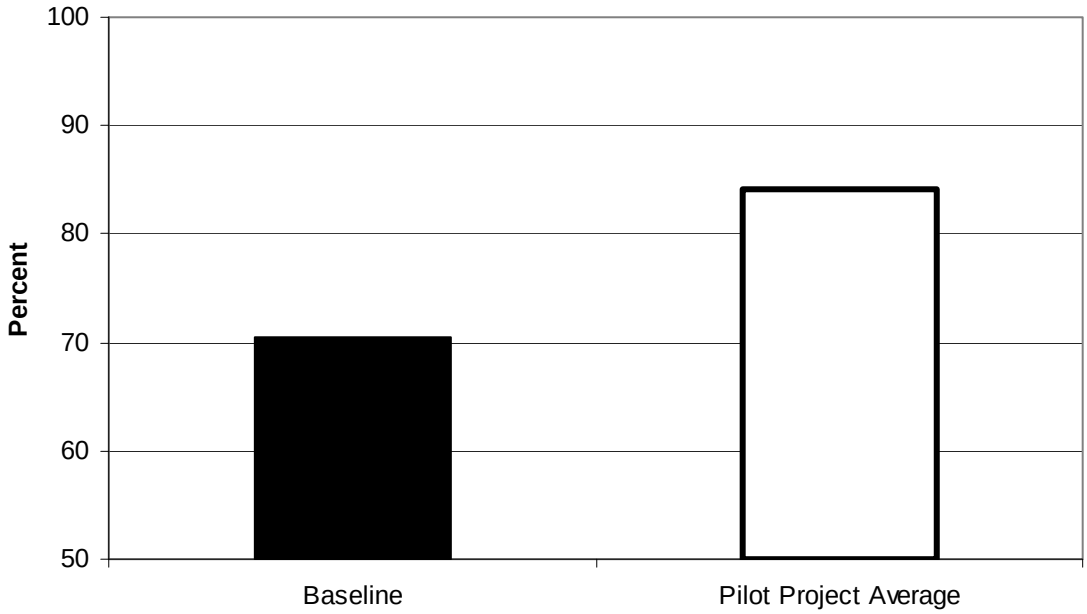


Strategies to increase post-admission session-by-session attendance

The average baseline attendance rate for the three change teams that chose to focus on increasing post-admission session-by-session attendance (e.g., both group and one-on-one sessions) was 70.6%. Over the course of seven months, the average attendance rate

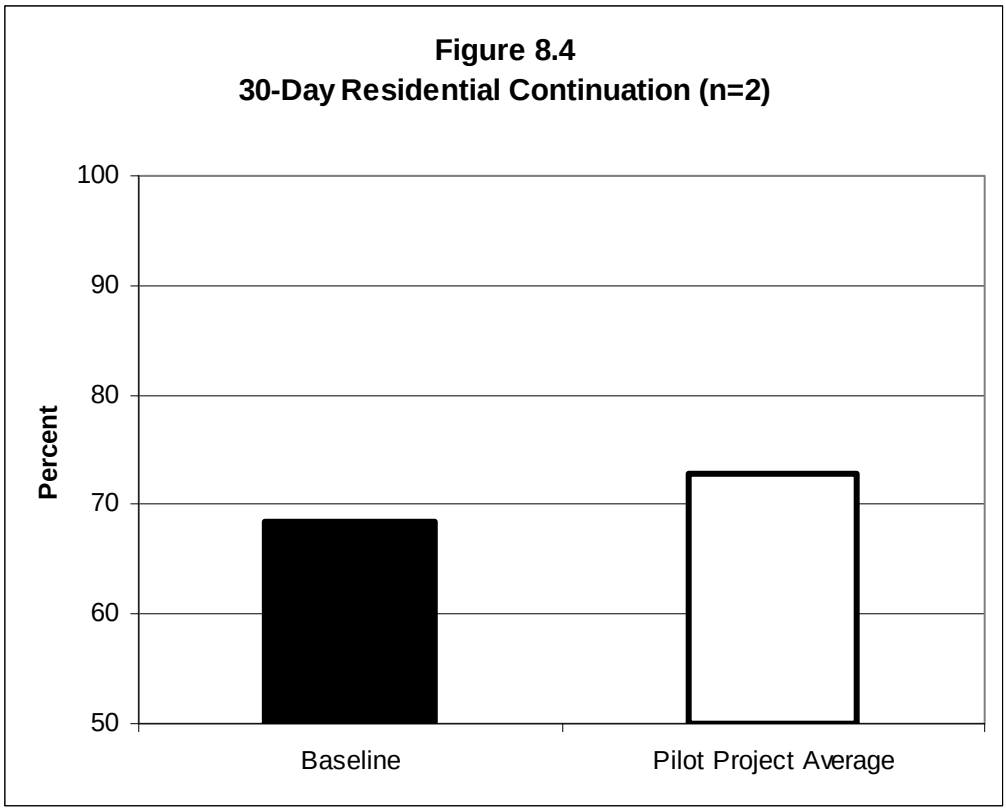
increased to 84.1%, which represents a 19.1% improvement over baseline (Figure 8.3). The change teams implemented a variety of strategies, which included (1) providing clients with a weekly schedule of group and individual session appointments; and (2) calling clients the day before a scheduled group or individual session to remind them of their appointment.

Figure 8.3
Post-Admission Session-by-Session Attendance (n=3)



Strategies to increase 30-day continuation in a residential setting

The average baseline 30-day continuation for the two teams that chose to focus on increasing overall performance on this measure was 68.5% of clients. Over the course of seven months, the average continuation rate increased to 70.6%, which represented a 6.4% improvement over baseline (Figure 8.4). The change teams implemented a variety of strategies, which included (1) meeting with clients once a week for four weeks to see how they are doing in treatment and administering a questionnaire at the last meeting (week four) to ask clients for feedback on what could approve their experience; (2) adjusting meal, mail, and medication times to better accommodate clients' schedules; and (3) establishing a welcome/orientation group whereby a staff member from five different departments meets with each new client for the first five days of treatment to provide information and answer questions.



Pilot Project Lessons Learned

The project provided several agencies who volunteered staff time (with no outside financial assistance) the opportunity to interact in a non-competitive way to share ideas and help one another learn from the experiences of others. Throughout the project, the participants were given the opportunity to share their impressions of process improvement in general, as well as how process improvement strategies could be adopted by their respective agency to improve the treatment experience of their clients.

At the October 2008 Completion Conference, participants were asked to submit a quote relating to anything about the phase II pilot project (e.g., Change Team meetings, the use of data to inform change decisions, rapid cycle change projects, etc.) that was relevant to them and that they believed would be useful to future pilot project participants. The following are the testimonials/quotes collected during the Completion Conference. Names are included if they were provided by the participants:

"SHIELDS' motto is: (1) ***believing****: we believe that there is always room for improvement; (2)* ***building****: the Process Improvement Pilot Project gave us the tools to build a stronger foundation…; (3)* ***becoming****: becoming a 'team' for 'change' and working together to move forward to improve the way we service our participants has improved because of NIATx."* ~Charlotte Mims, SHIELDS Change Team Member

"There were lots of different inputs and it took some time to get it right…but it was and is a good project. It works."

~Anonymous

"Process Improvement protocols have had implications for policies and procedures beyond any current project. [We were] guided by NIATx to implement a simple intervention that resulted in enhanced patient engagement, retention, and treatment success. On behalf of our agency and clients, thank you."

~Stewart Sokol, Tarzana Treatment Centers, Inc. Change Leader

"This was such a wonderful experience for not only our treatment facility, but for me personally. Change in my professional and personal life is always a challenge and this showed me an effective way to jump start a change, see the results, and motivate me to continue to evolve."

~Anonymous

"We were given permission to break away from old 'traditional' ways of doing things. As a result, each Change Team Member feels responsible for contributing to a 'change' to our program that brings success. Small change = big success!"

~Anonymous

Sustainability and Next Steps

During the October completion conference, participants were asked to respond to the question "where do we go from here?" Attendees were asked to prepare for such a discussion and came to the conference equipped with many constructive recommendations, which are listed below:

- Do not separate data entry and completion report people at the Kick-Off Workshop. You should teach each Change Team member about data collection and key roles;
- Make data entry more automated, which includes programming the data sheet to automatically update weekly client continuation until a discharge date is entered;
- Make the client tracking spreadsheet easier to print out;
- LA County ADPA should do its own process improvement project to improve its interaction with its clients;
- The project was valuable in that it brought together agency representatives from around the County to tell LA County ADPA where it can improve;
- Combine data tracking with the County billing system;
- Continue with the conference calls because they are helpful and motivating
- The site visits were very valuable;
- Make the pilot project longer;
- Give agencies with multiple participating sites equal representation—do not combine them as if they were one agency with only one site.

Participants were then asked what LA County ADPA could offer to agencies to help sustain change. Responses included the following:

- More staff are needed;
- Technical assistance with data collection is needed;
- Receiving data from the county;
- Support for the process, which might include a point person to bring together the agencies that are working on the same problem;
- The development of a team of professionals by the county;
- A network of providers that could serve as peer mentors;
- An annual County-sponsored event for learning and sharing.

Evaluation of the Phase II Process Improvement Pilot Project

In January-February 2009, a UCLA team conducted a series of semi-structured phone interviews with Executive Sponsors, Change Leaders, and Change Team Members to evaluate the phase II pilot project to gather information that could be used to improve future training and technical assistance offerings around process improvement. In total, 10 Executive Sponsors, 12 Change Leaders, and 12 Change Team Members participated in a 20-30 minute phone interview. The team is currently in the process of coding and analyzing the data to prepare it for formal publication. Final results will be shared in a future Prop 36 evaluation report.

While the results of these interviews are not yet available, following the Phase I pilot project, a more limited set of focus group interviews yielded the following findings (for more detail, see Rutkowski and Urada, 2008).

- Programs generally maintained some or all of the changes that had been made during the pilot project.
- Programs reported that the pilot project had changed their general perspective on treatment.
- Some changes continued to be made, but they were not always being systematically tested.
- Staff movement and turnover tended to disperse the Change Teams, representing a major barrier to sustained effort.
- All three groups reported that the changes had spread to other parts of their program.
- Participants in the pilot program reported that guidance from the Project Director and Process Improvement Coach were instrumental in their success, and that in particular technical assistance with data collection was a key element.

Conclusions and Recommendations

Similar to the phase I project, the phase II pilot project generally resulted in successful changes at the participating programs.

Statewide, awareness of NIATx and use of process improvement methods increased dramatically between 2007 and 2009. It is difficult to gauge the actual statewide effect of

NIATx on show rates, completion rates, and time in treatment, however, due to other changes occurring at the same time. During this period Prop 36 offenders treatment show rates appeared to decrease while treatment completion rates and time in treatment among treatment completers increased (see Chapters 1 and 2), but substantial changes in the data systems contributing to these measures as well as innumerable other confounding factors makes it impossible to say whether these trends are all real and if so what portion of these changes may be attributable to adoption of NIATx methods.

The speed of the spread of the NIATx methods that has occurred statewide is simultaneously encouraging and unsettling. The scientific literature and prior focus group comments suggest that process improvement efforts can be ineffective, frustrating, and/or a waste of resources if implemented incorrectly (Rutkowski and Urada, 2008). Therefore, efforts must be made to both sustain successes and guard against the spread of partial or altered NIATx methods could eventually lead to negative results or perceptions.

The two Los Angeles pilot projects have demonstrated that when properly and fully implemented, with proper levels of support, NIATx process improvement methods can produce substantial benefits at relatively low cost. The success of these methods in reducing no-show rates and increasing treatment continuation show promise in addressing these key areas of concern in Prop 36.

References:

Langley, G., Nolan, K., Nolan, T., Norman, C., & Provost, L. (1996). The model for improvement. In The improvement guide: A practical approach to enhancing organizational performance (3–11). San Francisco: Jossey-Bass Publishers.

Rutkowski, B. (2009). The Los Angeles County Process Improvement Pilot Project, Phase 2 Project Implementation Guide and Final Report. Manuscript in preparation.

Rutkowski, B., & Urada, D. (2008). Treatment Process Improvement Methods and their Application to Proposition 36. In: Evaluation of the Substance Abuse and Crime Prevention Act 2008 Report. 125-157. Retrieved from: http://www.uclaisap.org/prop36/documents/2008%20Final%20Report.pdf

Chapter 9: Narcotic Treatment Programs

Bradley T. Conner, Ph.D., Vicky Album, M.Sc., and Jeremy Hunter, M.A.

Prop 36 has resulted in positive outcomes for a significant proportion of participants in terms of drug treatment completion, reduced drug use and recidivism, and increased employment (see Chapter 2), however despite these gains, there are notable differences in outcomes among Prop 36 sub-groups with some of the poorest outcomes being observed among opiate users. A primary reason for poorer outcomes among Prop 36 opiate users is the limited use of narcotic treatment programs (NTP).

An alarming trend in drug use patterns over the past 10 years is the rapid increase in the abuse of opiates other than heroin. Heroin use is declining while the illicit use of non-heroin opiates is on the rise. Non-heroin opiate abuse is typically abuse of prescription opiates, such as oxycontin, darvocet, and vicodin. Illicit use of non-heroin opiates is typically abuse of prescription opiates, such as oxycontin, darvocet, and vicodin. These drugs, when used properly, are effective at alleviating or managing pain. However they also have high abuse and dependence liability because of the feelings of euphoria they induce when taken at high doses. Adolescents and young adults are most at-risk for prescription opiate abuse and dependence.

Very few Prop 36 opiate users receive placement in NTP. The use of NTPs in Prop 36 has decreased steadily over the past three years. Only about half of the counties reported referring Prop 36 participants to NTPs. In Fiscal Year 2005-06, 16.5% of Prop 36 opiate users received NTP, decreasing to 13.5% in 2006-07, and then down even further to 11.8% in 2007-08. Prop 36 opiate users who received NTP maintenance had the greatest reductions in their opiate use from treatment intake to discharge when compared to opiate users who received outpatient drug-free or non-NTP detoxification treatment.

Prop 36 opiate users who appeared more stable at intake were more likely to receive detoxification or outpatient drug-free drug treatment, whereas those with unstable living arrangements, poor social support and family conflict were more likely to be placed in more intense treatments, NTP maintenance and residential drug treatment.

To improve treatment outcomes among Prop 36 opiate users, the provision and utilization of NTPs must be enhanced. NTP should be available to all Prop 36 opiate users regardless of county of residence. UCLA recommends the use of buprenorphine as an alternative to methadone especially in counties where methadone is unavailable.

With the current rise in prescription opiate abuse, especially among adolescents and young adults, it is likely that the number of opiate users in Prop 36 will continue to increase in the coming years. While NTPs may not be the appropriate treatment placement for every Prop 36 opiate user, NTPs are important tools in the treatment of opiate dependence.

Prop 36 has resulted in positive outcomes for a significant proportion of participants in terms of drug treatment completion, reduced drug use and recidivism, and increased employment (see Chapter 2), however despite these gains, there are notable differences in

outcomes among Prop 36 sub-groups with some of the poorest outcomes being observed among opiate users. A primary reason for poorer outcomes among Prop 36 opiate users is the limited use of narcotic treatment programs (NTPs). UCLA has reported previously that although NTPs have consistently been found to be effective at treating opiate dependence, only a minority of opiate users within Prop 36 are referred to these programs (Conner, 2008). This chapter will first provide background information on opiate use and the medications and treatment modalities used to treat opiate[47] dependence in. Then it will provide updated data on the use of narcotic treatment programs in Prop 36. It will conclude with specific recommendations for improving outcomes among Prop 36 participants who indicate that an opiate is their drug of choice (referred to hereafter as primary drug).

Opiate Use

It is estimated that 106,000 individuals 12 years old or older tried heroin for the first time in 2007 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2008). It is also estimated that 2.1 million individuals 12 years old or older illicitly used a prescription painkiller in 2007. These data present an alarming trend in drug use, while heroin use is on the decline the illicit use of non-heroin opiates is actually on the rise (SAMHSA 2008). Illicit use of non-heroin opiates is typically abuse of prescription opiates, such as oxycontin, darvocet, and vicodin. These drugs, when used properly, are effective at alleviating or managing pain. However they also have high abuse and dependence liability because of the feelings of euphoria they induce when taken at high doses.. Adolescents and young adults are most at-risk for prescription opiate abuse and dependence.

In 2006, treatment centers had more than 466,000 admissions for heroin dependence (SAMHSA, 2007). Admissions for primary abuse of and dependence on opiates other than heroin increased from 1% of all drug treatment admissions in 1997 to 5% in 2007 (SAMSHA, 2008). Data indicate that as many as 840,000 adolescents ages 12-17 currently abuse prescription drugs, making this illegal drug category the second most abused next to marijuana (SAMHSA, 2006).

Pharmacological Treatments

There are two primary types of medications used to treat the effects of opiates in the body, opioid agonists and opioid antagonists. Opioid agonists bind to opioid receptors present in the brain and throughout the rest of the central nervous system (CNS) and produce analgesic (pain relief) and euphoric (pleasure) effects. Heroin is an opioid agonist, as are the three medications used to treat heroin dependence. Opioid antagonists also bind to the opioid receptors in the CNS but they do not typically produce analgesia or euphoria. When an antagonist has been taken it prevents the person from experiencing the effects of opioids and opiates. In other words, when an antagonist is present a person cannot get "high" from using heroin.

[47] The terms opioid and opiate will be used throughout this chapter. Opioid will be used when referring to chemicals that occur naturally in the human brain. Although the term opiate is often used as a synonym for opioid, it is more properly limited to natural opium and any substance that includes natural opium, such as diacetylmorphine (heroin), hydrocodone, and oxycodone and will be used to refer to these compounds. Fully synthetic substances, those that do not contain opium, are referred to as synthetic opioids.

Agonists and antagonists can be full or partial. Full means that they bind completely to opioid receptors. When they are partial they bind only partially, leaving room for other compounds to bind and induce their effects. In other words, a person can still feel high when using heroin when they are also taking a partial antagonist. When both a full agonist and partial agonist are present, the partial agonist acts as a competitive antagonist, competing with the full agonist for receptor occupancy and producing a net decrease in the receptor activation observed with the full agonist alone

Agonists

Two full μ[48]-opioid agonist medications, methadone and Levo-Alpha-Acetylmethadol (LAAM), and one partial μ-opioid agonist medication, buprenorphine, have the approval of the U.S. Food and Drug Administration (USFDA) to be used as narcotic replacement medications for detoxification and maintenance treatment of opiate use disorders. Of these medications, methadone is the most widely used. Methadone was first developed in Germany prior to World War II as an analgesia and first used as a treatment for opiate dependence in the 1950s (Joseph et al., 2000). LAAM, a longer-acting medication than methadone, was approved for treating opiate dependence in 1993 (USFDA, 1993), however, manufacture of LAAM was discontinued in 2003 (USFDA, 2003). Both methadone and LAAM, according to Federal (SAMHSA, 2001) and State (California Health and Safety Code 11839-11839.22) regulations, must be administered under very specific conditions and in highly controlled environments. More recently, buprenorphine has also been approved to treat opioid dependence (USFDA, 2002). Research on the efficacy and effectiveness of NTP has been ongoing since the 1950s. Joseph and colleagues (2000) provide a comprehensive review of the research on methadone maintenance. Longshore and colleagues (2005) and Anglin and colleagues (2007a & b) provide results of a randomized clinical trial and a comprehensive review of the research on LAAM maintenance. Ling and colleagues (1998) provide the results of a randomized clinical trial of buprenorphine maintenance. All three medications have been shown to be effective in the treatment of opiate dependence.

The Drug Enforcement Administration (DEA) has listed Buprenorphine as a Schedule III drug whereas methadone and LAAM are Schedule II drugs (United States Department of Justice, Drug Enforcement Administration, 2007). Schedule III drugs have an accepted medical use and less potential for abuse or dependence than Schedules I and II drugs. Schedule III drugs are available only by prescription, though control of wholesale distribution is somewhat less stringent than Schedule I and II drugs. Prescriptions for Schedule III drugs may be refilled up to five times within a six month period. Conversely, Schedule II drugs have a high tendency for abuse and can produce dependency with chronic use. These drugs may have an accepted medical use and are only available by prescription. Distribution is carefully controlled and monitored by the DEA. Schedule II drugs are also subject to production quotas set by the DEA. As a result, these drugs require more stringent records and storage procedures than drugs listed on Schedules III and IV, however the DEA has imposed similar records and storage procedures for buprenorphine, though it is a Schedule III substance. Because buprenorphine is a Schedule III drug, it has approval to be delivered through a doctor's

[48] μ (mu) refers to the type of opiate receptors upon which these drugs act.

office, rather than a licensed clinic, as long as the doctor has a valid license to prescribe Schedule III controlled substances (this qualification is discussed in detail later in this chapter). Federal regulations also allow certified methadone maintenance programs to prescribe buprenorphine (SAMHSA, 2003), though participants that receive buprenorphine through a methadone clinic must meet the typical federal and state requirements for patients who attend these clinics, which eliminates some of the benefits of using a Schedule III substance rather than a Schedule II substance.

Antagonists

Naltrexone and Naloxone are commonly used opioid antagonists. Naltrexone completely blocks the effects of opiates and opioids. It is commonly used to treat both alcohol and opiate dependence. When a person takes Naltrexone as part of a treatment regime for opiate dependence, they do not report experiencing cravings for opiates and they do not feel the analgesic or euphoric effects of the opiate. Naloxone is used to counteract life-threatening depression of the central nervous system and respiratory system that occurs when a person has overdosed on opiates or synthetic opioids. Naloxone is a fast acting antagonist with high opioid receptor affinity, meaning it will replace a compound of lower affinity already present. It often produces immediate withdrawal symptoms by dislodging the opiate agonist that is present (e.g., heroin) and binding to the opioid receptors. This process will also counteract the effects of heroin overdose.

Suboxone

Suboxone is a combination of buprenorphine and Naloxone. It is used in the maintenance treatment of opiate dependence. Suboxone is a sublingual tablet (a tablet that is placed under the tongue to dissolve). When taken as directed the buprenorphine in Suboxone acts as a partial agonist preventing withdrawal symptoms and partially occupying opioid receptors while the low dosage of Naloxone has no effect. If the Suboxone, however, is dissolved and injected the Naloxone will block the effects of the buprenorphine and induce withdrawal symptoms. This combination may be preferable to buprenorphine alone (known as Subutex) in a maintenance paradigm as there is the potential to abuse buprenorphine by cutting it up and snorting it or dissolving and injecting it.

Narcotic Treatment Programs (NTPs)

Opiate dependence treatment is typically delivered using two different paradigms. The first is detoxification, which is the administration of an opioid agonist for a specified amount of time (typically 10, 14 or 30 days) starting with a large dosage and tapering the dosage amount until it reaches zero. The goal is abstinence from opiate use. The second paradigm is maintenance, which is long-term treatment of opiate dependence with an opioid agonist. The basic rationale of maintenance treatment comes from medical, public health, and harm reduction perspectives. The underlying principles are that some people are simply unable to stop using opiates, due in part to physiological changes in the brain that are relatively permanent, and that both the individual and society will benefit if these individuals are switched from using illicit drugs to legal drugs obtained under the supervision of physicians and sanctioned treatment clinics. Under the maintenance treatment paradigm there is no defined treatment cessation date, treatment is ongoing and

only ends at the patient's request, if the patient excessively violates regulations or clinic policies, or if the patient is unable to pay and has no access to public funds.

In 1997, the National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction unequivocally stated that maintenance treatment as part of a comprehensive NTP is the most effective means of treating opiate dependence (NIH Consensus Development Program, 1997). Since then there has been ongoing support from the field for the use of maintenance treatments (American Methadone Treatment Association, Inc., 2004; Mathias, 1997; National Institute on Drug Abuse, 1999). As such this chapter will focus on maintenance rather than on detoxification as the recommended treatment for Prop 36 participants who are dependent on opiate (hereafter NTP refers to a maintenance program unless otherwise noted).

The primary goals when administering maintenance medications are to:

- relieve narcotic craving
- suppress opioid withdrawal syndrome for 24–36 hours
- block the effects of administered heroin
- develop tolerance to the euphoria, sedation, or other narcotic effects of opioid medications which impair day-to-day functioning, emotional responses, or perception while improving functional status
- develop tolerance to the analgesic properties of the medications

Individuals receiving methadone in an outpatient clinic typically visit the clinic on a daily basis to receive their medication. Under its original design the individuals would stay at the clinic and participate in ancillary services such as drug testing, individual therapy, group counseling, and vocational training. While this is not always the case in the current funding era, ancillary services should be a fundamental part of any NTP for optimal benefits to be achieved.

With the approval of buprenorphine as a Schedule III heroin replacement drug there is the possibility of a loss of the ancillary services component of NTPs. Individuals receiving buprenorphine from a certified provider see a doctor at the doctor's office to obtain a prescription. Appointments can range in frequency from once per week to once per month, with the typical cycle being one appointment every 13 days. Clients are not required to receive ancillary services as part of this treatment program. The rule on NTP programs that also provide buprenorphine is that clients receiving buprenorphine must meet the same conditions as those receiving methadone. This means that methadone clinics that provide comprehensive ancillary services may still be the best providers of narcotic replacement therapy.

In the state of California, NTPs may be paid for privately or publicly. To assist with payment for services rendered to individuals who are unable to pay, federal, state, and local funds are distributed to the NTPs through county and direct provider contracts. Funding sources also include Medi-Cal and third- party payers such as private insurance companies.

NTP in Prop 36

Data from the California Outcomes Measurement System (CalOMS) indicate that from July 2006 to June 2007 there were approximately 29,086 individuals referred to treatment for opiate abuse or dependence. From July 2007 to June 2008 this number rose to 29,989. These numbers represent individuals seeking treatment voluntarily, individuals referred to drug treatment by non-Prop 36 California criminal justice systems, and Prop 36 participants.

UCLA collected information on NTP practices in Prop 36 from a survey of court administrators (see Appendix A). Analysis of the data from the 21 court administrators who responded suggested that the role of the court in assigning individuals to receive NTP varies widely across the state. On this survey administrators were asked "*Did the court(s) ever assign Prop 36 opiate users to Narcotic Replacement Therapy? (for example, methadone maintenance, Suboxone, buprenorphine. Do not count detox-only)"*. Responses indicated that the court assigned Prop 36 opiate users to NTP in 52.4% (11) of the 21 counties across the state that responded. Table 9.1 presents the breakdown of court criteria for placement in NTP. All of the court administrators that responded that NTP was assigned indicated that the decision was based on assessor's recommendations. Six of the court administrators indicated other criteria as well.

Table 9.1: Court Criteria for NTP Placement

	Number	*Percentage*
Based on assessor's recommendations	11	52.4%
At a bench officer's discretion, no formal criteria	3	14.3%
Only if drug free treatment was unsuccessful	0	0%
Only if drug free treatment was unavailable	0	0%
As the first option for treating opiate users	1	4.8%
Only if offender requests it	2	9.5%

Table 9.2 presents the breakdown of court reasons for not placing individuals in NTP. For the 47.6% (10) of administrators that reported not placing clients in NTP, 3 endorsed "Other" and their reported reasons for not placing clients in NTP as no opioid users in their counties, no requests for NTP services, just started offering services, or no money to pay for the services.

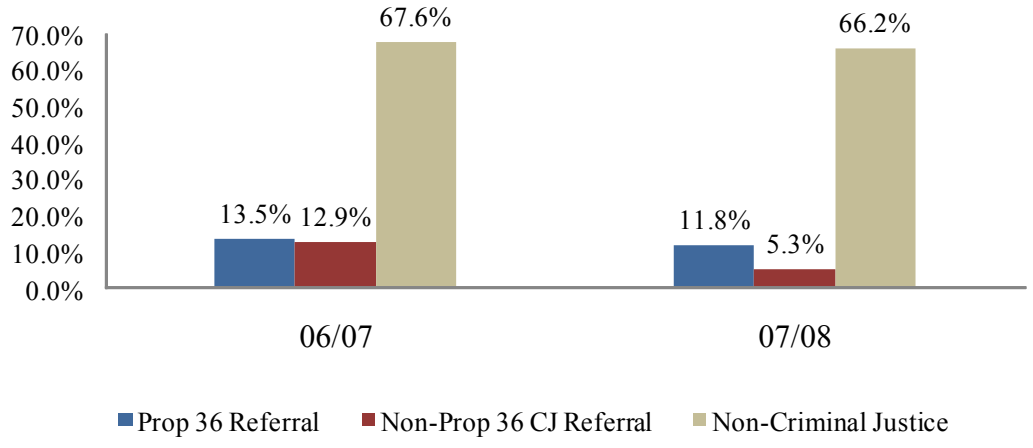
Table 9.2: Court Criteria for NTP Non-Placement

	Number	*Percentage*
Not offered to Prop 36 offenders by county policy	1	4.8%
Narcotic Replacement Therapy is unavailable in the county	3	14.3%
Philosophical opposition to Narcotic Treatment	3	14.3%
Other†	3	14.3%

† The 3 administrators that reported other stated the reasons as "presiding judge has some misgivings", "court was not asked to approve it…it does not come before the judge for formal approval", and "that is up to treatment providers"

As has been reported in the previous Prop 36 evaluation reports, NTPs have been used infrequently in Prop 36. Across the first 5 years of Prop 36, 9.7%, 12.7%, 12.9%, 16.0%, and 16.5% of Prop 36 clients who reported an opiate as their primary drug received NTP[49]. The increase in NTP placements across the years occurred primarily in the area of methadone detoxification. In contrast, across the same years, individuals seeking treatment for opioid use disorders outside of the criminal justice system received NTP between 75% and 85% of the time. In 2006 California changed the reporting system used to collect data on treatment admissions from CADDS to CalOMS. Figure 9.1 presents data on drug treatment placement among opiate users in Prop 36 from July 2006 to June 2007 and then from July 2007 to June 2008.

Figure 9.1 Percentage of Opiate Users receiving NTP by Year and Referral Source



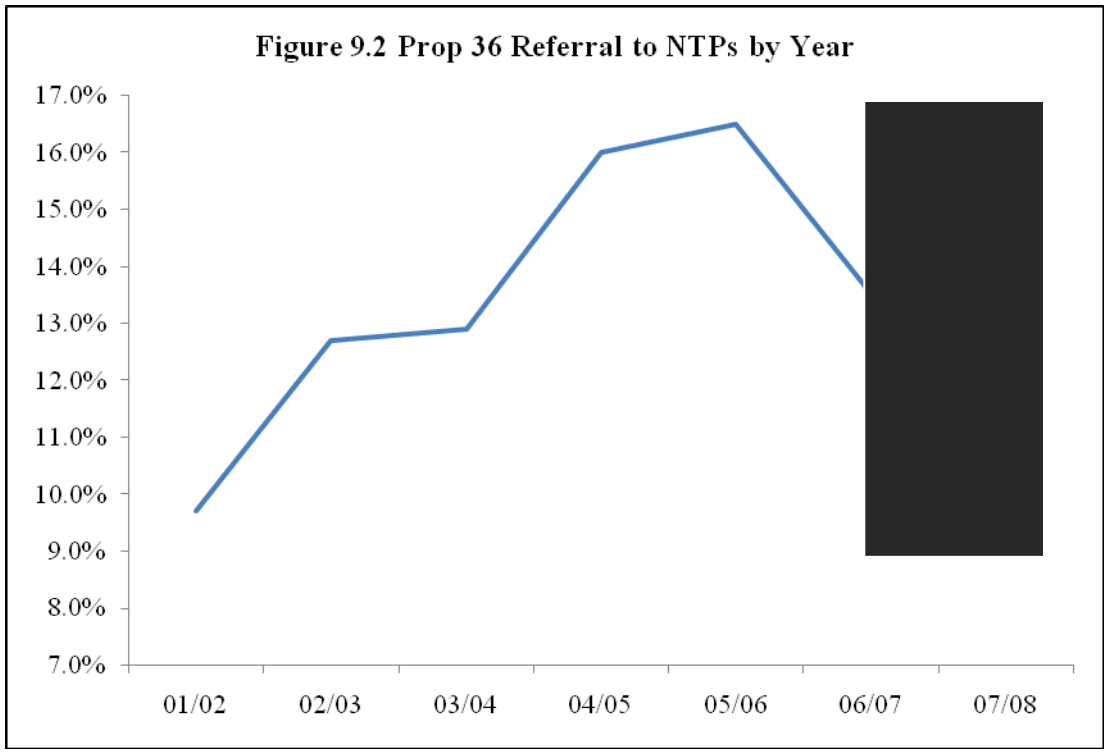
Note: Across all 3 referral sources there was a decline NTP placement for previous years, however, with the change from CADDS to CalOMS there was a significant reduction in the percentage of non-criminal justice referrals to an NTP for both years and a significant reduction in Non-Prop 36 CJ referrals in 07/08. These reductions may represent real reductions in placement or more accurate reporting with the change in data collection instruments.

Data from CalOMS indicate that, contrary to recommendations made by UCLA in previous reports to increase the use of NTPs, use of NTPs in Prop 36 is actually decreasing. Although the consistent decreases from the CADDS and CalOMS data systems across referral sources make it difficult to interpret the decrease from 16.5% in 05/06 to 13.5% in 06/07, the decrease from 13.5% in 06/07 to 11.8% in 07/08 appears to represents a real decrease in the percentage of Prop 36 participants receiving NTP because data for both years come from CalOMS (see Figure 9.2).

[49] Data come from the California Alcohol and Drug Data System (CADDS) and include all treatment admissions for Prop 36 probation or parole referrals, non-Prop 36 Criminal Justice (CJ) referrals, and all non-criminal justice referrals (including self referrals) from July 1, 2001 to June 30, 2006.

Outcomes for Prop 36 Participants with an Opiate as their Primary Drug

Data from Prop 36 eligible clients discharged during the 06/07 and 07/08 fiscal years were analyzed to determine differential outcomes based on treatment placement among Prop 36 participants that indicated that an opiate was their primary drug.

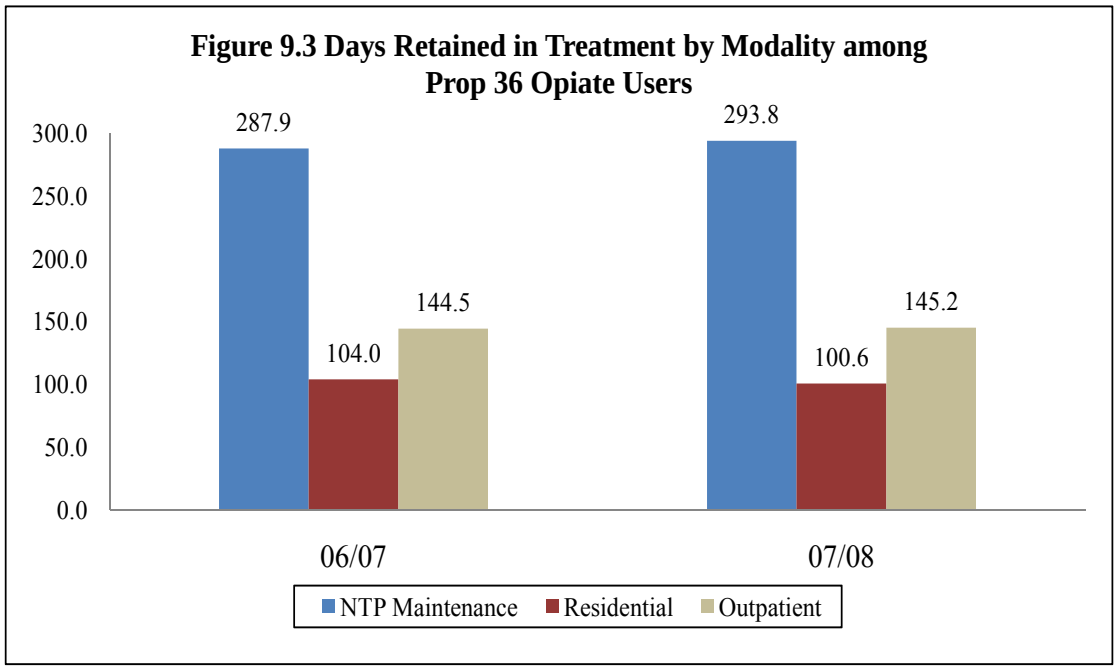


Note: The unshaded portion of the graph represents the years when date were taken from CADDS, shaded portion of the graph represents the two years when data were taken from CalOMS.

Treatment Completion and Retention

Completion rates are not the best indicator of positive outcome in NTPs, as maintenance treatment does not have a "completion" date. It is an ongoing treatment that typically lasts much longer that most other forms of drug treatment. Treatment duration is a much better measure of positive progress in treatment as keeping clients in treatment and on their medication should result in reduced illicit drug use.

Figure 9.3 presents data on the average length of time that opiate users stayed in treatment by treatment modality. These data are for all Prop 36 opiate users discharged in either 06/07 or 07/08. As seen in the figure Prop 36 opiate users spent more than twice as much time in drug treatment compared to opiate users in the other drug treatment modalities. Durations are categorized by the first treatment modality received if a client received more than one type of treatment. Although most clients receive treatment from only one modality, those who receive detoxification are more likely to have been subsequently transferred to another treatment. Additionally, as Detox is a treatment that typically occurs in a defined period of time it is not included in this figure.



Note: Days represents the average number of days that Prop 36 participants remained in drug treatment. The standard deviations for each of the means are: 06/07 NTP Maintenance SD = 298.6, Residential SD = 107.5, Outpatient SD =170.5; 07/08 NTP Maintenance SD = 329.5, Residential SD = 99.4, and Outpatient SD = 155.9.

As yet another alternative to looking at completion rates, UCLA analyzed data on the percentage of Prop 36 opiate users that completed at least 60 and 90 days of drug treatment by treatment modality (see Figures 9.4 and 9.5). Again, as detox treatments are typically time limited and less than either 60 or 90 days, data from NTP detox and non-NTP detox is not presented. Across both fiscal years there were significantly higher percentages of Prop 36 opiate users in NTP maintenance that completed at least 60 and 90 days of treatment.

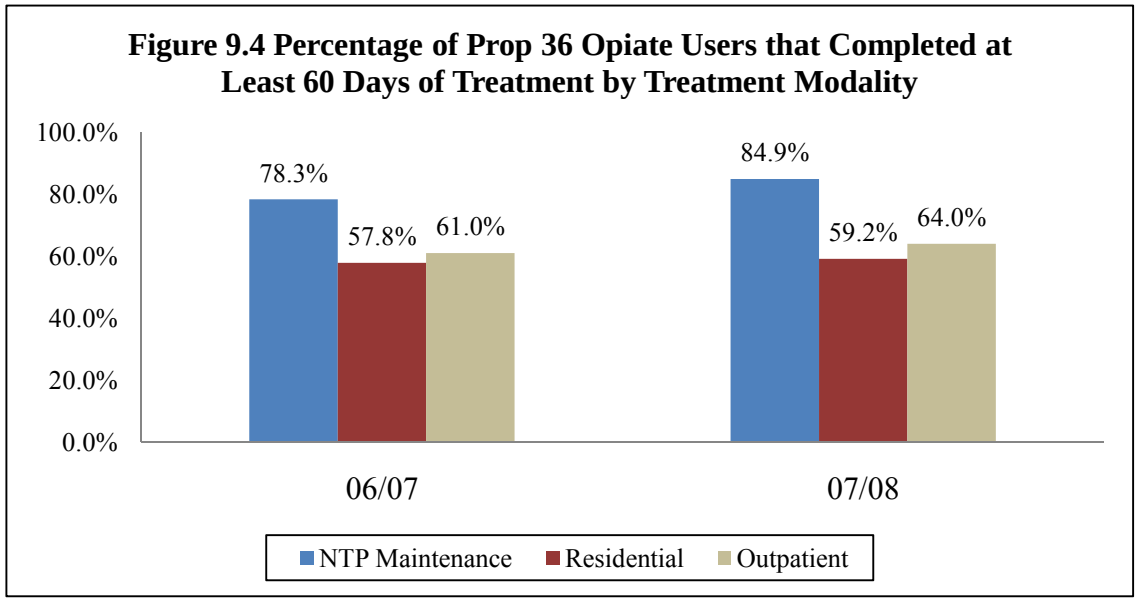
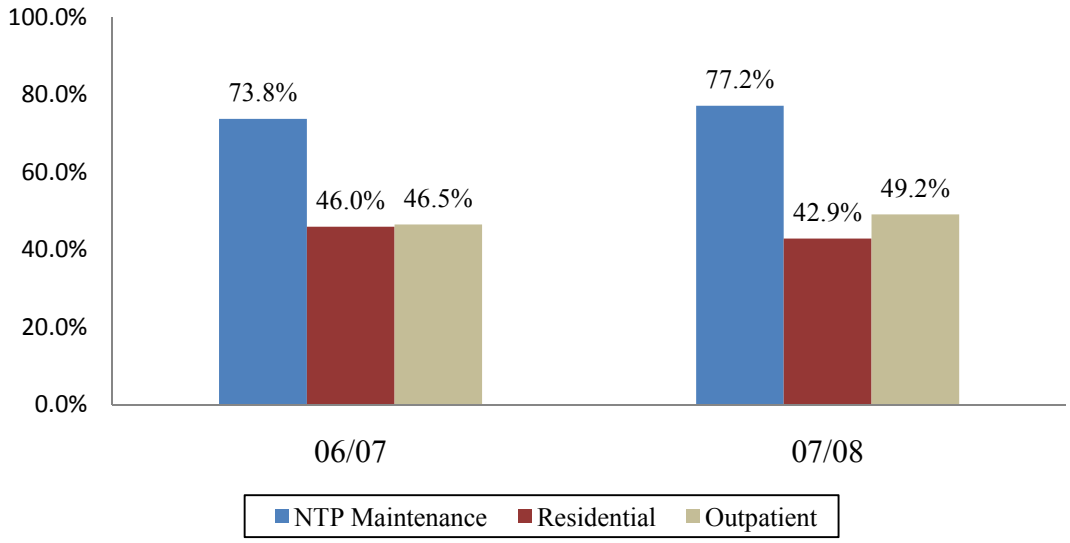


Figure 9.5 Percentage of Prop 36 Opiate Users that Completed At Least 90 Days of Treatment by Treatment Modality



The remaining outcomes measured in CalOMS are summarized in Tables 9.4 through 9.7. Data are only presented for those participants that had a discharge data listed in CalOMS. Table 9.4 presents the outcome data from fiscal year 06/07 for Prop 36 opiate users by treatment modality. Data are presented for the 30 days prior to drug treatment intake and 30 days prior to drug treatment discharge.

There were interesting differences across the different treatment modalities. There are clear differences in the patterns of opiate use of clients across the different modalities, with those attending either form of NTP being much more likely to have used an opiate in the 30 days prior to drug treatment intake than those in residential, outpatient drug-free, or non-NTP detoxification (the last 2 are represented as other in the figure) drug treatment. More than 94% of the opiate users placed in NTP maintenance or NTP detoxification had used an opiate in the 30 days prior to drug treatment intake, whereas between 58% and 62% of opiate users placed in residential and the other treatment modalities used an opiate in the 30 days prior to drug treatment intake in fiscal year 06/07. This pattern repeated in fiscal year 07/08 with 87% and 97% of opiate users placed in NTP maintenance and NTP detoxification respectively reporting the use of an opiate in the 30 days prior to drug treatment intake compared to 59% placed in residential drug treatment and 54% of those placed in other treatment modalities.

Opiate users that were employed in the 30 days prior to drug treatment intake were more likely to receive NTP maintenance than the other treatment modalities across both fiscal years. Opiate users that reported being homeless or reported being involved with the criminal justice system in the 30 drug treatment intake were more likely to be placed in residential treatment than in other treatment modalities across both fiscal years. Opiate users that reported having any amount of social support and no family conflict in the 30 days prior to drug treatment intake were more likely to be placed in either outpatient

drug-free drug treatment or non-NTP detoxification (referred to as the other treatment modalities) in 06/07. This pattern changed in that opiate users with no family conflict in the 30 days prior to drug treatment intake were more likely to be placed in NTP detoxification in 07/08. Opiate users who appeared more stable at intake were more likely to receive either of the forms of detoxification or outpatient drug-free drug treatment, whereas those with unstable living arrangements, poor social support and family conflict were more likely to be placed in more intense treatments, NTP maintenance and residential drug treatment.

Table 9.4 CalOMS Outcomes for Prop 36 Opiate Users Discharged in Fiscal Year 06/07 by Treatment Modality

	NTP Maintenance	NTP Detox	Residential	Out-patient	Detox
In the 30 Days Prior to Intake					
Incarcerated in Jail or Prison	21.1%	13.0%	49.5%	30.9%	26.5%
Used primary drug	94.4%	99.1%	61.3%	50.5%	95.4%
Employed (full- /part-time)	40.0%	8.9%	3.9%	35.3%	11.4%
Employment/school/training	42.2%	11.6%	6.9%	39.2%	11.4%
Living Arrangement					
Homeless	18.8%	30.4%	50.0%	6.2%	29.9%
Dependent living	37.5%	13.4%	32.9%	41.9%	44.0%
Independent living	43.8%	56.3%	17.1%	51.9%	26.1%
Social Support					
None	68.8%	83.0%	54.0%	50.3%	65.0%
Some	27.3%	15.2%	35.0%	39.8%	31.7%
Daily	3.9%	1.8%	11.0%	9.8%	3.3%
Any	31.2%	17.0%	46.0%	49.7%	34.9%
Family conflict	12.9%	13.0%	10.8%	6.9%	8.2%
In the 30 Days Prior to Discharge					
Incarcerated in Jail or Prison	7.0%	0%	6.3%	7.2%	2.0%
Used primary drug	47.2%	64.3%	19.1%	28.1%	65.1%
Employed (full-/part-time)	32.2%	10.7%	29.3%	43.7%	18.5%
Employment/school/training	36.7%	13.4%	37.4%	47.1%	20.7%
Living Arrangement					
Homeless	18.8%	9.8%	32.6%	6.3%	24.5%
Dependent living	35.0%	29.5%	34.8%	41.9%	41.9%
Independent living	46.3%	60.7%	32.6%	51.9%	33.7%
Social Support					
None	48.1%	53.6%	16.9%	42.7%	25.7%
Some	42.8%	41.1%	30.1%	43.6%	57.9%
Daily	9.1%	5.4%	53.1%	13.8%	16.4%
Any	52.0%	46.4%	83.1%	57.4%	74.3%
Family conflict	8.6%	4.4%	5.1%	4.0%	2.0%

Note: For the NTP Detox column there is likely overlap in the 30 days prior to intake and the 30 days prior to discharge as NTP Detox typically lasts less than 30 days.

Table 9.5 Differences in Intake to Discharge Outcomes for Prop 36 Opiate Users Discharged in Fiscal Year 06/07 by Treatment Modality

	NTP Maintenance	NTP Detox	Residential	Out-patient	Detox
Change from the 30 days prior to intake to the 30 days prior to Discharge					
Incarcerated in Jail or Prison	-14.1%	-13.0%	-43.2%	-23.7%	-24.5%
Used primary drug	-47.2%	-34.8%	-42.2%	-22.4%	-30.3%
Employed (full-/part-time)	-7.8%	1.8%	25.4%	8.4%	7.1%
Employment/school/training	-5.5%	1.8%	30.5%	7.9%	9.3%
Living Arrangement					
Homeless	0.0%	-20.6%	-17.4%	0.1%	-5.4%
Dependent living	-2.5%	16.1%	1.9%	0.0%	-2.1%
Independent living	2.5%	4.4%	15.5%	0.0%	7.6%
Social Support					
None	-20.7%	-29.4%	-37.1%	-7.6%	-39.3%
Some	15.5%	25.9%	4.9%	3.8%	26.2%
Daily	5.2%	3.6%	42.1%	4.0%	13.1%
Any	20.8%	29.4%	37.1%	7.7%	39.4%
Family conflict	-4.3%	-8.6%	-5.7%	-2.9%	-6.2%

Notes: Values in this table represent differences in the values reported at intake and at discharge. Negative numbers represent decreases in percentages from intake to discharge whereas positive numbers represent increases from intake to discharge. For the NTP Detox column the data are unreliable as there may be overlap in the 30 days prior to intake and the 30 days prior to discharge as NTP Detox typically lasts less than 30 days

There were also some interesting patterns in the data when comparing the outcomes from the 30 days prior to drug treatment intake to the 30 days prior to drug treatment discharge. In both years opiate users placed in NTP maintenance showed the largest reduction in opiate use in the 30 days prior to measurement (from intake to discharge) and those in outpatient drug-free and non-NTP detoxification (as shown in the other category in the tables) showed the smallest reductions. In both years the two NTP treatment modalities and residential drug treatment also showed significant reductions in the percentage of participants reporting use of an opiate in the 30 days prior to the measurement (see Figure 9.6). Across all types of treatment, in both 06/07 and 07/08, there were significant reductions in the percentage of participants involved in the criminal justice system. This pattern held true for most of the outcomes with some notable exceptions. In 06/07 the percentage of opiate users reporting homelessness did not change from intake to discharge for those participants in NTP maintenance. In 07/08

Table 9.6 CalOMS Outcomes for Prop 36 Opiate Users Discharged in Fiscal Year 07/08 by Treatment Modality

	NTP Maintenance	NTP Detox	Residential	Out-patient	Detox
In the 30 Days Prior to Intake					
Incarcerated in Jail or Prison	28.7%	20%	51.2%	30.1%	30.6%
Used primary drug	87.0%	97.8%	59.6%	45.6%	96.8%
Employed (full-/part-time)	23.2%	4.4%	3.5%	32.0%	10.3%
Employment/school/training	24.1%	8.7%	8.5%	35.3%	11.3%
Living Arrangement					
Homeless	17.8%	28.3%	45.8%	5.9%	27.8%
Dependent living	31.8%	34.8%	36.4%	46.9%	51.0%
Independent living	50.5%	37.0%	17.9%	47.2%	21.1%
Social Support					
None	67.9%	73.3%	56.9%	47.3%	75.8%
Some	27.4%	24.4%	34.0%	43.4%	21.7%
Daily	4.7%	2.2%	9.1%	9.3%	2.6%
Any	32.1%	26.7%	43.1%	52.7%	24.2%
Family conflict	10.2%	6.7%	10.6%	9.3%	10.2%
In the 30 Days Prior to Discharge					
Incarcerated in Jail or Prison	11.9%	13.3%	7.0%	7.3%	0.0%
Used primary drug	43.5%	53.3%	18.6%	26.5%	73.3%
Employed (full- or part-time)	27.8%	6.5%	19.7%	40.8%	14.4%
Employment/school/training	29.6%	19.6%	24.6%	44.4%	17.5%
Living Arrangement					
Homeless	18.7%	13.0%	36.4%	6.3%	20.6%
Dependent living	31.8%	34.8%	33.4%	40.4%	51.6%
Independent living	49.5%	52.2%	30.2%	53.3%	27.8%
Social Support					
None	56.6%	40.0%	15.5%	35.9%	23.2%
Some	33.0%	55.6%	33.1%	49.0%	59.3%
Daily	10.4%	4.4%	51.3%	15.0%	17.5%
Any	43.4%	26.7%	84.5%	64.0%	76.8%
Family conflict	9.2%	20.0%	3.3%	6.1%	2.0%

homelessness actually increased slightly for those in NTP maintenance. Additionally, in 06/07 employment decreased from intake to discharge in the NTP maintenance group, whereas it increased for all other treatment modalities. This was not true in 07/08.

Table 9.7 Differences in Intake to Discharge Outcomes for Prop 36 Opiate Users Discharged in Fiscal Year 07/08 by Treatment Modality

	NTP Maintenance	NTP Detox	Residential	Out-patient	Detox
In the 30 Days Prior to Intake					
Incarcerated in Jail or Prison	16.8%	6.7%	44.2%	-22.8%	-30.6%
Used primary drug	43.5%	44.5%	41.0%	-19.1%	-23.5%
Employed (full- or part-time)	-4.6%	-2.1%	-16.2%	8.8%	4.1%
Employment/school/training	-5.5%	-10.9%	-16.1%	9.1%	6.2%
Living Arrangement					
Homeless	-0.9%	15.3%	9.4%	0.4%	-7.2%
Dependent living	0.0%	0.0%	3.0%	-6.5%	0.6%
Independent living	1.0%	-15.2%	-12.3%	6.1%	6.7%
Social Support					
None	11.3%	33.3%	41.4%	-11.4%	-52.6%
Some	-5.6%	-31.2%	0.9%	5.6%	37.6%
Daily	-5.7%	-2.2%	-42.2%	5.7%	14.9%
Any	-11.3%	0.0%	-41.4%	11.3%	52.6%
Family conflict	1.0%	-13.3%	7.3%	-3.2%	-8.2%

Recommendations

The percentage of Prop 36 participants that report an opiate as their primary drug that receive NTP has been declining over the last 3 years. This decline is likely to result in worse outcomes for Prop 36 opiate users. Instead, the use of NTP should be increased in Prop 36. The use of buprenorphine in Prop 36 should also be increased, especially in counties where methadone is unavailable. There should be access to NTPs in all 58 counties across the state. Following these recommendations should result in improved outcomes for Prop 36 opiate users.

Note: Percentage represents the difference in the percentage of opiate users in Prop 36 that reported using any opiate in the 30 days prior to drug treatment intake and the percentage that reported using any opiate

in the 30 days prior to discharge (e.g. 94.4% of the opiate users receiving NTP maintenance reported using an opiate in the 30 days prior to the intake whereas on 47.2% reported using an opiate in the 30 days prior to discharge, a 47.2% reduction).

Conclusions

Data from CalOMS indicates that Prop 36 participants that received methadone maintenance had better outcomes following treatment than those placed in residential, outpatient, or non-NTP detoxification drug treatment. With the current rise in prescription opiate abuse among all segments of the population, but especially among adolescents and young adults, it is likely that the number of opiate users in Prop 36 will continue to increase in the coming years. Despite the unquestionable utility of NTPs for reducing drug use and crime among opiate users, the use of NTPs in Prop 36 has actually decreased over the last 3 years. While NTP may not be the appropriate treatment for every Prop 36 participant who reports an opiate as their primary drug of choice, it is an important tool in the treatment of opiate dependence.

References

American Association for the Treatment of Opioid Dependence (2006). Why Methadone Works. Accessed at: http://www.aatod.org/fact_methadone.html.

American Association for the Treatment of Opioid Dependence (2007). Drug Court Fact Sheet: Methadone Maintenance and Other Pharmacotherapeutic Interventions in the Treatment of Opioid Dependence. Accessed at: http://www.aatod.org/fact_drug_court.html.

American Methadone Treatment Association, Inc. Fact sheet: Why methadone treatment works. American Association for the Treatment of Opioid Dependence. Accessed at: http://www.aatod.org/fact_methadone.html.

Anglin M.D., Conner B.T., Annon J., & Longshore D. (2007a). Levo-Alpha-Acetylmethadol (LAAM) versus Methadone Maintenance: 1-Year Treatment Retention, Outcomes, and Status. Addiction, 102, 1432-1442.

Anglin M.D., Conner B.T., & Longshore D. (2007b). Levo-Alpha-Acetylmethadol (LAAM) versus Methadone Maintenance: Six-month Post Treatment Outcomes and Behavior Patterns. Manuscript under review for publication.

California Health and Safety Code 11839-11839.22. Accessed at: http://www.leginfo.ca.gov/cgi-bin/waisgate?WAISdocID=76538928933+3+0+0&WAISaction=retrieve.

Conner, B.T. (2008). Narcotic Treatment Programs. Evaluation of Proposition 36: The Substance Abuse and Crime Prevention Act of 2000 2008 Report (pp. 159-171). University of California, Los Angeles.

Joseph H., Stancliff S., & Langrod J. (2000). Methadone maintenance treatment (MMT): A review of the historical and clinical issues. The Mount Sinai Journal of Medicine, 67, 347-364.

Ling W., Charuvastra C., Collins J.F., Batki S., Brown L.S. Jr., Kintaudi P., Wesson D.R., McNicholas L., Tusel D.J., Malkerneker U., Renner J.A. Jr., Santos E., Casadonte P., Fye C., Stine S., Wang R.I., & Segal D. (1998). Buprenorphine maintenance treatment of opiate dependence: a multicenter, randomized clinical trial. Addiction, 93, 475-486.

Longshore D., Annon J., Anglin M.D., & Rawson R.A. (2005). Levo-Alpha-Acetylmethadol (LAAM) versus methadone: Treatment retention and opiate use. Addiction, 100, 1131-1139.

Mathias, R. (1997). NIH panel calls for expanded methadone treatment for heroin addiction. NIDA Notes, 12.

National Institute on Drug Abuse (1999). Principles of drug addiction treatment (NIH Publication No. 99-4180). Washington DC: National Institutes of Health.

National Institutes of Health Consensus Development Program (1997). Effective Medical Treatment of Opiate Addiction. Accessed at: http://consensus.nih.gov/1997/1998TreatOpiateAddiction108html.htm.

Office of National Drug Control Policy Drug Policy Information Clearinghouse. Heroin Fact Sheet June 2003. Accessed at: http://www.whitehousedrugpolicy.gov/drugfact/heroin/index.html.

Public Law 106-310: Children's Health Act of 2000. Accessed at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=106_cong_public_laws&docid=f:publ310.106.

Substance Abuse and Mental Health Services Administration (2001). Opioid drugs in maintenance and detoxification treatment of opiate addiction; Final rule. Federal Register, 66, 4075-4102. Accessed at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2001_register&docid=01-723-filed.

Substance Abuse and Mental Health Services Administration (2003). Opioid drugs in maintenance and detoxification treatment of opiate addiction; addition of buprenorphine and buprenorphine combination to list of approved opioid treatment medications. Federal Register, 68, 27937-27938. Accessed at: http://buprenorphine.samhsa.gov/InterimFinalRule-05-22-2003.pdf.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Treatment Episode Data Set (TEDS) (2008). Highlights - 2007. National Admissions to Substance Abuse Treatment Services, DASIS Series: S-45, DHHS Publication No. (SMA) 09-4360, Rockville, MD, 2009.

Substance Abuse and Mental Health Services Administration (2006). Non-Heroin Opiate Admissions: 2003. Drug and Alcohol Services Information System, 16. Rockville, MD.

Substance Abuse and Mental Health Services Administration (2007). Results from the 2006 National Survey on Drug Use and Health: National Findings (Office of Applied Studies, NSDUH Series H-32, DHHS Publication No. SMA 07-4293). Rockville, MD.

Substance Abuse and Mental Health Services Administration. (2008). Results from the 2007 National Survey on Drug Use and Health: National Findings (Office of Applied Studies, NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Rockville, MD.

United States Department of Justice Drug Enforcement Administration Office of Diversion Control Drug & Chemical Evaluation Section (2007). Lists of: Scheduling Actions Controlled Substances Regulated Chemicals. Accessed at: http://www.deadiversion.usdoj.gov/schedules/schedules.htm.

United States Food and Drug Administration Talk Paper T93-36 (August 3, 1993). FDA Announces LAAM Approved to Treat Drug Dependence. Accessed at: http://www.fda.gov/bbs/topics/ANSWERS/ANS00517.html.

United States Food and Drug Administration Talk Paper T02-38 (October 8, 2002). FDA Announces Subutex and Suboxone Approved to Treat Opiate Dependence. Accessed at: http://www.fda.gov/bbs/topics/ANSWERS/2002/ANS01165.html.

United States Food and Drug Administration Product Discontinuation Notice NDC 0054-3649-63 (August 23, 2003). Letter from Roxane. Accessed at: http://www.fda.gov/cder/drug/shortages/orlaam.htm.

Chapter 10: Key components of Prop 36 program success: Lessons from six high performing counties

Elizabeth Evans, M.A.

To gain an in-depth understanding of what practices or policies were responsible for Proposition 36 program successes, focus groups were conducted with key stakeholders in six high-performing counties from February to April 2009. Discussion topics covered key elements of success, recommendations for best addressing specific sub-groups of Prop 36 clients, the impact of California's state budget crisis, and current needs.

These seven key components of Prop 36 program success emerged from the focus groups with county stakeholders: (1) engage the client quickly, (2) monitor client progress, (3) cultivate buy-in among clients, (4) cultivate buy-in among key stakeholders, (5) attract a judge[50] who works well with clients and stakeholders, (6) build and maintain a diverse and high-quality treatment system, and (7) diversify funding resources and support for the program. Practices that county stakeholders felt helped to build or maintain each key component are presented. Current Prop 36 program needs and issues related to the operation of the program are also summarized.

Strategies were not formally evaluated and thus it is not possible to comment on their effectiveness. However, strategies were identified by several counties as the reason for their success.

It may not be possible for counties to implement all of the practices and policies that were identified but it is hoped that this chapter serves as a resource when considering possible improvements to the Prop 36 program.

Introduction

To gain an in-depth understanding of what strategies or policies were responsible for Prop 36 program successes, focus groups were conducted with key stakeholders in six counties from February to April 2009. Discussion topics covered key elements of success, recommendations for best addressing specific sub-groups of Prop 36 clients, the impact of California's state budget crisis, and current needs. Digital recordings of the discussions were transcribed verbatim and reviewed for accuracy. Patterns within and across the focus-group transcripts were analyzed. Summarized in the chapter are the seven key components of success that emerged and attendant goals and practices. Related issues and current needs are also summarized.

The effectiveness of the practices described in this chapter was not evaluated. Rather, the goal of this chapter is to summarize practices perceived to be successful by stakeholders in counties where Prop 36 performance appeared to be relatively strong. Additional research is necessary to rigorously establish the effectiveness of individual practices.

[50] Although in many courtrooms a commissioner presides over Prop 36 cases rather than a judge, for simplicity the term "judge" is used throughout this chapter to refer to either type of bench officer.

Methods

To select counties for participation, counties were sorted by population size categories (large, medium, small, very small) and then ranked according to a composite score comprised of seven Prop 36 program performance and outcome indicators (see Appendix 10.1 for more information).[51] Six of the eight top-ranked counties that were invited, participated in a focus group. Participating counties were large-sized or medium-sized and they were located in different geographical areas of the state. Each focus group lasted between 1.5 and 2.0 hours and was held within each county.

Members of the counties' Prop 36 oversight or workgroup committees participated in the discussions and the groups were composed of representatives of drug and alcohol program administration, probation, the courts, prosecutors, public defenders, treatment providers, and others. A total of 59 individuals participated in the focus groups and results of background surveys completed by participants are provided in Appendix 10.2. Digital recordings of the discussions were transcribed verbatim and reviewed for accuracy. Patterns within and across the focus-group transcripts were analyzed and aggregated into themes. Most of the views that are summarized were expressed by the majority of participants but, in some instances, minority opinions are also included. In all instances, only viewpoints that were expressed by stakeholders in more than one county are included.

Key components of success

Key component #1: Engage the client quickly

Goal Clients receive services quickly, ideally within 24 hours of arrest on the offense that made them eligible for the program and no more than 7 days after that date.

Practices

1. Establish a "Prop 36 court." Staff the Prop 36 court with a core group who oversee a dedicated Prop 36 calendar. Set aside days each week for the same judge(s) to handle all Prop 36 cases. Consider holding clients in custody until they can be seen by the Prop 36 court.
2. Make it easy for clients to complete all of the pre-treatment steps. Minimize the number of "steps" that the client needs to complete before treatment entry. Locate court, probation, and treatment assessment within walking distance from one another.

[51] These methods are not intended to represent a definitive method for ranking counties. The selection of counties may have varied with the use of different variables or methods (e.g. case mix adjustment analysis). Therefore, while the methods were useful for identifying one set of counties that appeared to have performed relatively well, it cannot be concluded that any county is not performing well on the basis that it was not invited to participate in a focus group. Work to develop appropriate performance and outcome measures is underway (see Chapter 12).

3. Implement a clinically trained court-based assessment unit that focuses on conducting rapid assessments.
4. Escort clients through the Prop 36 pipeline, that is, from court to probation and to treatment. This practice is relatively cheap and simple and it minimizes opportunities for clients to no show to treatment. It also builds trust among clients by underscoring that the court cares about the client's welfare and that the court is willing to "go the extra mile" to ensure that the client receives treatment.
5. Expedite processes by making regular communication easy between all of the key stakeholders. Discussion of individual cases should begin at program entry and then continue as the client progress through the program, in response to reports from treatment and/or probation. Staff should feel like it is easy to reach each other by phone or email at any time to discuss cases.
6. Designate one person (or a team of people) who serves as a "bridge" between the client and the key stakeholders, facilitating communication regarding individual client progress. This person has access to clinical assessment information and can call for a reassessment of needs or for a change in treatment level as needed. This person knows "who to contact" and "how to get things done." This person checks on the status of each client regularly.
7. Provide clients with a Prop 36 program orientation session before treatment entry. Tell clients in clear and simple language (both verbally and in writing) about program processes, expectations, rules, and next steps. Explicitly tell clients that they are on probation, parole, or both. Connect clients with local supportive services (e.g., CalWORKS, Medi-Cal, Veterans Affairs etc) for which they are eligible. Use orientation as an opportunity for clients to talk with key stakeholders in more detail, especially to clarify the legal obligations of the Prop 36 program.

Key component #2: Monitor client progress

Goal Detect and respond appropriately to client behavior. Do not let clients "get lost in the system" or "go off the court calendar" or "slip through the cracks." Enhance client engagement. Prevent drug use relapse and recidivism.

Practices

1. Conduct face to face check-ups with clients. Require appearances before the judge weekly and/or at key points of the program such as after orientation, after assessment, during treatment, at treatment completion, and at regular intervals after treatment completion while the client is on probation. Use these interactions to build a relationship with the client so that the client will want to not disappoint the judge and other key stakeholders. To minimize costs and scheduling conflicts, in-person check-ups do not always have to be done by the judge but can also be performed by probation officers, case managers, or someone who has the authority to recommend rewards and sanctions to the court as needed.
2. Utilize an "engagement and retention" specialist or a case management specialist. This person's primary job consists of staying in touch with clients (by phone, email, letters, in-person visits) to facilitate continued engagement with key

players and linkage to services that support recovery. The specialist handles clients from intake through program graduation, increasing interactions with the client as needed and especially at times when clients may be more at risk for drug use relapse, for example at treatment exit. The specialist also continues to monitor clients after the clients are moved to a "banked" probation caseload and are more likely to "fall off of probation's radar."

   a. To minimize costs, services do not always have to be performed by a county administrative employee but can also be done by a contracted worker, probation staff, or even public defender staff.
   b. Services might also be reserved for high need cases only, such as clients with co-occurring disorders, clients who are pregnant or parenting young children, clients with a more severe criminal history, or clients who are facing their third Prop 36 probation violation.

3. Drug test clients effectively. Testing needs to occur randomly and also for cause, frequently, and in all settings (at visits to court, probation, and drug treatment). It is best if testing occurs on-site with immediate results that are tied to a quick response. Use oral swabs for clients who cannot urinate or if a same-gender monitor is not available. Test results should be used as a tool to change the level of treatment and/or level of supervision. Change the frequency of testing based on whether the client is performing well or poorly. Testing should continue after completion of treatment, while the client is still on probation, through program graduation.
4. Use resources to fund fieldwork by probation officers. Probation officers visit clients in treatment and in court to check on client progress and to write progress reports.
5. Respond to problem behavior immediately before it gets worse. In response to dirty urine tests or no show to treatment, immediately involve probation and the courts. Have probation actively seek out and arrest the client, and bring the client before the Prop 36 judge.
6. If the client engages in problem behavior continually, terminate the client from the Prop 36 program and, if it is available in the county, refer the client to drug court.

Key component #3: Cultivate buy-in among clients

Goal Create a culture that is non-adversarial. Include the client as being "a part of the Prop 36 system," not as being opposed to the system. Show the client that all of the key players share the common goal of focusing on the welfare of the client.

Practices

1. Personalize the communication with clients.
   a. Create a "family feeling" in the courtroom. The judge takes brief notes on the names, ages, and welfare of the client's children, facts about important events in the client's life, and the client's overall status. During the next court appearance, the judge makes a point of asking about important people and events in the client's life.

b. The judge refrains from sitting above the client behind a "bench," but instead sits at a table that is "on the same level" as the client.
c. If non-English speaking family members of the client are present in court, the court provides a translator so that family members are kept informed and can participate in the interactions.
d. If a client is doing well, the judge praises the client in open court. The judge might also express praise physically, with a handshake or a hug.
e. At program graduation, the client has a picture taken with the judge and other key stakeholders. The picture is a reminder of what the client has accomplished and is also a source of support if the client feels at risk for relapse.

2. Send a consistent message to the client that all key players are focused on what the client needs to do well, not on "punishment" of the client.
    a. Key stakeholders work as a team (a "united front") and do not let the client divert attention away from the focus. Interactions show the client that when there is inappropriate behavior, key stakeholders will not seek to "punish" the client or make the client "pay the consequences" but that there will be a swift and sure response.
    b. Treat clients with respect. If a client is doing poorly in the program, key players express disappointment in front of the client in lieu of exasperation, irritation, or anger.
    c. Eliminate treatment program shopping among clients. Make it clear to clients that program staff determine the level of care and that treatment assignment is based on assessment and significance of need for services, not client preference. Show clients that programs within a particular treatment level offer very similar services and make the point that no matter which program treats the client, the type and quality of care that will be received will be essentially the same.
    d. Show the client that all of the players keep in touch with each other on the client's progress. Treatment provider staff "use" probation officers to "play the heavy" or to "backup" treatment staff when needed. Probation officers regularly visit treatment programs to remind clients of the Prop 36 program rules.
3. Build client motivation. Cultivate a sense of hope about the future among clients.
    a. Praise and celebrate client successes in open court. Allow successful clients to act as role models to other clients who are also in court.
    b. Provide small symbolic rewards to clients for good behavior like a candy bar, fruit, or "gold stars" which culminate in the opportunity for the client to participate in a raffle of prizes at graduation.
    c. Hold graduation ceremonies. Enhance the significance of the event by including local "dignitaries" such as the county sheriff, police chief, county supervisor, or mayor.
    d. "Package" fees and fines so that the client can pay two fines for the price of one, motivating the client to complete the Prop 36 program with a "clean slate," having paid outstanding fines for all cases, not just for the Prop 36 case.

e. Use motivational interviewing techniques to communicate with clients. This is a skill that is useful to all key stakeholders, not just to treatment provider staff.
f. In small communities, county stakeholders are likely to see clients "around the neighborhood" and even though they are not at work, stakeholders make a point of greeting the client and checking on how they are doing.
g. For clients with dependent children, tap into another source for motivating clients by driving home the point that sobriety is a benefit to the client's children. Allow the children of clients who are doing well to choose a toy at the next court appearance.
h. Recognize that employment builds client confidence and gives clients another reason to stay clean. If the client is not working, require the client to job seek and to complete community service hours. These activities may enhance job skills and lead to employment.
i. With clients who continue to test positive for drugs or no show to treatment, use short remands to jail on a concurrent non-Prop 36 offense ("flash incarceration") or "catch and release" techniques. This last practice means that probation brings the client into court and is seen by the Prop 36 judge and then, after remaining in court all day, the client is released.
j. Host a Prop 36 alumni association for clients to share success stories. If it is not possible to create a Prop 36 alumni association, include clients in existing alumni associations such as those run by SASCA/BASN.

4. Maximize the opportunities for clients to succeed in treatment
    a. Give the client a chance to "get clean" and oriented to the program requirements, especially in the early phase of the program.
    b. Bundle minor program infractions (e.g., positive urine test, missed treatment appointment) to be considered as one violation rather than as several violations. Prepare criminal justice stakeholders to expect drug use relapse and to agree that minor program infractions do not always need to be counted as a program violation.
    c. If the client is facing a third program violation but seems amenable to treatment, refrain from terminating the client from the program. Instead, consider options for retaining the client in Prop 36 treatment. For example, order a short jail stay on a concurrent non-Prop 36 offense and arrange to have the client be escorted right from jail to residential treatment. Depending on the client's behavior, and at the discretion of the team, extend the client's probation term.

Key component #4: Cultivate buy-in among key stakeholders

Goal Achieve a "critical mass" of stakeholders who believe in the effectiveness of the Prop 36 program. These stakeholders brainstorm, continue to fine-tune the program, and seek inspiration on how to solve problems as they arise.

Practices

1. Create opportunities for stakeholders to witness the program. Have stakeholders attend Prop 36 court sessions and graduations so that they can personally see the impact of the program.
2. Monitor and evaluate program performance. Collect data on indicators of program performance and client outcomes (e.g., treatment retention and completion, number of violations, recidivism, drug use, employment etc.) and review the data each month. Hire a professional evaluator. Recognize what is not working and fix it. Use data to hold key stakeholders accountable. Produce data by treatment program and encourage healthy competition in client outcomes between programs.
3. Celebrate and publicize the successes of the program.
4. Review the literature. Use research findings to inform program operation and to pick up "counterintuitive wisdom." In particular, some stakeholders may not be aware of research indicating that (a) among offenders, legal coercion may produce higher recovery rates than voluntary treatment, (b) treatment is cheaper than incarceration in terms of incarcerated days saved but also in terms of reduced caseloads for criminal justice stakeholders, and (c) addiction is a chronic relapsing condition for many individuals.
5. Identify and utilize local experts. Establish a "brain trust" of local people who are knowledgeable about substance abuse and who can provide training and insight on how to improve the program. Recognize that staff from drug court or mental health court can educate colleagues who are new to Prop 36. Word of mouth from a trusted colleague can be more powerful than attendance at meetings, trainings, and conferences.
6. Hold educational meetings and trainings for key stakeholders. Address misinformation about program purposes and requirements. Provide up-to-date statistics and factual data on program outcomes.
7. Build trust between key stakeholders. Hold a key stakeholder retreat at regular intervals. "Break bread" together. Hold potlucks. Get to know one another outside of work roles.
8. Include treatment providers at the planning table as equals. Make funding for treatment a priority, especially when there are budget constraints.
9. Learn from other counties. Visit nearby counties and observe processes. Attend statewide Prop 36 conferences. Encourage all key stakeholders to participate in learning activities together.
10. Acknowledge philosophical differences among stakeholders. Some key stakeholders may not believe in the effectiveness of treatment. Public defenders may feel they are obligated to do whatever the client wants (for example, take a case to trial) even if it is not in the best interest of the client. Criminal justice stakeholders may not wish to play the role of a "social worker."
11. Recognize the value of having a core group of staff who operate the program over time. Continuity of staff makes it easier to build relationships, trust, stability, and teamwork. 'Veteran" staff are also more knowledgeable about county resources and how to allocate those resources appropriately and they are better able to implement program procedures consistently. Moreover, staff who have invested

time and dedication in "the Prop 36 baby" translates into doing whatever it takes to "make the program roll along." Staff with a history of working together on drug court or other types of collaborative courts is also valuable.

12. Attract mid-level to senior-level staff to operate the Prop 36 program. Staff at these levels are knowledgeable about what is needed to create behavioral change among drug using offenders and they tend to value longer term results. Also, among criminal justice stakeholders, mid- to senior-level staff face less pressure to try cases for professional advancement and thus they are more willing to give treatment a chance.

Key component #5: Attract a judge who works well with clients and stakeholders

Goal The judge connects with the client and quickly becomes the primary key stakeholder that the client wishes to not disappoint. The judge facilitates communication between key stakeholders. The judge plays a key role in garnering political and financial support for the Prop 36 program.

Practices

Interactions between the judge and clients

1. The judge is charismatic, speaks plainly with clients, and is able to connect with clients. Just by talking with clients, the judge creates a verbal "social contract." Clients who feel like the judge is "my judge" will be more willing to do whatever it takes to be successful in the program.
2. The judge acts **"**parental" with clients, setting clear boundaries, showing that he/she cares, giving praise, and having "stern talks" as needed. The judge lets the client know that even if the client "messes up," as long as the client stays engaged with treatment/probation and returns to court, chances for treatment will be given, otherwise the client will be "too scared" to come back to the program.
3. The judge personalizes each interaction with the client. The judge asks about the client's children, job, and life in general. The judge shows the client that the client is a fellow person and that the judge cares about the client's welfare.
4. The judge uses the courtroom to teach other clients who are waiting to have their case handled. Praise and sanctions are communicated in open court.
5. The judge encourages clients who are on an immigration hold to opt out of Prop 36 so that person can receive time served and be deported but when they return to the county there will not be a warrant out for their arrest (as there would have been if the person had accepted Prop 36 and then "disappeared" because of deportation).
6. For clients who are chronically noncompliant with the program, the judge holds amenability hearings to determine whether the client should stay in Prop 36 or be terminated from the program.
7. The judge makes it harder for the client to opt out of treatment than to stay in treatment. For example, if a client is unmotivated, the judge sets a higher than usual jail offer or, to remind the client of what jail is like, the judge remands the

client to a short jail stay (one week or less, "flash incarceration") if there is a pending concurrent non-Prop 36 charge.

8. For clients who no show to court, the judge sets a high bench warrant amount. This is one way to ensure that the warrant is served and that the client will be arrested and brought back to court.
9. For clients who express a preference for jail/prison time to treatment, the judge makes it clear that when the client is released, the judge will still be on the bench ready to "stay on the client until the client gets clean." The judge is ready to "harass the client to sobriety."

Interactions between the judge and key stakeholders

10. The judge either chose to be a "Prop 36 judge" or came to embrace that role. The judge is experienced. He/she has served as a judge for mental health court, dependency court, drug court, or some other type of public health oriented collaborative justice court. The judge is knowledgeable about drug addiction, co-occurring disorders, behavior modification, and the principles of effective treatment**.** The judge seeks to apply as many of the key elements of drug court as is possible.
11. The judge respects the expertise of each key stakeholder. The judge creates a community of equals and especially makes a point of valuing the recommendations of drug treatment professionals. The judge uses his/her position to get all of the key stakeholders to come to the table, communicate with each other, and reach consensus. The judge is a problem solver and facilitates a culture of collaboration.
12. The judge attends trainings. The judge participates in the National Association of Drug Court Professionals. The judge has received training on narcotic replacement therapy.
13. The judge occasionally pays a friendly visit to key stakeholder staff at their office, just to check in and to see how different aspects of the program are operating outside of the courtroom.
14. The judge advocates for the program, testifying in front of the County Board of Supervisors and speaking at state or national venues. The judge garners political support for the program.

Key component # 6: Build and maintain a diverse and high-quality treatment system

Goal The treatment system can promptly meet the needs of different types of clients.

Practices

1. Use standardized, multi-dimensional treatment assessments and placement criteria to determine treatment and placement needs. Clients are not assigned to a treatment level and treatment services solely based on the level of the offense that was committed.
2. Make it easy for clients to enter and stay in treatment.

a. Build-up treatment capacity so that services can be provided when and where they are needed and for as long as needed.
b. Residential treatment must be available, even if it is "reserved" for only the neediest clients as determined by clinical assessment.
c. The length of stay in treatment is long enough to make an impact on client behavior. Many Prop 36 clients need 12 to 18 months of treatment.
d. Minimize or eliminate the use of treatment entry waiting lists. If residential treatment is needed but it is not available, find another way to engage the client, perhaps by having the client attend Prop 36 program orientation sessions. Get creative and "patch together" treatment programming to better meet client needs. For example, when there are no residential beds available, rather than placing the client on a waiting list, combine sober living with detoxification or intensive outpatient treatment.
e. If a client is using drugs, place the client into detoxification care or sober living for at least seven days and then transfer the client to outpatient, residential, or another needed level of care. Clients need time to "get clean" before they are ready to take treatment seriously.
f. If a client is employed, structure program requirements to accommodate their work schedule. For example, offer urine testing in the early morning hours and in the evenings so that the client can be tested before or after work.
g. Allow clients to enroll in treatment without having to pay a treatment enrollment fee. Use a sliding scale to determine affordable drug testing fees.

3. Diversify available treatment options. Treatment services that are matched to client needs will be more effective.
    a. Methadone maintenance and methadone detox treatment needs to be available for heroin/opiate users. Educate outpatient and residential programs to enhance acceptance of "dosing" by these types of clients.
    b. Place women with dependent children in perinatal programs.
    c. Train treatment staff on effective treatment practices for methamphetamine users.
    d. Homeless clients may require more frequent contact with a case manager or other staff who oversee client progress.
    e. Assign clients who have relapsed to non-medical detoxification treatment.
    f. Enhance cultural competency. Be aware of cultural differences and provide training to enhance cultural proficiency among all stakeholders, not just among treatment providers. Employ bilingual staff, especially the staff who answer the phone are the first people that new clients meet in treatment. Recognize that some client groups may face greater stigma regarding asking for help. Target outreach efforts to populations of interest and place outreach activities wherever those populations gather. When appropriate, make the client's family, friends, and mentors a part of the treatment team. For example, Latino/Hispanic clients seem to receive more support for recovery from their family and from their community. Also, young Latino/Hispanic males often look up to and respect the

opinion of their older peers. (For more on cultural competency and Hispanic clients, see Chapter 6)

4. Adjust the client's treatment level in response to how the client is doing. Provide capacity for a treatment level that consists of education only. Allow clients to enter this level when appropriate, for example clients may "step down" to this level as a reward for completing a more intense level of care. As an alternative, if a client is doing well, allow the client to come to treatment less frequently.
5. Build a high quality treatment workforce.
    a. Train treatment program staff to use evidence-based best practices. Training needs to occur on an ongoing basis. Potential training topics include: the Matrix Model of treatment, seeking safety, contingency management, cognitive behavioral therapy, motivational interviewing, methadone maintenance and other narcotic replacement therapies, cultural competency, and minimizing barriers to treatment entry.
    b. Employ certified drug treatment counselors. Certified counselors seem to be more open to trying different types of treatment techniques.
    c. Create a drug treatment system of care. Treatment provider staff can recognize when a client might benefit from services that are offered by another program. Create opportunities for treatment provider staff to get to know one another and the strengths of each program that serves Prop 36 clients in the county. Encourage treatment programs to refer clients to one another to better meet client needs.
6. Connect to other systems of care. Eligible clients can benefit from services offered by the Department of Veterans Affairs (VA), the Department of Mental Health, Child Welfare Services, the Employment Development Department, and other health and human services agencies.
7. Create linkages between the Prop 36 program and other types of court-supervised treatment. In this system, programs are seen as existing on an integrated continuum so that, as needed, clients can be routed to treatment that is offered by different programs. For example, clients with a mental health disorder might be better served by drug court, mental health court, or another type of specialty court that can offer supportive services (e.g., psychiatric medication, evaluation by a psychiatrist, housing, mental health treatment) in addition to drug treatment. If a dually diagnosed client is not doing well in Prop 36, consider suspending Prop 36 and referring the client to one of these other types of courts. Once the client is stabilized the client can be returned to Prop 36 treatment.
8. Special efforts are needed to effectively treat parolees (see also Chapter 5). In many counties, parole is not a part of the regular county team of key stakeholders or the "Prop 36 system," parolees are not handled by the "Prop 36 judge," and engaging parole as a key stakeholder can be challenging. Also, usually parole agents do not know that the client is on probation in addition to being on parole.
    a. Keep in mind that whether a parolee is referred to the Prop 36 program is at the discretion of the parole agent and/or the parole board. Some parolees are treated through other non-Prop 36 types of programming and those other options may be better equipped than Prop 36 to meet the needs

of parolees. Also, parole agents may prefer that the parolee receive residential treatment or at least three treatment contacts per week.

b. Create a good working relationship with parole agents who handle Prop 36 cases. Invite parole agents to county stakeholder meetings. Encourage treatment provider staff to get to know individual parole agents. Understand that one client could be supervised by several parole agents.
c. Educate parole agents about the Prop 36 program. Parole agents can make parolees "tow the line" however agents are also often misinformed about the requirements of the Prop 36 program.
d. Establish a welcoming treatment environment. Parolees who are released from prison into drug treatment need time to adjust to the new setting, to "decompress," and "adapt to treatment." Also, parolees tend to be more resistant to treatment and the idea of needing treatment. Provide training to treatment staff on being cognizant of the needs of parolees.
e. Cultivate treatment programs that specialize in treating parolees. Arrange to have a parole agent on site at the treatment program.

Key component # 7: Diversify funding resources and generate broad support for the program

Goal Strengthen the network of resources and political support for the Prop 36 program to compensate for funding restrictions or reductions

Practices

1. Seek alternative sources of funding to support specific elements of the program. Submit proposals for federal, state, and private grant money.
2. Plan for administrative costs. Collaboration and coordination between key stakeholders costs money. When possible, arrange for the county to refrain from using any of the Prop 36 funding to support administrative fees. Put every penny into providing drug treatment. Have key stakeholder agencies contribute staff and/or funds instead of using the Prop 36 allocation.
3. Mix and match funding streams to diversify service options for clients. For example, if a client is on parole and probation simultaneously, tap into parole sources of funding for treatment and/or monitoring to supplement Prop 36 resources.
4. Build relationships and trust between the Prop 36 program and the County Board of Supervisors. Provide the Board with data on program accomplishments and outcomes. Invite Board members to participate in the Prop 36 oversight committee/workgroup. Seek county funding to supplement Prop 36 resources. Ask the Board for help with navigating county contracting processes.

Summary

In summary, county stakeholders from six high-performing counties provided information on practices and policies responsible for Prop 36 program successes. Strategies were not formally evaluated and thus it is not possible to comment on their effectiveness. However, strategies were identified by several counties as the reason for their success. Moreover, while some of the practices require significant resources and effort to implement, many others are simple and relatively cheap. During the discussions, stakeholders also talked about current Prop 36 program needs and issues related to the operation of the program and these viewpoints are summarized in Appendix 10.3. It may not be possible for counties to implement all of the practices that were identified as key components but it is hoped that this chapter serves a resource when considering possible improvements to the Prop 36 program.

Chapter 11: Arrests and Crime Trends

Darren Urada, Ph.D., Jia Fan, M.S., and Doug Anglin, Ph.D.

In years 4, 5, and 6, Prop 36 Treatment completers had fewer re-arrests over a 12 month follow-up period than offenders who did not. This was also true of Year 1 offenders tracked over a 6 year follow-up period. The percentage of offenders being arrested each year remained relatively stable across years 4, 5, and 6, but remained higher relative to a comparison group of offenders in the pre-Prop 36 era.

Criminal justice stakeholders in Prop 36 were concerned that the program could influence the overall crime rate in California. As in earlier evaluation reports of California crime trends, patterns cannot be definitively causally attributed directly or indirectly to the effects of Prop 36. Crime trends are notoriously difficult to attribute to narrow policy efforts; rather they result from the convergence of many factors. Observationally, in the years before and after Prop 36 was passed in 2001, the violent crime rate in California decreased faster than rates did in the rest of the nation, though not as fast as they had prior to Prop 36 implementation. Overall property crime rates and drug arrest rates increased slightly in California initially after Prop 36 took effect, but in subsequent years have decreased to a greater extent than in the rest of the nation.

For the first time, UCLA examined incarceration patterns before and after Prop 36 to assess whether changing incarceration patterns may plausibly contribute to patterns in crime trends. After Prop 36 implementation, the composition of California's prison population shifted. The drug offender population in California's prisons dropped by 7.4 percentage points while the population incarcerated for crimes against persons (murder, non-negligent manslaughter, forcible rape, robbery, and aggravated assault) increased by almost the same amount, 6.8 percentage points. In 2007 approximately 15,000 more offenders were incarcerated for crimes against persons than would have been the case if the percentages had not shifted. This suggests that one aim of Prop 36 has been achieved, even if the degree to which Prop 36 contributes cannot be definitively determined. California prisons are being used more to house those who commit violent crimes and less for those who commit drug crimes. This may plausibly have contributed to the drop in violent crime while property crimes and drug arrests increased, at least initially.

To assess an additional potential contributor, UCLA examined the increase in the number of sworn law enforcement officers in California. California's increase in law enforcement officers was slightly larger than increases seen in the rest of the nation. These increases, although modest, may have played a role in some of the crime reductions, but cannot explain all patterns in the crime trends.

The inability to determine, among all possible contributors, the degree to which Prop 36 has played a part these trends is a major shortcoming of this type of research. Although these analyses represent an attempt to begin examining cumulative potential explanations, other unexamined factors may have contributed to the trends. Continuing research and more sophisticated analyses are needed to clarify these possibilities.

This chapter updates previous examinations of new arrests for drug, property, and violent offenses among Prop 36 offenders, then examines overall statewide crime and arrest rates over time to describe what changes may have occurred after Prop 36 implementation and to investigate factors that may be associated with these changes, specifically if any changes, at least in part, can be attributed to the effects of Prop. 36.

Prop 36 Arrests

As in previous reports, analyses of re-offending were twofold. First, new arrests in the follow-up period were compared across three groups of offenders to observe *re-offending in relation to the degree of offender participation in Prop 36*. Second, Prop 36-eligible drug offenders, including those who did and those who did not participate in treatment, were compared to a pre-Prop 36-era group of drug offenders. This second comparison examines *re-offending under the implementation of two policy alternatives*: implementation of Prop 36 policy, under which drug offenders had an opportunity to accept community supervision with treatment versus implementation of pre-Prop 36 policy, under which similar offenders were either sentenced to prison/jail or placed under community supervision with less likelihood of exposure to treatment.

Both sets of analyses are performed on the fourth, fifth, and sixth year cohorts. Analyses of Prop 36's first three years were presented in prior reports (Urada & Hawken, 2008; Urada, Longshore, & Hawken, 2004). Analyses were also repeated on the first year cohort to examine arrests over a 7 year follow-up period.

Re-Offending in Relation to the Degree of Offender Participation in Proposition 36
Populations were sorted into three mutually exclusive groups: those who were referred for an assessment (i.e., those who accepted the opportunity to participate) but who did not receive treatment; those who entered but did not complete treatment; and those who completed treatment. Re-offending outcomes were adjusted for demographic and criminal history characteristics of offenders.

Prop 36 Policy Implementation versus Pre-Prop 36 Policy Implementation
This evaluation also compared the population arrested for Prop 36-eligible drug offenses in the program's first year and a pre-Prop 36-era population arrested for eligible offenses during the 12-month period between July 1997 and June 1998[52]. Re-offending outcomes were adjusted for background characteristics of offenders and the unemployment rate in

[52] Prop 36 eligibility is determined at sentencing, not at the time of arrest. UCLA used eligible convictions to select offenders in order to obtain the best possible precision in identifying offenders eligible for Prop 36. There are two trade-offs. First, it is possible that there were different charging practices and plea-bargaining practices between the pre-Prop 36 and Prop 36 eras, which could potentially bias results. This bias was mitigated to the extent possible by adjusting for differences in demographic and criminal history characteristics, as described. Second, this focuses our analyses on following offenders with a new conviction. In particular the subset of parolees that entered Prop 36 through a parole violation and did not have a new court conviction are not included in these analyses. Although this is a relatively small number and they were excluded from both the Prop 36 years and comparison years, due to their parole status this group of offenders is of interest because they may be particularly active. UCLA is currently working with CDCR to obtain data on this subgroup for future research and plans to present findings in future reports.

California for the year of each offender's arrest. The adjustment for unemployment accounts for economic conditions that might have affected re-offending.

Re-Offending Measure

The primary measure of re-offending was based on new arrests that occurred during the period after the Prop 36-eligible conviction. Arrests are an imprecise measure of offending because many offenses are undetected by law enforcement and because an officer's arrest decision, given detection of a possible offense, is, in many cases, discretionary (Blumstein, 2002). Moreover, occurrence of an arrest does not necessarily mean that the person committed a crime. On the other hand, the offense for which an arrestee is later charged or convicted depends on a series of additional discretionary decisions by prosecutors and judges (Blumstein & Cohen, 1979; Forst, 2002), and the disposition of an arrest (e.g., charge dismissed, defendant acquitted, or defendant convicted) is often missing from criminal justice records. New arrests, therefore, are the most appropriate indicator of re-offending for the purpose of group comparison. Arrests come "closer to the crime" than other data available in criminal justice records and are most commonly used by criminologists to measure re-offending (Maltz, 2001).

Separate measures were used to examine the percentage of offenders with a new arrest for a drug offense, property offense, and violent offense. The time period in which re-offending could occur was 12 months after the Prop 36-eligible conviction. Violations of probation or parole were not counted unless the violation was a new offense resulting in arrest. Issuance and execution of warrants were not counted. Accordingly, measures of re-offending reflected new criminal activity.

Year Four, Five, and Six Re-arrests

Re-arrest trends were examined for offenders who were referred to Prop 36 in Years 4, 5, and 6 (FY 2004-2005, 2005-2006, and 2006-2007, respectively). Patterns of re-arrests in these years were very similar to those in prior years (Urada & Hawken, 2008). Treatment completers had far fewer re-arrests than offenders who were referred but not treated, and those who started but did not complete treatment (see Figure 11.1).

Arrests were also examined over a much longer, six-year follow-up period for the cohort of offenders from Prop 36's first year. Six years after Prop 36 participation, the percentage of offenders that had been arrested was higher (as would be expected since the percentage arrested can only go rise over time), but the differences between groups mirror those found at 12 months. That is, treatment completers continued to be re-arrested substantially less often than those who did not complete treatment, particularly on drug and property charges. Note that 26.6% had drug arrests and 5.4% had property arrests in the first 12 months (Urada, Longshore & Hawken, 2007), possibly before many had completed treatment. These results are unexpectedly positive, considering that most long-term treatment outcome studies have demonstrated that the benefits of treatment completion, especially among offender populations, tend to diminish over time, especially without continued exposure to treatment (McLellan et al., 2002; Marlowe et al., 2006). Additional more sophisticated analyses to describe the timing of arrests over time and receipt of additional treatment services. Such analyses are planned for future reporting.

Figure 11.1
New Arrests During 12 Months After Offense
Prop 36 Offenders, Years 4-6

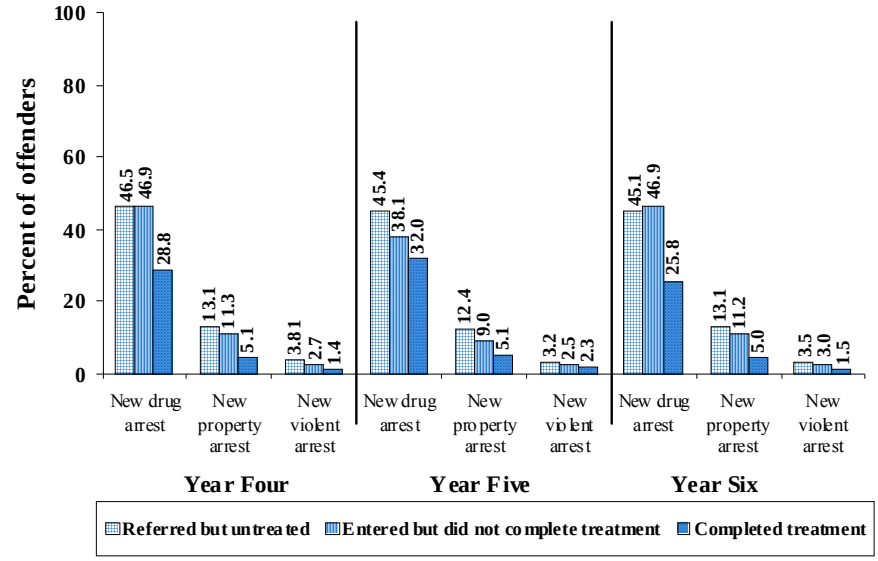
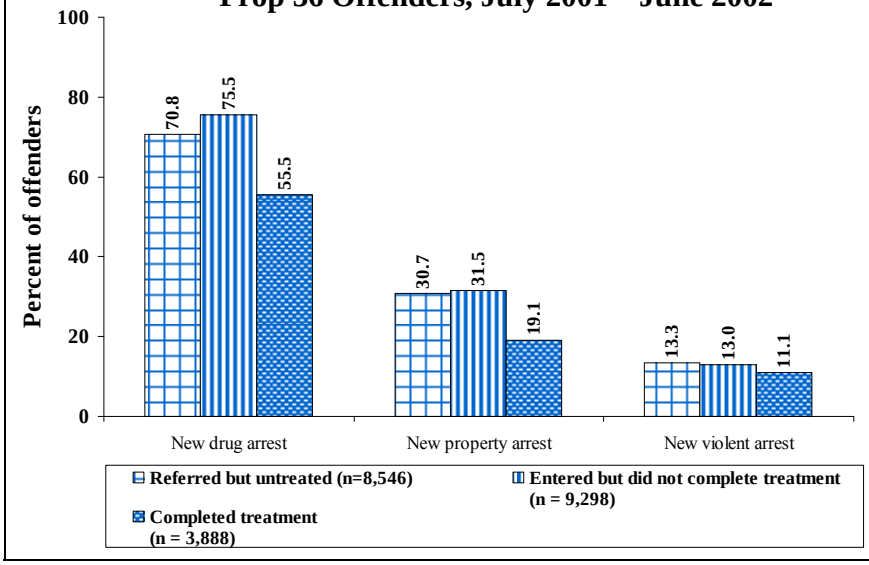


Figure 11.2
New Arrests During 6 Years After Qualifying Offense
Prop 36 Offenders, July 2001 – June 2002



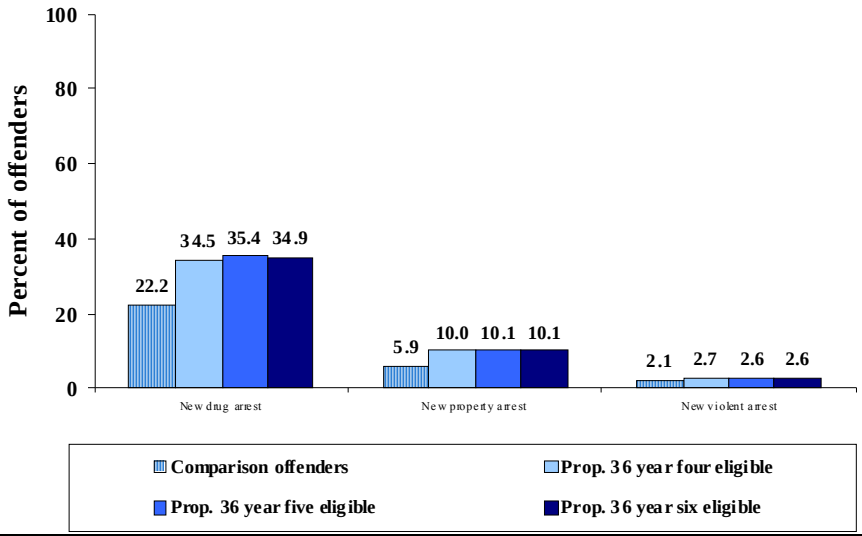
Re-Offending Under Prop 36-Era and Pre-Prop 36-Era Policies

Prop 36's fourth, fifth, and sixth years were also compared to the pre-Prop 36-era group over a 12-month follow-up period. Patterns of re-arrests during Prop 36 years were stable and similar to patterns seen in Prop 36's earlier years. Across crime categories, Prop 36-era offenders were more likely to be re-arrested compared to pre-Prop 36-era offenders, especially among drug arrests (see Figure 11.3).

Pre-Prop 36-era drug offenders were more likely than Prop 36-era drug offenders to be sentenced to jail or prison following arrest for the eligible offense. Accordingly, pre-Prop 36-era offenders had less opportunity to re-offend because, during the follow-up period, they were more likely to be in custody for part or all of the period. This difference in sentencing is one aspect of the policies being compared. Hence, for a clear look at outcomes of these policies, there should be no adjustment for it. However, adjustments were made based on age, ethnicity, prior arrests over the last 12 months (drug, property, and violent), statewide unemployment rate, and county of conviction.

Note that a substantial amount of time has passed since comparison group offenders were convicted of offenses in 1997-1998. As time passes, additional changes other than Prop 36 (e.g. economy, culture, other policies and practices) have accumulated that cannot be easily accounted for making it increasingly difficult to attribute changes between this group and the Prop 36 years to Prop 36 itself. That said, differences between the comparison group and Prop 36 years have remained fairly stable over the years.

Figure 11.3
New Arrests During 12 Months After Offense
Prop 36 Years 4-6 vs Pre-Prop 36 Comparison Group



Note: as in prior UCLA reports, arrest rates in Figure 11.3 have been adjusted to control for differences in criminal history, demographics, and employment rate between years. It is therefore not appropriate to compare these arrest percentages to rates in Figures 11.1 or 11.2, which represent cohorts from a single year and are therefore are raw (unadjusted) rates.

Crime Trends

Previous UCLA examinations of crime and arrest trends have resulted in conclusions that increases in drug and property arrests were somewhat greater in California than they were nationally while arrests for violent crimes fell slightly more in California than they did nationally, but that the role that Prop 36 played in these trends could not be conclusively determined. These results are consistent with those reported recently by other authors. Gardiner (2008) concluded that drug arrests for under the influence of and possession of controlled substances increased in Orange County and that these increases were partially attributable to Proposition 36, though it was impossible to rule out all competing hypotheses. Ehlers and Ziedenberg (2006) also concluded that between 2000 and 2004 California's violent crime rate had declined at a rate higher than the national average, though they too stopped short of declaring a conclusive causal link between Prop 36 and violent crime. This chapter provides updated data, refines comparisons to contrast California to the rest of the nation (national numbers minus California), and examines possible contributors to the crime and arrest trends.

Violent crime and property crime rates refer to all offenses known to law enforcement (not only arrests) as reported in Uniform Crime Reports (UCR) collected by the United States Department of Justice Federal Bureau of Investigation (FBI) and published in a series of annual reports (FBI 1996-2008).

UCRs are submitted by local law enforcement agencies that tabulate the number of offenses brought to their attention based on reports of crime received from victims, officers who discover infractions, or other sources. These reports are submitted each month to the FBI either directly or through state UCR programs (FBI, 2008). These figures have been adjusted by the FBI to include estimated crimes for regions in which no reports were submitted.

The violent crime category includes the offenses of murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault. Property crimes include burglary, larceny-theft, and motor vehicle theft (FBI, 2008).

The FBI does not report the number of drug abuse related crimes in the same way that it does for violent or property crimes since such incidents are rarely reported, but the FBI does compile statistics on "arrests for drug abuse violations." Therefore, while they are not equivalent to crime rates, these arrest rates will be used as the best available proxy for drug offenses in this chapter. Drug abuse violations include crimes related to the possession, sale, and manufacture of illicit drugs. In 2007, possession accounted for 82.5% of all drug abuse violation arrests (FBI, 2008).

To aid interpretation of trends, California rates are compared to rates from the rest of the nation. These "rest of the nation" rates were computed by subtracting California incidents and populations from national totals, then computing an adjusted rate. This comparison is meant to allow identification of California trends that differ from broader national

trends.[53] Still, even where trends in California differ from those in the rest of the nation, the analyses reported in this chapter cannot definitively identify the full array of contributors to crime and arrest trends. That is, although certain trends may have emerged at the same time as Prop 36 implementation, other factors may explain these trends to a greater degree than Prop 36 policies.

Caution must also be exercised in interpreting California totals relative to those of the rest of the nation. The FBI (2008) lists the following as some factors known to affect the volume and type of crime that occur from place to place (or in this case state to state):

- Population density and degree of urbanization.
- Variations in composition of the population, particularly youth concentration.
- Stability of the population with respect to residents' mobility, commuting patterns, and transient factors.
- Modes of transportation and highway system.
- Economic conditions, including average income, poverty level, and job availability.
- Cultural factors and educational, recreational, and religious characteristics of the region's population.
- Family conditions with respect to divorce and family cohesiveness.
- Climate.
- Effective strength of law enforcement agencies.
- Administrative and investigative emphases of law enforcement.
- Policies of other components of the criminal justice system (i.e., prosecutorial, judicial, correctional, and probational).
- Citizens' attitudes toward crime.
- Crime reporting practices of the citizenry.

California is a very large and diverse state, which ameliorates some of these concerns, but to the extent that California varies from the rest of the country on factors such as those listed above, these may affect crime and arrest rates differentially to an unknown extent. Prop 36 is only one factor that differentiates California from the rest of the nation, and other factors may mask, augment, or reverse any potential effects of Prop 36.

Later in this chapter UCLA examines two possible factors that may have affected crime and arrest trends: number and rate per capita of sworn law enforcement officers, and levels of incarceration for different offenses. Increases in law enforcement staffing are commonly offered as a partial explanation for reductions in crime (e.g. Allday, 2009; Welch, 2009), while the allocation of more prison space to violent offenders was one of

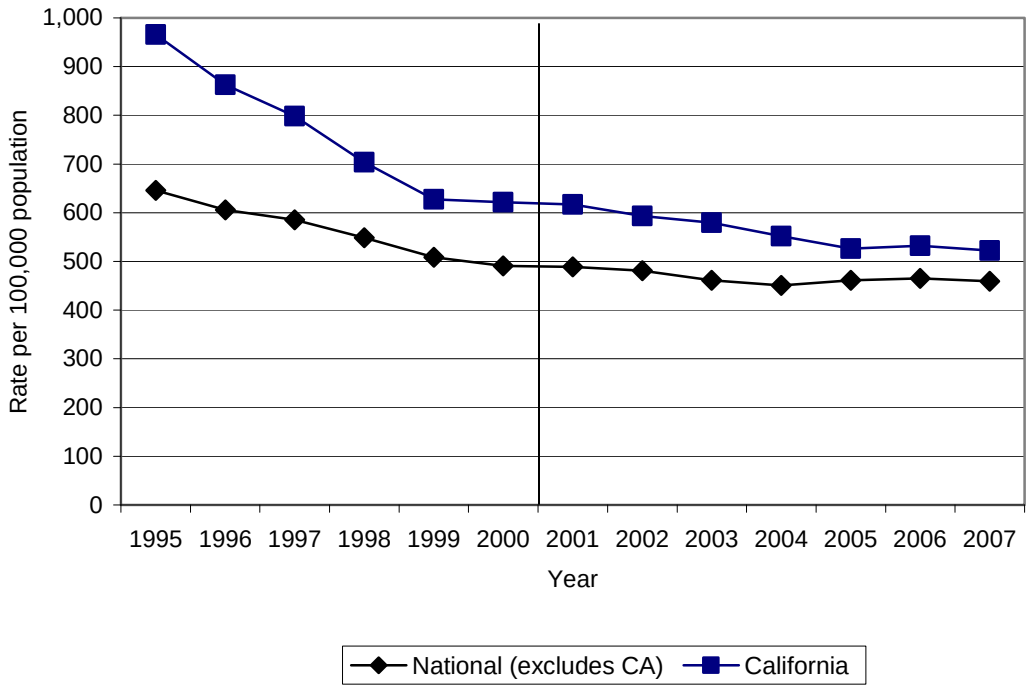
[53] Several other states have passed laws similar to those created by Prop 36 including Arizona (Proposition 200, 1996), Maryland (SB 194, HB 295, 2004), Hawaii (SB 1188, 2002), Washington State (SB 2338, 2002), and Kansas (HB 2309, 2003) (Rinaldo, & Kelly-Thomas, 2005). However, because each of these differs somewhat from the other and these comprise a relatively small portion of the national population, they were included in the "rest of the nation" analyses.

the initial rationales among proponents of Prop 36. These factors are also under the control of policymakers, making them particularly important to understand.

Violent Crime

As shown in Figure 11.4, reported violent crime fell more in California than it has in the rest of the nation, both during the period preceding Prop 36 and afterward. The vertical line indicates when Prop 36 was implemented. In 2000, the year prior to Prop 36 implementation, California's rate of 621.6 violent crimes per 100,000 population was higher than the rest of the nation by 130.8 crimes. By 2007, the difference was only 63.3 crimes.

Figure 11.4
Violent Crime Rates



This does not necessarily mean, however, that Prop 36 caused this change. An even larger narrowing between state and national numbers occurred in the late 1990's, before the Prop 36 era, and preliminary analyses indicate that statistically the rate of decrease actually flattened more in California than in the rest of the nation after Prop 36 implementation. Despite these mixed findings, it can be stated, however, that Prop 36 has not been associated with a net increase in violent crime, as arguments against the proposition in the State's voter information guide implied might be the case[54] (California

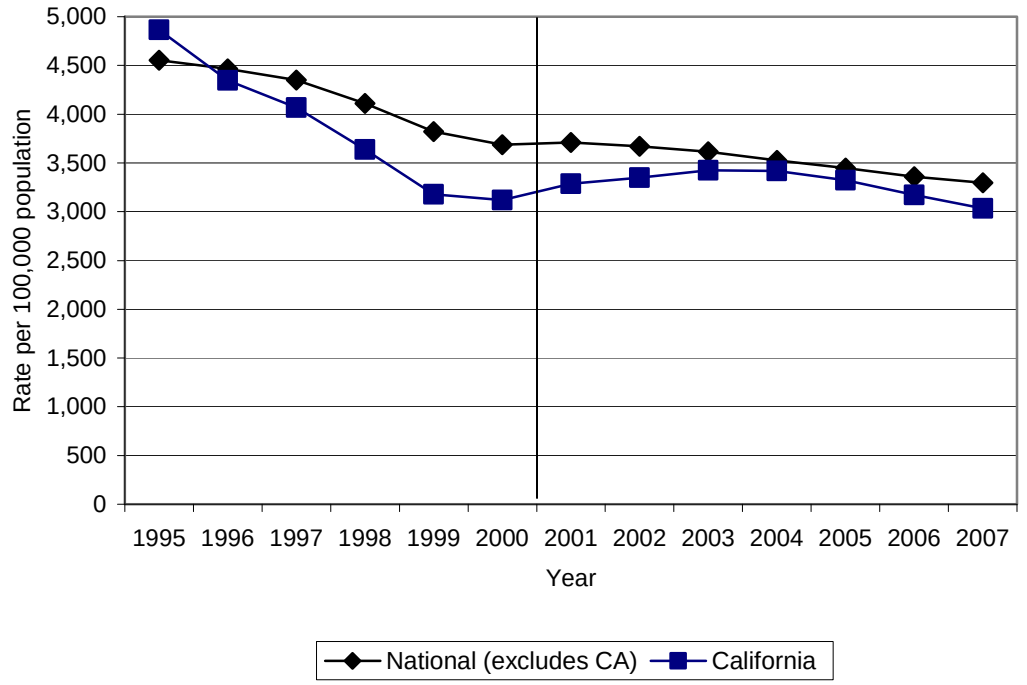
[54] "Puts Potentially Violent Drug Abusers on the Street. Proponents claim Proposition 36 deals only with non-violent drug users. In reality, it will allow an estimated 37,000 felony drug abusers to remain on our

Secretary of State, 2000a). Potential reasons for the narrowing between state and national numbers will be discussed in more detail later.

Property Crime

Figure 11.5 shows property crime rates over the same 13 year period. Following the passage of Prop 36, property crime rates initially increased in California even as national rates fell, but in 2005, 2006, and 2007 rates in California actually decreased faster than the national rate. In 2000, there were 568.6 fewer property crimes per 100,000 population in California than the rest of the nation, while in 2007 there were 262.3 fewer in California. As with other crime rates, it is not possible to causally link changes in these rates to Prop 36.

Figure 11.5
Property Crime Rates



Drug Arrests

As explained above, UCRs do not report incidents of drug crimes, so for this category of offenses, arrests (FBI 1996-2008) were used as a proxy instead.

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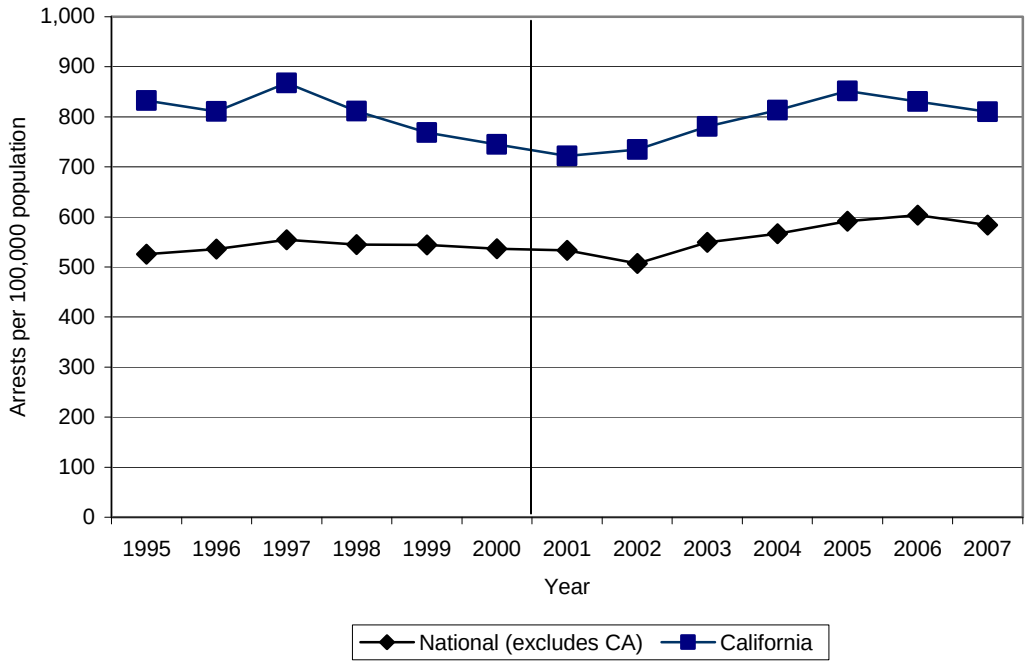
streets every year—many of them addicted to drugs that often ignite violent criminal behavior." Argument against Proposition 36.

As shown in Figure 11.6, between 2001 and 2005, drug arrest rates rose somewhat more in California than in the rest of the nation, but then decreased more in 2006 and 2007. In 2000, there were 208.4 more arrests per 100,000 population in California than in the rest of the nation. In 2007, the California rate was similarly 226.9 arrests higher than in the rest of the nation. Overall for the period 2002 through 2007, national and California drug arrests moved in similar directions.

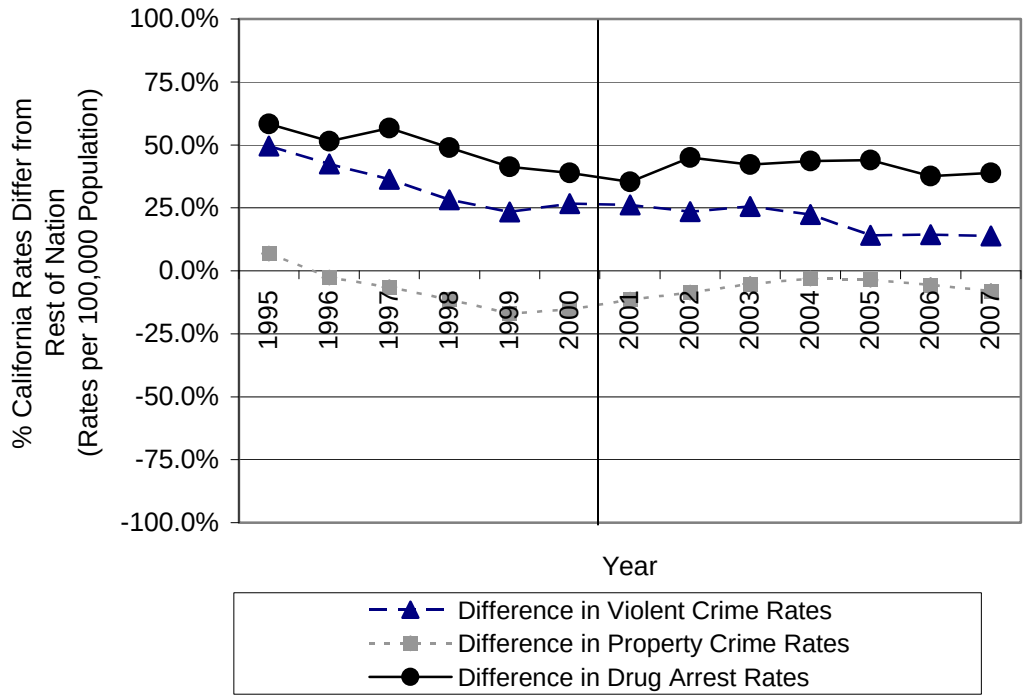
Figure 11.6
Drug Arrest Rates



Summary of Trends

In Figure 11.7, the difference in rates of violent and property crime and in drug arrests between California and the rest of the nation is shown as a percentage. Negative percentages indicate that California rates were lower than rates in the rest of the nation, while positive percentages indicate that California rates were higher. Trends close to the '0' line indicate little variation from national trends. Shown in this way, the degree to which trends in California differed from those in the rest of the nation is more easily discernable. In the Prop 36 era, violent crime decreased faster while both drug arrests and property crimes increased faster in California immediately after Prop 36 passage but then decreased faster in later years. Further passage of time will allow stronger evaluation of whether these trends are robust. Application of multivariate statistical techniques may identify some of the factors that may influence these trends.

Figure 11.7
Percentage Difference between California and Rest of Nation:
Violent & Property Crime Rates and Drug Arrest Rates



Potential factors Contributing to Crime and Arrest Trends

Prop 36 Eligible Offenders

UCLA has reported arrest statistics for Prop 36 eligible offenders that are generally, but not perfectly, consistent with these trends. Overall, relative to a comparison group, offenders who became eligible for Prop 36 were more likely to be arrested for drug and property crimes, while there was little difference in violent crimes (Urada & Hawken, 2008; Urada, Longshore, & Hawken, 2007). However, over a 30-month follow-up period, small reductions in drug and property crime arrests were also observed in each successive Prop 36 annual cohort. That is, offenders who became eligible for Prop 36 in FY 2003-2004 were arrested slightly less often than those who became eligible in 2002-2003, who in turn were somewhat less likely to be arrested than those who became eligible in 2001-2002. This is generally consistent with the initial rise then fall in the drug and property crime rates reported above. While this might partly be interpreted as resulting from improvements in Prop 36 implementation over time, the size of the reductions in the Prop 36 eligible populations were fairly small (drug arrests dropped from 49.0% in the first year cohort to 46.1% in the third year cohort; property arrests

dropped only slightly from 16.4% to 16.0%), and therefore cannot, on their own, account for the size of the statewide changes reported above based on the numbers currently available. Arrest data on newer cohorts, particularly the 2006-2007 cohort, is necessary to determine whether arrests have continued to decrease among more recent Prop 36 eligible offenders and to thereby discern whether this recent drop in arrest rates might be influenced in part by changes in arrest rates of Prop 36 offenders.

For violent crime, arrest patterns among Prop 36 eligible offenders are inconsistent with the crime trends reported above. That is, although rates were low, there was a modest trend for Prop 36 offenders to be arrested for violent crimes slightly more often than offenders in a pre-Prop 36 comparison group (Urada & Hawken, 2008; Urada, Longshore, & Hawken, 2007). Prop 36 may have contributed indirectly to the decrease in violent crime rates in California, however, by allowing more violent non-Prop 36 offenders to be incarcerated as prison space became more available and thus rendering these offenders unable to commit further such crimes in the community. It is also possible that unrelated concurrent trends such as the increase in police officers in the state over the same period may have played a role. These possibilities will be explored next.

Increases in Sworn Law Enforcement Officers

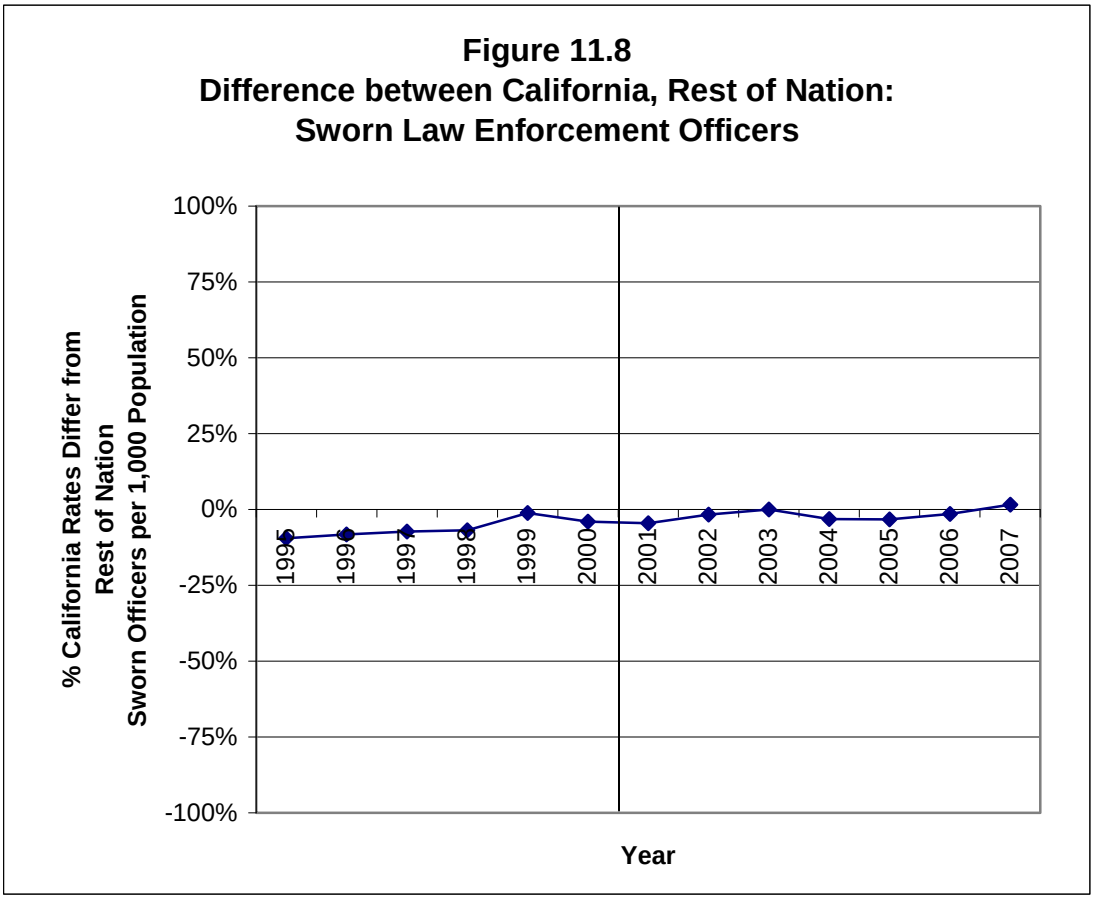
According to the FBI (FBI 1996-2008), between 1995 and 2007 the number of sworn law enforcement officers in California rose by 16,948. This represented an increase of 27.5%, and increased the number of officers per 1,000 population from 2.18 to 2.48. Between the years 2000 and 2007, the number of sworn officers increased by 12.3% and the number per 1,000 population increased from 2.38 to 2.48. In the rest of the nation, between 1995 and 2007 the number of sworn officers increased by 19.3%, and officers per 1,000 population rose from 2.41 to 2.44. Between 2000 and 2007 the national increase in officers was 6.9%, but because this failed to keep pace with a faster increase in the population, the number of officers per 1,000 population fell slightly from 2.48 to 2.44.

The net effect, shown in Figure 11.8, is that the number of sworn officers per 1,000 population grew somewhat more in California than in the rest of the nation, both over the 1995-2007 period and during the Prop 36 era. While the difference in state and national law enforcement increases is small in percentage terms, it may nevertheless partly explain the difference in state and national crime and arrest rates. However, it is not easy to reconcile both the state's decrease in violent crimes and increase in property crimes solely on the basis of the relative increase in law enforcement presence. Explanatory mechanisms such as the deterrent effect of an increased law enforcement presence would predict decreases in both types of crimes, which is not the case here.

It must also be noted that these increases in law enforcement were also associated with growth in the economy at that time. Since, as previously noted, economic factors may also play a role in crime, it is difficult to separate the effect of increased law enforcement from the broader effects of economic growth during this period. Data from 2008 and 2009 may be illuminating in this regard, given the recent sharp downturn in the economy.

Challenges are known to introduce measurement error into the data collected on police strength (Eck & Maguire, 2000), preventing strong conclusions from being drawn. This data also does not take into account changes in policing practices (e.g. community policing, use of new technologies) that may have an effect independent of the number of sworn officers.

Figure 11.8
Difference between California, Rest of Nation:
Sworn Law Enforcement Officers



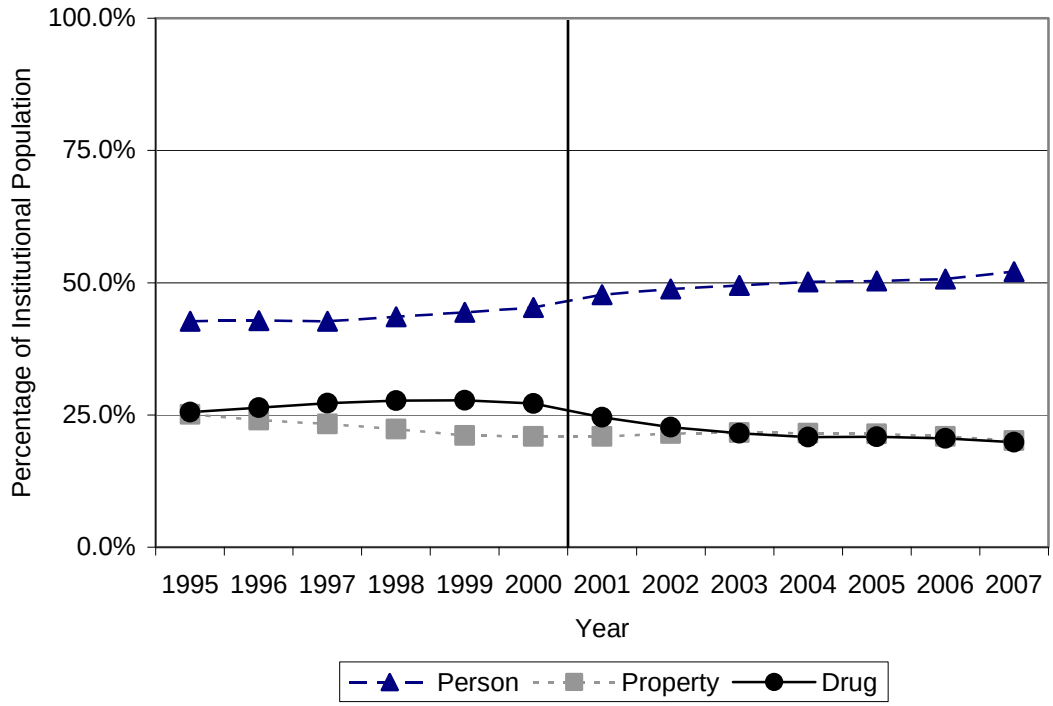
Changes in California's Incarcerated Population

One of the initial arguments for Prop 36 was that it would help keep violent criminals behind bars, given California's overcrowded prisons and consequent shortage of beds[55] (California Secretary of State, 2000). A few researchers have attempted to discern whether Prop 36 has had an impact on crime and incarceration, and have concluded that it has (Males, Macallair, and Jamison, 2002; Bailey and Hayes, 2006; Ehlers and Zeidenberg, 2006). UCLA examined this with the newest data available.

[55] "We don't want violent criminals to be released early to make room for nonviolent drug users. We must keep violent criminals behind bars, and try a different approach with nonviolent drug users." Argument in Favor of Proposition 36

Statistics from the California Department of Corrections (CDCR, 2008) suggest that Prop 36 has in fact been associated with such an effect. As shown in Figure 11.9, prior to Prop 36, between 1995 and 2000, the percentage of California's felon institution population incarcerated for drug offenses increased from 25.5% to 27.2%. However, immediately after Prop 36 was implemented in 2001, the percentage declined sharply. By 2007 drug offenders accounted for only 19.8% of the inmate population. At the same time, the percentage incarcerated for "crimes against persons", which includes homicide, robbery, assault and battery, sex offenses, and kidnapping (similar to but somewhat broader than the FBI's definition of violent offenses) increased from 45.3% in 2000 to 52.1% in 2007. That is, as the drug offender population in California's overcrowded prisons[56] dropped by 7.4 percentage points, the population incarcerated for crimes against persons increased by almost the same amount, 6.8 percentage points. This percentage corresponded to approximately 15,000 offenders in 2007.

Figure 11.9
CDCR Felon Institution Population by Offense Category



Detailed annual data on prison populations were not available in the same offense categories from any single source for both the state and the nation as is the case for crime and arrest data, so it was not possible to make precise comparisons between the state and the rest of the nation with prison incarceration data. The data above come from a state source (CDCR, 2008), while the most similar national data located by UCLA was prison

[56] Occupancy was at 196.5% of design capacity in 2007 (CDCR, 2008, table 5).

population data collected by the Department of Justice's Bureau of Justice Statistics (West & Sabol, 2008), which reported data only through 2005. According to this source, national prison population data followed trends similar to those in California, but were less pronounced. Between 2000 and 2005 the percentage of the nationwide prison population incarcerated for drug offenses decreased from 20.9% to 19.7%, a drop of 1.2 percentage points. In California over the same period the comparable drop was 6.3 percentage points. Nationally, the percentage incarcerated for violent crimes (defined somewhat more broadly in the national data than in the state's "crimes against persons" category) increased by 4.4%. In California over the same period, the percentage incarcerated for crimes against persons increased by 5.0%. The difference between these national and California numbers would be larger if it were possible to remove California from the national numbers. California accounted for approximately 12.5% of all state prisoners nationwide in 2007 (West & Sabol, 2008).

There is at least one shortcoming to the incarceration explanation, however. The percentage of California's prison population accounted for by property offenses has been largely flat in recent years: 20.9% in 2000 compared to 20.2% in 2007 (CDCR, 2008). Therefore, changes in incarceration alone cannot easily explain the overall increase in property crimes during the Prop 36 years.

Conclusions

Since Prop 36 was implemented in 2001, drug and property crime rates have risen overall in California and these increases were somewhat greater than in the rest of the nation. These initial increases have reversed in recent years, however. These statewide trends are consistent with arrest patterns found specifically in Prop 36 offenders. Over the same time period, violent crime also has fallen in California and this decrease has been greater than in the rest of the nation. As noted earlier, Prop 36 may not necessarily have contributed much to these trends. A number of causes are possible, a few of which have been covered here, but of the potential explanations investigated, none can fully explain all of the patterns of crime and arrest trends. A plausible set of explanations covering many different domains can be assembled to explain the crime patterns, the validity of such explanations is not easily proven.

The increase in drug arrests is consistent with the explanations reviewed above: Prop 36 eligible offenders are arrested more often for drug crimes, at least in part due to the fact that they are on the street more often than the comparison group during the period before Prop 36, which is confirmed by the incarceration data. Added to this, increased law enforcement presence may also contribute to more arrests.

The decrease in violent crime is very consistent with the incarceration explanation. After Prop 36 was implemented, the proportion of prison space used to incarcerate offenders who had committed violent crimes against persons rose while the proportion used to incarcerate offenders who had committed drug crimes dropped sharply. It is hard to imagine that incarcerating approximately 15,000 more violent offenders would not have at least some short-term impact on violent crime rates (to place this figure in context,

191,025 violent offenses occurred in California in 2007). Increases in law enforcement may have also contributed either toward the incarceration of violent offenders, the deterrence of new offenses, or both.

The increase in property crime is difficult to account for either with incarceration or law enforcement explanations, but it is consistent with previous findings on Prop 36 eligible offenders. That is, offenders who become eligible for Prop 36 do tend to get re-arrested for property crimes more often than comparable pre-Prop 36 offenders. Reduced incarceration of drug offenders may be tied to increases in property offenses in part due to attempts by offenders to finance further drug use. Ideally, drug use reductions achieved through treatment would ameliorate this effect of reduced incarceration, and lower arrest rates are indeed associated with treatment completion (Urada & Hawken, 2008). However, in many cases the treatment system does not appear to have adequate resources to provide the types of treatment (e.g. residential) that would optimally reduce arrest rates (Hawken, Urada, Anglin, & Longshore, 2007) or to provide close supervision (see Urada et al., 2009).

One of the most interesting patterns to emerge is the drop in drug and property crimes in recent years, reversing earlier trends. This trend is not easily explained with the law enforcement data presented here. The number of California officers per 1,000 population rose and fell over the years, and there were actually slightly more sworn officers per 1,000 population in 2003 than in 2006 (both on an absolute basis and relative to the rest of the nation), which is incongruent with property crimes being lower in 2006. It is possible that changes in policing policy (e.g. community policing) could have played a more important part than actual staff levels, but this hypothesis could not be tested with the data at hand. Nor do the crime patterns easily fit within the incarceration explanation. The property crime rate dropped while the percentage of the prison population incarcerated for property crimes did the same. Other explanations may be required.

For example, in 2006-2007, with the inclusion of Offender Treatment Program dollars, funding for Prop 36 programs increased to an all-time high, as did treatment completion rates (see Chapter 2). It is possible that this and/or other continuing Prop 36 improvements contributed to improved outcomes, but further monitoring of trends and outcomes among recent cohorts (especially follow up of the 2006-2007 cohort) is needed to confirm this hypothesis. There could also be a cumulative effect of treatment across cohorts. Treatment completers are arrested less often than non-completers, as presented in this chapter (see also Urada & Hawken, 2008; Urada, Longshore, & Hawken, 2007), but in any given one-year cohort this reduction has been eclipsed by higher arrests among the rest of the Prop 36 eligible offenders, including offenders who did not enter treatment, or entered treatment but did not complete it. However, across sequential years of Prop 36 cohorts, it is possible that reduced arrests among the accumulated number of treatment completers in subsequent years could eventually eclipse the effect of the other offenders, especially if across years non-completers are converted into completers over multiple treatment episodes, which would be consistent with a life-course perspective on drug use (e.g. Anglin, Hser, & Grella 1997; Hser et al., 2007). Continuing research and monitoring are needed to clarify these possibilities.

References

Allday, E. (2009). Violent crime rates drop dramatically in S.F. San Francisco Chronicle. Retrieved April 17, 2009 from: http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2009/04/03/BASU16RQIS.DTL

Anglin, M. D., Hser, Y. I., & Grella, C. E. (1997). Drug addiction and treatment careers among clients in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, 11(4), 308-323.

Bailey, A., & Hayes, J. M. (2006). Who's in Prison? San Francisco: Public Policy Institute of California.

California Secretary of State (2000a). Argument in favor of proposition 36. Voter Information Guide. Retrieved January 25, 2009, from http://vote2000.sos.ca.gov/VoterGuide/text/text_noarg_36.htm

California Secretary of State (2000b). Argument in favor of proposition 36. Voter Information Guide. Retrieved January 25, 2009, from http://vote2000.sos.ca.gov/VoterGuide/text/text_yesarg_36.htm

California Department of Corrections and Rehabilitation (2008). California Prisoners and Parolees, 2007. Retrieved November 1, 2008 from http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Annual/CalPris/CALPRISd2007.pdf

Eck, J. & McGuire, E. (2000). Have Changes in Policing Reduced Violent Crime? An Assessment of the Evidence. In Albert Blumstein and Joel Wallman eds. The Crime Drop In America. Cambridge, UK: Cambridge University Press.

Ehlers, S., & Ziedenberg, J. (2006). *Proposition 36: Five Years Later*. Washington D.C.: Justice Policy Insitute.

Hawken, A., Urada, D., Anglin, D. & Longshore, D. (2007). Funding Implications of Improvements to SACPA. In: Evaluation of the Substance Abuse and Crime Prevention Act 2005 Report. Retrieved April 13, 2007 from the UCLA ISAP website:http://www.uclaisap.org/prop36/documents/SACPAEvaluationReport.pdf

Hser, Y-I., Longshore, D., & Anglin, M.D. (2007). The life course perspective on drug use: A conceptual framework for understanding drug use trajectories, *Evaluation Review, 31,* 515-547.

Males, M., Macallair, D., & Jamison, R. (2002). Drug use and justice: An examination of California drug policy enforcement. San Francisco, CA: Center on Juvenile and Criminal Justice.

Rinaldo, S., Kelly-Thomas, I. (2005). Comparing California's Proposition 36 (SACPA) with Similar Legislation in Other States and Jurisdictions. Berkeley, CA: The Avisa Group. Accessed at: http://www.prop36.org/pdf/ComparisonProp36OtherStates.pdf.

United States Department of Justice, Federal Bureau of Investigation. (2008). Crime in the United States, 2007. Retrieved (January 13, 2009), from http://www.fbi.gov/ucr/cius2007/index.html

United States Department of Justice, Federal Bureau of Investigation. (2007). Crime in the United States, 2006. Retrieved (January 13, 2009), from http://www.fbi.gov/ucr/cius2006/index.html

United States Department of Justice, Federal Bureau of Investigation. (2006). Crime in the United States, 2005. Retrieved (January 13, 2009), from http://www.fbi.gov/ucr/05cius/

United States Department of Justice, Federal Bureau of Investigation. (2005). Crime in the United States, 2004. Retrieved (January 13, 2009), from http://www.fbi.gov/ucr/cius_04/

United States Department of Justice, Federal Bureau of Investigation. (2004). Crime in the United States, 2003. Retrieved (January 13, 2009), from http://www.fbi.gov/ucr/03cius.htm

United States Department of Justice, Federal Bureau of Investigation. (2003). Crime in the United States, 2002. Retrieved (January 13, 2009), from http://www.fbi.gov/ucr/02cius.htm

United States Department of Justice, Federal Bureau of Investigation. (2002). Crime in the United States, 2001. Retrieved (January 13, 2009), from http://www.fbi.gov/ucr/01cius.htm

United States Department of Justice, Federal Bureau of Investigation. (2001). Crime in the United States, 2000. Retrieved (January 13, 2009), from http://www.fbi.gov/ucr/00cius.htm

United States Department of Justice, Federal Bureau of Investigation. (2000). Crime in the United States, 1999. Retrieved (January 13, 2009), from http://www.fbi.gov/ucr/99cius.htm

United States Department of Justice, Federal Bureau of Investigation. (1999). Crime in the United States, 1998. Retrieved (January 13, 2009), from http://www.fbi.gov/ucr/98cius.htm

United States Department of Justice, Federal Bureau of Investigation. (1998). Crime in the United States, 1997. Retrieved (January 13, 2009), from http://www.fbi.gov/ucr/97cius.htm

United States Department of Justice, Federal Bureau of Investigation. (1997). Crime in the United States, 1996. Retrieved (January 13, 2009), from http://www.fbi.gov/ucr/96cius.htm

United States Department of Justice, Federal Bureau of Investigation. (1996). Crime in the United States, 1995. Retrieved (January 13, 2009), from http://www.fbi.gov/ucr/95cius.htm

Urada, D. & Hawken, A. (2008). Re-Offending and Crime Trends. In: *Evaluation of the Substance Abuse and Crime Prevention Act 2008 Report*. Prepared for the Department of Alcohol and Drug Programs, California Health and Human Services Agency. Los Angeles: UCLA Integrated Substance Abuse Programs.

Urada, D., Longshore, D., & Hawken, A. (2007). Re-Offending. In: *Evaluation of the Substance Abuse and Crime Prevention Act 2005 Report*. Prepared for the Department of Alcohol and Drug Programs, California Health and Human Services Agency. Los Angeles: UCLA Integrated Substance Abuse Programs.

Urada, D., Gardiner, C., & Anglin, D. (2009). Commentary : Current Status and Future of California's Substance Abuse and Crime Prevention Act (Proposition 36). http://www.uclaisap.org/prop36/html/reports.html

Welch, W.M. (2009). Murders and other violence drop in L.A. USA Today. Retrieved April 17, 2009 from:

http://www.usatoday.com/news/nation/2009-04-09-lacrime_N.htm
West, H.C., & Sabol, W.J. (2008). Prisoners in 2007. Bureau of Justice Statistics Bulletin, U.S. Department of Justice Office of Justice Programs. Retrieved January 25, 2009 from http://www.ojp.usdoj.gov/bjs/pub/pdf/p07.pdf

Chapter 12: Performance Measurement[57]

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Increasing pressures for cost containment and improved outcomes are prompting publicly-funded substance abuse treatment delivery systems to develop performance and outcomes measurement capabilities to foster accountability and quality care. While various performance and outcomes measurement initiatives and efforts are underway to identify and adopt common empirically–based measures for substance abuse treatment, this is still an emerging area in a field that is transitioning from an acute care to a chronic care approach to understanding and supporting recovery.

To date, the most widely used performance measures for substance use treatment include initiation, engagement, retention, and use of evidence-based practices. Continuity of care measures and surveys of clients' experience with care are also currently under development and testing.

Although a number of performance measurement models exist, further testing and refinement are necessary, especially regarding different settings and special client populations. Caution must also be exercised to anticipate and address unintended consequences, and organizational factors that may be associated with measurement issues should be considered in the development of such a measurement system.

Background

Measurement of performance and outcomes are essential steps in understanding, managing, and ultimately improving an agency or system of care. Performance measures are used to gauge the performance of treatment programs, or of the broader care system, while outcome measures gauge progress in an area of life function or status measured at the patient level that is expected to be positively influenced by a treatment. (McLellan et al., 2007).

Both performance and outcome measures have already been discussed in this report. Performance measures include show rates (Chapter 1), treatment completion rates (Chapter 2), and treatment retention rates (Chapter 2). Chapters 1 and 2 also reported treatment outcome measures in several domains (drug use, employment, family/social, criminal justice, health, mental health) drawn from the California Outcome Monitoring System (CalOMS). Chapter 11 reported on arrest outcomes.

[57] This chapter was developed in part by members of UCLA's Continuum of Services System Re-engineering (COSSR) evaluation as part of the COSSR evaluation and was adapted for use in this report as part of an ongoing effort to achieve research synergy and cost efficiency across evaluations through collaboration. The COSSR evaluation team has submitted a new report to the California Department of Alcohol and Drug Programs that is under review at this writing. The COSSR team would like to acknowledge the assistance of Mady Chalk, Jack Kemp, and the various state directors who shared materials used to draft this chapter.

Chapters 3 through 7 also examined many of these performance and outcome measures within specific populations. For some of these populations, one or more measures were less relevant (e.g. treatment completion rates in methadone maintenance programs), while in other cases measures took on added importance (e.g. social support outcomes among women), demonstrating the importance of choosing appropriate measures depending on the population of interest.

Chapters 8 and 10 went a step further to discuss how performance can be improved through a variety of locally generated techniques. Chapter 8 in particular discussed process improvement techniques advocated by the Network for the Improvement of Addiction Treatment (NIATx) to identify performance problems, measure them, and implement or change practices to improve performance.

Although both performance and outcome measurement are important, ultimately because traditional methods used to measure outcomes tend to be costly (requiring post-treatment follow-up), time-consuming, and too dependent upon scarce research skills to be useful or practical for management, the field is increasingly looking to measure process as a proxy (McLellan et al., 2007). Therefore, the focus of this chapter will be on performance measurement. This is the first step in implementing performance management, which will be discussed further in future reports.

The goal of this chapter is to provide a broader perspective on performance measurement by reviewing the literature and other available information, and to identify relevant measures commonly in use nationally that could potentially be applied to Prop 36. The first section of this chapter discusses the nature and importance of performance measurement in general. The second section describes performance measurement models currently established or recommended by expert groups across the field. The chapter concludes with a brief description of performance measurement considerations for Prop 36 and other offender populations.

Introduction: Framework for Performance Measurement

The need to improve accountability and ensure the quality of publicly-funded substance abuse treatment provided in the United States has been emphasized at the federal, state, and local levels, and has been underscored by the seminal Institute of Medicine Quality Chasm Reports (IOM, 2001; 2006). Pressures for cost containment and improved outcomes have directed federal, state, county and treatment agencies toward the use of performance and outcomes management data systems, evidence based practices, and quality improvement strategies.

One major challenge that is currently being confronted by the field is that current data and treatment systems tend to approach substance dependence as an acute, curable medical disorder rather than as a chronic disease subject to relapse. This model has dominated the field of addiction over the last three decades, especially since the American Medical Association (AMA) in 1954 and World Health Organization (WHO) Expert Committee in 1957 recognized drug addiction as a physiological medical disease.

Because of this, the performance and accountability efforts of virtually all addiction treatment programs since the 1970s have focused solely on client outcomes measured as change in predominately drug and alcohol use, criminal activity, and productivity by way of employment over discrete, episodic treatment periods (e.g. from admission to discharge) (McLellan, Chalk, & Bartlett, 2007). This has resulted in the continuing dominance of measures of 'treatment completion' at discharge, with the underlying assumption that once addicted individuals "complete" an episode they will no longer use drugs and will return to "normal health" with lifetime immunity to drug use (Dennis et al., 2006).

Such acute treatment models do not address the chronic and relapsing nature of addiction. The environmental influences that individuals are exposed to once they 'complete' treatment will be triggers for relapse (Stitzer, et al. 1983). Hser et al. (1997) argue that the current treatment system leads many to develop "treatment careers," which entail having a number of relatively short treatment episodes over time, which are typically not integrated in any way. McLellan et al. (2005) also contend that this tendency has led many to conclude that "treatment is not effective," since the majority of individuals entering treatment do not result in "successful completion." Furthermore, Stitzer and colleagues (1983) assert that the therapeutic success of this episodic strategy is counterproductive. Research demonstrates that successful completion of interventions based on an acute care model will result in only temporary symptom reduction (McLellan et al., 2005) and without engagement into some form of social support venue or activity or formal continuing care management/monitoring, prolonged success will be elusive. On the other hand, some therapeutic models of treatment have been designed to address addiction as a chronic illness, including (1) methadone maintenance opiate addiction, which maintains addicted patients in a more stable and functional state over time, rather than attempt to "cure" them (Ball and Ross 1991); (2) therapeutic communities and other long-term residential programs, which take the position that some addicts require treatment over an extended period of time (De Leon, et al. 2000); and (3) self-help therapeutic programs, which assert that recovery is a life-long process and therefore urge substance dependent individuals to remain active in these programs for considerable periods (Humphreys, 2004).

A recent review of the research on treatment effectiveness in the United States suggests that factors related to improved client outcomes are engagement in treatment (Simpson et al., xxxx), longer stay or duration in treatment (retention) (DATOS studies - Hubbard et al., date; Simpson et al., xxxx), use of evidence based practices and approaches, including appropriate medications (cite, NQF), receiving supplemental services for medical, psychiatric and/or family problems (xxxxx, xxxx), promoting participation in mutual self-help groups (McLellan, xxxx), and ensuring care continuity or continuing care post-initial treatment (cite).

As the current treatment system evolves toward a chronic care model, a performance system that monitors critical elements of a chronic care model – engaging, retaining, and transferring clients between appropriate levels of care will be critical.

Performance Measurement Models

In general, the substance abuse field has lagged behind health care in terms of measuring and managing performance (Garnick et al., 2002; McLellan, Bartlett & Chalk, 2006). However, performance measurement initiatives have been recently launched and are gaining momentum. This section reviews several important efforts specific to substance abuse treatment performance that are currently underway.

Washington Circle

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) in 1998 supported the development of the Washington Circle Group, a multidisciplinary group of service providers, researchers, managed care representatives, and policymakers, charged with identifying and establishing a set of performance measures for substance abuse treatment (McCorry et al. 2000). The performance measures developed by the Washington Circle are the most widely adopted and well-known in the substance abuse field. They represent a core set of measures, which specify treatment services patients receive across the four stages in the continuum of care: prevention (education), intervention (recognition), treatment, and maintenance (recovery).

The identification of efficient performance measures for substance abuse treatment is still in the developmental phase. Washington Circle measures are being further adapted and specified (Garnick et al., 2009). However, initiation and engagement measures in particular have emerged as useful treatment performance measures for outpatient treatment. These measures have most recently been refined based on testing among publicly-funded substance abuse outpatient treatment settings (Garnick et al., 2006; 2009).[58]

- Initiation: the percentage of individuals who have an initial outpatient or intensive outpatient service and then went on to receive a second substance abuse service (other than detoxification or crisis care) within 14 days after the initial service. Index services with substance abuse services in the previous 60 days are excluded, since these suggest treatment had been previously initiated.

- Engagement: the percentage of individuals who initiated outpatient or intensive outpatient substance abuse treatment and received two additional services within 30 days after initiation.

In addition, there is substantial evidence that prescription medications are effective as adjuncts for the treatment of opioid addiction and alcohol use/dependence (see for example Garbutt, 2009; CSAT, 2005; also see section on Opioid Addiction Treatment

[58] It is important to note that the "episode of care" is defined differently for outpatient and intensive outpatient services in that they should include only clients who are starting new episodes of treatment, whereas it is not a requirement for the continuity of care measures (Garnick et al., 2009).

below), and the Washington Circle Group is developing performance indicators for medication assisted treatment geared toward alcohol and opioid addiction that can be applied in treatment settings. Continuity of care measures are also under development.

The Washington Circle measures have been adopted by a number of national, state and local entities. The National Committee for Quality Assurance (NCQA), a private not-for-profit organization founded in 1990 and created to improve health care quality, adopted the Washington Circle identification, initiation, and engagement measures for inclusion in its Health Plan Employer Data and Information Set (HEDIS®) in 2004(or 2003?) (Garnick et al., 2000b; NCQA, 2007, 2009). HEDIS is the most widely used set of quality measures in the nation's managed health care sector (Harris et al., 2008). The Center for Substance Abuse Treatment and the Robert Wood Johnson Foundation's (RWJF) Strengthening Access and Retention (STAR) grants are also using Washington Circle measures as part of their reporting requirements. The Network for the Improvement of Addiction Treatment (NIATx – see Chapter 8) has also adopted Washington Circle measures as a key part of their process improvement efforts.

To date, research studies examining the application of Washington Circle performance measures to substance abuse treatment outcomes have been limited. In a study linking Oklahoma administrative data with state criminal justice system data, Garnick et al. (2007) reported that clients who initiated new episodes of outpatient treatment and were engaged in treatment were significantly less likely to be arrested or incarcerated during the following year. These results have also been replicated using Washington State data (Campbell, forthcoming).

Several studies have been conducted at the Veterans Administration (VA) to examine the HEDIS measures in relationship to patient outcomes and settings. The Veterans Administration has adapted the three WC measures – identification, initiation, and engagement - to monitor delivery of care (Harris et al., 2008). In one of the studies examining whether process measures are associated with facility-level client improvement on clinical outcomes 7 months post-treatment, Harris et al., (2007) observed that higher initiation rates were not associated with facility-level improvement in Addiction Severity Index (ASI) alcohol composites but were modestly related to increased improvement in ASI drug composite scores. Harris et al. also found that identification and engagement rates were unrelated to average improvement clinical outcomes. The authors suggested that the Washington Circle measures that target processes early in treatment may not be sufficient to impact post treatment outcomes and suggested that they be supplemented with other measures of treatment effectiveness.

A second study found that VA patients meeting the engagement measure improved significantly more in the alcohol, drug and legal domains of the ASI than patients who did not engage. A stronger relationship was found for alcohol and legal outcomes for patients receiving outpatient services. However, the authors note that although the benefits for patients who were engaged were statistically significant, they were less so clinically (Harris et al., 2008, Does meeting…).

McCarty (2007) proposes that the somewhat mixed findings from some of the studies examining the association of Washington Circle process measures (e.g., initiation) with improvements in outcomes (e.g., Garnick et al., 2007; Harris et al., 2007) may be due to differences in methodology (testing different aspects of performance measurement systems) rather than the measures themselves. At a minimum, the mixed findings underline the developmental status of these performance measures and strongly imply that caution must be exercised in their implementation and interpretation.

National Quality Forum

The National Quality Forum (NQF) recently developed a set of consensus standards related to performance. The NQF, a non-profit organization whose members are drawn from a broad cross section of the health care system, was established to develop and implement a national strategy for health care quality measurement and reporting. In 2007, the NQF, with support from the Robert Wood Johnson Foundation, issued voluntary consensus standards on evidence-based practices for the treatment of substance use conditions.[59] These include: 1) screening and brief interventions, 2) proven psychosocial interventions, 3) medication access, 4) wraparound services, and 5) aftercare and recovery management. These standards are intended to guide providers on how to achieve desired outcomes, purchasers in making reimbursement and coverage policies, and patients in making decisions about services (NQF, 2007). In a presentation given at the summit on using performance outcome measures to improve treatment in Los Angeles, Capoccia (2008) organized the nationally endorsed treatment practices into the following domains and sub-domains:

1. Identification of substance use conditions
    a. Screening and case finding
        i. During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems, and any tobacco use.
        ii. Healthcare providers should employ a systematic method to identify patients who use drugs that considers epidemiologic and community factors and the potential health consequences of drug use for their specific population.
    b. Diagnosis and assessment for positive screens
        i. Patients who have a positive screen for – or an indication of – a substance use problem or illness should receive further assessment to confirm that a problem exists and determine a diagnosis. Patients diagnosed with a substance use illness should receive a multidimensional, biopsychosocial assessment to guide patient-centered treatment planning for substance use illness and any coexisting conditions.
2. Initiations and engagement in treatment
    a. Brief intervention: patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism guidelines and/or any

[59] For more information see the NQF web site at www.qualityforum.org

tobacco use should receive a brief motivational counseling intervention by a healthcare worker trained in this technique.

b. Promoting engagement in treatment for substance abuse illness: Healthcare providers should systematically promote patient initiation of care and engagement in ongoing treatment for substance use illness. Patients with substance use illness should receive supportive services to facilitate their participation in ongoing treatment.

c. Withdrawal management: Supportive pharmacotherapy should be available and provided to manage the symptoms and adverse consequences of withdrawal, based on a systematic assessment of the symptoms and risk of serious adverse consequences related to the withdrawal process. Withdrawal management alone does not constitute treatment for dependence and should be liked with ongoing treatment for substance use illness.

3. Therapeutic interventions to treat substance use illness
    a. Psychosocial interventions: Empirically validated psychosocial treatment interventions should be initiated for all patients with substance use illnesses.
    b. Pharmacotherapy
        i. Pharmacotherapy should be recommended and available to all adult patients diagnosed with opioid dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly inked with psychosocial treatment/support.
        ii. Pharmacotherapy should be offered and available to all adult patients diagnosed with alcohol dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support.
        iii. Pharmacotherapy should be recommended and available to all adult patients diagnosed with nicotine dependence (including those with other substance use conditions) and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with brief motivational counseling.
4. Continuing care management of substance use illness: Patients with substance abuse illness should be offered long-term, coordinated management of their care for substance use illness and any coexisting conditions, and this care management should be adapted based on ongoing monitoring of their progress.

Texas Christian University

A team at Texas Christian University (TCU) has measured engagement somewhat differently than Washington Circle. This measure assesses client motivation and readiness for treatment as well as participation during the first month following admission (Simpson, Joe, Dansereau, and Chatham, 1997a; Simpson, Joe, Rowan-Szal,

and Greener, 1997b). The goal is to focus on client motivation and readiness at admission as an important determinants of attendance and drug use during treatment, which are in turn related to program completion and other treatment outcomes (Prochaska, et al. 1992; Stahler, et al. 1993; De Leon 1996; Simpson, et al. 1997b; Joe, et al. 1998; Simpson, et al. 1997b, Joe, et al. 1998; Simpson, 2004).

SAMHSA National Outcome Measures (NOMs)

SAMHSA, in partnership with the states, developed national standards of measurement and reporting in several areas of client functioning, referred to as the NOMs, as a way of evaluating all treatments they support. The goal of NOMs is to "improve service efficiency and effectiveness through the use of indicators of program accountability and performance" (SAMHSA, 2005). In 2007, reporting of the NOMs became a requirement for all states receiving substance abuse and prevention block grants. Although largely outcome based, NOMs currently includes the following performance domains:

- Capacity/Access to services
- Retention
- Evidence-based practices

Each of these is discussed in further detail below.

Access

One of the factors impeding treatment entry is waiting time - the period when individuals seeking treatment are delayed in receiving services or even denied referral for a service of interest (Appel et al., 2004; Farabee et al., 1998; Rotstein & Alter, 2006). The likelihood of treatment-seeking substance abusers actually entering treatment after assessment is often less than 50% (Donovan et al., 2001; Stark et al., 1990). In part, this is related to substance abusers' limited tolerance for treatment wait time, with longer waits associated with higher rates of pretreatment attrition (Festinger et al., 1995; Hser et al., 1998; Kaplan & Johri, 2000). Access is a priority performance measure among several states across the country given that substance users who wait for treatment services are less likely to enter treatment and often continue to engage in criminal activity including using illicit drugs, and placing them and society at increased risk for public health problems (Chawdhary et al., 2007; Festinger et al., 1995; Hser et al., 1998; Pollini et al., 2006).

Access is particularly important for special populations, including highly severe drug users (daily use), injection users, homeless, and pregnant women. Among injection drug abusers who attempted to enter treatment, the majority (67%) did not go to their first visit because they were placed on a waiting list (Pollini, McCall, Mehta, Vlahov, & Strathdee, 2006). Waiting time has also been shown to negatively affect treatment engagement and retention (Simpson et al., 1997; Bell et al., 1994; Claus & Kindleberger, 2002), although its effect is inconsistent as other studies have not supported this relationship (Addenbrooke & Rathod, 1990; Best et al., 2002). Some studies indicate that waiting lists undermine the opportunity to reach substance abusers during a possible "teachable moment" (Carlson, 2006).

In Prop 36, barriers to access can apply to at least two timepoints. Upon conviction and acceptance of Prop 36, the offender typically must access an assessment at an assessment center. Following completion of assessment, they must then access treatment. Barriers at either time point may decrease show rates (see Chapter 1 for more information on Prop 36 show rates).

Currently, there is not a clear performance definition for treatment access. Waiting time has been described as "a function both of whether prospective clients can get into the queue and how quickly they get off the queue and into treatment" (Friedmann, Lemon, Stein, & D'Aunno, 2003). Wait time has also been characterized as the period between clinic intake assessment and actual program admission (Schottenfeld, O'Malley, Abdul-Salaam, & O'Connor, 1993; Best et al., 2002). More recent conceptualizations of waiting time have included the time substance abusers must wait to initially present for treatment services once they or others recognize a problem, which includes phone screenings in addition to intake assessments (Chawdhary et al., 2007; Rotstein & Alter, 2006). According to several state directors, access should be captured both in terms of wait time from first call for screening to assessment and wait time from first assessment to first treatment session.

Retention

Previous investigations into the treatment process found that a longer stay in treatment (retention) is among the few consistent predictors of better post-treatment outcomes (Anglin & Hser 1990; De Leon 1990; Hubbard, Craddock, Flynn, Anderson & Ethridge 1997). Results from several national treatment evaluation studies with adults have concluded that there is an important relationship between treatment retention (length of time) and treatment outcomes, such as decreased drug use, decreased criminal involvement (Gossop et al., 2003; Hubbard et al., 2003; Simpson, 1979, 1981; Simpson et al., 1997; Simpson & Sells, 1982; Garner et al., 2009; Dennis et al., 2006). Similarly, a comprehensive review by Williams and Chang (2000) supports the important relationship between retention and treatment outcome (especially reduced drug use) with adolescent populations. In addition to supporting the relationship between treatment retention and treatment outcome, these studies identified minimum retention thresholds of approximately 90 days for outpatient and residential care, and approximately one year for methadone treatment. Hser and others (2001) observed critical optimal doses of treatment retention for adolescents – at least 90 days in outpatient or residential programs or 21 days in short-term residential have successful outcomes. These clinical expectations or thresholds of minimum dosages of treatment exposure (retention) have been associated with a greater likelihood of continuing in recovery beyond the initial treatment phase and treatment discharge (De Leon, 1984; 1985; 1991), with longer stays associated with incrementally favorable behavioral outcomes over time (Simpson, 1979; 1981; Simpson et al., 1997). Thus, treatment retention at these thresholds are potentially a very important performance measure.

Use of Evidence-based Practices

Use of evidence based practices (EBPs) is considered to be an essential performance measure in substance abuse settings (NQF, 2007; SAMHSA NOMS, 2006). Such practices are an integral part of the movement toward focusing on health care quality (IOM, 2001). Performance improvement systems have included the use of EBPs as a mechanism to improve outcomes. While the use of EBPs in community settings has been increasing, difficulties remain (e.g., workforce barriers, fidelity, knowledge of specific practices/approaches and their effectiveness) (Ganju, 2006; Glasner-Edwards & Rawson, in press; Herbeck, Hser, & Teruya, 2008; Lamb, Greenlick & McCarty, 1998). Additionally, there is no consensus on procedures or criteria for determining what constitutes evidence-based practices (Glasner-Edwards & Rawson, in press). The Addiction Technology Transfer Center refers evidence-based practices as "interventions that show consistent scientific evidence of being related to preferred client outcomes" (check for cite). To date, progress has been made in determining the specific pharmacological and behavioral approaches and interventions that are considered to be evidence-based for effectively treating substance use disorders (SAMHSA, 2005; McGovern & Carroll, 2003; Miller & Wilbourne, 2002). In this context, the phrase evidence-based practice has been defined and referred (IOM, 2001) to as an intervention that:

- has a high quality evaluation design and methodology;
- has been replicated by other researchers;
- has a manual available;
- has been validated by some form of documented scientific evidence;
- integrates best practice evidence with clinical expertise and patient values; and
- has consistent scientific evidence showing that they improve client outcomes.

Although there have been a wide array of interventions and programs for substance use disorders that have been supported empirically as listed by the SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) (SAMHSA, 2005), critics argue that what constitutes evidence-based can vary and can constrain practitioner and patient choice (Chambless & Ollendick, 2001). Furthermore, while the treatments that are considered to be effective are established through empirical research, the absence of efficacy or effectiveness studies does not mean that a given intervention approach is ineffective (Miller et al., 2005).

A review of the existing literature suggests that consensus regarding the optimal procedures to identify and measure practices with sufficient empirical foundation to be considered "evidence-based" has not yet been reached (Miller et al., 2005). The American Psychiatric Association's (APA, 2006) most recently published "practice guidelines" for the treatment of addiction synthesizes research evidence in the form of both a literature review and clinical recommendations to guide the selection of appropriate modalities, levels of care, and practices for each of the major substances of abuse. A different model for addressing this issue has been developed by the National Institute on Drug Abuse (NIDA). The NIDA "Blue Book," describes a set of 13 overarching "principles" that characterize the most effective drug abuse treatments (NIDA, 1999; 2000). These "principles" include broad concepts such as "effective

treatment attends to multiple needs of the individual, not just his/her drug use," and are intended to help clinicians make empirically informed decisions about treatment. A comprehensive set of 47 consensus-based Treatment Improvement Protocols (TIPs), referred to as "best practice guidelines" have been set forth by CSAT. These are conceptually similar to practice guidelines, although distinguished by a subtle qualitative difference. Rather than serving as a guide for clinicians and patients, their intended purpose is to guide treatment program planning and outline processes that facilitate dissemination of research-based intervention strategies into clinical settings (Lacroix, 2002). In addition, some states have legislated lists of EBPs (e.g., Oregon and Wyoming), which include treatments that have met sufficient standards of evidence quantity and quality. Although these lists offer one method for promoting awareness and use of EBPs, using specific lists for recommending such practices may be premature and may seriously limit the array of treatments needed to serve a diversity of treatment populations.

Forum on Performance Measures for Behavioral Health and Related Service Systems

The importance of the consumer perspective in evaluating the quality of care is an area that has long been recognized. However, while satisfaction surveys are important in measuring whether a person received what was expected, research has found that satisfaction is not closely associated with treatment outcomes (cites). The SAMHSA-supported Forum on Performance Measures for Behavioral Health and Related Service Systems (known at the Forum on Performance Measures), a collaborative effort among the Adult Mental Health Workgroup, the Child/Adolescent Mental Health Workgroup, the Mental Health Statistical Improvement Program, the Washington Circle (Adult Substance Abuse) and the Washington Circle Subcommittee on Adolescent Substance Abuse, was charged with the coordination of efforts across mental health and substance abuse service systems to identify and develop common indicators focusing on quality care.

Clients' Experience with Care

The Forum has been developing and testing a consumer Modular Survey[60] of perceptions of care that can be widely used across patient populations and settings in the domains of access, quality/appropriateness, and outcome/improvement (McCorry 2007; Doucette, 2008). Eight of the seventeen items addressing the areas of social connectedness and client perception of care in the final NOMs set were from the Modular Survey. After pilot testing, 12 measures have been identified: seven for quality and five for perceived outcomes (Bartlett et al., 2005?). These initial "down-payment" set of common measures for the consumer survey-based perception of care include:

- Quality/appropriateness of treatment/services
    - My calls were returned within 24 hours
    - When I needed services right away, I was able to see someone as soon as I wanted

[60] See the Washington Circle web site for more information about the Modular Survey. (http://www.washingtoncircle.org/)

    - The people I went to for services spent enough time with me
    - I helped to develop my treatment/service goals
    - The people I went to for services were sensitive to my cultural background (race, religion, language, sexual orientation, etc.)
    - I was given information about different services that were available to me
    - I was given enough information to effectively handle my condition
- Perceived outcomes of treatment/services
    - My symptoms are not bothering me as much
    - I am better able to cope when things go wrong
    - I am better able to accomplish the things I want to do
    - I am less likely to use alcohol and other drugs
    - I am doing better in work/school

SAMHSA CSAT has also pilot tested a set of client perception items specifically for substance abuse treatment, which was coordinated with the Mental Health Statistics Improvement Program and the National Outcomes Measures. Thirty-five items addressing treatment relationship, self-recognition of problem, recovery/relapse prevention, and social connectedness were developed are being pilot tested.

Continuity of Care

There is a growing body of research on the effectiveness of continuing care across a variety of treatment modalities. Overall, studies have demonstrated that the best single predictor of positive outcomes (reduced drug use, reduced criminal activity, and increased functioning) over time (most at one year follow-up) was subsequent participation in continuing care (both formal and informal) as well as months of (or time in) aftercare attendance. Studies have also found positive correlations between self-help participation and long-term outcomes (for a comprehensive review see Humphreys, 2004). Because participation in these groups has also been linked to improved outcomes in other formal treatment programs (Hawkens, Catalano and Miller 1992), treatment clients in neighborhoods where there are less available "other forms of social support" to engage clients are lacking may be more at risk of dropping out. Participation in these types of groups can serve to fill the often considerable amount of time that might otherwise be spent on consumption and consumption-related activities (Tucker et al., 1990). Further research is needed to establish guidelines for when clients are ready to enter continuing care and to develop performance measures to monitor progress.

Focusing simply on completion, rather than "continued participation in aftercare or social support," limits our ability to understand long-term symptom reduction and success among substance-dependent individuals (McLellan et al., 2005). Due to the chronic, relapsing nature of addiction, treatment clients are frequently urged to participate in continuing care[61] after their initial phase of treatment has ended. Continuing care is provided in a variety of formats and modalities, including group counseling, individual

[61] This phase of care was previously referred to in the field as "aftercare," but the more common term is now continuing care, which better conveys the idea that active participation in treatment should continue rather than it being a 'separate entity' (McKay, 2005).

therapy, telephone counseling, brief checkups, and self-help meetings. For instance, when substance abuse treatment is delivered in inpatient or residential settings, continuing care can consist of outpatient "continuing care" group therapy sessions or follow-up phone sessions, or participation in self/mutual help programs. These continuing care services are intended to ease the transition from the controlled therapeutic environment and maintain progress achieved in the program.

Specific performance measures that fit a continuum of care approach to recovery from substance abuse are in the early stages of development and are currently limited. For example, the Washington Circle group expanded its original measures – identification, initiation, and engagement – to include continuity of care performance measures after assessment service, detoxification, short-term residential, long-term residential, and inpatient (Godley et al., 2008, ppt). Step-down to a less intensive care, a readmission to the same level of care, or a step-up to a more intensive level of care is considered as continuity of care; no assumptions are made regarding the appropriateness of the care regarding this measure (Garnick et al., 2009). Continuity of care measures were developed by levels of care so that episodes of care can be differentially considered for each level. The measures have been defined for the following levels of care.

- *After assessment:* the percentage of individuals who have a positive assessment for substance abuse and received another substance abuse service (other than detoxification or crisis care) within 14 days.
- *After detoxification:* the percentage of individuals who received a detoxification service and received another substance abuse service (other than detoxification or crisis care) within 14 days of discharge from detoxification. (Two methods of calculating the detoxification measure were specified.)
- *After short-term residential, long-term residential, or inpatient treatment:* the percentage of individuals who have a stay that is followed by another service (other than detoxification or crisis care) within 14 days after discharge.

The Washington Circle continuity of care measures are currently being pilot tested and several studies have already been completed. In one published study examining the feasibility of calculating the measures using existing sate and local administrative data, Garnick et al., (2009) reported that state agencies were able to make the calculations but found wide variation in the measures (e.g., initiation and engagement rates across states). In another study, investigators reported continuity of care was significantly associated with higher rates of abstinence from both alcohol and marijuana (Godley et al., 2008).

Special Considerations for Prop 36 and Other Offender Populations

While a substantial number of those involved in the criminal justice system have substance use problems (Lurigio, 2000; Taxman, Perdoni, & Harrison, 2007; Wexler & Fletcher, 2009), most offenders do not receive treatment while in prison (Mumola, 1999). Further, offenders who do receive treatment while incarcerated face particular challenges when transitioning to community based treatment (aftercare), and typically have multiple and diverse needs. They often lack the knowledge, skills, and resources necessary to

adjust to life in the community when released, which may increase the risk of relapse and recidivism (Leshner, 1997). SAMHSA CSAT has published a Treatment Improvement Protocol (TIP) that addresses the "continuity of offender treatment for substance use disorders from institution to community" (CSAT, **xxxx**). This TIP presents guidelines for ensuring continuity of care, including provision of case management, assessment of risk and needs, offender accountability (e.g., graduated sanctions), and ancillary services (e.g., housing, employment). While aftercare is important, a recent review of drug treatment aftercare following release from prison concluded that "the claim of certainty about aftercare effectiveness is not well substantiated and that the precise nature of aftercare services needed is not well understood" (Pelissier, Jones, and Cadigan, 2007, p. 311). The authors recommended that research is needed to "identify the most effective type and intensity of aftercare."

Substance abuse treatment has consistently demonstrated declines in the substance abuse and criminal activity of drug offenders (Anglin & Perrochet, 1998; Farabee et al., 2001; Parker & Auerhahn, 1998; Peyton & Gossweiler, 2001; Wexler & Fletcher, 2009; White & Gorman, 2000). Over the last several decades, there has been a trend toward providing community-based substance abuse treatment and criminal justice supervision to eligible drug-involved offenders in lieu of incarceration (e.g. Prop 36), as a less punitive, potentially more effective, and cost-effective means of weakening the connection between drugs and crime (Anglin, Longshore, & Turner, 1999; Belenko, 2001; Hser et al., 2003; Peyton & Gossweiler, 2001; Wellisch, Prendergast, & Anglin, 1993). For offender populations, evidence of treatment attendance (participation), readiness, and urine drug screen testing are three of the most relevant and valid measures of offenders' progress and success (Joe et al., in press; Simpson et al., 2004).

Urada & Gonzales (2008) reviewed a number of possible performance and outcome measures and weighted the advantages, disadvantages, and possible unintended consequences of using each, particularly within the context of available California data systems and implementation of Prop 36. The authors concluded that ideally several complementary measures would be used as a package to offset the individual weaknesses of each measure. One possible combination would be treatment show rates, treatment initiation within 14 days, treatment engagement within 30 days, CalOMS outcome measures and pre-post arrests comparisons. All of these measures have potential and if all measures were used, the package of measures would monitor performance at the beginning of the process (treatment show rates, treatment initiation within 14 days), during treatment (treatment engagement within 30 days, arrests), and outcomes at treatment discharge (CalOMS discharge outcome variables), and after treatment (arrests). Still, significant challenges remain. For example, data on treatment initiation and engagement are not available on a statewide basis.

UCLA's Continuum of Services System Re-engineering (COSSR) evaluation will release a new report later this year that will include summaries and recommendations related to performance and outcome measurement as well as to performance management. It is expected that this report will inform and serve as a foundation for future development of performance measurement within Prop 36.

References

Agosti, V., Nunes, E., & Ocepeck-Welikson, K. (1996). Patient factors related to early attrition from an outpatient cocaine research clinic. American Journal of Drug & Alcohol Abuse, 22, 1-5.

Andrews, D., Zinger, I., Hoge, R. D., Bonta, J., Gendreau, P., & Cullen, F. (1990). Does correctional treatment work? Criminology, 28, 369-404.

Butzin, C. A. Martin, S. S., & Inciardi, J. A. (2002). Evaluating component effects of a prison-based treatment continuum. Journal of Substance Abuse Treatment, 22, 63-69.

Campbell, C. I., Alexander, J. A. (2002). Culturally competent treatment practices and ancillary service use in outpatient substance abuse treatment. Journal of Substance Abuse Treatment, 22, 109-119.

Center for Substance Abuse Treatment. (1998). Continuity of Offender Treatment for Substance Use Disorders from Institution to Community. Improvement Protocol (TIP) Series 30. DHHS Publication No. (SMA) 98-3245. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2005a). Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-04048. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2005b) *Substance Abuse Treatment for Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 44. DHHS Publication No. (SMA) 05-4056. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2005c) *Substance Abuse Treatment for Persons with Co-Occurring Disorders.* Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3922. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Daley, M. C. (2005). Race, managed care, and the quality of substance abuse treatment. Administration & Policy in Mental Health, 32, 457-476.

Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., Lynde, D., Osher, F. C., Clark, R. E., & Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. Psychiatric Services, 52(4), 469-476.

Evans, E., Spear, S. E., Huang, Y. C., & Hser, Y. (2006). Outcomes of drug and alcohol treatment programs among American Indians in California. American Journal of Public Health, 96, 889-896.

Finn, P. (1996). Cultural responsiveness of drug user treatment programs: Approaches to improvement. Substance Use & Misuse, 31, 493-518.

Fletcher, B. W., & chandler, R. K. (2006). Principles of drug abuse treatment for criminal justice populations (NIH Publication No. 06-5316). Rockville, MD: National Institute on Drug Abuse.

Fosados, R., Evans, E., & Hser, Y. (2007). Ethnic differences in utilization of drug treatment services and outcomes among Proposition 36 offenders in California. Journal of Substance Abuse Treatment, 33, 391-399.

Friedmann, P.D., Saitz, R., & Samet, J. H. (2003). Linking addiction treatment with other medical and psychiatric treatment systems. Principles of addiction medicine (3rd Ed.). Chevy Chase, MD: American Society of Addiction Medicine.

Friedmann, P. D., Taxman, F. S., & Henderson, C. E. (2007). Evidence-based treatment practices for drug-involved adults in the criminal justice system. Journal of Substance Abuse Treamtetn, 32, 267-277.

Garbutt, J. C. (2009). The state of pharmacotherapy for the treatment of alcohol dependence. Journal of Substance Abuse Treatment, 36(1), S15-23.

Grant, B. F., Stinson, F. S., Dawson, D. A., Chou, P., Dufour, M. C., Compton, W., Pickering, R. P., Kaplan, K. (2004). Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders. Archives of General Psychiatry, 61, 807-816.

Grella, C. E., & Stein, J. A. (2006). Impact of program services on treatment outcomes of patients with comorbid mental and substance use disorders. Psychiatric Services, 57(7), 1007-1015.

Kessler, R. C., Nelson, C. B., McGonagle, K. A., et al. (1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. American Journal of Orthopsychiatry, 66, 17-31.

Leshner, A.I. (1997). Addiction is a brain disease and it matters. *Science,* 278(3), 5

Lewin Group, Inc. (2001). Health Resources and Services Administration Study on Measuring Cultural Competence in Health Care Delivery Settings: A Review of the Literature. Prepared under contract with the Health Resources and Services Administration, DHHS.

Lundgren, L. M., Amodeo, M., Gerguson, F., & Davis, K. (2001). Racial and ethnic differences in drug treatment entry of injection drug users in Massachusetts. Journal of Substance Abuse Treatment, 2, 145-153.

Lurigio, A. J., (2000). Drug treatment availability and effectiveness: Studies of the general and criminal justice populations. Criminal Justice and Behavior, 27(4), 495-528.

McLellan, A.T.; Chalk, M.; & Bartlett, J. (2007). Outcomes, performance, and quality--What's the difference?, Journal of Substance Abuse Treatment, 32(4), 331-340.

Mulola, C. J. (1999). Substance abuse and treatment, state and federal prisoners, 1997. Washington, DC: Bureau of Justice Statistics.

National Alliance on Mental Illness. Dual diagnosis and integrated treatment of mental illness and substance abuse disorder. Accessed on 4/21/2009: http://www.nami.org

National Institute on Drug Abuse. Strategic Plan on Reducing Health Disparities: NIH Health Disparities Strategic Plan, Fiscal Year 2004-2008 (Revised July 2004).

Niv, N., & hser, Y. (2006). Drug treatment service utilization and outcomes for Hispanic and White methamphetamine abusers. Health Services Research, 41, 1242-1257.

Perron, B. E., Mowbray, O. P., Glass, J. E., Delva, J., Vaughn, M. G., & Howard, M. O. (2009). Differences in service utilization and barriers among Blacks, Hispanics, and Whites with drug use disorders. Substance Abuse Treatment, Prevention, and Policy, 4:3.

Simpson, D. W. (1997). Effectiveness of drug-abuse treatment. In: J. A. Egertson, D. M. Fox, & A I. Leshner (Eds.), Treating drug abusers effectively (pp. 41-73).

Malden, MA: Blackwell Publishers, co-published with the Milbank Memorial Fund.
Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (2003). Co-Occurring Disorders: Integrated Dual Disorders Treatment (draft version). Accessed on April 22, 2009 at http://mentalhealth.samhsa.gov/cmhs/Community Support/toolkits.
Simpson, D. D. (2004). A conceptual framework for drug treatment process and outcomes. Journal of Substance Abuse Treatment, 27, 99-121.
Simpson, D. D., Joe, G. W., & Brown, B. S. (1997). Treatment retention and follow-up outcomes in the drug abuse treatment outcome study (DATOS). Psychology of Addictive Behaviors, 11, 294-307.
Taxman, F. S., Soule, D., & Gelb, A. (1999). Graduated sanctions: Stepping into accountable systems and offenders. Prison Journal, 79, 182-204.
Taxman, F., S., & Thanner, M. (2006). Risk, need, and responsivity: It all depends. Crime & Delinquency, 52, 28-51.
Thanner, M. H., & Taxman, F. S. (2003). Responsitivity: the value of providing intensive services to high-risk offenders. Journal of Substance Abuse Treatment, 24, 137-147.
Urada, D., & Gonzales, R. (2008). Performance Monitoring & Outcome Measurement in Drug Treatment Systems. In: Evaluation of the Substance Abuse and Crime Prevention Act 2008 Report. 231-264. Retrieved from: http://www.uclaisap.org/prop36/documents/2008%20Final%20Report.pdf
Wells, K., Klap, R., Koike, A., & Sherbourne, C. (2001). Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. American Journal of Psychiatry, 158, 2027-2032.
Wexler, H. K., & Fletcher, B. W. (2007). National criminal justice drug abuse treatment studies (CJ-DATS) Overview. The Prison Journal, 87, 9-24.
Wu, E., El-Bassel, N., Gilbert, L., Piff, J., & Sanders, G. (2004). Sociodemographic disparities in supplemental service utilization among male methadone patients. Journal of Substance Abuse Treatment, 26, 197-202.

Appendix A: UCLA's Proposition 36 Stakeholder Survey

Participants
Respondents in all 58 counties were asked to complete the Prop 36 Stakeholder survey by email. By March 24, 2009 UCLA had received completed or partially completed surveys from 41 of California's 58 counties. However, because many of the non-responding counties had small populations, the total population of the participating counties represented 90.3% of the state population. Response rates by agency varied, with the greatest number of responses coming from lead agencies (39 counties responded, one of which stated that they had no Prop 36 offenders), followed by assessment (26), probation (22), court administrators (21), public defenders (14), and district attorneys (10). Some counties had more than one respondent per section of the survey. Individual item response rates were lower in part because stakeholders lacked time, did not have the information readily available, or handled so few Prop 36 clients during the time period covered by the survey that prospective respondents felt many questions were not applicable or determined that the resources required to complete the survey outweighed perceived benefits.

Surveys
Surveys were designed by UCLA to address evaluation research questions agreed upon with ADP. Draft copies of the stakeholder survey were sent to representatives from each stakeholder group for feedback, and UCLA revised the instrument where appropriate.

As noted above, UCLA divided the survey into distinct sections corresponding to agencies involved in Prop 36: the lead agency (most often the county alcohol and drug administrator), assessment, court administration, district attorney, public defender, and probation.

Questions focused on Prop 36 operation and needs, perceived strengths and weaknesses of Prop 36 in each county, needs and services available to special populations, offender management strategies, suggestions for improving Prop 36, and performance measurement.

All surveys were formatted as Microsoft Word Forms, which participants could complete and return electronically. Additional copies were made available on the internet. Upon request, paper copies of the surveys were made available.

Procedures
The survey along with a cover letter was emailed to the designated primary Prop 36 contact for each county on December 19, 2008. Follow-up phone calls were placed to ensure that the survey was received and to answer any questions about it. The survey was re-emailed as needed to individuals who reported not receiving the survey previously.

Respondents were sent a letter thanking them for their participation and, if allowed, a $25 money order.

Appendix B: UCLA's Proposition 36 Treatment Program Survey

Participants
UCLA selected a random sample of 105 Prop 36 providers who served more than 5 clients in 2006-2007 according to records in CalOMS. Of these, 67 responded (63.8%). Four responded that they were not (were no longer) Prop 36 providers, leaving 63 valid responses from providers in 25 different counties.

Survey Construction
Surveys were designed by UCLA to address evaluation research questions agreed upon with the Department of Alcohol and Drug Programs. Draft copies of the treatment provider survey were sent to two current and former treatment providers for feedback, and UCLA revised the instrument where appropriate in response.

Questions focused on program characteristics, treatment services, treatment population, treatment characteristics, and performance measurement. Respondents were also asked if they had any additional comments/information regarding the implementation/operation of Prop 36 in their treatment programs.

Procedures
Initial scripted phone calls were made in December 2008 to confirm whether programs served Prop 36 clients, verify mailing addresses, and obtain the names of the program directors to whom the surveys were to be addressed. The surveys, along with cover letter and payment form, were express mailed via DHL in December, 2008. Programs with only P.O. Box delivery available were sent the surveys via First Class U.S. Mail.

Follow-up calls were placed to ensure that the survey was received and to answer any questions about it. The survey was re-mailed, faxed, or e-mailed as needed to individuals who reported not receiving the survey previously. Additional calls were placed and e-mails sent to non-respondents.

Respondents were sent a letter thanking them for their participation and a $75 money order.

Study staff created the data entry database using Filemaker Pro v.5 database software. The data entry fields were pre-tested and minor adjustments were made. A notes section was added to indicate any inconsistencies with the data (e.g., marking two responses, when only one should have been marked; writing in a range [e.g., 3-5] instead of the average [e.g., 4]). Data was entered, cleaned, exported, and converted into an SPSS database for analysis.

Appendix 1.1 Prop 36 eligibility criteria for probationers and parolees

There are some Prop 36 eligibility exceptions. Prop 36 does not apply to any offender previously convicted of one or more serious or violent felonies, unless the current drug possession offense occurred after a period of five years in which the offender remained free of both prison custody and the commission of an offense that resulted in (1) a felony conviction other than a non-violent drug possession offense or (2) a misdemeanor conviction involving physical injury or the threat of physical injury to another person. Also ineligible is any non-violent drug possession offender who has been convicted in the same proceeding of a misdemeanor not related to the use of drugs or any felony. Prop 36 does not apply to any offender who, while using a firearm, unlawfully possesses (1) a substance containing cocaine base, cocaine, heroin, or methamphetamine or (2) a liquid, non-liquid, plant substance, or hand-rolled cigarette, containing phencyclidine. Prop 36 does not apply to any offender who, while using a firearm, is unlawfully under the influence of cocaine base, cocaine, heroin, methamphetamine, or phencyclidine. Prop 36 does not apply to any offender who refuses drug treatment as a condition of probation or parole.

Terms of Proposition 36 Participation for Parolees and Probationers

Factor	Parolees	Probationers
Controlling Law	Penal Code 1210, 3063.1, 3063.2	Penal Code 1210, 1210.1, 1210.5
Adjudication Authority	Board of Prison Terms	Superior Court
Supervision Authority	Parole and Community Services Division, California Department of Corrections and Rehabilitation	County probation department
Serious or Violent Background	Parolees who have ever been convicted of a serious or violent felony are ineligible.	Offenders with prior serious or violent felony convictions are eligible if the conviction is more than five years old and they have been free of both prison custody and non-drug possession felony or violent misdemeanor convictions during that period.
Disposition of charges	Placement in Proposition 36 is the final disposition. Failure to complete treatment must be charged as a new violation.	Original charges remain open for dismissal upon successful completion or re-sentencing upon failure to complete treatment.
Term of supervision	Placement on parole occurs before placement in Proposition 36 and will terminate independently of parolees' progress in treatment.	If not already on probation, offenders are placed on probation. Probation will not terminate prior to completion of treatment.
Disposition of drug violations	Parolees become ineligible upon the second violation subsequent to placement (first violation for those on parole before July 2001).	Probationers become ineligible upon the third violation subsequent to placement (second violation for those on probation before July 2001).
Source: Joseph Ossmann, Acting Director for the Office of Substance Abuse Programs, California Department of Corrections and Rehabilitation		

Appendix 1.2 Characteristics of Prop 36 clients entering treatment during FY 2007-08 by county

			Referral type		Race/ethnicity				Sex		Age	Employment status				Primary drug type[62]					Prior tx
			%		%				%		Mean	%				%					%
County	Size[63]	N	Prbtn	Parole	Wht	Hisp	AfrAmr	Oth[64]	Women	Men	Age	Full time	Part time	Unemp	NILF[65]	Meth	CocCrck	MJ	Her	Alc	Yes
Alameda	1	908	93.4	6.6	44.9	20.4	24.1	10.6	31.1	68.9	35.6	27.9	8.9	39.2	24	53.6	15.3	12.8	10.4	6.8	43.4
Alpine*	4	0	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Amador	4	27	100	*	81.5	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Butte	3	486	74.7	25.3	74.9	8.6	3.9	12.5	34.8	65.2	36.3	13.2	11.9	40.3	34.6	61.5	5.4	12.8	6	14.2	71.2
Calaveras	4	46	97.8	2.2	84.8	*	*	*	39.1	60.9	*	*	*	34.8	*	65.2	*	*	*	*	63.0
Colusa	4	21	85.7	14.3	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Contra Costa	1	888	79.7	20.3	47.4	17	28.6	6.9	24.1	75.9	33.7	11.7	9.4	43.5	35.5	45.7	14.6	22.2	5.5	10.7	47.1
Del Norte	4	27	63	37	88.9	*	*	*	*	*	*	*	*	*	*	74.1	*	*	*	*	*
El Dorado	3	209	82.8	17.2	72.3	19.6	*	*	34.9	65.1	29.6	16.3	15.3	29.7	38.8	45.9	*	24.4	*	21.5	52.5
Fresno	1	1824	75.7	24.3	31.2	48	13.6	7.2	25.4	74.6	33.9	21.1	11.4	37	30.6	50.8	12.1	16.9	6.2	12.1	54.6
Glenn	4	99	73.7	26.3	58.6	33.3	*	*	35.4	64.7	33.5	24.2	*	40.4	*	76.8	*	*	*	*	55.6
Humboldt	3	222	75.2	24.8	82.4	*	*	11.8	36	64	36.1	14	9.5	33.3	43.2	56.3	*	19.8	15.3	*	61.7
Imperial	3	269	85.9	14.1	16.7	78.1	*	*	24.5	75.5	33.9	8.6	9.3	58	24.2	47.2	*	15.2	27.1	*	63.2
Inyo*	4	14	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Kern	2	1285	79.4	20.6	49.6	38.4	9.7	2.4	32.2	67.8	34.8	19.8	10.6	38.7	30.9	57	5.1	19.8	5.8	10.4	10.5
Kings	3	309	91.9	8.1	33	51.5	6.8	8.8	27.2	72.8	33.1	29.1	12.6	33.0	25.2	60.2	*	17.2	*	13.9	56.0
Lake	4	133	75.2	24.8	76.7	*	*	*	34.6	65.4	36.8	18.8	13.5	33.1	34.6	60.9	*	18.8	*	12.8	65.4
Lassen	4	45	66.7	33.3	93.3	*	*	*	42.2	57.8	*	*	*	*	71.1	53.3	*	*	*	*	68.9
Los Angeles	1	9366	85.9	14.1	25.1	43.3	25.8	5.7	23.6	76.4	37.1	19.1	10.8	33.1	37.1	40.4	29.6	12	8	8.4	58.2
Madera	3	442	80.3	19.7	45	46.2	5.0	3.8	24.4	75.6	31.3	15.4	11.1	45.7	27.8	52.5	*	22	5.4	16.5	67.7
Marin	2	168	94.1	6	60.7	16.1	18.5	*	25.6	74.4	35.4	17.9	21.4	23.8	36.9	38.1	19.6	14.9	*	20.2	58.7
Mariposa*	4	21	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Mendocino	3	259	63.7	36.3	65.6	12	9.7	12.7	33.6	66.4	36.1	19.3	10.8	32.8	37.1	56	6.6	17	*	16.6	71.6
Merced	3	356	82.3	17.7	29.8	50.3	12.1	7.9	24.7	75.3	35	8.2	8.7	51.1	32.0	60.4	5.9	21.4	*	7.9	64.1
Modoc*	4	10	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Mono*	4	2	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Monterey	2	347	91.6	8.4	34	52.5	9.2	*	28.5	71.5	34.4	17.3	10.7	33.7	38.3	48.7	20.5	12.1	12.1	6.6	36.9

[62] Primary drug type does not equal 100%. Per Department of Alcohol and Drug Program policies pertaining to public release of alcohol and other drug treatment data by county, a primary drug type of "other" was omitted from the table.

[63] County size reflects categories developed by the County Alcohol and Drug Program Administrators' Association of California (CADPAAC). Code 1 indicates a large-sized county (N=13), code 2 indicates a medium-sized county (N=12), code 3 indicates a small-sized county (N=14), and code 4 indicates a very small-sized county (N=19).

[64] Per Department of Alcohol and Drug Program policies pertaining to public release of alcohol and other drug treatment data by county, race/ethnicity of "Asian American/Pacific Islander," "Native American," and "Other" was aggregated into one category called "Other."

[65] Not in the labor force.

Napa	3	270	67	33	63	22.6	*	*	20.7	79.3	35.5	21.5	*	*	59.6	56.7	*	13	*	21.1	64.8
Nevada	3	79	88.6	11.4	84.8	*	*	*	36.7	63.3	34.4	*	*	21.5	50.6	51.9	*	*	*	*	60.8
Orange	1	4178	83.0	17.0	52.6	35.3	3.5	8.6	27.3	72.7	34.0	27.2	13.3	42.1	17.4	59.5	6.9	14.9	12.0	5.9	42.1
Placer	2	184	82.1	17.9	77.2	15.2	*	*	38.0	62.0	28.0	16.3	*	26.1	50.0	46.7	*	21.7	*	15.8	48.9
Plumas	4	26	76.9	23.1	76.9	*	*	*	*	*	*	*	*	*	*	88.5	*	*	*	*	69.2
Riverside	1	1438	78.9	21.1	41.9	42.2	9.2	6.6	24.5	75.5	36.1	25.0	13.1	23.2	38.8	71.1	7.4	8.6	6.3	6.1	36.2
Sacramento	1	1620	68.5	31.5	43.8	19.2	28.2	9.0	25.1	74.9	37.0	10.9	8.8	39.9	40.4	49.0	18.7	16.4	9.7	5.4	44.0
San Benito	4	82	93.9	6.1	25.6	64.6	*	*	26.8	73.2	31.6	*	*	46.3	22.0	57.3	*	25.6	*	*	65.9
San Bernardino	1	2368	85.6	14.4	29.2	43.9	9.2	17.8	27.0	73.0	35.8	24.2	11.6	26.0	38.2	62.8	8.6	14.6	5.7	7.6	36.9
San Diego	1	2218	76.7	23.3	43.7	31.5	15.5	9.3	25.4	74.6	36.4	24.5	11.2	31.7	32.7	51.4	10.1	16.3	10.4	11.1	60.3
San Francisco	1	377	58.9	41.1	25.5	17.8	43.2	13.5	16.5	83.6	38.7	13.3	8.5	19.1	59.2	17.0	40.1	13.5	10.6	16.5	29.3
San Joaquin	2	1173	87.0	13.0	43.3	29.1	19.5	8.2	24.8	75.2	35.9	10.4	7.7	40.4	41.5	54.7	13.2	14.1	12.1	4.9	35.6
San Luis Obispo	2	402	87.3	12.7	71.9	21.9	*	*	29.9	70.2	30.6	22.4	20.9	35.3	21.4	49.3	4.5	24.4	8.2	13.2	69.0
San Mateo	1	753	90.7	9.3	41.2	25.9	17.7	15.3	25.5	74.5	36.9	20.9	14.9	36.9	27.4	46.6	19.0	17.1	5.6	11.4	69.5
Santa Barbara	2	524	90.1	9.9	38.7	50.4	4.8	6.1	34.5	65.5	33.4	21.2	13.7	32.1	33.0	66.6	10.5	8.2	8.0	5.7	44.3
Santa Clara	1	2323	91.9	8.1	31.1	44.4	9.6	14.9	30.2	69.8	36.3	18.9	11.2	36.2	33.8	61.1	12.2	11.2	3.4	8.7	58.4
Santa Cruz	2	366	95.6	4.4	65.3	29.8	*	*	37.7	62.3	33.1	18.3	23.2	40.2	18.3	48.9	7.9	7.1	29.0	6.8	70.5
Shasta	3	362	60.8	39.2	78.7	5.0	4.7	11.6	35.4	64.6	35.9	16.9	7.5	42.8	32.9	61.9	*	15.5	*	12.2	51.3
Sierra*	4	1	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Siskiyou	4	32	96.9	3.1	65.6	*	*	*	*	*	*	*	*	*	75	59.4	*	*	*	*	*
Solano	2	431	78	22	16.5	60.3	14.6	8.7	29.5	70.5	36	17.4	10.7	35.3	36.7	45.9	15.8	18.3	6.0	12.8	55.2
Sonoma	2	599	87.7	12.4	68.6	16.5	5.7	9.2	28.9	71.1	36.1	17.2	14.9	32.9	35.1	54.1	5.5	16.7	9.7	13.2	53.9
Stanislaus	2	643	85.9	14.2	57.2	29.6	6.8	6.4	23.8	76.2	36.6	14.6	11.7	18.4	55.4	71.1	5.4	5.4	14.3	3.3	47.5
Sutter	3	0	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Tehama	4	115	53	47	69.6	17.4	*	*	27.8	72.2	33.4	*	15.7	47.8	27.8	73.9	*	*	*	*	78.1
Trinity*	4	18	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Tulare	2	910	81.2	18.8	38.6	52.6	3	5.8	27.0	73.0	32.3	18.8	11.5	44.1	25.6	58.2	4.2	23.6	6.4	7.1	52.6
Tuolumne	4	59	91.5	8.5	83.1	*	*	*	49.2	50.9	36.3	*	*	39	33.9	64.4	*	*	*	*	50.9
Ventura	1	1102	90.2	9.8	41.1	50	3	6	26.1	73.9	33.6	20.2	10.5	40.3	29	58.4	9.4	9.4	14	8.4	46.1
Yolo	3	177	32.8	67.2	46.9	31.1	13	9.1	18.6	81.4	36.3	*	*	31.6	61.6	66.7	*	*	*	10.7	74.6
Yuba	3	240	63.3	36.7	70.8	15.4	*	*	27.5	72.5	35.4	20.8	12.5	39.2	27.5	60.8	*	13.8	10.4	*	59.9
STATE	--	41,107	82.7	17.3	40.7	36.8	14.3	8.5	26.7	73.3	35.5	19.8	11.3	35.3	33.6	52.6	14.2	14.4	8.6	8.9	50.9

***** Per Department of Alcohol and Drug Program policies pertaining to public release of alcohol and other drug treatment data by county, data on drug treatment client characteristics cannot be reported by county when that county has a population of less than 20,000 people or when the number of clients is less than 16, or when such a number could be arrived at by subtracting the number of clients in one category from the total.

Appendix 1.3: Characteristics of Prop 36 clients entering treatment during FY 2006-07 by county

		N	Referral type		Race/ethnicity				Sex		Age	Employment status				Primary drug type[66]					Prior tx
			%		%				%		Mean	%				%					%
County	Size [67]	N	Prbtn	Parole	Wht	Hisp	Afr Amr	Oth [68]	Women	Men	Age	Full time	Part time	Unemp	NILF [69]	Meth	Coc crck	MJ	Her	Alc	Yes
Alameda	1	1083	92.1	7.9	39.5	23.2	26.4	10.9	29.2	70.8	36.1	24.5	10.9	36.3	28.4	50.1	17.6	12.5	11.7	6.7	39.0
Alpine	4	0	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Amador	4	49	83.7	16.3	87.8	*	*	*	*	*	36.4	*	*	34.7	*	69.4	*	*	*	*	51.0
Butte	3	337	79.5	20.5	72.7	11	5.6	10.7	30.6	69.4	36.5	14.8	17.8	35.3	32.1	69.7	5.6	11	5.6	7.7	69.4
Calaveras	4	44	88.6	11.4	90.9	*	*	*	43.2	56.8	*	*	*	*	*	56.8	*	*	*	*	56.8
Colusa	4	29	86.2	13.8	*	*	*	*	*	*	*	*	*	*	*	79.3	*	*	*	*	*
Contra Costa	1	708	81.6	18.4	47.5	18.8	27.1	6.6	23	77	34.8	15	11.7	39	34.3	50.3	14.4	17.1	5.9	11.4	39.6
Del Norte	4	24	75	25	75	*	*	*	*	70.8	*	*	*	*	*	*	*	*	*	*	*
El Dorado	3	238	92.9	7.1	77.7	12.2	*	*	30.7	69.3	29.3	18.5	15.6	26.5	39.5	46.6	*	22.3	*	26.9	52.5
Fresno	1	1978	75.3	24.7	33.7	47.1	11.5	7.7	24	76	34.4	25.3	11	32.3	31.4	54.4	12.8	15.2	5.5	10.4	55.7
Glenn	4	30	--	100	*	60	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Humboldt	3	195	83.1	16.9	78	*	*	14.9	35.9	64.1	37.1	14.9	10.3	29.2	45.6	45.1	*	20	22.6	9.2	57.4
Imperial	3	400	86.5	13.5	22.5	70.5	*	*	27.7	72.3	34.2	10	7	53.5	29.5	56	*	12.8	20.8	6.5	54.9
Inyo	4	21	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Kern	2	1377	83.8	16.2	53.2	37.1	7.8	1.9	31.4	68.6	34.9	22	11.5	31.5	35.1	61.4	5.5	16.3	3.7	10.2	*
Kings	3	311	93.9	6.1	34.7	52.4	*	*	27.1	72.9	33.1	31.2	14.5	26.1	28.3	61.4	*	14.8	*	14.5	45.1
Lake	4	148	77	23	78.4	*	*	*	37.2	62.8	36.3	28.4	12.8	23.7	35.1	66.9	*	24.3	*	*	66.2
Lassen	4	38	71.1	29	86.8	*	*	*	*	*	*	*	*	*	55.3	57.9	*	*	*	*	89.5
Los Angeles	1	9667	85.3	14.7	25.5	43.2	25.4	5.9	22.7	77.3	37.2	20.9	10.7	31	37.5	42.6	29.5	11.1	8.1	7.1	54.9
Madera	3	455	78.9	21.1	39.3	47.5	6.2	7	26.8	73.2	31.1	16.7	8.4	32.8	42.2	53.6	4.6	22.9	*	16.3	63.7
Marin	2	126	96.8	3.2	71.4	*	17.5	*	19.8	80.2	39	21.4	14.3	31.8	32.5	34.1	24.6	*	*	19.8	51.6
Mariposa	4	52	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Mendocino	3	269	71.4	28.6	74.0	10.4	*	*	33.5	66.5	35.1	13.8	14.9	38.7	32.7	62.1	*	16.7	*	16.7	63.7
Merced	3	400	80.8	19.3	36.0	45.0	11.3	*	23.8	76.3	34.2	11.8	13	43.3	32	62.3	6.3	20	*	9.3	65.3
Modoc	4	18	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Mono	4	4	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*

[66] Primary drug type does not equal 100%. Per Department of Alcohol and Drug Program policies pertaining to public release of alcohol and other drug treatment data by county, a primary drug type of "other" was omitted from the table.

[67] County size reflects categories developed by the County Alcohol and Drug Program Administrators' Association of California (CADPAAC). Code 1 indicates a large-sized county (N=13), code 2 indicates a medium-sized county (N=12), code 3 indicates a small-sized county (N=14), and code 4 indicates a very small-sized county (N=19).

[68] Per Department of Alcohol and Drug Program policies pertaining to public release of alcohol and other drug treatment data by county, race/ethnicity of "Asian American/Pacific Islander," "Native American," and "Other" was aggregated into one category called "Other."

[69] Not in the labor force.

Monterey	2	405	86.9	13.1	34.6	49.4	9.6	6.4	27.4	72.6	35.1	21.7	8.9	25.4	44	50.6	17.3	7.7	14.8	9.4	30.5
Napa	3	184	80.4	19.6	63.6	27.2	*	*	18.5	81.5	34.7	15.2	*	19	61.4	63	*	*	*	21.7	59.2
Nevada	3	127	84.3	15.8	84.3	*	*	*	27.6	72.4	34.3	26	*	21.3	40.9	67.7	*	14.2	*	*	57.1
Orange	1	4575	85.6	14.4	52.6	37.1	3.3	7.1	25.5	74.5	34.3	28.4	11.5	44.8	15.3	64	6.3	12.7	9.8	6.1	45.0
Placer	2	291	88	12	79.4	12.7	*	6.9	33.3	66.7	32	19.9	12.4	25.4	42.3	60.8	*	15.8	6.2	12.7	43.0
Plumas	4	36	83.3	16.7	72.2	*	*	*	*	*	*	*	*	*	*	58.3	*	*	*	*	60.0
Riverside	1	1948	81.4	18.6	40.8	41.8	6.9	10.5	25.5	74.5	36.3	26.7	12.5	21.6	39.2	75.1	6.3	5.2	7.9	5.4	42.6
Sacramento	1	1783	74.9	25.1	45.9	18.5	26	9.6	26.7	73.3	37.5	14.6	11.4	36.3	37.7	52.9	16.6	15.1	9.2	5.2	46.1
San Benito	4	95	88.4	11.6	25.3	68.4	*	*	40	60	32.7	23.2	*	40	30.5	68.4	*	*	*	*	68.4
San Bernardino	1	2341	86.5	13.5	42	41	11.8	5.2	27.4	72.6	35.9	31.7	12.9	20.8	34.7	68.1	6.5	13.1	3.7	8.1	37.9
San Diego	1	2541	82.3	17.8	47.1	28	15.7	9.1	25.5	74.5	37.1	23.6	12	31.6	32.9	57.7	10.8	13.2	8.2	9.5	60.6
San Francisco	1	402	68.2	31.8	22.4	18.9	45.8	13	19.2	80.9	39.6	16.2	8.7	24.4	50.8	21.4	34.6	12.7	15.4	13.9	33.8
San Joaquin	2	1366	90.1	9.9	41.2	31.9	19	7.8	26.5	73.5	36.4	12.2	7.8	42.4	37.6	54.4	10.8	13.7	15.2	5.3	41.7
San Luis Obispo	2	355	81.4	18.6	67.3	23.7	*	*	33.9	66.1	33.4	25.1	15.5	37.8	21.7	59.2	*	16.1	10.4	*	71.6
San Mateo	1	863	90	10	40.4	28.2	16.5	15	24.9	75.1	36.6	21.1	16.8	32.9	29.2	48.0	18.4	14.8	4.8	13.0	68.0
Santa Barbara	2	719	95.4	4.6	41.2	50.6	5	3.2	34.1	65.9	31.6	21.3	7.5	30.2	41	64.5	9.7	14.1	6.4	5.0	51.5
Santa Clara	1	2524	95.3	4.7	32.5	43.8	8.3	15.5	30.1	69.9	36.4	21.4	11.9	32.8	33.9	64.9	9.2	11.9	3.3	8.3	65.1
Santa Cruz	2	317	96.5	3.5	69.1	23.3	*	*	29.3	70.7	34.8	25.2	17.7	38.2	18.9	50.8	10.7	5.4	23.3	9.8	69.0
Shasta	3	486	57.2	42.8	79.6	6.2	3.9	10.4	31.7	68.3	35.9	20.4	7.6	37.2	34.8	71.8	*	15.0	6.4	*	49.6
Sierra	4	--	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Siskiyou	4	52	90.4	9.6	69.2	*	*	*	34.6	65.4	34.2	*	*	*	71.2	48.1	*	*	*	*	46.2
Solano	2	553	64.2	35.8	28.6	34.5	25.3	11.7	25.1	74.9	37	25.7	14.7	32.2	27.5	55.7	20.1	14.3	4.0	5.4	52.6
Sonoma	2	573	91.8	8.2	67	20.6	4.5	7.9	31.4	68.6	35.6	20.4	14.8	30.7	34	57.6	4.7	15.7	8.0	12.9	53.8
Stanislaus	2	709	86.3	13.7	57.4	30.2	6.4	6	20.7	79.3	37.7	20.2	10	19.8	50.1	70.5	6.4	*	16.2	*	44.7
Sutter	3	0	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Tehama	4	150	68	32	72	14.7	*	*	28.0	72.0	36	12.7	12.7	45.3	29.3	78	*	11.3	*	*	72.5
Trinity	4	--	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Tulare	2	805	83.4	16.7	40.4	51.4	2.2	6	30.8	69.2	32.8	17.4	11.4	47.2	24	67.2	2.7	17.3	5.1	7.3	46.2
Tuolumne	4	43	97.7	2.3	95.4	*	*	*	46.5	53.5	38	*	*	48.8	*	58.1	*	*	*	*	81
Ventura	1	1009	92.5	7.5	46.8	44.3	3.1	5.9	29.7	70.3	34.2	21.5	11.3	39.8	27.4	61.7	10.7	8.5	11.9	7	46.8
Yolo	3	145	55.2	44.8	52.4	36.6	*	*	24.1	75.9	36.3	11.7	*	49	35.2	69.7	*	*	*	*	58.6
Yuba	3	298	64.4	35.6	71.5	15.4	*	*	28.5	71.5	35.8	25.5	11.7	36.9	25.8	67.8	*	9.4	11.1	*	57.9
STATE	--	43,872	84.3	15.7	42.1	36.2	13.9	7.9	26.4	73.6	35.9	22.1	11.5	33.3	33.2	56.4	13.6	12.8	9.1	8.1	50.0

* Per Department of Alcohol and Drug Program policies pertaining to public release of alcohol and other drug treatment data by county, data on drug treatment client characteristics cannot be reported by county when that county has a population of less than 20,000 people, when the number of clients in a category is less than 16, or when such a number could be arrived at by subtracting the number of clients in one category from the total.

Appendix 1.4 Research and information resources on Prop 36

1. Anglin MD, Urada D, Brecht ML, Hawken A, Rawson R, Longshore D (2007). Criminal justice treatment admissions for methamphetamine use in California: A focus on Proposition 36. *Journal of Psychoactive Drugs*, Nov Supplement, 4: 367-81.
2. Auerhahn K. (2004). California's incarcerated drug offender population, yesterday, today, and tomorrow: Evaluating the war on drugs and Proposition 36. *Journal of Drug Issues*, (34) 1: 95-120.
3. The Avisa Group. (2005). Comparing California's Proposition 36 (SACPA) with similar legislation in other states and jurisdictions. Retrieved from http://www.prop36.org/pdf/ComparisonProp36OtherStates.pdf.
4. Banys P (2001). Exploring the opportunities of Proposition 36. *Journal of Psychoactive Drugs,* 33(4): 329-37.
5. Brecht, M.L., Stein, J., Evans, E., Murphy, D., & Longshore, D. (2008). Predictors of intention to change HIV sexual and injection risk behaviors among heterosexual methamphetamine-using offenders in drug treatment: A test of the AIDS risk reduction model. *Journal of Behavioral Health Services and Research*. Published online January 24, 2008.
6. California Department of Alcohol and Drug Programs (2008). *Substance Abuse and Crime Prevention Act of 2000 (Prop. 36)*. Available at http://www.adp.ca.gov/sacpa/prop36.shtml
7. Colker AC (2003). Behavioral health issue brief: California's Proposition 36 and other state diversion programs: moving drug offenders out of prison and into treatment: year end report-2003. *Issue Brief Health Policy Tracking Services*, 1-24.
8. Cosden M, Basch JE, Campos E, et al. (2006). Effects of Motivation and Problem Severity on Court-Based Drug. Treatment. *Crime and Delinquency*; 52:599-618.
9. Drug Policy Alliance. (2006). *Proposition 36: Improving lives, delivering results*. New York: Drug Policy Alliance.
10. Ehlers S, Ziedenberg J. (2006). *Proposition 36: Five years later*. Washington DC: Justice Policy Institute.
11. Evans, E., Li, L., & Hser, Y.I. (2008). Client and program factors associated with dropout from court mandated drug treatment. *Evaluation and Program Planning.* (e-pub online).
12. Evans, E., Li, L., & Hser, Y.I. (2008). Treatment entry barriers among California's Proposition 36 offenders. *Journal of Substance Abuse Treatment*, 35: 410-418. (e-pub online).
13. Evans, E. & Longshore, D. (2004). Evaluation of the Substance Abuse and Crime Prevention Act: Treatment clients and program types during the first year of implementation. *Journal of Psychoactive Drugs,* SARC Supplement 2: 165-174.
14. Evans, E., Longshore, D., Prendergast, M., & Urada, D. (2006). Evaluation of the Substance Abuse and Crime Prevention Act: Client characteristics, treatment

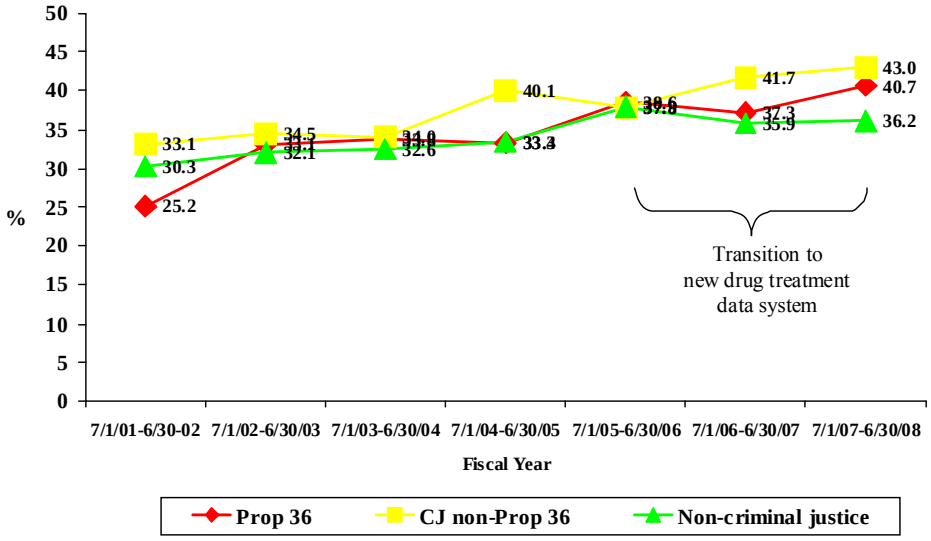
completion and re-offending three years after implementation. *Journal of Psychoactive Drugs,* SARC Supplement 3: 357-369.

15. Farabee, D., Hser, Y.H., Anglin, M. D., & Huang, D. (2004). Recidivism among an early cohort of California's Proposition 36 offenders. *Criminology & Public Policy, 3*(4): 563-584.
16. Fosados, R., Evans, E., & Hser, Y.I. (2007). Ethnic differences in services utilization and outcomes among Proposition 36 offenders in California. *Journal of Substance Abuse Treatment*, 33: 391-399.
17. Gardiner CL (2008). From inception to implementation: How SACPA has affected the case processing and sentencing of drug offenders in one California County. Dissertation, University of California Irvine. Available at http://www.ncjrs.gov/pdffiles1/nij/grants/223468.pdf.
18. Gelber S, Rinaldo D. (2005). *Proposition 36 today: A study of California stakeholders in ten counties*. Berkeley, CA: The Avisa Group.
19. Hardy, M., Teruya, C., Longshore, D., & Hser, Y. (2005). Initial implementation of California's Substance Abuse and Crime Prevention Act: Findings from focus groups in ten counties. *Evaluation and Program Planning,* 28: 221-232.
20. Hser, Y.I., Evans, E., Teruya, C., Huang, D., & Anglin, M.D. (2007). Predictors of short-term treatment outcomes among Proposition 36 clients. *Evaluation and Program Planning*, 30: 187-196.
21. Hser, Y.-I., Teruya, C., Brown, A.H., Huang, D., Evans, E., & Anglin, E. (2007). Impact of California's Proposition 36 on the drug treatment system: Treatment capacity and displacement. *American Journal of Public Health*, 97, (1): 104-109.
22. Hser, Y.I., Teruya, C., Evans, E., Longshore, D., Grella, C., & Farabee, D. (2003). Treating drug-abusing offenders. Initial findings from a five-county study on the impact of California's Proposition 36 on the treatment system and patient outcomes. *Evaluation Review,* 27(5): 479-505.
23. Jett KP (2001). Proposition 36: Issues and challenges. *Journal of Psychoactive Drugs*, 33(4):321-8.
24. Klein, D., Miller, R. E., Noble, A., & Speiglman, R. (2004). Incorporating a public health approach in drug law: Lessons from local expansion of treatment capacity and access under California's Proposition 36. *The Milbank Quarterly*, 82(2): 723-757.
25. Little Hoover Commission. (2008). *Addressing addiction: Improving and integrating California's substance abuse treatment system*. Report to the State of California. Available at https://www.policyarchive.org/bitstream/handle/10207/8195/Report190%20-%20no%20cover.pdf?sequence=5
26. Niv, N., Hamilton, A., & Hser, Y.I. (2008). Impact of court-mandated substance abuse treatment on clinical decision making. *Journal of Behavioral Health Services & Research*. In press.
27. Percival GL. (2004). The influence of local contextual characteristics on the implementation of a statewide voter initiative: The case of California's Substance Abuse and Crime Prevention Act (Proposition 36). *The Policy Studies Journal*, (32), 4: 589-610.

28. Prendergast, M, Greenwell, L., Farabee, D., Hser, Y.I. (2009). Influence of perceived coercion and motivation on treatment completion and re-arrest among substance-abusing offenders. *Journal of Behavioral Health Services & Research*, 36 (2): 159-76.
29. Riley, K. J., Ebener, P. A., Chiesa, J., Turner, S., & Ringel, J. (2000). *Drug offenders and the criminal justice system: Will Proposition 36 treat or create problems?* Santa Monica, CA: RAND.
30. Sharif B. (2003). The Substance Abuse and Crime Prevention Act: Challenges and promises for public health. *California Journal of Health Promotion*, 1(1): 3242.
31. Speiglman R, Klein D, Miller R, Noble A. (2003). Early implementation of Proposition 36: Criminal justice and treatment system issues in eight counties. *Journal of Psychoactive Drugs*, May Supplement, (35): 133-41.
32. UCLA ISAP. Annual Statewide Evaluation Reports on SACPA, covering 2002 to 2008, are available at http://www.uclaisap.org/prop36/html/reports.html.
33. Wiley D, Beattie M, Nguyen H, Puckett K, Banerjee K, Poon W. (2004). When you assume...the reality of implementing a legally mandated substance abuse treatment program. *Journal of Psychoactive Drugs*, May Supplement (2):175-80.
34. Wittman FD. (2001). Prevention, community services and Proposition 36. *Journal of Psychoactive Drugs*, 33(4):343-52.

Appendix 2.1 Treatment Completion Rates Based on Individuals Discharged During FY 02/03-07/08

Appendix 2.1
Treatment Completion Rates by Referral Source
Based on Discharges Occurring in Fiscal Year



Difference in Treatment Completion Rates by Method

	New method	Old method	Difference
	%	%	%
Prop 36			
FY 2001-02	25.2	34.4	-9.2
FY 2002-03	33.1	34.3	-1.2
FY 2003-04	33.8	32.0	1.8
FY 2004-05	33.3	32.2	1.1
FY 2005-06	38.6	35.0	3.6
CJ non-Prop 36			
FY 2001-02	33.1	36.0	-2.9
FY 2002-03	34.5	37.5	-3.0
FY 2003-04	34.0	36.9	-2.9
FY 2004-05	40.1	38.0	2.1
FY 2005-06	37.8	38.0	-0.2
Non-CJ			
FY 2001-02	30.3	34.2	-3.9
FY 2002-03	32.1	30.0	2.1
FY 2003-04	32.6	30.6	2.0
FY 2004-05	33.4	35.8	-2.4
FY 2005-06	37.9	37.6	0.3

Appendix 2.2 Characteristics of treatment completers and non-completers by referral source

(N=158,119)

	Prop 36 Probation (N=34,416)		Prop 36 Parole (N=6,416)		Drug Court (N=2,773)		Other CJ (N=32,347)		Non-Criminal Justice (N=84,167)	
	Completed (N=14,019) 43.3%	Non-completed (N=18,397) 56.8%	Completed (N=1,780) 27.7%	Non-completed (N=4,636) 72.3%	Completed (N=1,591) 57.4%	Non-completed (N=1,182) 42.6%	Completed (N=13,923) 43.0%	Non-completed (N=18,424) 57.0%	Completed (N=30,451) 36.2%	Non-completed (N=53,716) 63.8%
Age, Mean (SD)	35.8 (10.8)	34.7 (10.8)	37.7 (9.6)	36.1 (9.6)	35.0 (10.7)	33.9 (11.3)	31.6 (11.6)	29.7 (11.4)	36.1 (12.9)	34.1 (13.6)
Race,%										
White	45.1	38.5	46.0	40.2	43.1	31.4	44.8	37.7	47.8	41.2
Hispanic	35.6	38.0	31.7	34.0	32.7	36.6	36.9	38.9	29.1	35.8
African American	10.7	14.8	15.2	19.0	16.0	24.6	9.8	14.5	16.4	15.9
Asian/Pac Is	3.5	3.4	2.6	2.7	3.0	2.8	3.3	2.7	1.9	1.8
Amr.Ind/Alsk Nat	1.3	1.3	1.6	1.4	1.5	1.1	1.4	1.7	1.6	1.4
Other	3.9	4.0	3.0	2.7	3.7	3.5	3.8	4.4	3.3	4.0
Women, %	28.1	28.6	21.4	18.0	37.6	28.4	34.4	36.3	38.2	40.5
Education, %										
< High School	35.5	39.6	38.7	45.1	40.3	44.5	44.1	51.9	36.2	46.4
High School	45.3	44.2	46.4	43.3	43.5	40.3	38.2	35.2	40.2	36.4
> High School	19.2	16.2	14.9	11.7	16.2	15.2	17.7	12.9	23.6	17.2
Homeless, %	10.9	11.1	18.1	11.2	18.2	20.6	12.7	12.7	28.9	17.6
Pregnant, %	5.6	5.1	5.8	3.5	4.6	4.0	8.2	7.3	5.0	5.7
TB, %	2.0	2.2	4.1	3.4	3.2	2.0	2.0	1.9	1.8	2.2
Hepatitis C, %	4.6	5.2	9.3	8.8	6.6	5.2	4.5	4.9	7.1	10.5
STD, %	3.1	3.0	3.3	2.6	4.2	2.4	3.4	3.4	3.2	3.5
Ever diagnosed with MH illness, %	14.3	15.7	16.6	16.0	13.7	14.8	15.2	18.1	24.2	25.2
Has children under 18 years, %	46.4	46.2	50.6	50.8	49.1	46.2	55.5	58.0	40.9	40.6
Primary drug, %										
Methamphetamine	57.4	52.7	57.4	54.1	48.8	40.7	40.6	37.8	23.2	19.1
Cocaine	12.9	14.3	12.4	15.2	20.0	28.0	8.0	9.1	11.1	8.8
Marijuana	13.4	16.0	8.4	11.6	9.6	10.6	20.7	26.3	12.2	16.9
Alcohol	8.9	8.0	11.1	7.2	10.2	6.0	24.8	18.7	35.1	22.8
Heroin	6.1	7.9	9.6	10.8	10.2	13.8	4.6	6.8	17.1	31.0
Other	1.4	1.1	1.2	1.1	1.18	<1.0	1.3	1.4	1.4	1.4
Age at first use of primary drug	21.3 (8.7)	20.6 (8.4)	20.5 (8.3)	19.9 (7.7)	20.7 (8.1)	20.6 (7.9)	18.1 (7.1)	17.5 (6.8)	18.5 (7.8)	18.5 (7.7)
Employment, %										
Full or part-time	36.1	30.0	26.7	31.5	17.0	11.9	26.7	21.2	16.7	17.2

Appendix 2.2 Characteristics of treatment completers and non-completers by referral source

(N=158,119)

	Prop 36 Probation (N=34,416)		Prop 36 Parole (N=6,416)		Drug Court (N=2,773)		Other CJ (N=32,347)		Non-Criminal Justice (N=84,167)	
	Completed (N=14,019) 43.3%	Non-completed (N=18,397) 56.8%	Completed (N=1,780) 27.7%	Non-completed (N=4,636) 72.3%	Completed (N=1,591) 57.4%	Non-completed (N=1,182) 42.6%	Completed (N=13,923) 43.0%	Non-completed (N=18,424) 57.0%	Completed (N=30,451) 36.2%	Non-completed (N=53,716) 63.8%
Full-time	24.5	18.7	18.4	20.1	11.6	7.4	17.5	12.6	11.1	10.5
Part-time	11.6	11.3	8.3	11.4	5.4	4.5	9.2	8.6	5.6	6.7
Unemployed	51.7	58.2	58.0	57.2	72.5	77.3	53.3	56.2	62.2	59.2
Not in labor force	12.2	11.8	15.3	11.3	10.5	10.8	20.1	22.6	21.2	23.7
Prior alcohol or drug treatment, %	50.2	47.7	56.5	49.0	52.8	55.2	41.3	40.4	48.6	48.2
No. of prior treatment admits, mean (SD)	2.1 (3.6)	2.2 (3.4)	2.3 (3.4)	2.2 (2.5)	2.2 (2.3)	2.6 (4.3)	2.1 (3.9)	2.1 (2.5)	3.8 (7.7)	3.5 (5.6)
In past 30 days, %										
Arrested	21.2	27.0	16.9	18.9	24.5	31.2	11.9	13.5	8.4	6.9
Medical problems	14.1	15.2	15.5	14.0	8.8	14.3	15.2	16.4	22.8	20.9
Used a needle	4.9	6.7	10.0	10.0	5.5	6.8	3.1	5.4	14.0	25.5
Incarcerated in jail	28.5	33.4	22.3	21.0	57.2	73.9	26.8	24.7	10.8	8.2
Incarcerated in prison	1.3	2.1	17.4	11.4	5.2	2.8	7.3	6.8	1.8	1.7
ER visit-medical	4.9	5.7	5.5	6.2	3.1	5.0	6.2	7.1	15.5	11.3
ER visit-psych	1.5	1.7	2.6	2.0	2.2	1.9	1.5	2.1	4.2	4.5
Psych facility	0.9	1.0	<1.0	1.1	1.3	<1.0	1.0	1.6	3.4	3.8
Family conflict	6.7	8.4	7.2	7.9	4.4	4.9	8.2	10.6	16.0	15.9

Data source: CalOMS data on client characteristics at entry into first treatment episode ending between July 1, 2007 and June 30, 2008. Unique individuals are the unit of analysis. Omitted from analyses are individuals whose CalOMS admission record was missing and those who were marked at discharge as deceased.

Appendix 2.3 Treatment experiences of treatment completers and non-completers by referral source

(N=158,119)

	Prop 36 Probation (N=34,416)		Prop 36 Parole (N=6,416)		Drug Court (N=2,773)		Other CJ (N=32,347)		Non-Criminal Justice (N=84,167)	
	Completed (N=14,019) 43.3%	Non-completed (N=18,397) 56.8%	Completed (N=1,780) 27.7%	Non-completed (N=4,636) 72.3%	Completed (N=1,591) 57.4%	Non-completed (N=1,182) 42.6%	Completed (N=13,923) 43.0%	Non-completed (N=18,424) 57.0%	Completed (N=30,451) 36.2%	Non-completed (N=53,716) 63.8%
Waited to enter treatment, %	35.3	30.4	35.4	30.2	44.1	57.0	34.8	30.0	33.6	26.4
Days waited to enter treatment, Mean (SD)	12.6 (18.5)	11.5 (16.8)	13.3 (20.7)	11.2 (16.5)	16.6 (25.3)	15.9 (15.6)	20.9 (36.3)	15.9 (24.3)	12.6 (30.1)	11.1 (24.5)
Modality, %										
Outpatient	81.2	88.3	59.7	83.8	54.4	57.6	66.3	76.8	35.2	50.6
Residential < 30 days	<1.0	<1.0	3.6	1.5	4.6	1.2	2.9	<1.0	2.1	<1.0
Residential ≥ 30 days	14.1	8.9	29.3	11.8	39.0	40.2	26.5	20.6	23.0	14.9
Detox	3.3	1.6	6.4	1.4	1.8	<1.0	4.1	<1.0	32.0	11.0
NTP detox	<1.0	<1.0	<1.0	<1.0	<1.0	<1.0	<1.0	<1.0	4.9	10.1
NTP maintenance	<1.0	<1.0	<1.0	1.2	<1.0	<1.0	<1.0	<1.0	2.8	12.7
Retention, %										
≤ 30 days	4.4	31.1	9.9	37.6	8.8	25.6	8.5	31.9	38.2	39.7
31- 60 days	3.5	18.5	7.0	19.5	7.7	18.0	5.2	18.3	7.8	15.5
61-89 days	5.1	12.1	8.9	12.6	6.2	11.3	8.2	12.7	5.9	9.7
≥90 days	87.0	38.2	74.2	30.3	77.3	45.1	78.1	37.1	48.1	35.1
Discharge status, %										
Satisfactory progress	--	18.6	--	15.8	--	30.6	--	23.9	--	31.2
Unsatisfactory progress	--	81.5	--	84.3	--	69.5	--	76.1	--	68.8

Data source: CalOMS data on first treatment episode ending between July 1, 2007 and June 30, 2008. Unique individuals are the unit of analysis. Omitted from analyses are individuals whose CalOMS admission record was missing and those who were marked at discharge as deceased.

Appendix 2.3a Mean and median length of stay in treatment among treatment completers and non-completers by referral source

	Prop 36 Probation (N=34,416)				Prop 36 Parole (N=6,416)				Drug Court (N=2,773)				Other CJ (N=32,347)				Non-Criminal Justice (N=84,167)			
	Completed (N=14,019) 43.3%		Non-completed (N=18,397) 56.8%		Completed (N=1,780) 27.7%		Non-completed (N=4,636) 72.3%		Completed (N=1,591) 57.4%		Non-completed (N=1,182) 42.6%		Completed (N=13,923) 43.0%		Non-completed (N=18,424) 57.0%		Completed (N=30,451) 36.2%		Non-completed (N=53,716) 63.8%	
Retention, in Days	Mean (SD)	Med	Mean (SD)	Med	Mean (SD)	Med	Mean (SD)	Med	Mean (SD)	Med	Mean (SD)	Med	Mean (SD)	Med	Mean (SD)	Med	Mean (SD)	Med	Mean (SD)	Med
Outpatient	228.1 (126.6)	202	100.9 (126.2)	62	202.5 (123.4)	178	79.6 (119.1)	49	418.9 (220)	411	165.7 (180.5)	104	215.0 (158.6)	176	104.3 (134.3)	65	219.2 (158.0)	182	111.2 (159.4)	65
Residential <30 days	80.3 (92.4)	39	85.3 (90.3)	53	82.3 (75.3)	34	51.0 (55.6)	32	35.2 (33.5)	27	35.8 (29.7)	24	52.7 (68.1)	30	52.9 (62.2)	29	40.0 (59.9)	28	29.5 (52.4)	11
Residential ≥ 30 days	163.7 (119.5)	141	85.6 (107.4)	52	132.8 (98.1)	91	64.2 (72.3)	37	161.3 (150.7)	95	78 (91.3)	41	150.4 (108.2)	120	75.3 (95.3)	42	114 (111.7)	90	57.9 (90.6)	30
Detox days	51.0 (90.9)	13	54.3 (83.9)	13	33.7 (69.2)	10	93.1 (425.4)	19	81.8 (180.1)	21	26.2 (41.3)	7	29.1 (70.8)	5	45.4 (85.6)	7	24.6 (61.1)	7	28.5 (74.9)	4
NTP detox	133.1 (221.1)	24.5	170.0 (177.7)	130	43.4 (66.6)	20	101.2 (137.5)	57	--	--	--	--	168 (103.3)	177.5	144.7 (192.8)	90.5	72.7 (116.8)	20	101.5 (284.3)	20
NTP main	337.5 (180.0)	318	277.9 (351.8)	173	269 (214.4)	182	227.0 (201.8)	174	--	--	--	--	841.4 (1293.3)	202	720.3 (920.2)	397	495.6 (870.1)	164.5	476.4 (788.6)	175

Appendix 2.4 Episodes of Treatment Over 12 Months Following Prior Treatment Discharge, by Referral Source

	Prop 36 Probation (N=34,416)			Prop 36 Parole (N=6,416)			Drug Court (N=2,773)			Other CJ (N=32,347)			Non-Criminal Justice (N=84,167)		
	Prior treatment discharge status was…														
	Completed (N=13,025)	Non-completed (N=20,013)	Total (33,038)	Completed (N=1,458)	Non-completed (N=4,371)	Total (N=5,829)	Completed (N=1,064)	Non-completed (N=1,468)	Total (N=2,532)	Completed (N=13,313)	Non-completed (N=18,620)	Total (N=31,933)	Completed (N=29,879)	Non-completed (N=53,298)	Total (N=83,177)
Had another treatment episode within, %															
3 months of prior discharge	4.2	13.5	9.8	5.0	10.1	8.9	3.4	9.1	6.7	2.7	9.3	6.6	6.4	7.6	7.1
6 months of prior discharge	7.6	22.3	16.5	10.1	17.4	15.6	6.6	15.1	11.5	5.4	16.5	11.9	11.5	12.9	12.4
9 months of prior discharge	9.6	27.0	20.2	13.8	21.5	19.6	8.2	18.3	14.1	7.4	20.2	14.9	14.8	16.2	15.7
12 months of prior discharge	11.4	29.9	22.6	15.6	24.7	22.4	9.4	20.5	15.8	9.0	22.9	17.1	17.0	18.4	17.9
No. of days between prior discharge and next treatment episode, mean (SD)	148.1 (98.9)	129.8 (88.6)	133.5 (91.1)	150.5 (92.7)	139.5 (94.5)	141.4 (94.3)	138.3 (98.0)	132.7 (92.9)	134.1 (94.1)	163.0 (97.9)	137.9 (90.5)	143.4 (92.7)	144.7 (93.6)	139.2 (93.2)	141.0 (93.3)
No. of treatment episodes following prior discharge, mean (SD)	1.1 (0.4)	1.2 (0.4)	1.2 (0.4)	1.2 (0.4)	1.2 (0.4)	1.2 (0.4)	1.2 (0.4)	1.2 (0.5)	1.2 (0.4)	1.1 (0.4)	1.2 (0.4)	1.1 (0.4)	1.3 (0.7)	1.2 (0.5)	1.3 (0.6)
No. of days in treatment across all treatment episodes, mean (SD)	125.4 (102.6)	125.5 (108.3)	125.4 (107.2)	103.7 (92.2)	93.7 (93.3)	95.5 (93.2)	111.4 (108.2)	137.2 (119.5)	130.8 (117.2)	102.8 (89.6)	113.0 (107.1)	110.8 (103.6)	72.9 (96.3)	98.5 (107.1)	89.8 (104.3)
Status of last discharge on record indicated, %															
Completion	55.7	39.7	42.9	43.4	27.6	30.3	49.0	36.2	39.4	50.7	36.1	39.3	53.5	29.1	37.4
Non-completion	44.3	60.3	57.1	56.6	72.5	69.7	51.0	63.8	60.6	49.3	63.9	60.7	46.5	70.9	62.6

Data Source: CalOMS data on unique clients who had a treatment episode that ended between July 1, 2006 and June 30, 2007.

Appendix 10.1 Technical notes

UCLA compiled a set of readily available information for the singular purpose of identifying a group of counties where Prop 36 implementation was relatively strong. These methods were not meant to represent a definitive method for ranking counties. Other counties may have attained higher rankings if different variables were used or if different methods such as case mix adjustment analysis were employed. It cannot be concluded that any county that was not invited to participate was not performing well. Further work to develop appropriate performance and outcome measures is underway (see Chapter 12).

The readily available Prop 36 program performance and outcome indicators consisted of seven items: (1) percentage of Prop 36 offenders that completed treatment, (2) percentage of Prop 36 offenders with 90 or more days of treatment, (3) percentage of Prop 36 offenders that did not drop out of treatment within the first 30 days following admission, (4-5) percentage of treated Prop 36 offenders re-arrested, over 30 months from eligibility determination, for any arrest type (4) and for drug only arrests (5), (6-7) percentage of treated Prop 36 offenders sentenced to be re-incarcerated, over 30 months from eligibility determination, in jail (6) or in prison (7).

Indicators were analyzed by county and then aggregated into one composite "score" for each county. Counties were sorted by population size categories (large, medium, small, very small) and then ranked by their score. Counties invited to participate included four top-ranked large-sized counties, three top-ranked medium-sized counties, and one top-ranked small-sized county. The top-ranked very small-sized counties treated twenty or fewer Prop 36 clients in Fiscal Year 2007-08 and thus it was decided to invite these counties to participate in focus groups at a later date.

Of the eight counties that were invited, six participated in the focus groups and the remaining two reported scheduling conflicts and requested that a focus group be held at a later date. Of the six counties that participated, half were large-sized counties and half were medium-sized. Participating counties were located in different geographical areas of the state. Members of the counties' Prop 36 oversight committees were invited to participate. These committees were composed of representatives of drug and alcohol program administration, probation, the courts, prosecutors, public defenders, treatment providers, and others.

Focus groups were conducted in the six counties from February to April 2009 to gain an in-depth understanding of what strategies or policies stakeholders felt were responsible for Prop 36 program successes. Discussion topics covered key elements of success, recommendations for best addressing specific sub-groups of Prop 36 clients, the impact of California's state budget crisis, and current needs. Focus group topics were reviewed by the Prop 36 Evaluation Team. Focus groups lasted between 1.5 and 2.0 hours and were held at county sites. Participants were encouraged to use aliases during the sessions in an effort to maintain confidentiality on digital recordings and participants were assured

that no individual or county would be identified in findings. During the discussions, an assistant took written notes and produced a summary of key points shortly thereafter. Digital recordings of the discussions were transcribed verbatim and reviewed for accuracy. Patterns within and across the focus-group transcripts were analyzed and major themes were identified. A preliminary draft of the summary of the themes that emerged from the focus groups was shared with focus group participants for comment and correction.

Appendix 10.2 Characteristics of focus group participants

Characteristics of focus group participants (N=59)	
Age, mean (SD)	49.4 (10.3)
Female, %	50.9
Race/ethnicity, %	
White	62.5
African American	12.5
Hispanic	12.5
Asian	7.1
Multiracial	5.3
Highest degree, %	
High School Diploma/Equivalent	3.5
Associates Degree	12.3
Bachelors Degree	24.6
Masters Degree	28.1
Juris Doctorate (J.D., or equivalent)	22.8
Doctoral Degree (Ph.D., or equivalent)	8.8
Years worked at current agency, Mean (SD)	13.3 (8.3)
Years worked in the county, Mean (SD)	16.2 (9.2)
Months worked on Prop 36, Mean (SD)	49.4 (38.0)
Stakeholder group, %	
County Alcohol and Drug Administration	27.5
Treatment Provider	25.5
Probation Department	15.7
Court Officer/Administration	9.8
District Attorney's Office	9.8
Public Defender's Office	5.9
Other	5.9

Appendix 10.3 Current needs and related issues

During focus group discussions, participants identified current program needs and talked about issues related to the operation of Prop 36.

Current program needs

1. Increase the number of residential treatment beds and the number of sober living facilities.
2. Enhance stakeholder ability to supervise clients more intensely. Give judges the discretion for deciding how to handle the third Prop 36 program violation. Provide funding to hire more probation officers. Give probation officers the ability to arrest/sanction clients.
3. Improve how clients with mental health disorders are handled. Trained professionals need to assess and diagnose for mental health disorders (Axis I and Axis II disorders). Provide on-site services and peer support for dually diagnosed clients.
4. Provide more funds and minimize restrictions on how funds can be spent. If 100% of the county were to participate in the Prop 36 program, the county would not be able to afford it. There would be too many people being referred to the program and there would not be enough resources to serve them all. Allow for funds to be used to pay for mental health medication.
5. Improve efforts to integrate vocational training and employment preparation into treatment.
6. Standardize the definition of program elements (e.g., "assessed" etc) that counties are required to report on to the Department of Alcohol and Drug Programs.
7. Standardize the definition of program completion. Counties currently have different standards of treatment and thus to complete the program, County A may require clients to finish only 6 months of treatment while County B may require 18 months. Problems arise when a client is arrested in one county and lives in another county. The situation creates a "tug of war" between counties who have differing standards for treatment completion. Counties cannot give out of county clients more or less treatment than what is provided to in county clients. However clients may not receive "enough" treatment to meet completion criteria for the county that is handling the case.
8. Tie funding allocations to county performance and outcomes, not just to county size.
9. Raise awareness that in some counties, the primary drug problem among many clients is alcohol or OxyContin.
10. Within a county, enhance consistency between courts and between stakeholder groups in how Prop 36 is implemented. Within counties there is regional variation in the level of support for Prop 36 and in the operation of the program. In some areas within a county, offenders receive more encouragement to waive Prop 36 and be "channeled out of" the Prop 36 program. As one consequence, the percentage of underserved populations varies by region within a county.

Issues related to the operation of Prop 36

1. Some eligible offenders may opt out of Prop 36 because doing jail time seems easier and may require less time to complete. Other reasons cited by stakeholders for Prop 36 opt-out include: parolees who are precluded from participating in Prop 36, not being ready for treatment, having a partner that uses, having tried Prop 36 before and it was perceived by the participant as not having been effective, having other pending charges and so Prop 36 would provide little benefit, and being charged with sales and pleading to possession and agreeing to jail time plus standard probation.
2. Fiscal cuts threaten the survival of the Prop 36 program. There are even fewer residential treatment slots, longer waiting lists, and more clients who are "lost" to the program. Cutbacks have also resulted in the layoff of key staff, especially probation officers. Cutbacks also negatively impacts stakeholder morale by "taking the wind out of your sails." Finally, in some counties, the Prop 36 program competes with the California Department of Corrections and Rehabilitation (CDCR) for treatment beds. Typically, CDCR can pay treatment programs more money for beds and many treatment providers work with the Prop 36 program out of loyalty, but as economic times worsen, many providers may "follow the money" and increasingly contract with CDCR, reducing the availability of treatment for Prop 36 clients.
3. Several positive indirect consequences have resulted from Prop 36. Counties were compelled to create levels of care and/or a system of care and this change has benefitted all clients (Prop 36 or not). Another consequence, county stakeholders support and advocate for one another and are more aware of each other's roles, strengths, and resource needs.
4. In some cases, counties are better able to treat "needier" clients with the resources that are offered through drug court as opposed to Prop 36. For example, in some counties clients with mental health disorders will be sent though drug court first and then, once stabilized, brought in to Prop 36. This reduces the number of "frequent fliers" who recycle through the criminal justice system, unnecessarily clogging up the courts etc.
5. Some stakeholders felt that Prop 36 should be expanded to include other types of non-drug offenses such as petty theft, auto burglary, and other non-violent misdemeanor crimes that drug users tend to commit.