
***ADDRESSING ADDICTION:
IMPROVING & INTEGRATING CALIFORNIA'S
SUBSTANCE ABUSE TREATMENT SYSTEM***



LITTLE HOOVER COMMISSION

March 2008



State of California

LITTLE HOOVER COMMISSION

March 27, 2008

The Honorable Arnold Schwarzenegger
Governor of California

The Honorable Don Perata
President pro Tempore of the Senate
and members of the Senate

The Honorable Dick Ackerman
Senate Minority Leader

The Honorable Fabian Núñez
Speaker of the Assembly
and members of the Assembly

The Honorable Michael Villines
Assembly Minority Leader

Dear Governor and Members of the Legislature:

This report contains two essential conclusions. First, California can reduce substance abuse, but it must adopt a new model to transform the way counties deliver treatment. Second, Proposition 36 has shown promise despite its flaws, and rather than throw it out, California can and should fix it.

In both areas, the key to moving forward is leadership, from the governor, working with the heads of agencies on a coordinated strategy for substance abuse treatment, and from the Legislature, to make the necessary legal changes and to ensure they are implemented.

The Commission decided to revisit its 2003 study, "For Our Health and Safety: Joining Forces to Defeat Addiction," because of its strong belief that a successful strategy for fighting addiction has tremendous leverage in reducing the social ills fueled by substance abuse.

The state can tote up the cost of failing to curb substance abuse and addiction in its outlays for child welfare, foster care, juvenile justice, prisons and mental health, problems that will continue to grow unless addressed.

California's current budget crisis may force the state to cut services in these important program areas. If the state is serious about cutting overall expenses, it should shift money to substance abuse treatment to avoid the larger costs of treating the consequences of addiction.

The state has far more resources to draw from than it did in 2003. We know more than ever about the pathology of substance abuse, and now have a wide array of evidence-based strategies to attack it. We know that early intervention in many cases can effectively and inexpensively stop a substance abuse problem from turning into far harder-to-treat addiction. We know more about powerful strategies to increase the amount of time that addicts in recovery stay sober.

In testimony and interviews with researchers and practitioners, however, it became clear that the state has not organized, required or inspired treatment efforts to improve outcomes. California's collection of political priorities, funding streams and regulations is not a substance abuse treatment system. It is an incoherent un-system that spreads money around with little accountability, with no linkage to measurable results. California cannot afford to let this situation continue.

The state must adopt a model for treatment that emphasizes prevention and screening and early intervention, and recognizes the need for continuing recovery services. California must then build its system of funding and standards to drive treatment providers toward this model.

California's leaders must not place the burden for the state's substance abuse strategy on one department. A successful strategy needs cooperation and the focused resources of all departments whose services are fueled by substance abuse. Only the leadership of the governor, along with agency secretaries and the Legislature, can appropriately and efficiently direct the resources where they can best be used.

How much will a new system cost? The state cannot know the answer until it tracks what it spends in a strategic way and, separately, better understands what results it currently gets for its treatment dollars. Santa Clara County is one local government that tracks outcomes, and its results may provide a starting point for discussion: The county, which has organized its treatment programs around an outcome-based model, spends \$4,369 on average for each client that goes through a treatment episode.

Currently, the state spends just over \$1 billion each year on substance abuse treatment through the programs of various departments. That amount clearly can be spent more effectively.

In 2003, as California began implementing Proposition 36, policy-makers embraced a shared outlook on the potential for treatment to turn around lives damaged by substance abuse. In passing the Substance Abuse and Crime Prevention Act, voters sent a clear message that they wanted a new approach: substance abuse treatment for nonviolent drug offenders, not incarceration. In the discussion about how to best attack this disease, there was agreement that substance abuse treatment was a solid strategy for reducing crime. Though the results have fallen short of the promises, the research reinforces the position that treatment is good for individuals and for society.

The state's implementation of Proposition 36 has foundered on the issue of flash incarceration. Legislation that would have added flash incarceration for nonviolent low level drug offenders has been challenged in court. The Commission heard testimony from judges and others that flash incarceration is a useful tool for drug court programs and evidence from a Hawaii program suggests it can motivate offenders to stay sober while on probation.

The state, however, should not use the court case, or the lack of flash incarceration, as an excuse to delay implementing reforms, allowed by existing law, that could reduce addiction and increase accountability for drug offenders through a combination of treatment and escalating sanctions that stop short of jail.

If leadership was important before, it is critical now. The Commission urges you to move forward to implement its recommendations to improve California's treatment system and with it, public safety, and stands ready to assist you.

Sincerely,

A handwritten signature in black ink, appearing to read "Daniel W. Hancock", written in a cursive style.

Daniel W. Hancock
Chairman

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Executive Summary

Addiction plays a key role in many of California’s most pressing problems. Prison overcrowding, an overburdened foster care system, mental illness and soaring health care expenses all are fueled in part by alcohol and drug abuse.

In its 2003 report, “For Our Health and Safety: Joining Forces to Defeat Addiction,” the Commission found that the state allocated resources for substance abuse treatment without a strategy to improve outcomes at the local level or to link efforts among state departments. Collaboration among state and local agencies was poor, despite the fact that many public servants, from beat cops to mental health professionals to government administrators in Sacramento, often were dealing with the same troubled people. The situation has not changed.

The Commission has returned to this topic because addiction continues to stoke the need for state services and because the Substance Abuse and Crime Prevention Act, approved by voters as Proposition 36, has elevated the treatment system’s responsibilities. Now, the system is the foundation for a sentencing law that diverts as many as 50,000 nonviolent drug offenders into treatment.

Through public hearings, meetings of two Commission-created advisory committees, extensive interviews with providers, local government officials and treatment experts and a review of research, the Commission identified four critical problems that the state must address now:

- ***California lacks a coherent substance abuse treatment system.*** Funded by state and federal money, counties use widely divergent approaches to treatment with little oversight or accountability for results. The state has not integrated a coherent substance abuse treatment strategy into California’s health care, foster care or corrections systems. As a result, the state spends billions of dollars addressing the consequences of abuse, outlays that could be reduced or avoided with a greater emphasis on substance abuse treatment. Currently, treatment is often reserved for the most dependent and is not given to those in the earliest abuse stages, where it can be the most cost-effective.
- ***State leaders have not used their influence and power to control funding to drive improvements in the system.*** Elected officials

rarely focus on substance abuse policy. In part because of this lack of attention, the Department of Alcohol and Drug Programs is a timid agency that distributes money to counties with little effort to upgrade practices that would improve outcomes. State leaders have not used the power of the purse to coordinate substance abuse treatment across departments and require better treatment outcomes.

- ***Treatment advances are not systematically implemented in the field.*** The state has not put in place incentives for adopting evidence-based approaches that could improve treatment quality and outcomes. Absent a focus on results, government agencies that fund treatment, and the providers who administer treatment, largely have opted to treat as many people as possible, regardless of outcomes. This approach is built on a cost structure that results in low pay for the treatment workforce, high staff turnover, and inexperienced and undereducated counselors.
- ***Funding is limited and not used strategically.*** Despite evidence that spending money on treatment is cost-effective and saves money, California does not maximize funds available for treatment or use available money efficiently. Regulations governing public funding streams are outdated and limit providers' ability to implement best practices in treatment. With private insurers paring benefits for substance abuse treatment, taxpayers increasingly are left to pay for an ever larger share of treatment costs.

New issues and knowledge have emerged that make the state's haphazard approach to addressing alcohol and drug abuse even more short-sighted and inefficient. Methamphetamine use has exploded into an epidemic, adding pressure to an already burdened treatment system and fueling problems in other corrections, health and human service systems. In the past five years, more has been learned about the relationship between substance abuse and mental illness, the prevalence of these co-occurring disorders and the need to treat both disorders simultaneously. California, however, has not yet shaped laws and regulations to recognize this reality. And most importantly, the passage and implementation of the Substance Abuse and Crime Prevention Act, or Proposition 36, places substance abuse treatment as a focal point of the state's criminal justice system. While Proposition 36 is an improvement over past policies, which rarely provided treatment to drug offenders, results so far are disappointing.

Improving Proposition 36 is directly linked to improving the state's treatment system, which will require building a new model of treatment

based on science, efficient delivery of services in the right settings and, perhaps most of all, more leadership and guidance from policy-makers.

This new system would integrate substance abuse treatment into most health and human services. The state's foster care system and public health clinics, for example, must screen for alcohol and drug problems among clients, collect data, and share in the responsibility of providing treatment that could rebuild families and reduce state expenses.

The state should no longer distribute money to treatment providers without holding them accountable for better outcomes. We know enough about what types of treatment strategies work; it is time to drive the system toward proven practices. Additionally, because we know that substance abuse problems are often accompanied by other ailments, particularly mental health issues, the state must require treatment providers to develop partnerships with other health and human service systems.

At the heart of a new, improved and integrated substance abuse treatment system are two key requirements: elected officials, judges, and directors of health and human service agencies must recognize substance abuse as a key driver of their systems and prepare adequate responses; and to help them, the state Department of Alcohol and Drug Programs must transform itself into an intellectual leader in the field of substance abuse, setting standards and guidelines, rewarding success and penalizing poor outcomes, and providing advice to policy-makers and others on cost-effective programs and strategies.

As the state continues to grapple with severe budget shortfalls, the Commission urges leaders to look at improving and expanding substance abuse treatment as a way to save money.

While improving the substance abuse treatment system will undoubtedly improve Proposition 36 outcomes, other changes are needed to better implement this important public policy.

A Commission review of the program found that only 19 percent of offenders referred to Proposition 36 complete their treatment program. Too many offenders are evading treatment without penalty; many others with long-standing and serious addiction problems are not getting the treatment they need.

Imperfect as it may be, however, Proposition 36 has added hundreds of millions of dollars for treatment, helping many receive support for the first time. The proposition also has generated data on drug use that has given policy professionals and treatment providers alike a far more

detailed picture of California's alcohol and drug abuse problems, including the explosion of methamphetamine use and subsequent human damage.

Research conducted by the University of California, Los Angeles, also showed that Proposition 36, however flawed, is cost effective. In addition to helping people put their lives on track, it helped the state save money, mainly through reduced jail and prison expenses. When Proposition 36 is successful – when offenders complete treatment – it also improves public safety.

Rather than try to replace Proposition 36, the state should fix it. It should require counties to use risk and needs assessments to determine what programs can best help offenders, and motivate offenders to finish their treatment through the use of rewards as well as a system of escalating sanctions. Drug court models, which feature frequent drug testing, frequent interaction between offenders and judges, and collaboration among treatment providers, judges, law enforcement and prosecuting and defense attorneys, have proven to be the most effective way to handle drug offenders, and they should be required in each county. Above all, Proposition 36 funding should be distributed based in part on outcomes. The state can and should steer counties toward proven practices by setting goals – such as increasing the number of offenders who enter treatment, or remain in treatment – and then rewarding the counties that achieve those goals.

While the subject is currently in litigation, the Commission believes flash incarceration – placing non-compliant offenders in jail for brief periods – should be an option available to judges, as experts say it can be a valuable tool to motivate offenders.

The debate over flash incarceration that consumed much of the legislative discussion surrounding Proposition 36 during the past few years has sidetracked policy-makers, however. Proposition 36 showed that the state as a whole was not prepared for the massive increase in demand for substance abuse treatment created by the new law. To the extent the state did not take the necessary actions to improve alcohol and drug treatment programs where and when they could have made a difference, Proposition 36 could not fully succeed, as its ultimate success rested on those programs.

Proposition 36 can be far more effective, but not before policy-makers develop a comprehensive strategy to use research and planning to improve and coordinate the fight against addiction and the harms it causes.

In its second review of the alcohol and drug treatment system, the Commission met many state officials, county administrators, treatment providers and experts in addiction treatment who were impressive in their passion and knowledge. Their task is difficult, decidedly unglamorous, yet critically important to the public's health. What the Commission found is that California has the talent and intellectual capital to build a first-class addiction treatment system.

The state can play a powerful role in guiding local officials, setting standards for treatment providers and showing counties how to maximize the flexibility in program choices they have, and use its power of the purse to drive changes to create an outcome-based system. Helping people trapped by substance abuse improves their lives and the lives of those around them and ultimately, reduces demand for state services. At the state level, the experience of the past five years shows that this difficult job is beyond the scope and capacity of the Department of Alcohol and Drug Programs alone. The department is a central part of the solution, but success will require sustained leadership from the governor and the Legislature.

Recommendation 1: The state should transform substance abuse treatment into a performance-driven system based on a comprehensive model of care through the use of incentives and mandates to improve quality, transparency and outcomes.

- ❑ ***Adopt a comprehensive model of care.*** The new system should include an emphasis on screening and early intervention to get clients the most appropriate treatment at the earliest stage possible; integration of treatment with other health and human services; and, easily accessible information on outcomes. The system also should incorporate treatment strategies for life-long recovery.
- ❑ ***Tie funding to outcomes. Counties that demonstrate quality and improved outcomes should be rewarded.***
 - ✓ ***Require performance management.*** The governor and Legislature should pass legislation giving the Department of Alcohol and Drug Programs the ability to distribute an annually increasing portion of funding to counties based on outcomes. The department should allow counties to determine their priorities and require that counties set performance goals. More funding should go to counties that meet their goals.
 - ✓ ***Prioritize quality, not quantity.*** The Department of Alcohol and Drug Programs should require counties to assess the cost of providing evidence-based practices and prioritize those practices in their funding distribution.

- ✓ ***Require Continuous Quality Improvement as a condition of program licensure.*** The Department of Alcohol and Drug Programs should rewrite regulations regarding program licensure to include outpatient programs and should require all provider programs to adopt continuous quality improvement measures.
- ***Standardize counselor certification and create tiered levels of certification.*** The Department of Alcohol and Drug Programs should develop a code of ethics, curriculum and examinations that ensure uniformity in counselor education. The governor and Legislature should pass legislation creating graduated levels of counselor certification to encourage professional development and higher wages in the treatment workforce without excluding peer counselors.
- ***Eliminate regulatory and statutory barriers that hinder counties from adopting a comprehensive model of care and a system that provides proven, cost-effective treatment.***
 - ✓ ***Amend regulations for Medi-Cal and other funding streams to allow for best practices.*** The governor and Legislature should rewrite Medi-Cal rules to allow primary care clinics to more easily offer substance abuse treatment and to allow substance abuse treatment clinics to more easily offer mental health and general health care services. The governor and Legislature should rewrite rules for treatment funding to allow providers more flexibility to use best practices, such as recovery support services, and to cover U.S. Food and Drug Administration-approved medications, such as buprenorphine.
 - ✓ ***Prioritize co-occurring disorders.*** The Department of Mental Health and the Department of Alcohol and Drug Programs must work together and with the federal government to clarify regulations regarding funding streams and to encourage the treatment of co-occurring disorders. The Mental Health Services Oversight and Accountability Commission should adopt a policy urging counties to use Proposition 63 funding to expand county capacity to treat people with co-occurring disorders.
 - ✓ ***Activate reimbursement codes that allow billing for Screening and Brief Intervention programs.*** The Department of Health Care Services and the Department of Finance should activate the reimbursement codes to allow billing for screening and brief interventions in both Medi-Cal and private health plan programs.
 - ✓ ***Repeal the Uniform Accident and Sickness Policy Provision.*** The governor and Legislature should overturn this outdated

law that discourages hospitals from screening patients for substance abuse problems.

Recommendation 2: The state should institutionalize understanding, leadership and oversight of substance abuse issues to provide a more cohesive, cost-effective statewide substance abuse policy. Specifically, the state should:

- ❑ ***Create a substance abuse policy council.*** The governor should convene a council of substance abuse experts to act as an advisor to the Department of Alcohol and Drug Programs and other state agencies on improving responses to substance abuse issues. The council should examine barriers to data collection and collaboration among systems as a first step.
- ❑ ***Require annual substance abuse reports.*** The Health and Human Services Agency should require departments within the agency that deal with substance abuse issues to collect standardized data on substance abuse within their system, create strategies for reducing alcohol and drug abuse and publish annual reports on their findings. The Department of Corrections and Rehabilitation should perform the same functions. The Department of Alcohol and Drug Programs should coordinate with other agencies to prepare an annual report as it is required to produce by Health and Safety Code Section 11755 (p) that also includes a comprehensive catalog of public spending on prevention and treatment, as well as outcomes of the treatment.
- ❑ ***Make the Assembly Select Committee on Alcohol and Drug Abuse a permanent, joint committee.*** The Legislature should signal its commitment to addressing substance abuse as a distinct policy issue by creating a permanent committee that includes members of both the Assembly and Senate. The committee should review all current laws regarding substance abuse treatment to ensure implementation and identify needed reforms to reflect the current understanding of substance abuse and addiction.

Recommendation 3: The state should transform programs for nonviolent drug offenders by tying funding to outcomes, requiring drug court models where appropriate, and requiring counties to tailor programs to offenders' individual risks and needs. Specifically, the state should:

- ❑ ***Work with judiciary to develop standards for a continuum of services.*** The state should work with the judiciary to develop guidelines for best practices for diversion, Proposition 36 and felony drug court programs, including models for screening and assessment, treatment practices and supervision practices, as well as guidelines for moving offenders from program to program, based on their success or failure. Each county should be required to develop a Proposition 36 drug

court to handle the offenders who need more intensive treatment and supervision.

- ***Adapt the goal of the Offender Treatment Program – incentivizing best practices – into Proposition 36 and use guidelines to define success.*** The state should merge the Offender Treatment Program and the Proposition 36 program into a single program and rewrite funding regulations to allow the state to reward or penalize counties based on performance. The state should set priorities, tie funding to those priorities and annually publish data rating the counties on how well they meet these outcomes. The priorities could include:
 - ✓ Lowering re-arrest rates of Proposition 36 offenders.
 - ✓ Lowering the number of offenders who fail to enter treatment.
 - ✓ Increasing the number of offenders who stay in treatment for at least 90 days.
- ***Coordinate Proposition 36 and Proposition 63.*** The Mental Health Services Oversight and Accountability Commission should encourage counties to use Proposition 63 money for Proposition 36 offenders. Proposition 63 funding streams, such as the Community Services and Supports fund, should be used to provide mental health services to Proposition 36 offenders who suffer from co-occurring disorders. The state Department of Alcohol and Drug Programs must first require counties to conduct screening for co-occurring disorders – paid for by Proposition 36 funds – to fully understand the number of offenders with co-occurring disorders.
- ***The Department of Corrections and Rehabilitation should place more focus on parolees in Proposition 36 programs.*** The state should assign more parole agents to specific Proposition 36 caseloads, and design space in planned re-entry facilities for Proposition 36 programs for parolees. To reduce recidivism and prison costs, the state should create financial incentives for providers who develop successful Proposition 36 programs for parolees.
- ***Redesign the contract between the Department of Alcohol and Drug Programs and UCLA to allow UCLA to publish reports independently of the department.*** The current relationship allows the department too much authority over evaluations of a program that it runs, setting up an inherent conflict of interest.

Background

Alcohol and drug addiction wrecks families, overruns neighborhoods and drains public coffers. The misery caused by substance abuse is tallied in innumerable ways in California. Approximately 80 percent of parents involved in child maltreatment cases use alcohol and drugs.¹ Alcohol-related highway accidents killed 1,462 people in 2004 and injured 31,538.² Alcohol and drug abuse costs the state's economy more than \$44 billion in everything from lost productivity to increased criminal justice and health care costs.³

In all, more than 2.7 million Californians are dependent on or abuse alcohol and drugs – about 9.3 percent of the state's population.⁴ Most people who use or abuse alcohol or drugs do not need treatment, and many can change unhealthy behavior through a brief intervention. Those who develop dependence on alcohol and drugs, however, need treatment and a lifelong effort to remain in recovery.

Daunting as this disease is, there is hope. We now know more about addiction and how to fight it than ever before.

Understanding Addiction

Addiction is a chronic, relapsing disorder. It is considered a brain disease because it changes the brain's structure and functioning. Brain-imaging studies from drug-addicted people show changes in the areas of the brain that control judgment, decision-making and memory; changes which researchers believe explain the destructive behaviors often attributed to addiction.⁵

Evidence suggests that genetic factors account for between 40 and 60 percent of a person's vulnerability to addiction.⁶ The enduring myth that addiction is a moral weakness is not supported by science.⁷

Decades of research have produced a growing body of knowledge about how to treat substance abuse disorders. While relapse is almost an inevitable part of recovery and addiction is a lifelong affliction, we now know which treatment strategies produce the best outcomes. For example, there are proven best-practices for treating methamphetamine addiction. Voluminous research shows methadone or buprenorphine are

Stages of Alcohol & Drug Involvement

Abstinence: No use at all.

Experimental Use: Minimal use, typically associated with recreational activities; often limited to alcohol use.

Early Abuse: Regular and frequent use, often involving more than one drug; greater frequency than experimental use; adverse personal consequences begin to emerge.

Abuse: Regular and frequent use over an extended period of time; several adverse consequences emerge.

Dependence: Continued regular use despite repeated severe consequences; signs of tolerance; adjustment of activities to accommodate drug seeking and drug use.

Recovery: Return to abstinence; some may relapse and cycle through the stages again.

Source: Physician Leadership on National Drug Policy. August 2002. Adolescent Substance Abuse: A Public Health Priority.

safe medications for treating people dependent on heroin. There is consensus on the best ways to care for a growing population who suffers from both mental and substance abuse disorders.

Research is transforming the field of addiction treatment in significant ways: integrating more medications into the traditional model of behavioral therapy; developing a chronic care model that emphasizes lifelong management instead of short-term treatment; and, showing the importance and value of screening and brief interventions in primary care and other health care settings that traditionally have been ignorant of, or undervalued, the importance of addressing substance abuse.

All of these changes have important implications both for the treatment workforce and for the public agencies that fund treatment. Substance abuse counselors traditionally have been peer counselors in recovery with limited education and training. Evolving to a more professional model will require more training and standards for counselors to ensure they can implement evidence-based practices in their work with clients. Public agencies that fund

treatment have been using an acute care model in which treatment is seen as the “cure” and the only step needed. Funding streams and contracts need to be revamped as the concept of treatment – and the settings in which it can take place – shifts to a long-term recovery model that includes recovery management services after relatively short stints in formal treatment. Just as diabetics return for routine visits with a doctor, experts suggest alcohol and drug addicts in recovery benefit from check-up appointments with treatment or primary care providers.⁸

Treatment Improves Outcomes

In California, substance abuse treatment is a sound investment. According to data collected by the state Department of Alcohol and Drug Programs, Californians who entered treatment in 2006 reduced their contact with the criminal justice system by 57 percent,⁹ and the number who had a job grew from 24,433 upon entering treatment to 30,198 upon exiting treatment, a 24 percent increase in employment.¹⁰ Both of these statistics illustrate positive results not only for individuals and families, but also for public coffers.

A long-term study conducted on northern California patients in the addiction treatment system run by Kaiser Permanente, the state's largest health maintenance organization, showed that providing substance abuse treatment reduces the health care costs of those struggling with addiction while adding only minimal costs to the system.¹¹ Medical care costs decreased by \$155 per month five years after admission to treatment for the patients who sought help, while costs for a comparison group remained stable.¹² The study found that while the average medical costs for those with substance abuse problems was four times higher than the comparison group in the six months before the study group was admitted to treatment, average costs were only twice as high five years later, even with the addition of the treatment costs.¹³

Earlier Study: State Lacked Overall Strategy

In 2003, the Little Hoover Commission reviewed the state's alcohol and drug treatment system because of the immense role addiction played in the state's health, social and criminal justice programs. The Commission's report, "For Our Health and Safety: Joining Forces to Defeat Addiction," concluded that California had no real plan to combat substance abuse or the harm it causes.

The Commission found that state and community leaders, lacking an over-arching plan, had not set priorities or directed resources to where they could do the most good. Alcohol and drug treatment programs were not being held accountable for the quality of their care or the number of successful outcomes. State and local agencies were failing to integrate services for clients who often faced other complex problems while coping with alcohol and drug dependence. Tax dollars were poured into social services and corrections systems in part to deal with the devastation caused by addiction, but there was little focus on the prevention and treatment systems that have proven to be the most cost-effective way to deal with this disease.

Policy-makers dealt with the symptoms, but not the root cause.

In its 2003 report, the Commission recommended the state:

- Create a high-level council to develop a unified strategy to cost-effectively reduce the expense, injury and misery of alcohol and drug abuse.
- Work with counties to set broad goals for treatment programs and help counties to ensure that treatment is available to those whose substance abuse imposes the greatest harm to their communities.

- Implement outcome-based quality-control standards for treatment personnel, programs and facilities and encourage continuous quality improvement.
- Facilitate the integration of alcohol and drug treatment with other social services to effectively reduce abuse and related public costs.
- Maximize available resources that can be applied to treatment.

The Commission returned in 2007 to the topic of substance abuse to see what progress the state had made since the Commission's 2003 review and to examine more closely the results of the Substance Abuse and Crime Prevention Act, or Proposition 36, which was in its infancy in 2003. Proposition 36 placed significant new responsibilities on the state's treatment system by annually sending thousands of drug offenders to treatment.

Despite the new money pumped into the treatment system by Proposition 36, little has changed since 2003. Few of the Commission's recommendations made then have been implemented, and many of the same problems persist. This is discouraging, given the important benefits of a well-run substance abuse treatment system. Consider: More than 86,000 Californians who entered publicly-funded drug treatment in 2006 had children.¹⁴ Their recovery is not just about improving their lives; it is about making broken families whole again.

In revisiting its 2003 report, the Commission has identified both continuing problems that blunt the state's response to substance abuse as well as new challenges and issues confronting the state. New issues include:

- Methamphetamine, an insidious drug that creates short-term euphoria but also has potential for long-term devastation, has become an epidemic in both rural and urban California.
- Evidence continues to mount that substance abuse and mental illness are intertwined diseases that must be treated simultaneously.
- Data generated by Proposition 36 has given us a much deeper understanding of substance abuse patterns in California. What we now know is unsettling: There is a large group of longtime drug users in California who have myriad health problems and criminal histories, and California's criminal justice and treatment systems are not properly prepared to handle them.

Methamphetamine Surges

During the past 15 years, methamphetamine has become California's most prevalent problem drug. Admissions to treatment for people citing methamphetamine as their primary drug increased by 500 percent between 1992 and 2004, surpassing admissions for alcohol.¹⁵ Fifty-five percent of Proposition 36 offenders cited methamphetamine as their primary drug in 2004-05, far surpassing other illegal drugs. The next highest illegal drug was cocaine/crack at 13.7 percent.¹⁶ A survey of county welfare directors conducted for a state Senate committee found that in some California counties, 75 percent or more of children removed from their homes came from families involved with methamphetamine use.¹⁷ Given its explosive spread, toll on abusers and social impact, methamphetamine presents unique problems for the state.

Labs produce toxic waste, expensive to clean up. Clandestine labs where methamphetamine can be made using household chemicals and medications have sprung up across the state, creating toxic byproducts that endanger public health. State officials estimate that up to 2.8 million pounds of toxic waste from methamphetamine labs have been dumped in California.¹⁸ Clean-up of an individual site can cost up to \$4,000.¹⁹ The number of labs operating in the state is believed to have dropped during the past few years as federal regulations have made it increasingly difficult to acquire large quantities of the precursor chemicals needed for methamphetamine manufacture. Much of the production has moved to Mexico, particularly the state of Michoacán.²⁰ Seizures of clandestine labs recently has increased, however, with 336 labs seized and closed in 2006 compared to 282 in 2005.²¹ State narcotics officials are concerned that new Mexican restrictions on the ingredients used to manufacture methamphetamine may shift some production back to California.²²

Demographics of methamphetamine users differ from users of other illegal drugs. Methamphetamine users are unlike the users of many other illegal drugs. Most significantly, women comprise a much higher proportion of methamphetamine users compared to users of other drugs and can account for nearly half of methamphetamine users in treatment studies.²³ Female methamphetamine users often also suffer from Post

Effects of Methamphetamine

Methamphetamine stimulates the brain's reward systems, particularly the neurotransmitter dopamine. Smoked, snorted, injected or swallowed, methamphetamine's effects can last up to 12 hours.

The result is intense feelings of pleasure, excitement and alertness. Chronic use, however, leads to devastating effects. Methamphetamine changes the brain's chemistry and can lead to convulsions, anxiety, aggressive behavior and the inability to feel pleasure. Longtime methamphetamine users can acquire severe health problems, ranging from psychosis to disfigurement. Compulsive scratching and digging under the skin to remove illusionary "meth bugs" can cause permanent damage. Many methamphetamine users also develop major dental problems because of the drug's damaging effect on teeth.

The drug's side effects age an addict's outward appearance and wreak havoc on the brain and body.

Source: California Department of Alcohol and Drug Programs. February 2007. Methamphetamine Treatment: A Practitioner's Reference.

Traumatic Stress Disorder due to domestic violence or other mental health issues and may require residential treatment that allows children to stay with them.²⁴

Methamphetamine use among men who have sex with men²⁵ is as much as 10 times higher than in the general population,²⁶ and the odds for becoming infected with HIV are three times higher for men who have sex with other men while using methamphetamine.²⁷

Methamphetamine use among Latinos is growing. One-third of all methamphetamine-related treatment admissions in 2004 were Latino,²⁸ and one study found that nearly half of methamphetamine treatment admissions in Los Angeles in 2004 were Latino.²⁹ Treating this population requires culturally appropriate treatment programs that are staffed with Spanish speakers.

Methamphetamine users can be treated effectively. Methamphetamine users can have the same treatment outcomes as those abusing or addicted to other drugs. Treatment also can present unique challenges. Prolonged methamphetamine use damages the brain, and recovering users typically display psychological problems, including cognitive impairment – such as confusion or inability to remember or follow directions – as well as anhedonia, the inability to experience pleasure. Effective treatment requires frequent contact with clients, easy-to-follow instructions and help for clients to manage their emotions.

Richard Rawson, associate director of UCLA's Integrated Substance Abuse Programs, who testified to the Commission about the methamphetamine epidemic in California, has developed an outpatient treatment model for methamphetamine users, called the Matrix Model, and believes that 50 to 60 percent of methamphetamine users can be treated successfully using a highly-structured outpatient model.

Rawson notes that as many as one-third of methamphetamine users have severe dependence issues and require residential treatment.³⁰ Research conducted by UCLA into Proposition 36 outcomes shows that residential treatment benefits heavy methamphetamine users. According to the research, daily methamphetamine users who received outpatient treatment instead of residential treatment had 18 percent more felony arrests and 17 percent more misdemeanor arrests in the 30 months after treatment when compared to daily methamphetamine users who received residential treatment.³¹ This result is important to policy-makers: While residential treatment is much more expensive than outpatient treatment – UCLA used estimates suggesting that residential treatment cost \$34.78 per day compared to \$6.13 per day for outpatient treatment – residential

programs for heavy methamphetamine users may be more cost effective if they lower re-arrest rates.

Slow response to methamphetamine epidemic. Rawson told Commission staff that California, as with the nation as a whole, was slow to respond to the growth of methamphetamine use. Despite evidence that reducing the availability of the precursor chemicals needed to produce methamphetamine slowed the drug's spread, the federal government and California did not enact legislation greatly restricting the sale of medications containing pseudoephedrine and ephedrine products until 2005. Failure to quickly react to the methamphetamine epidemic may have been due to its early emergence in rural, instead of urban communities, and its relatively slow spread in the Northeastern part of the country, home to federal decision-makers.

California has responded to methamphetamine in several ways. In 1998, the Bureau of Narcotic Enforcement in the state Attorney General's Office created the California Methamphetamine Strategy, or CALMS, to combat production of the drug. The state Department of Alcohol and Drug Programs created the California Methamphetamine Initiative, which has sponsored a \$28.5 million public education campaign and created a guide for treating methamphetamine users. The Governor's Prevention Advisory Council formed an Ad Hoc Committee on Methamphetamine, which released a report in 2005 with five recommendations, including that communities create local Meth Action Teams to prevent and treat methamphetamine use.

While each of these responses produced positive results, they were separate, rather than coordinated efforts. The state lacks a systematic plan to deal with the methamphetamine epidemic.

A Better Understanding of Co-Occurring Disorders

Awareness is increasing around the country and in California that mental illness and addiction are often intertwined. In 2002, the federal Substance Abuse and Mental Health Services Administration declared the treatment of co-occurring disorders a national priority and, in a report to Congress, stated that public health systems should consider co-occurring disorders as the expectation, not the exception.³²

The need to properly address co-occurring disorders is apparent:

- The U.S. Surgeon General has reported that 41 to 65 percent of adults with a lifetime substance abuse disorder also have at least one mental health disorder, and about 51 percent of adults with a lifetime mental health disorder also have a substance abuse

disorder.³³ Among adults with a diagnosed serious mental illness, 20.3 percent also were dependent on or abused alcohol or drugs.³⁴

- Individuals with co-occurring disorders incur huge costs to the health care system. The rate of hospitalization for co-occurring patients in public health care settings is more than 20 times that of patients with substance abuse problems alone.³⁵
- If only one disorder is treated, both usually get worse.³⁶

Agreement on how to treat co-occurring disorders, but implementation remains difficult. There is consensus on how to treat co-occurring disorders. A framework created by the National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors can be used to steer clients into appropriate treatment settings based on the severity of their mental illness and addiction disorders. After convening a panel of experts, the federal Center for Substance Abuse Treatment created a Treatment Improvement Protocol, referred to as a TIP, that describes the proper treatment procedures for individuals with co-occurring disorders. Integrated treatment, provided in one clinical setting by one team or program, is recommended. In California, the County Alcohol and Drug Program Administrators Association of California and the California Mental Health Directors Association jointly developed a set of guidelines for treating co-occurring disorders.

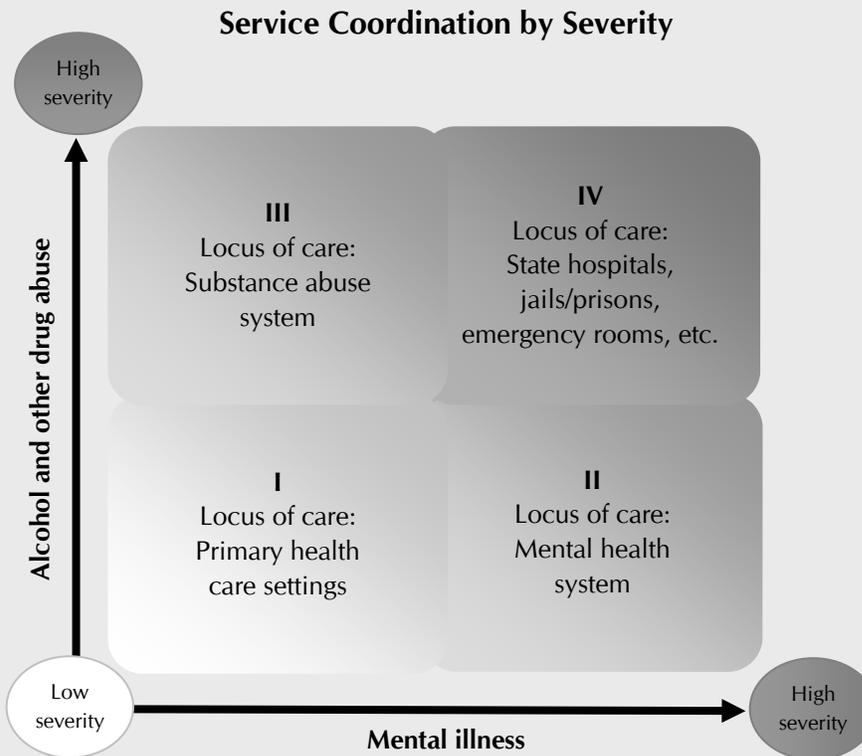
Despite this growing base of knowledge, the multi-faceted problems of co-occurring clients present multiple difficulties for the addiction and mental health fields.

Substance abuse and mental health departments and providers have distinct cultures, workforce differences and a long history of battling for money and influence in state and local governments. In California, efforts at both the state and county levels to merge mental health and alcohol and drug departments have provoked mistrust and animosity among administrators. Effective collaboration has proven difficult.

Federal funding streams are difficult to blend in order to treat an individual with multiple disorders. Data collection systems have not been updated to gather comprehensive information on clients with co-occurring disorders. The result is that a majority of people with both substance abuse and mental health disorders do not receive appropriate care. A 2005 study based on data from the National Surveys of Drug Use and Health found that less than one-third of patients with co-occurring mental health and substance use disorders who were being treated in mental health systems also received substance abuse treatment.³⁷

Treating Co-Occurring Disorders

The National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors created this four-quadrant matrix to place clients with co-occurring disorders in appropriate settings based on the severity of their disorders. Using this framework could help better place and treat clients with integrated care from both substance abuse and mental health providers.



Source: U.S. Substance Abuse and Mental Health Services Association. November 2002. "Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders." Executive Summary. Page 5.

State has failed to respond. In California, co-occurring disorders have yet to be made a priority by state government. In fact, the state does not even have a clear understanding of how prevalent they are. The statewide data collection system for the Department of Alcohol and Drug Programs reports that only 16 percent of clients in publicly-funded treatment programs have a mental health problem,³⁸ though department officials and many stakeholders told the Commission that the number is underreported because treatment providers are not required to provide a more thorough mental health screening. The state Department of Mental Health just began requiring mental health clinics to ask clients about substance abuse issues in 2006 and has yet to publish any findings.

Counties taking the lead. California counties that provide treatment or contract with providers for treatment programs see more closely than the state the prevalence of co-occurring disorders. Some are redesigning their treatment systems to better serve clients with multiple disorders.

Ventura County recently won an award from the federal Substance Abuse and Mental Health Services Administration for its operation of an Integrated Dual Diagnosis Treatment center in Oxnard. San Diego, San Francisco, Santa Clara, Kern, San Mateo and Placer counties are working with nationally-known experts Ken Minkoff and Christie Cline to implement their Comprehensive Continuous Integrated System of Care model. Both San Mateo and Kern counties used funding from the Mental Health Services Act, or Proposition 63, to redesign their systems to better integrate mental health, substance abuse and general health programs.

Approved by California voters in 2004, the Mental Health Services Act provides a large new funding source for innovative programs that could allow counties to expand services for people diagnosed with both a mental illness and an addiction disorder. The act imposes a 1 percent income tax on personal income of more than \$1 million to support five new funding streams to be spent mostly at the county level. The new money goes to efforts to improve workforce education and training and to create new programs that address needs of the mentally ill. The act created the 16-member Mental Health Services Oversight and Accountability Commission, which provides guidance and oversight for the distribution of funds. The Department of Mental Health also has oversight of the act.

While a handful of counties have used some of the act's funding to expand co-occurring treatment, the initiative does not specifically highlight the need for more co-occurring treatment. Policy statements adapted by the commission and regulations created by the department so far do not explicitly advocate for increasing the treatment of co-occurring disorders.

Proposition 36: Major Policy Shift Reveals State's Drug Problem

For the 20 years preceding voters' approval of the Substance Abuse and Crime Prevention Act in 2000, or Proposition 36, most offenders charged with drug crimes in California faced one of two possibilities. Many went to jail or prison – between 1980 and 1999, the population in state prisons on a drug charge increased by more than 2,400 percent.³⁹ Other low-level, nonviolent offenders who were sentenced to probation and told by a judge to enter treatment faced virtually no penalty if they ignored that order.

Neither strategy effectively reduced offenders' drug use. Virtually every study of prison inmates and drug use shows almost all return to using

after release, and probation is so ineffective that one state superior court judge calls it a revolving door for drug offenders.⁴⁰

In enacting Proposition 36, voters dramatically reversed two decades of criminal justice policy by making substance abuse treatment a key component of the response to drug crimes. The initiative guaranteed treatment and prohibited incarceration for anyone charged with a nonviolent drug possession offense.

The overwhelming passage of the initiative – it received 61 percent of the vote – signaled Californians’ dissatisfaction with the status quo. Proposition 36 was based on a simple idea with merit. Because 80 percent of all offenders, regardless of their crime, are involved with alcohol and drugs,⁴¹ reducing alcohol and drug abuse should reduce crime.

By emphasizing treatment and limiting law enforcement’s and the courts’ role in handling drug offenders, Proposition 36 fundamentally changed the way the state dealt with more than 50,000 offenders every year. The complete text of Proposition 36 is included in Appendix D.

Elements of the law include:

- ***Aimed at nonviolent, low-level offenders.*** Individuals arrested and convicted of nonviolent drug possession are placed on county probation and ordered by the court into as much as one year of community-based treatment with up to six months of follow-up care. Parolees facing revocation for drug-related parole violations also qualify for drug treatment. Excluded are individuals convicted of drug sales or offenses such as property crimes, as well as anyone with a non-drug-possession felony or violent crime conviction in the previous five years.
- ***Guaranteed funding.*** The initiative guaranteed \$120 million from the state’s General Fund to be spent annually for five years on drug

Implementation Varies By County

Regulations developed by the state after the initiative was approved give counties significant leeway in developing Proposition 36 programs. Counties submit annual plans to the Department of Alcohol and Drug Programs detailing how they will handle Proposition 36 offenders. The department gave itself little authority to require counties to use proven practices by stating in regulations that it would approve county plans if they contained four elements, including which agencies worked on the plan, how the county would assess offenders’ needs and how drug testing would be utilized.

The department distributes money to counties based on a formula that includes county population, annual treatment caseload and number of drug arrests.

Programs vary by county, most significantly between small and large counties, but many counties share similar features: Fifty-five counties designated a health agency, typically the alcohol and drug agency or behavioral health agency, as the lead agency in charge of Proposition 36 programs. Most counties have designated judges and probation officers who handle Proposition 36 offenders. Many counties developed treatment programs with between three and six levels of care, according to the offender’s degree of addiction and needs.

Kern County, for example, has six options, ranging from a six-month education and prevention program for offenders with no history of drug use to a program for alcohol- and drug-dependent offenders that includes 45 days of residential treatment. Kern County typically has 2,100 to 2,300 Proposition 36 offenders each year. By contrast, Calaveras County, which has only about 20 offenders in treatment at any given time, has three levels of treatment, ranging from an education-based early intervention program to residential treatment.

Source: William E. Ford, Bernard L. Brookes, Stephanie Hauser, Health Systems Research, Inc. September 12, 2005. “Substance Abuse and Crime Prevention Act of 2000: Analysis of FY 2004/05 Plans from the 58 Counties.” Washington, D.C.

treatment, vocational training, family counseling, literacy training, and court and probation costs. After the first five years, the governor and Legislature annually determine how much to spend on the program.

- ***Handling non-compliant offenders.*** Judges can revoke probation and Proposition 36 status if a non-drug-related probation offense is proved. Probationers are allowed three nonviolent drug-related arrests or probation violations before facing revocation and possible jail time – a practice referred to as “three strikes” or “three bites at the apple” by stakeholders. Parolees can be sent back to prison for a non-drug-related parole violation or two drug-related violations.
- ***Conviction can be expunged.*** Probationers who successfully complete treatment and their probation term can petition the court to set aside their recorded conviction.
- ***Evaluation required.*** The initiative required the state to set aside 0.5 percent of annual funding to hire a public university to evaluate the program. The state Department of Alcohol and Drug Programs, the lead state agency overseeing Proposition 36, hired the University of California Los Angeles’ Integrated Substance Abuse Program to conduct the reviews. UCLA has published four reports detailing the demographics of Proposition 36 offenders, outcomes, a cost-benefit analysis and recommendations for improving outcomes.

New law reveals extent of state’s drug problem. UCLA’s data shows that the state had a worse drug problem than many imagined, and the number of offenders who need intensive treatment – including long-term residential programs – far exceeds capacity. Among the findings:

- ***A majority use methamphetamine.*** In each year UCLA has studied the initiative, methamphetamine far surpassed other illegal drugs or alcohol as offenders’ primary drug.
- ***Many have long drug histories.*** About one-quarter of Proposition 36 offenders trace their drug use back more than 20 years, according to UCLA’s data. One Sacramento treatment provider, a methadone clinic, found that its Proposition 36 offenders had been using heroin or other opiates for an average of more than 22 years.⁴² Despite these long histories, 49.2 percent of offenders in 2004-05 had no previous interaction with a treatment program.
- ***A wide range of severity.*** The frequency of drug use among Proposition 36 offenders varies considerably. In 2004-05, 24.9 percent of offenders said they were daily drug or alcohol users, and another 10 percent said they used drugs or alcohol three to

six times per week. In the same year, 37.1 percent said they had not used in the past month. (UCLA researchers suggested that the number who had not used alcohol or drugs in a month may be due to the fact that many were incarcerated or under probation or parole oversight.)

Treatment providers, judges and county officials told the Commission that a majority of Proposition 36 offenders have other issues that must be addressed along with their substance abuse problems. Data collected by the Department of Alcohol and Drug Programs suggest only about 15 percent of Proposition 36 offenders identified themselves as having mental health issues,⁴³ however, state and county officials and treatment providers suggest that number is dramatically underreported because there is not a thorough screening process for mental illness.

Many counties and treatment providers suggest that more than 60 percent of offenders have some mental health problem, ranging from bipolar disorder to less severe problems such as anxiety, that require specific treatment in addition to addiction treatment. Many Proposition 36 clients have other problems, including unemployment and homelessness, that require attention if the client is to succeed, stakeholders said.

A Difference in Numbers

In analyzing offenders' journeys through the Proposition 36 system, the Commission used data provided by UCLA to follow the Proposition 36 offenders in 2003-04 from referral to a treatment program to treatment completion. That analysis resulted in the finding that 19 percent of offenders referred to the program in 2003-04 completed treatment.

In their reports and presentations on Proposition 36, the Department of Alcohol and Drug Programs and UCLA typically use a much larger number when describing the percentage of offenders who complete treatment. In the April 2007 report on Proposition 36, for example, UCLA states that 32 percent of offenders from 2003-04 completed treatment.

The different numbers occur for two reasons. When discussing treatment completion, UCLA and most treatment evaluators only include the offenders who enter treatment. Thus, UCLA omits offenders who are referred to treatment but do not show up for treatment. Also, due to problems with the state's treatment data reporting system, there are a significant number of offenders (6,857 in 2003-04) who entered treatment but whose treatment outcome is unknown because treatment providers did not report an outcome. This subset of offenders may or may not have completed treatment. While UCLA omits this group from its description of treatment completers, the Commission includes them.

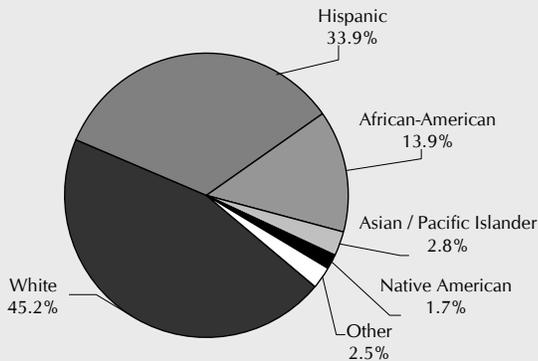
The Commission's overall analysis of treatment completion reveals a much smaller percentage of offenders completing treatment. The Commission believed it was important to look at the entire Proposition 36 system, not just treatment, in evaluating the program to determine outcomes. In addition, the Commission believed it was important to note that there was a group of offenders with unknown outcomes. The department believes the number of offenders with unknown outcomes will be much smaller in future reports due to recent improvements in the data collection system.

In the chapter on Proposition 36 the Commission uses UCLA's and the department's treatment completion numbers to allow for accurate comparisons among subsets of offenders, because it was impossible to determine the demographics of offenders who were referred to treatment but did not show up or offenders whose treatment outcomes were unknown. Thus, while the Commission's analysis reveals an overall treatment completion rate of 19 percent, it will use a 32 percent completion rate in the Proposition 36 section. See Appendix E for the Commission's analysis.

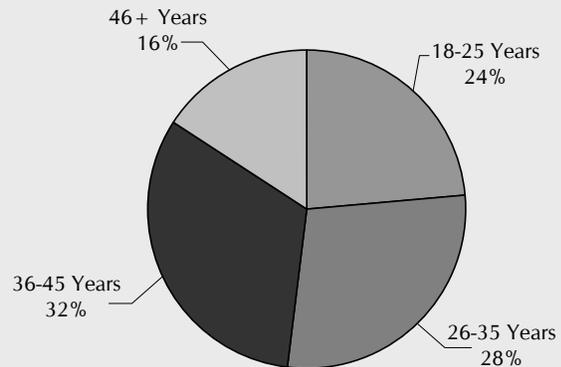
Proposition 36 Offender Characteristics

Data compiled by researchers at the University of California Los Angeles Integrated Substance Abuse Programs provide a detailed look at Proposition 36 offenders. A majority of offenders list methamphetamine as their primary drug; age, race and the number of years since first drug use varies widely; a large majority receive outpatient treatment; and nearly half have never received substance abuse treatment before. The graphs below reflect characteristics for the population of 39,202 Proposition 36 treatment clients between July 1, 2004 and June 30, 2005.

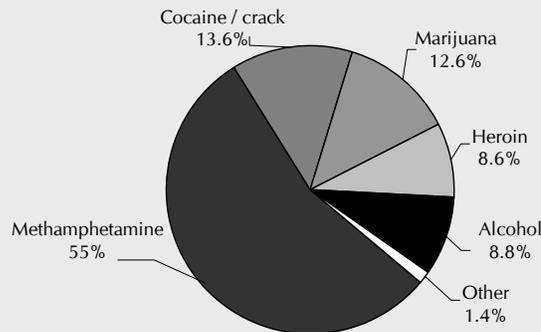
Race / Ethnicity



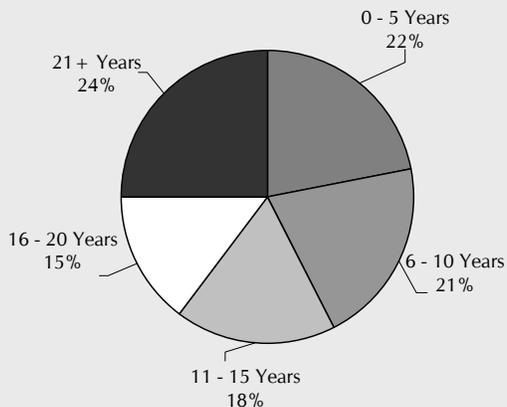
Age



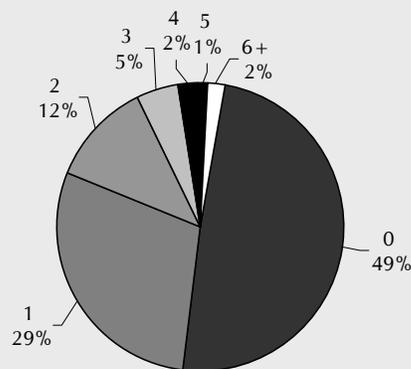
Primary Drug Use



Years Since First Use



Number of Prior Treatment Admissions



Source: University of California Los Angeles Integrated Substance Abuse Programs, April 13, 2007. "Evaluation of the Substance Abuse and Crime Prevention Act Final Report."

Outcomes mixed. Proposition 36 has produced benefits for the state. The initiative pumped millions of dollars into an under-funded treatment system at a critical time, as the state grappled with a methamphetamine epidemic. A cost-benefit analysis done by UCLA shows the initiative saves the state money, mostly by reducing incarceration. There are thousands of offenders who went through Proposition 36 and are now in recovery and leading productive lives.

The Commission, however, encountered no stakeholder who was satisfied with the results of Proposition 36. An analysis of the data by the Commission shows that only 19 percent of offenders initially referred to the program in 2003-04 could be confirmed as completing their required treatment program.⁴⁴ Thousands of offenders did not even make it to treatment. They were referred by the courts but either did not show up for their assessment or vanished after the assessment but before entering treatment. A graphic illustration of the Commission's analysis is included as Appendix E.

Still, thousands of success stories illustrate how Proposition 36 salvaged once-ruined lives and families. A Ventura County judge is visited once a year by a former Proposition 36 participant who shows her his annual sobriety medallion from a self-help group and tells her she saved his life. In El Dorado County, a woman graduating from a Proposition 36 program told a packed courtroom that she was a valued member of her family – rather than a burden – for the first time in years. A former Proposition 36 offender told the Commission in a public hearing that after more than a decade of alcohol and methamphetamine dependence, he has been sober for three years, is seeking a bachelor's degree from California State University, Sacramento and has a job helping others overcome their addictions.

Some of the benefits of the initiative include:

- **Expanded treatment.** Proposition 36 pumped millions of dollars into an under-funded treatment system in the state. The Department of Alcohol and Drug Programs estimates treatment capacity has grown by 66 percent as a result of the proposition's \$120 million annual outlays.⁴⁵ More than 200,000 drug offenders have received some treatment through Proposition 36.⁴⁶ Half had never received treatment before, according to UCLA's data. In its first year alone, Proposition 36 offered treatment to the parents of 70,000 children.⁴⁷
- **Cost effective.** A cost-benefit analysis conducted by UCLA found that the state saved \$2.50 for every \$1 invested in Proposition 36. The study found the biggest savings came through reduced prison and jail costs.⁴⁸

- **Required collaboration.** The new law brought together judges, prosecutors, defense attorneys, law enforcement officials and treatment providers to develop Proposition 36 programs. In many counties, these collaboratives remain committed to working together to help offenders overcome addiction and change criminal lifestyles.
- **Generated important data.** By requiring an annual evaluation, Proposition 36 is creating a detailed demographic picture of alcohol and drug use in the state and treatment outcomes. These evaluations encompass a large number of drug offenders and should provide important information for policy-makers and treatment and criminal justice experts in California and around the country.

There are numerous problems with Proposition 36, however. Frustrated law enforcement officials said too many Proposition 36 offenders have been arrested repeatedly without consequence, due to the law's stipulation that offenders can be arrested three times before facing expulsion from the program and a jail sentence. County alcohol and drug administrators and treatment providers complain that the state has not provided guidance or signaled priorities in adding this new population to the existing treatment system. Experts who study drug treatment programs in criminal justice systems said the initiative does not allow officials enough leeway to place offenders in programs most appropriate to their treatment needs or the risk they represent to the community.

Data captured by UCLA illustrate some of the initiative's problems:

- **Too few enter treatment.** More than one quarter of offenders referred to treatment through Proposition 36 never show up. The state has not done enough to determine where these people go. Many may have been arrested on more serious charges, and some may decide after initially accepting Proposition 36 that they would rather opt for a traditional sentence, which can mean only days in jail.⁴⁹
- **Too few complete treatment.** Thirty-two percent of the offenders who entered treatment actually completed treatment in 2003-04, the latest year for which data is available to determine treatment outcomes due to an unfortunate lag time in department-produced data. Less than one-third of the offenders in many of the state's largest counties, such as Los Angeles and Alameda, are completing treatment. Fewer than half of Proposition 36 offenders stayed in treatment for at least 90 days, which research indicates is the minimum period of treatment needed to produce positive outcomes in reducing alcohol and drug use.⁵⁰

- ***Some groups lag behind.*** Data show that 26.1 percent of African-Americans who entered treatment completed treatment, compared to 35.2 percent for whites and 30 percent for Latinos.⁵¹ Heroin users showed lower completion rates than other drug and alcohol users: Only about one-quarter who entered treatment complete treatment.⁵² Just over a quarter of the parolees who entered a program completed treatment, compared to 32.8 percent of those who were on probation.⁵³ Parolees are a special and important population within Proposition 36 because they tend to have more complex problems and are not under the jurisdiction of a judge.
- ***Re-arrest rates high.*** UCLA found that 42.7 percent of those who completed treatment were re-arrested on a drug charge within 30 months of their referring offense. By comparison, 60.5 percent of those who began, but did not complete, treatment were re-arrested. The high re-arrest rate for those who completed treatment has raised concerns about the effectiveness of the program.

Despite the disappointment in numbers, several experts told the Commission that Proposition 36 treatment completion rates were typical, if not higher than expected, for a substance abuse treatment program within the criminal justice system. Many also suggested it would be unreasonable to expect above-average results given the enormous policy change Proposition 36 imposed on the criminal justice and treatment systems, and the volume of offenders the initiative affects.

No System, No Accountability

Substance abuse is a key driver of California's most costly problems.

As many as two-thirds of all parents who enter the state's \$19-billion child welfare system are affected by substance abuse,⁵⁴ while an estimated 60,000 to 70,000 children who are born each year in California have been exposed in the womb to alcohol, tobacco or other drugs.⁵⁵

California hospitals incur \$1.3 billion in costs due to alcohol-related incidents.⁵⁶ Studies conducted by Kaiser Permanente in California show that the health maintenance organization's members who sought substance abuse treatment had medical costs more than four times that of other clients prior to seeking treatment.⁵⁷

Severe overcrowding in California's \$10-billion prison system has prompted federal judges to consider taking control of the system away from the state. County jail policies in 20 counties are guided by court-imposed population caps, which force sheriffs, every day, to release offenders early.⁵⁸ Approximately 80 percent of the offenders in these over-packed prisons and jails are involved with substance abuse,⁵⁹ and for many, addiction is an integral part of their criminal lifestyles.

Despite these costs, and the havoc addiction wreaks on families and neighborhoods, alcohol and drug abuse is too frequently ignored as a distinct problem by policy-makers. Treatment is undervalued as a means to reduce social costs borne by not only families of addicts, but taxpayers as well.

During the past decade, governors from both parties and the Legislature have shown little interest in changing this dynamic. California voters, not policy-makers, enacted the most radical change in substance abuse policy by supporting the Substance Abuse and Crime Prevention Act of 2000, or Proposition 36.

Additionally, the Department of Alcohol and Drug Programs, the lead state agency in charge of alcohol and drug abuse policy, is but a tiny player within the massive Health and Human Services Agency, accounting for less than 1 percent of the agency's annual budget. The department lacks the strategic capacity and leadership to advocate for improvement or coordinate the state's substance abuse treatment efforts.

Too often, treatment remains an afterthought within the health care field. Substance abuse screening, interventions and treatment are not frequently provided by physicians, clinics or other health care providers.

This dearth of attention comes despite important and exciting advances in the field of addiction treatment. Medications for combating alcohol and heroin dependence have become well-established, and research is underway on medications that could help people recovering from cocaine and methamphetamine addiction.⁶⁰ The Network for the Improvement of Addiction Treatment, a partnership between private foundations and the federal government, has created important strategies to help treatment providers employ better business practices to increase the number of clients they treat and to keep those clients in treatment longer. The Institute of Medicine published a report in 2006 that made a compelling argument for breaking down the silos that separate substance abuse, mental health and general health treatment in favor of a more integrated approach that addresses all of these intertwined health issues simultaneously.

These advances challenge treatment providers and the public agencies that fund them to rethink their practices. With the growing understanding that addiction is a chronic, lifelong disease, many experts are urging treatment providers to adopt the chronic care model used in medical settings to their own treatment programs. Even the definition of treatment is evolving. A decades-old model, heavy on peer counseling in specialized settings, is gradually being updated to a more sophisticated model that employs brief treatment sessions in many health care settings, and in specialized treatment centers, combines evidence-based interventions and the use, where appropriate, of medication-assisted treatment.

Coinciding with the evolution of the treatment field is an expanded role for treatment. Substance abuse treatment now has become a critical component of California's criminal justice system. Through Proposition 36, as many as 50,000 criminal offenders are sent every year to treatment, thrusting a public-safety role onto a system ill-prepared to handle it.

In revisiting its 2003 study of California's alcohol and drug treatment programs, the Commission hopes to underscore the importance of this overlooked public problem, and illustrate what a systematic, evidence-based statewide treatment strategy might do to improve lives and public safety.

Through public hearings, meetings of two Commission-created advisory committees, extensive interviews with providers, local government

officials and treatment experts, and a review of research, the Commission identified four critical problems that the state must address to move forward:

- ***California lacks a coherent substance abuse treatment system.*** Funded by state and federal money, counties use widely divergent approaches to treatment with little oversight or accountability for results. The state has not integrated a coherent substance abuse treatment strategy into California's health care, foster care or corrections systems. As a result, the state spends billions of dollars addressing the consequences of abuse – outlays that could be reduced or avoided with a greater emphasis on treating substance abuse. Treatment is often reserved for the most dependent and is not given to those in the earliest abuse stages, where it can be the most cost-effective.
- ***The governor and Legislature have not exercised their leadership roles.*** Elected officials rarely focus on substance abuse policy. In part because of this lack of attention, the Department of Alcohol and Drug Programs is a timid agency that distributes money to counties with little effort to upgrade practices that would improve outcomes. State leaders have not used their influence to coordinate substance abuse treatment across departments.
- ***Treatment advances are not systematically implemented in the field.*** The state has not put in place incentives for adopting evidence-based approaches that could improve treatment quality and outcomes. Absent a focus on results, government agencies that fund treatment, and the providers who administer treatment, largely have opted to treat as many people as possible, regardless of outcomes. This approach is built on a cost structure that results in low pay for the treatment workforce, high staff turnover, and inexperienced and undereducated counselors.
- ***Funding is limited and not used strategically.*** Despite evidence that spending money on treatment is cost-effective and saves money, California does not maximize funds available for treatment or use available money efficiently. Regulations governing public funding streams are outdated and limit providers' ability to implement best practices in treatment. With private insurers paring benefits for substance abuse treatment, taxpayers increasingly are left to pay for an ever larger share of treatment costs.

In 2008, California's enormous budget deficit requires cutbacks in many state services, including substance abuse treatment. Governor Arnold Schwarzenegger's proposal for funding Proposition 36 in the 2008-09 fiscal year, at about \$108 million, is less than half of the \$228 million

that researchers at the University of California Los Angeles have suggested is an appropriate funding level for the program.

Such tough financial times, however, provide an opportunity for policy-makers to rethink state approaches to the costliest public problems. With limited dollars, policy-makers must consider an investment in substance abuse treatment as a way to avoid costs in programs such as foster care and corrections. Screening for substance abuse problems and brief interventions conducted in primary care settings can reduce alcohol and drug use and lower health care costs.⁶¹ Drug courts, which allow judges and treatment providers to work with drug offenders on substance abuse problems without sending offenders to jail or prison, and dependency drug courts, which work with substance-abusing parents in danger of losing custody of their children, save money.⁶² Kaiser Permanente, the state's largest health maintenance organization, provided substance abuse treatment to clients who needed it and lowered clients' health care costs while only adding 3 to 6 cents to members' costs.⁶³

Within the substance abuse treatment system, policy-makers responsible for allocating limited resources should demand quality. The state can and should insist that treatment providers use research to improve their practices and improve outcomes. To promote better care and better outcomes, policy-makers can and should require collaboration among the state and county mental health and alcohol and drug agencies and other health and human services.

The challenges facing California's substance abuse treatment system are not unique to the state. A 2006 report by the Institute of Medicine found nationwide weaknesses in treatment systems' collaboration and integration with other health care providers; problems with the treatment workforce's ability to adapt to new evidence-based treatments; and, a dearth of outcomes-based incentives in treatment funding streams.⁶⁴

California can and should be a national leader in pushing the substance abuse treatment field into a more modern and mainstream era. The state is rich with examples of successful changes that counties and providers have made, harnessing new research and data to provide better services for those suffering from alcohol and drug problems:

- Santa Clara County moved to a quality-based strategy, increasing payments to treatment providers while requiring that providers increase the education levels of their counselors and meet other benchmarks.
- El Dorado County has brought together a key judge, probation officers, treatment providers and attorneys to create a

collaborative drug court model that has dramatically increased the number of Proposition 36 offenders who complete treatment.

- A Ventura County clinic won a national award for providing integrated care for people with co-occurring mental health and substance abuse disorders.

Individual providers and counties are responding to new knowledge about what works. The state must develop incentives and requirements that ensure a cohesive statewide system oriented toward results, that can heal individuals and families, improve public safety and lower the costs of public programs that pay for the consequences of untreated substance abuse.

An Isolated System

Despite the ramifications substance abuse has on numerous public problems, treatment remains separated from the health care field and an afterthought of many public programs that deal with the tragic results of addiction. This compartmentalization has led to incoherent and haphazard policies that waste money and do not best serve the needs of Californians.

For example, according to data collected by the Department of Alcohol and Drug Programs, nearly 20,000 Californians received alcohol or drug addiction treatment in 2006 but remained homeless upon discharge from treatment.⁶⁵ Providing treatment without helping people find transitional housing is a poor way to spend limited resources, as lack of housing makes follow-up care difficult and is a likely contributor to continued substance abuse problems.

Isolated from health care. Substance abuse problems are not emphasized enough in the health care field. This is not a California-specific problem: medical schools across the country rarely provide a specific course on addiction medicine,⁶⁶ and a national study of doctors' practices showed that less than 20 percent used any formal alcohol screening tool with patients who they know consume alcohol.⁶⁷

In California, a survey conducted in 2007 by the State Interagency Team for Children and Youth, which was designed to coordinate policy for children in California, found that many public agencies, ranging from schools to mental health clinics to public health clinics, do not screen clients or families for alcohol and drug abuse or dependence problems.⁶⁸ In addition, agencies that do screen for alcohol and drug use often do not use validated screening tools appropriate for their clientele, the survey found.

One key barrier to increasing substance abuse screening and treatment within the health care system is the Uniform Accident and Sickness Policy Provision Law, which was enacted by many states, including California, in the 1950s, and allows insurers to deny accident or injury claims if there is evidence the claim is based on an incident involving alcohol or drug abuse. Emergency physicians are sometimes reluctant to screen for substance abuse problems for fear that the patient's health plan will not reimburse the hospital's costs.⁶⁹

Data not collected. Illustrating California's failure to properly address substance abuse issues is the state's lack of data regarding the problem.

The state Department of Social Services, which runs the state's foster care system, does not routinely include in its data collection system information on whether parental substance abuse was a key factor in the removal of a child from a home. Estimates suggest as many as two-thirds of parents entering the child welfare system are affected by substance abuse.⁷⁰ Yet, the state does not have accurate data on the problem because there is no box to check regarding substance abuse issues when social workers document a case for the child welfare system/case management system (CWS/CMS), California's version of the federal Statewide Automated Child Welfare Information System. Information reported to the federal government from California in 2004 suggested that only 2 to 4 percent of families whose children were removed from the home had substance abuse issues.⁷¹

In addition, there is growing national consensus that alcohol and drug addiction and mental illness are intertwined, yet the state Department of Alcohol and Drug Programs and the Department of Mental Health have done little to study how many Californians suffer from co-occurring disorders. The Department of Alcohol and Drug Programs' data collection system, the California Outcomes Measurement System, or CalOMS, requires substance abuse treatment providers to ask only four mental health-related questions – questions that many in the field said were inadequate. The CalOMS data system suggests that only 16 percent of Californians in substance abuse treatment have a mental health problem.⁷² Providers told the Commission that percentage is much higher. The Department of Mental Health just began requiring mental health treatment providers to collect information about substance abuse problems within their client population in 2006 and has yet to report the results.

No clear direction on co-occurring disorders. As the lack of data illustrates, the state Department of Alcohol and Drug Programs and Department of Mental Health have been unable to conduct meaningful collaboration on treating people with co-occurring disorders.

There have been numerous attempts to study the issue. At least three groups have been formed to provide guidance for the state:

- The Dual Diagnosis Task Force was created in 1996.
- The Co-Occurring Disorders Workgroup was created in 2002.
- The Co-Occurring Joint Action Council was created in 2005.

Each group has produced reports with specific recommendations, including identifying all possible funding sources for co-occurring disorders, creating a dual license for facilities that wish to provide both mental health and substance abuse treatment, and identifying and promoting evidence-based practices for co-occurring treatment. Few of these suggestions have been implemented, however.

The lack of clear direction is hindering progress on the issue.

County officials say they are apprehensive about using any funds from Medi-Cal programs for co-occurring treatment because state regulations are murky on whether it is allowed and counties are concerned that a state audit could result in the loss of funding. The state has no formal policy on using money from the Substance Abuse and Crime Prevention Act, or Proposition 36, for mental health treatment. County officials from two counties – Sacramento and Yolo – told the Commission they have been informally discouraged from using the money to pay for mental health treatment for Proposition 36 offenders, even if it offers the best chance to help offenders stay sober and exit the criminal justice system. The state and counties should do a better job of treating co-occurring disorders by using funds together, such as Proposition 36 and the Mental Health Services Act, or Proposition 63.

No Leadership, No Strategy

Little interest from elected leaders. For the past decade, governors from both parties and the Legislature have paid little attention to substance abuse policy even as they directed billions of dollars to programs that were fueled by alcohol and drug problems.

Corrections spending grew by 79 percent between fiscal year 2002-03 and 2007-08,⁷³ for example, largely due to a skyrocketing inmate population. At least 56 percent of inmates have a high need for programs to help them overcome addiction⁷⁴ – a key to becoming a law-abiding citizen – but the state spends only about 1.7 percent of its corrections budget on alcohol and drug treatment for inmates.⁷⁵

A lack of interest in the topic has led to little oversight or understanding of substance abuse as a critical public policy issue and haphazard development of spending patterns. Even when policy was created to shed light on the problem, lack of follow-through left the state no better off. A 2004 law requires the state Department of Health Services to issue an annual report on the number of babies born with illegal drugs in their system, but no report has been issued.⁷⁶

While other states, such as Oregon, Pennsylvania and Washington, have recognized major advances in addiction treatment and passed major legislation intended to use research-based practices to improve publicly-funded treatment, California has not. The key recommendation from the Little Hoover Commission's 2003 report on substance abuse treatment – the creation of a high-level council to help coordinate substance abuse policy and funding among law enforcement and health agencies – was ignored.

These years of inattention by the state's elected leaders have generated multiple problems: The state department charged with overseeing most of the state's prevention and treatment programs has a limited, timid agenda; the state lacks data and analysis concerning addiction and its effect in California; there is little effort to prioritize how resources are distributed; and, public agencies have not collaborated to leverage funds and provide research-backed services that treat the complex problems of citizens who need help.

A weak department. Established in 1978, the Department of Alcohol and Drug Programs is the lead state agency responsible for overseeing alcohol and drug abuse prevention and treatment programs. The department had a nearly \$680 million annual budget in fiscal year 2007-08 and 335 employees. The department is a tiny player within the state's Health and Human Services Agency: the department's annual budget is less than 1 percent of the nearly \$79 billion in spending the agency oversees.

The department's historic role has been as a pass-through agency, steering federal and state funds to counties, which then administer programs or contract with private providers. The department does little to advocate for the field of addiction treatment and has failed to promote changes in policy as understanding of treatment best-practices has grown. For example:

- Certification of treatment programs by the department remains voluntary, and residential facilities that are licensed by the department face little scrutiny regarding the quality of their programs or whether their clients have successful outcomes.

- A 1990 statute requires the department to issue an annual report that “portrays the drugs abused, populations affected, user characteristics, crime-related costs, socioeconomic costs, and other related information deemed necessary in providing a problem profile of alcohol and other drug abuse in the state.”⁷⁷ This report could provide policy-makers with a better understanding of how to respond to substance abuse problems in the state. The department does not produce the report.
- The department has been active in convening expert committees to address new trends, but rarely turns reports and recommendations into action. Committees made up of participants in the field such as the Co-Occurring Disorder Joint Action Council and the Continuum of Services System Re-Engineering Task Force have produced important recommendations for improving alcohol and drug treatment services in California. Advocates, treatment providers and others in the field complain, however, that they see little evidence that leaders at the department, and its parent agency, the Health and Human Services Agency, are working to implement the recommendations.

“Although many attempts have been made to convene workgroups and achieve consensus related to these issues (improving the quality of treatment), the Department of Alcohol and Drug Programs has been unable to develop or implement innovations, program designs, competencies, approaches or standards,” Elizabeth Stanley-Salazar, the vice president and director of public policy for Phoenix House, one of the largest treatment providers in the state, told the Commission.

County officials and treatment providers told the Commission that Kathy Jett, the director of the department from 2000 to 2007, did an admirable job of leading the department during her tenure.

Jett was appointed by Governor Arnold Schwarzenegger to a new job in February 2007 with the Department of Corrections and Rehabilitation. Schwarzenegger appointed Rene Zito to replace Jett. Before her appointment, Zito ran treatment programs, serving as the director of programs at a Marin County facility for the past seven years.

Zito had no prior experience in state government. In an appearance before the Commission last summer, she had difficulty answering questions about her department and deferred to other department officials to answer virtually every question Commissioners asked. While her passion for improving addiction prevention and treatment is apparent, numerous treatment providers, advocates and county

professionals expressed little confidence in her ability to help a weak department grow stronger.

The Commission shares those concerns.

No strategy. With a weak department overseeing alcohol and drug policy and little interest from elected leaders, the state has no real strategy for attacking substance abuse problems. Funding streams that support treatment have evolved in a haphazard manner and are not geared toward the state's biggest problems or most cost-effective solutions, and outdated laws that hinder appropriate treatment have not been updated.

Drug Medi-Cal is one of the largest sources of treatment funding in the state, accounting for about one-quarter of the Department of Alcohol and Drug Programs' budget. A 2004 report on Drug Medi-Cal by the Legislative Analyst's Office found that spending on opioid replacement therapies for heroin and other opiate users, typically methadone, grew by more than 208 percent between fiscal year 1994-95 and 2004-05 and consumed about three-fourths of the state's entire Drug Medi-Cal budget.⁷⁸

The increased spending on opioid replacement therapy is not inherently a bad idea, but neither was it a result of a clear analysis or policy direction. The spending increase on treatment for heroin and opiate addicts was due to a confluence of unrelated events. A federal court order based on a legal case, *Sobky v. Smoley*, eased access to methadone treatment. Budget-related decisions by the Legislature limited the growth of Drug Medi-Cal, shrinking spending on the other types of treatment the program covers. And an effective lobbying campaign by methadone clinics and supporters led to the passage in 1996 of AB 2071, which simplified and clarified the process for opioid replacement therapy reimbursement through Drug Medi-Cal.

During the same period that narcotic opiate users began to consume most of the Drug Medi-Cal budget, methamphetamine became the biggest problem drug in the state. A policy based on sound data might have shifted Drug Medi-Cal priorities toward the treatment of methamphetamine, which is now the primary drug for 36 percent of overall treatment admissions in California. Only 16 percent of those admitted to treatment in the state list heroin as their primary drug.⁷⁹

Providing substance abuse treatment for adolescents is a cost-effective way of spending treatment dollars. California, however, lacks a comprehensive system for treating adolescent substance abuse. "This is an area of health care that the state has virtually ignored," Thomas

Renfree, executive director of the County Alcohol and Drug Program Administrators of California, told the Commission.

More than 220,000 adolescents in the state need treatment, but only about 10 percent of them receive it.⁸⁰ The bulk of public spending on treatment programs for youth is in the juvenile justice system. Because of this default policy, the easiest way for an adolescent to get drug treatment in California is to get arrested.

The lack of treatment options for youth is discouraging given indications that adolescents are using harder and different drugs. A study of youth in treatment in Los Angeles County found that the number of youths listing methamphetamine as their primary drug rose significantly – from under 20 percent to nearly 40 percent – between 2002-03 and 2004-05,⁸¹ and the California Student Survey found that 15 percent of 11th graders reported non-medical use of prescription painkillers like Vicodin or OxyContin.⁸²

Health and Safety Code Section 11834.02 calls for the Department of Alcohol and Drug Programs to license residential substance abuse treatment facilities that are defined as “any premises, place or building that provides 24-hour residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse.” The department has interpreted this statute’s reference to “nonmedical services” to mean that residential treatment facilities cannot have licensed medical professionals, such as doctors or psychiatrists, on staff or providing regular care to clients. The department has forbidden medical professionals from working regularly in these facilities.

The statute describing residential treatment facilities and the department’s insistence that medical personnel not be allowed to operate regularly at these facilities is based on an outdated model of addiction treatment that does not account for advances in the understanding of substance abuse and treatment. The statute ignores the need to treat co-occurring disorders simultaneously and the 2006 recommendation by the Institute of Medicine to integrate medical, mental health and substance abuse treatment in recognition that general health, mental health and substance use are interrelated. The statute is outdated and needs revision.

Advances Not Implemented

There is no silver bullet “cure” for addiction – it is a chronic disease. Relapse is an inevitable part of recovery. In fact, about 40 to 60 percent of substance abuse treatment recipients relapse after treatment.⁸³

Despite the high relapse rate, research into alcohol and drug treatment has given us a sound understanding of the best methods to help people with substance abuse problems recover and stay sober. Advice from researchers and experts abound on how best to develop programs with better results. The federal Substance Abuse and Mental Health Services Administration (SAMHSA), hosts an easy-to-use Web site, www.nrepp.samhsa.gov, detailing evidence-based practices for different categories of people experiencing different types of addiction problems. The Center for Substance Abuse Treatment, a division within SAMHSA, has produced 45 lengthy papers, called Treatment Improvement Protocols, or TIPs, that detail best practices for various addiction treatments, including treatment for people with co-occurring disorders, stimulant dependence or HIV/AIDS.

Important new techniques also have been developed to help treatment programs improve their business practices to increase client engagement and retention – two keys to improved outcomes. Work in this area done by the Network for the Improvement of Addiction Treatment, or NIATx, has shown impressive results.⁸⁴

Additionally, research continues to grow into the use of medicine to treat addiction. Drugs have been approved by the U.S. Food and Drug Administration for use in treating alcoholism. Others are undergoing clinical trials and could help prevent relapse in people addicted to stimulants like methamphetamine.

Despite the growing understanding of how addiction works and how best to treat it, California has implemented few meaningful processes to improve the quality of treatment or the treatment workforce.

NIATx Improves Business Practices

A partnership between the Robert Wood Johnson Foundation, the federal Center for Substance Abuse Treatment, the National Institute on Drug Abuse and several other treatment organizations, the Network for the Improvement of Addiction Treatment (NIATx) helps treatment providers improve their business practices to improve treatment outcomes.

NIATx focuses on four areas that providers can change, often without spending more money, that increase the number of people who enter and remain in treatment:

- ***Reduce waiting times.*** Providers are encouraged to streamline paperwork, allow walk-in appointments and become more welcoming to potential clients.
- ***Reduce no shows.*** Providers are encouraged to place reminder calls to clients before appointments, use case management to keep better track of clients, and provide simple rewards, such as gift certificates, for clients who attend sessions.
- ***Increase admissions.*** Providers are encouraged to develop marketing strategies and provide a more welcoming orientation for potential clients.
- ***Increase continuation.*** Providers are encouraged to train staff in contingency management strategies, develop individualized treatment plans and create special group sessions for clients with special needs.

The NIATx process has produced positive outcomes. A pilot project in Los Angeles County conducted by six providers using the four strategies reduced the number of people who failed to show up for their initial assessment appointment from 34 percent in March 2006 to an average of 6.8 percent in the following five months.

Sources: Network for the Improvement of Addiction Treatment. "Improving Efficiency and Effectiveness of Addiction Treatment through Business Process Improvement." Also, Beth Rutkowski, University of California at Los Angeles' Integrated Substance Abuse Programs/Pacific Southwest Addiction Technology Transfer Center. Spring 2007. "The Los Angeles County Process Improvement Project." Page 4.

Program quality not measured. The Department of Alcohol and Drug Programs issues licenses to residential treatment programs. Licensure is based almost solely on health and safety concerns and not program quality. Facilities are required to have local fire inspection clearance, for example, and to provide the state with sample meal menus.

Outpatient treatment clinics, where about 70 percent of Californians receive treatment, are not regulated by any state agency. Clinics may undergo a voluntary certification process run by the department, but the statute explaining certification states explicitly that "certification, or lack thereof, shall not convey any approval or disapproval by the department."⁸⁵ Clinics seeking certification must submit detailed plans to the department regarding their programs, but the department does not use data on client outcomes when certifying clinics.

Workforce underpaid and undertrained. For decades, addiction treatment in California has relied on a paraprofessional workforce comprised largely of those in recovery. Most counselors are passionate about recovery and work very hard under difficult situations. Salaries remain low. A 2004 workforce study by UCLA's Integrated Substance Abuse Programs found that more than half of the counselors who responded to the survey earned less than \$35,000 per year.⁸⁶ This has led to a

continuing dearth of high-quality counselors and a chronic turnover problem, as the most educated or effective workers find higher-paying jobs in other related fields, or even in treatment programs in state prisons or county jails, which often offer better pay and benefits.

UCLA's workforce survey also found that more than half of the counselors surveyed and one-third of the program directors surveyed did not have a bachelor's degree.⁸⁷ As understanding grows about the nature of addiction and the best ways to aid recovery, treatment practices have gained complexity. Consequently, the need has increased for counselors to have more advanced training and education.

This new knowledge leaves policy-makers facing limited treatment budgets with an important decision: Should funding continue to be used to serve as many people as possible by keeping salaries and program costs low, or should workforce salaries and training be bolstered, adding cost to the system and decreasing the number of clients served? This question has not been fully contemplated or answered.

In an attempt to address the need for more workforce training, the department has developed a counselor certification process. According to regulations adopted in 2005, at least 30 percent of staff providing alcohol and drug counseling in any program must be certified by April 1, 2010. The department has allowed nine non-governmental agencies to certify counselors. Counselors who work in privately-run facilities that do not receive public funds are exempt.

Many in the treatment community complained to the Commission that the department's certification process is flawed and is not doing enough to improve workforce competence. Standards are among the lowest in the nation – one association representing substance abuse counselors noted that hairdressers in California face more stringent professional standards than do substance abuse counselors.⁸⁸

Counselor Certification Process

According to regulations adopted in 2005, at least 30 percent of staff providing alcohol and drug counseling in any program must be certified by April 1, 2010. The department has allowed nine non-governmental agencies to certify counselors. Counselors who work in privately-run facilities that do not receive public funds are exempt.

To earn certification, counselors must:

- Complete 155 hours of classroom education on alcohol and drug treatment strategies.
- Complete 160 hours of supervised, on-the-job training.
- Complete 2,080 hours of paid or unpaid work providing counseling services.
- Achieve a score of 70 percent on a test administered by the certifying agency.
- Sign a document stating whether the counselor has had his or her prior certification revoked.
- Sign a document pledging to abide by the certifying agency's code of conduct.

Certified counselors must take 40 hours of classroom education every two years to maintain certification. The department has the power to revoke a certification based on an investigation of a complaint from the public.

The nine agencies allowed to issue certifications are:

- The Association of Christian Alcohol & Drug Counselors, based in Redlands.
- The Breining Institute, based in Orangevale.
- The California Association for Alcohol and Drug Educators, based in Ventura.
- California Association of Alcoholism and Drug Abuse Counselors, based in Sacramento.
- California Association of Addiction Recovery Resources, based in Sacramento.
- California Association of Drinking Driver Treatment Programs, based in Sacramento.
- California Certification Board of Chemical Dependency Counselors, based in Long Beach.
- Forensic Addictions Corrections Treatment, based in La Jolla.
- Indian Alcoholism Commission of California, Inc., based in Sacramento.

Source: California Department of Alcohol and Drug Programs, Chapter 8, Division 4, Title 9, California Code of Regulations. "Counselor Certification."

In addition, each of the nine different non-governmental agencies certifying counselors has its own requirements and code of ethics. The department has provided very few specific standards as to what treatment practices should be taught in certification programs. Regulations state that certifying agencies should include some curriculum on treating specialized populations, such as clients with co-occurring disorders, but the department does not require teaching evidence-based practices for these specialized populations. The certifying agencies are required to notify the state if they issue a certificate to someone who has had his or her certificate revoked by another agency, but there is no statewide database for state officials or consumers to determine a counselor's record or whether a counselor has ever had a certification revoked.

Report Sheds Light on Poor Quality

The state Department of Alcohol and Drug Programs issues licenses to residential treatment facilities that must be renewed every two years. Requirements for licensure focus on physical structure of the facility and such issues as food preparation, maintenance of personnel and client records and on-site personnel with knowledge of cardio-pulmonary resuscitation and first aid. The treatment program within the facility is required to “demonstrate that it provides adequate opportunities for residents to participate in activities consistent with stated goals and objectives,” but little else is explicitly required. The department can investigate complaints that are lodged against treatment facilities.

Thirteen department investigators monitor 895 licensed facilities, and one advocacy group charges that the state has failed to adequately oversee treatment facilities that handle sick and vulnerable Californians.

This year, the Justin Foundation, a non-profit group based in the Bay Area and founded by the mother of a man who died while enrolled in a residential treatment program, released a report critical of the department’s oversight of residential facilities. Based on a review of public records, the foundation reported that 67 people had died in state-licensed facilities between 2000 and 2006.

Of the 67 deaths, 40 percent were blamed at least partially on failures by staff, according to reviews performed by the state Department of Alcohol and Drug Programs.

Among the deaths cited were:

- A man who had been released from a mental health facility who committed suicide after a counselor refused his request to return to the mental health facility.
- A parolee who overdosed after counselors failed to question or search him upon his return from an errand that took several hours.
- An alcoholic with a history of seizures who was undergoing unsupervised detoxification.

Source: The Justin Foundation. October 2007. “The War on Addiction: Inadequate Regulation, Standards and Oversight Allow Untrained, Unskilled and Unethical Counselors to Jeopardize Lives, Health and Recovery.”

The lack of standards and oversight is problematic given the important role substance abuse treatment plays: Providers care for clients with life-threatening illnesses who often arrive sick and both physically and emotionally vulnerable.

Funding not tied to outcomes. The state continues to dole out federal and state dollars to counties based almost exclusively on population and historic spending levels, with no rewards for using best practices or producing improved outcomes, and no penalties for poorly-performing programs.

Funding for alcohol and drug prevention and treatment generally flows from federal or state sources to counties that run programs or contract with providers. State Health and Safety Code Section 11814 requires the Department of Alcohol and Drug Programs to base its allocations to counties on population levels and makes no mention of performance.

The department has taken a key step toward outcomes-based funding by launching the California Outcomes Measurement System, or CalOMS, which requires providers to submit data to counties regarding client outcomes. That data is then submitted to the state. Data gathered include information such as age, gender, race, drug use history and other family history. Outcomes, such as alcohol and drug usage upon leaving treatment or interaction with the criminal justice system, also are reported.

In addition to CalOMS, the department has created a new office, called the Performance Management Branch (PMB), in an effort to better understand outcomes. The new office, however, appears to be more focused on regulations than results. A two-page description of the branch’s duties provided to the Commission lists tasks as ensuring that counties are in compliance with federal requirements. In describing the vision for the office, the department states that “Eventually

Law Enforcement's Effect on Substance Abuse Unknown

The bulk of public monies devoted to substance abuse are spent on law enforcement-related activities, but it is difficult to discern their effect on reducing alcohol and drug abuse.

The federal government spends about 65 percent of its drug control budget on supply reduction or enforcement activities. While there is no similar data comparing state spending, an estimate by the Legislative Analyst's Office prepared for the Commission found that the state spent \$5.7 billion on law enforcement-related activities pertaining to alcohol and drug use in fiscal year 2005-06. Costs include policing, courts, and corrections. The \$5.7 billion invested in law-enforcement activities far surpasses the estimated \$1 billion spent annually on treatment.

Law enforcement activities are significant: In 2006, the California Attorney General's Bureau of Narcotic Enforcement, with a budget of \$60 million, made nearly 9,000 arrests and seized more than 3 million marijuana plants and 25,000 tabs of Ecstasy.

When the Commission asked the bureau to provide information on how its actions influenced drug supply, as measured by the price of drugs or the quality of drugs, the bureau noted they are rarely asked to provide such information to policy-makers who set budgets and did not have it readily available.

Are arrests and drug seizures reducing supply and helping alleviate the state's addiction problem? A June 2007 report by the U.S. Department of Justice on illegal drug use in Northern California suggests the answer may be no, as it notes that methamphetamine, marijuana, powder cocaine and crack cocaine are all widely available. The state has conducted no thorough effort to determine what enforcement efforts are working, despite spending hundreds of millions of dollars on these efforts. If policy-makers wish to hold treatment providers accountable for outcomes, they should do the same for law enforcement.

The Attorney General's Bureau of Narcotic Enforcement should provide an annual report to the Legislature that examines the effect of expenditures on drug supply, prices, quality of drugs and other relevant information that could help policy-makers make better funding decisions.

Sources: Council on Foreign Relations. April 6, 2006. "The Forgotten Drug War." Also, Legislative Analyst's Office, January 10, 2008. "LAO Estimate of 2006 State and Local Drug Enforcement Costs." Also, Attorney General's Office, Bureau of Narcotic Enforcement, September 26, 2007. "Bureau of Narcotic Enforcement Yearly Report Totals." Also, U.S. Department of Justice. June 2007. "Northern California High Intensity Drug Trafficking Area Drug Market Analysis."

PMB will be engaged in working with counties and providers in setting targets and benchmarks for county AOD (alcohol and drug) performance outcomes."⁸⁹

Department officials said that this is a long-term goal that has not been fully thought out, however, and there are no plans in place to ensure this important mission is ever fulfilled.

Funding Underused, Restricted By Outdated Rules

Alcohol and drug treatment is one of the soundest investments governments can make.

The California Drug and Alcohol Treatment Assessment, conducted in 1994, found that the benefits of treatment outweighed the costs by 7 to 1.⁹⁰ One year later, RAND found that of the country's three main responses to illegal drugs – interdiction, prevention and treatment –

treatment was the most cost-effective.⁹¹ More recently, University of California Los Angeles researchers have shown that the state's investment in treatment through the Substance Abuse and Crime Prevention Act, or Proposition 36, saved taxpayers \$2.50 for every \$1 investment, mostly by cutting the high cost of incarceration,⁹² now more than \$43,000 a year per person for state prison.⁹³

Despite the overwhelming evidence that spending money on treatment saves money, complicated state regulations, limits on treatment in publicly-funded programs that prevent best practices and a lack of relationships between primary care providers and alcohol and drug treatment all act as barriers to treatment expansion and limit the possibility for increasing positive outcomes. These barriers, combined with advances in research, underscore the need for the state to rethink regulations about funding streams to capture all of the federal dollars available.

Maximizing federal funding is particularly important given the continuing decline of private funding for treatment. Many insurance providers do not cover addiction treatment as a benefit. A study released this year by the Substance Abuse and Mental Health Services Agency found that 77.4 percent of treatment in the country in 2003 was paid for by public sources, while only 22.6 percent was paid for by the private sector.⁹⁴ That represents a major change from 1986, when the private sector paid for about half of the treatment delivered. Private insurers, who paid 29.6 percent of treatment costs in 1986, only paid for 10.1 percent in 2003.⁹⁵

This decline puts a greater burden on public programs and peer-based services, such as Alcoholics Anonymous and Narcotics Anonymous, to help people who are struggling with substance abuse. An estimated 7,379 A.A. groups and an estimated 3,719 N.A. groups are active in California.⁹⁶

Drug Medi-Cal not maximized. California's substance abuse treatment program for those who qualify for Medi-Cal is known as Drug Medi-Cal. While Medi-Cal is overseen by the Department of Health Care Services, Drug Medi-Cal is overseen by the Department of Alcohol and Drug Programs. Like Medi-Cal, Drug Medi-Cal provides a \$1 federal match for every \$1 spent by the state. Drug Medi-Cal is one of the largest sources of substance abuse treatment funding in California, accounting for 26 percent of the state Department of Alcohol and Drug Programs' budget.⁹⁷

But experts and treatment providers say Drug Medi-Cal regulations written by the state to dictate funding distribution are overly complex and do not reflect current understanding of how best to treat addiction. Among the problems with Drug Medi-Cal:

- ***Too complicated.*** A 2004 study of Drug Medi-Cal by the Legislative Analyst’s Office (LAO) found that the state spent more than 14 percent of available funding for the program on administrative costs – more than double that of regular Medi-Cal, in part because of the state’s overly-complicated rate-setting regulations.⁹⁸ The regulations dictate which types of clients can receive certain modes of treatment, the minimum numbers of hours each week or month that services must be provided, as well as the minimum and maximum number of participants for group counseling sessions. The LAO concluded the regulations were enacted by the state to constrain costs, but have had the unintended effect of increasing administrative expenses.
- ***Limits hinder appropriate treatment.*** Drug Medi-Cal’s payment limits on treatment run counter to research into how best to treat addiction and they prevent providers from making decisions as to appropriate treatment techniques. For example, while Drug Medi-Cal provides reimbursement for group counseling sessions, it does not cover ongoing individual counseling. The “Principles of Effective Treatment,” published by the National Institute on Drug Abuse, state that individual and/or group counseling sessions are critical components of treatment.⁹⁹ By prohibiting individual counseling, treatment providers do not have the needed flexibility to determine and carry out appropriate treatment based on client needs. Recovery management, such as follow-up appointments with primary-care doctors or treatment providers once treatment is complete, is emerging as an important aspect of addressing the chronic nature of addiction.¹⁰⁰ Drug Medi-Cal, however, reimburses treatment under an acute model – no post-treatment funding is allowed.
- ***Medicine benefits outdated.*** Drug Medi-Cal still allows for the use of Levo-Alpha Acetylene Methadone, or LAAM, which is no longer used to treat opiate users, but does not cover buprenorphine, a medication which has been approved by federal authorities as a treatment for heroin and other opiate addictions. Methadone remains the primary medication to treat heroin users, and it is covered by Drug Medi-Cal. But methadone must be distributed in a clinic setting that requires extensive state and federal licensing, and methadone clinics might not be financially viable in rural California. Buprenorphine could present a significant advantage to counties that lack methadone clinics to treat opiate users, as it can be distributed by physicians. While the cost per dose for buprenorphine is higher than methadone, the overall cost per treatment episode can be lower.¹⁰¹

Other sources underutilized. The state does not take advantage of other treatment programs that include a federal match.

The Healthy Families program is California's version of the federal State Children's Health Insurance Program. Among other services, it provides alcohol and drug treatment and is attractive to states because the federal government pays \$2 for every \$1 the state spends on the program. In 2006, however, only 1,468 youth – of more than 750,000 insured by Healthy Families – received substance abuse treatment.¹⁰² A barrier to increasing the use of substance abuse treatment through Healthy Families is that youth must be referred to treatment by a primary care provider. Additionally, 19 of the state's 24 Healthy Families health plans limit the number of outpatient counseling sessions to 20 per year, and do not cover family therapy sessions. These limits are inadequate based on research that shows that most clients need 24 to 36 treatment sessions during a three-month period to achieve initial sobriety,¹⁰³ and that family-oriented counseling is effective in treating adolescent substance abuse.¹⁰⁴

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated Medicaid program that provides screening, diagnostic and medically necessary treatment to anyone under age 21 who qualifies for Medi-Cal. EPSDT can be administered through both Drug Medi-Cal and Mental Health Medi-Cal, and is an important funding source for both mental health and substance abuse treatment because it allows a much broader range of services than regular Medi-Cal. Like the rest of the Medi-Cal program, the federal government pays for half of the program's costs. Since 1999, the state has allowed an EPSDT "supplement" benefit for Drug Medi-Cal, which allows for substance abuse treatment services that regular Drug Medi-Cal does not, such as individual counseling. The EPSDT supplement could allow treatment providers more flexibility in providing treatment and allow the use of more evidence-based practices. A review of the program by the California Senate Office of Research, however, found that the supplement has not been used.¹⁰⁵ Department officials confirmed to Commission staff that the supplement is not used by any county. A key barrier to tapping the EPSDT supplement benefit is that substance abuse treatment providers must receive prior approval from the Department of Health Care Services before using the benefit. After the service is provided, claims for reimbursement are administered through the Department of Alcohol and Drug Programs. Getting prior approval from one state agency and then submitting claims to a separate agency is cumbersome and acts as a barrier to using the benefit.¹⁰⁶

Approved by California voters in 2004, the Mental Health Services Act, or Proposition 63, imposed a 1 percent income tax on personal income of

more than \$1 million to support new services for the mentally ill. Proposition 63 represents a large new funding source – the initiative generated revenues of \$1.34 billion in fiscal year 2005-06 – to provide innovative programs that could allow counties to expand services for people diagnosed with both a mental illness and an addiction disorder. Funding streams within the initiative are dedicated to “whatever it takes” treatment that could include substance abuse treatment, and workforce development, that could increase programs’ co-occurring capabilities. Co-occurring disorders have not been a priority, however. The initiative does not specifically highlight the need for more co-occurring treatment, and policy statements adapted by the Mental Health Services Oversight and Accountability Commission, which acts as overseer and policy-setter for the initiative, and regulations created by the Department of Mental Health do not explicitly advocate for increasing the treatment of co-occurring disorders. A commission subcommittee on co-occurring disorders has released recommendations to the full commission calling for funding for co-occurring treatment. The commission has not yet voted to adopt those recommendations as state policy, but may take that action in 2008.

Unknown, uncoordinated spending. There is another key issue regarding substance abuse treatment funding in California: We do not know how much public money is spent on treatment. Because multiple state agencies, including Department of Social Services and the Department of Corrections and Rehabilitation, as well as local governments all fund some substance abuse programs, treatment is dispersed and no state entity is charged with tabulating how much is spent and where.

A recent estimate compiled by the non-profit group Children and Family Futures estimated the state will spend slightly more than \$1 billion in fiscal year 2008-09 on treatment.¹⁰⁷ Based on this calculation, the Department of Alcohol and Drug Programs only oversees about two-thirds of state spending on treatment.

Without a clear picture of how much the state spends and where that money goes, treatment funding will remain uncoordinated and measuring the impacts of treatment will be difficult.

Building a Better System

California can reduce the misery and cost of substance abuse.

As a first step, the state must embrace a model for substance abuse treatment that acknowledges substance abuse as a public health problem that requires distinct responses and incorporates a current understanding of effective treatment practices. Features of this model should include:

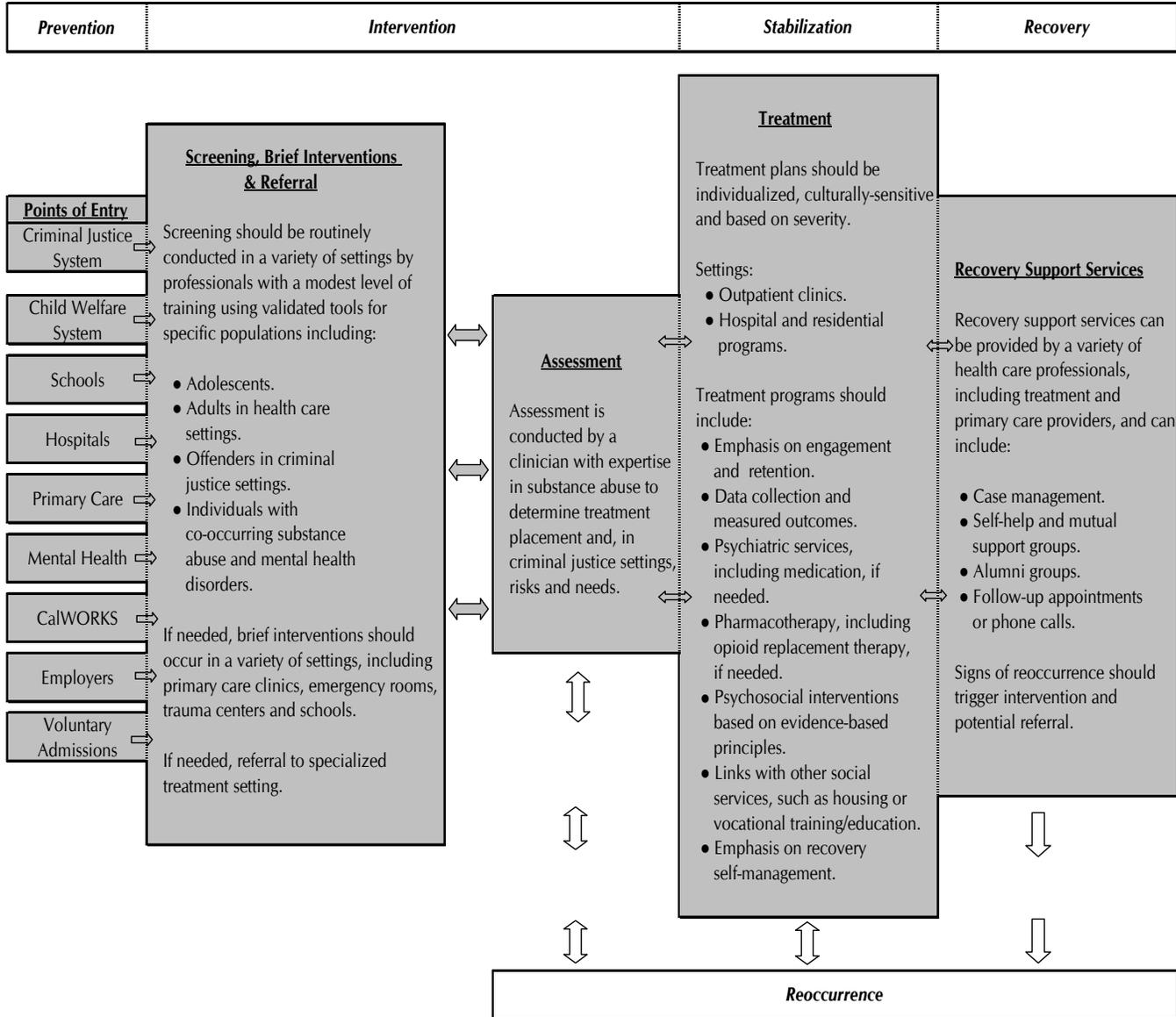
- Validated substance abuse screening tools in virtually all health, human service and criminal justice systems.
- Capacity to provide brief interventions, if needed, in these settings.
- Relationships between specialized treatment providers and other systems to encourage referrals and data sharing.
- Specialized treatment providers that use validated assessment tools to properly place clients in individualized, culturally-sensitive programs.
- Treatment programs that use evidence-based practices in both treatment and administration, provide psychiatric services when needed, and provide links to other health and human services.
- Funding streams that acknowledge substance abuse as a chronic disease, allow for best practices during treatment, and provide for recovery support services after initial treatment.
- State leadership and oversight, including data collection and analysis that allows policy-makers to reward cost-effective programs and respond to new developments.

This is an ideal-world model that will be difficult to fully attain, but the timing to drive toward this model is opportune. The substance abuse treatment field is transforming as research fuels advances. Re-engineering the state's substance abuse treatment system would make California a national leader on this critical public-policy problem.

Reform also could save money in multiple public systems.

A Model Chronic Care System for Substance Abuse Treatment Services

The state's substance abuse treatment service system should be designed with the assumptions that addiction is a chronic disease and reoccurrence is normal; clients have individualized and multiple needs; and, a continuum of care is necessary.



Building the new system will require leadership, from the governor, the Legislature, the Health and Human Services Agency and the Department of Finance. It also will require raising the quality of treatment from existing providers and rationalizing funding streams to allow money to be directed to where it can produce the best outcomes. Recommendations for improving state substance abuse treatment systems from two other groups are summarized in Appendix F.

Re-engineer State Activities to Drive Change at the Local Level

Change at the state level will be a critical component of a new system, and the Department of Alcohol and Drug Programs cannot address the problems of substance abuse by itself. Because addiction drives the costs of other state programs, such as social services, mental health, Medi-Cal and corrections, the agencies that administer these programs must share responsibility and resources to combat the problem.

Change should begin with a more thorough understanding of the state's substance abuse problem. Other systems, such as correctional systems and child welfare services, must do a better job of gathering data regarding the role addiction plays in their programs. Additionally, mental health and substance abuse agencies must begin gathering thorough data on the number of their clients with co-occurring disorders.

Armed with information, these systems must develop strategies and work with the Department of Alcohol and Drug Programs to reduce substance abuse.

Absent this necessary state-level cooperation and leadership, too many public programs fail to address addiction, leaving the department to deal with the clients of other state programs without any accompanying money. These are missed opportunities the state no longer can afford.

State officials need not look far for ideas on how to build an improved treatment system. Examples of change abound in California.

Some public health clinics around the state are moving to incorporate substance abuse and mental health treatment into their programs, providing badly-needed services to clients whose alcohol and drug problems are intertwined with other health problems. California counties are re-engineering their behavioral health systems to expand treatment for the large portion of clients who are both mentally ill and alcohol- and drug-addicted. One county, Santa Clara, implemented performance management measures that combined increased payments to treatment providers with new requirements that providers lowered staff turnover and better prepared clients for a sober future.

These reforms happened at the local level because local leaders are better positioned to recognize the needs of their communities. The challenge for the state is to use the power of the purse to steer all counties toward these evidence-based models.

At the heart of these needed changes is a transformed Department of Alcohol and Drug Programs. A new department would shed its historic role as a benign agency that simply doles out funding to counties and inspects the physical structures of treatment facilities to one that is an intellectual leader in the substance abuse field in California. The department must set standards and guidelines, disseminate best practices, provide advice to policy-makers on cost-effective programs and distribute funding to programs with proven outcomes.

Frustratingly, the Department of Alcohol and Drug Programs has started down the path toward a redesigned treatment system, but has failed to generate meaningful momentum. A task force that included stakeholders, government officials and experts produced a thoughtful report in September 2006 that laid out a conceptual framework for re-engineering substance abuse treatment in California. The plan called for a “Continuum of Services System,” based on the concept of addiction as a chronic disease and consistent with the Institute of Medicine’s recommendations for standards of care, performance measurement, and transparent quality and cost measures.

Within the department, planning has progressed to a detailed check list of objectives and tasks for proceeding with the re-engineering that reflects the input of top experts in the state. The check list, however, has not been adopted or made widely available.

Department officials told the Commission that the redesign process has proceeded to a pilot project in Santa Clara County that will allow two providers in the county to offer follow-up services to clients once they have completed initial treatment.¹⁰⁸ However, county officials were moving forward with the project and would have gone forward with it regardless of state involvement. While some professionals within the department saw the need and the promise of a statewide transformation, there is little evidence of a shift in the culture at the department, or signs that leadership at the department or the Health and Human Services Agency has embraced the concept to the point of taking action.

Continuum of Services System Re-Engineering Task Force

In 2006, the Department of Alcohol and Drug Programs established a task force to help the state reshape the treatment field in California “to insure system accountability, efficiency, and effectiveness, while delivering comprehensive, high quality AOD (alcohol and other drug) services.”

The task force included treatment providers, county officials and treatment experts, and focused on changes needed to adopt a chronic care model for the treatment field in the state. In a September 2006 report, the task force established six core principles:

- Services must be strength-based, comprehensive, integrated, and high quality, with demonstrated effectiveness.
- Services must share the following characteristics: accessible, affordable, individual and community-centered, culturally and gender appropriate, and responsive to individual and family needs and differences.
- Delivering quality and effective care requires outcome and data-based planning for California’s prevention, treatment, and recovery systems.
- Potential problems can be prevented by reducing risk factors and increasing protective factors in both communities and individuals.
- Transient or non-dependent alcohol or other drug problems can be resolved through acute care, including brief intervention and brief treatment services.
- Recovery from severe and persistent problems can be achieved through continuing and comprehensive AOD (alcohol and other drug) treatment and recovery maintenance services.

Since that report, the task force has compiled a list of specific objectives and tasks to enact these core principles. Tasks include seeking funding that requires collaboration among various health and human service providers, identifying and removing barriers for sharing data among systems, and modifying Medi-Cal regulations to achieve clarity on how funds can be used to treat people with co-occurring disorders.

This list of tasks has not been made public, however, and the department has instead focused its attention on a pilot project being conducted in Santa Clara County that will allow two providers to fund recovery support services.

Sources: California Department of Alcohol and Drug Programs, September 2006. “Continuum of Services System Re-Engineering Task Force Phase 1 Report,” and California Department of Alcohol and Drug Programs, “Continuum of Services System Re-Engineering Task Force System Improvement Model: Objectives and Major Tasks.”

Building an Integrated System

One of the most cost-effective steps in re-engineering substance abuse treatment is establishing incentives that would increase screening and brief interventions in more settings and, by extension, encourage more collaboration between treatment providers and other health care and human services providers.

Substance abuse treatment in California remains largely a specialized and an isolated component of the health care system. Too often, alcohol

Brief Interventions Encourage Behavior Change

Brief interventions are used in many health care settings to encourage patients to change health-related habits, such as altering diets or taking medications as prescribed.

Interventions designed to address alcohol and drug use can involve a short conversation between a health provider and patient, typically after a screen indicating an alcohol or drug problem or risk of developing a problem. The patient typically receives feedback on alcohol or drug use, and intervention strategies include education, advice, and brief counseling. Sessions can last as little as 10 or 15 minutes.

Research indicates that the minimum number of contacts needed for brief interventions to show a reduction in alcohol use is three or four. The contacts could include follow-up phone calls, as research indicates the length of intervention is less important than the number of contacts.

Source: Office of National Drug Control Policy, Third National Leadership Conference on Medical Education in Substance Abuse, January 16, 2008. "Briefing Document on Screening and Brief Intervention." Page 4.

and drug problems are not recognized until costly, intensive treatment is required.

Screening and brief intervention programs are cost-effective. Many people abusing alcohol or drugs can benefit from brief episodes of treatment conducted by numerous types of health care providers. Screening for alcohol and drug abuse problems is a clear and critical first step toward identifying people in need of help.

Screening tools are available to help assess alcohol and drug problems among various populations, such as adolescents or pregnant women. Many screening tools can be delivered quickly and do not require intensive training.

Screening and brief intervention programs are designed to allow health care providers to offer small increments of treatment to those with developing substance abuse problems and referrals to treatment providers for those in need of more extensive problems. Studies have consistently shown that Screening, Brief Intervention and Referral to Treatment programs, referred to as SBIRT, effectively reduce alcohol and drug use.¹⁰⁹

Several studies also show that SBIRT programs save money – one found that trauma centers saved an estimated \$3.81 for every \$1 invested by reducing other health expenditures.¹¹⁰

Another study showed that linking primary care and substance abuse treatment leads to greater abstinence, more interaction with a physician and a lower mortality rate.¹¹¹

Efforts to promote screening, brief intervention, referral and treatment programs are increasing across the country and in California:

- California has received \$3.4 million from the federal government over 5 years to implement a screening, brief intervention, and referral to treatment program in San Diego. The program is run by the San Diego County Alcohol and Drug Services Department and San Diego State University Research Foundation. Bilingual health educators provide screening and brief intervention services in emergency rooms, trauma centers and primary care clinics, and make referrals to other programs for those in need of more extensive treatment.¹¹²

- To encourage screening, brief intervention, referral to treatment programs, the American Medical Association and the Centers for Medicare and Medicaid Services have both recently created reimbursement codes for screening and brief intervention programs that would allow primary care providers to bill for these services through private health care plans, or in California, Medi-Cal.¹¹³ The state has not yet activated the reimbursement code for Medi-Cal however.
- Some community-based nonprofit health clinics are implementing SBIRT programs for their clients. La Clinica de la Raza, a health care provider serving 41,000 clients in Alameda, Contra Costa and Solano counties, is hiring behavioral medicine specialists in some of its clinics to provide brief mental health and substance abuse treatment. A key to La Clinica's plan is the "warm hand-off," which allows a primary care provider to pass along clients in need of mental health or substance abuse to a specialist during a primary care visit. This method provides treatment to clients who might not otherwise seek mental health or substance abuse treatment because of the stigma of addiction or because treatment is unavailable to them.¹¹⁴

The state must address barriers to increasing SBIRT programs.

Billing codes that allow public and private health care providers to bill for screening and brief intervention services should be activated.

State Medi-Cal rules prohibit clinics from billing for two services in one day. La Clinica officials say about 75 percent of their mental health or substance abuse treatment will not be reimbursed because of the rules, requiring the clinic to seek grants to fund the program.

In addition, the Uniform Accident and Sickness Policy Provision Law, which was enacted by many states, including California, in the 1950s, allows insurers to deny accident or injury claims if there is evidence the claim was based on an incident involving alcohol or drug abuse. Emergency physicians often are reluctant to screen for substance abuse problems for fear that the patient's health plan will not reimburse the hospital's costs.¹¹⁵ Other states, such as Illinois, Indiana and Oregon have repealed their laws.

Finally, the Department of Alcohol and Drug Programs must take a stronger leadership role and work with other state agencies and departments to recommend appropriate screening tools for various populations.

State must require local partnerships. An improved treatment system will require considerable partnering among local agencies, as well as at the state level. Evidence of the effectiveness of such partnering among local agencies suggests the kinds of benefits that could be realized through a more systemic approach.

Twelve California counties have created dependency drug courts, which bring together child welfare agencies, alcohol and drug agencies and the courts to work with parents in danger of losing custody of their children due to substance abuse problems.¹¹⁶

Sacramento County combines money from the federal alcohol and drug block grant, tobacco litigation funding and child welfare funding to pay for a dependency drug court program that includes treatment, case management and regular appearances before a judge. Parents in the program sign a waiver that allows child welfare, alcohol and drug program and court officials to share information. An evaluation of the program found that 24 months after going through the dependency drug court program, 43.6 percent of parents were reunified with their children, compared to a 27.2 percent reunification rate with a comparison group of parents who did not go through the program.¹¹⁷ Evaluators estimated the program saved the child welfare system \$9.9 million in reduced out-of-home care costs.¹¹⁸

In this example, and in others the Commission has seen, the glue that holds the various pieces together is the judge, who functions as a case manager of last resort. The judge can force all the necessary partners to work together. Outside of the judicial system, a major challenge for the state is ensuring these partnerships are created and maintained.

The state can use its financial discretion to direct money to counties that create meaningful partnerships. The governor and Legislature could provide incentives to counties to test and adopt dependency drug courts, for example, and the state Department of Alcohol and Drug Programs should consider requiring counties to ensure that treatment providers have relationships with primary care providers and other health care services to allow more coordinated care for clients.

Improve capacity for co-occurring treatment. Along those lines, national studies show that simultaneously treating people with co-occurring mental health and substance abuse disorders with one integrated group of professionals produces better outcomes.¹¹⁹ Several California counties, including San Francisco, San Mateo, San Diego and Kern have launched major efforts to redesign their mental health and substance abuse systems to increase coordination and better accommodate clients with co-occurring disorders.

The state, however, has done little to help counties make these important changes. Recommendations from three different stakeholder committees have provided the state with a blueprint for handling co-occurring disorders. Repeatedly, state officials have asked treatment professionals to make recommendations, and then failed to move forward.

This has produced fatigue and frustration among stakeholders. At a meeting of the Co-Occurring Joint Action Council in October 2007, council members questioned whether the Department of Mental Health and the Department of Alcohol and Drug Programs were listening to their recommendations and whether there was value to continuing the council.

This must change. The state can take some immediate steps to improve treatment for co-occurring disorders.

The California Mental Health Services and Oversight and Accountability Commission, which acts as a policy-making body to guide Proposition 63 funding, could send a strong signal by adopting the recommendations of its own subcommittee on co-occurring disorders and making the expansion of co-occurring treatment a priority for Proposition 63.

The Department of Mental Health and the Department of Alcohol and Drug Programs should jointly issue a license for providers who offer co-occurring services. The state should require that both mental health and substance abuse programs screen for co-occurring disorders and have provisions in place to handle co-occurring clients, either with qualified staff or links to other providers.

The overlap of clients with co-occurring disorders raises the question of whether merging the two departments into one behavioral health department is the best strategy for a coherent treatment policy. Governor Schwarzenegger's 2004 California Performance Review cited the prevalence of co-occurring disorders as a key reason to combine the two departments,¹²⁰ but there is research suggesting mergers in other states led to reduced alcohol and drug programs.¹²¹ Substance abuse treatment professionals told the Commission they were concerned that combining the Department of Mental Health, with a nearly \$5 billion annual budget, and the Department of Alcohol and Drug Programs, with only a nearly \$680 million annual budget, could diminish substance abuse treatment in the state because it would be overshadowed by much larger mental health programs.

The Commission is not recommending a merger of the two departments at this time. However, it is skeptical that the two departments, existing independently, can overcome mutual defensiveness of siloed funding and

Proposition 63 and Co-Occurring Disorders

A subcommittee of the California Mental Health Services Oversight and Accountability Commission published findings and recommendations on March 2, 2007, regarding the use of Mental Health Services Act, or Proposition 63, funds for co-occurring disorders. The recommendations have not been adopted by the full commission, which along with the state Department of Mental Health, has oversight of the distribution of Proposition 63 money. Among the recommendations were:

- ***Integrated treatment.*** Public and private health plans funded by the Mental Health Services Act should be required to ensure integrated mental health and substance abuse services are available to all clients who need them.
- ***Standards.*** Standards should be created for integrated mental health and substance abuse treatment, including staffing patterns and screening instruments.
- ***Training.*** Funds should be used to co-train physicians or other workers who specialize in addiction medicine or psychiatry to increase the number of health care professionals who can treat both disorders.
- ***No wrong door.*** Any individual seeking co-occurring treatment should receive integrated treatment no matter what type of agency the client first entered.
- ***Housing.*** All counties seeking Mental Health Services Act funding should be required to have housing for those with co-occurring disorders.
- ***Collaboration.*** All counties seeking Mental Health Services Act funding should be required to show that substance abuse and mental health agencies are collaborating to provide co-occurring treatment.
- ***Proposition 36.*** Resources from the Mental Health Services Act and the Substance Abuse and Crime Prevention Act, or Proposition 36, should be combined to provide appropriate treatment for Proposition 36 offenders with co-occurring disorders.
- ***Criminal justice settings.*** Probationers and parolees with co-occurring disorders should be provided access to treatment, and prison and jail health staffs should be trained in treating co-occurring disorders.

vast differences in cultures to energetically pursue a cooperative strategy for co-occurring disorders. Short of evidence of progress, the Commission reserves the right to revisit this issue to determine whether a merger is the only option. In the meantime, the Legislature should provide more oversight to ensure that the two departments work together to deliver a co-occurring disorders strategy.

Leadership Essential to Driving Change

Transformation cannot be achieved without strong and consistent leadership from the governor, agency secretaries and department directors. As important is the Legislature, which can provide oversight and accountability.

Despite the pervasiveness of substance abuse, substance abuse treatment has been a low priority among lawmakers and policy-makers. This lack of interest among elected officials manifests itself in many ways: data on substance abuse is not collected, substance abuse treatment agencies and programs are isolated and largely ignored, and laws regarding substance abuse treatment policy are neglected.

This neglect comes despite a clear desire from California voters to enhance substance abuse treatment – most prominently in the Substance Abuse and Crime Prevention Act, or Proposition 36, which voters approved overwhelmingly in 2000.

A 2006 report detailing recommendations for improving alcohol and drug prevention and treatment, “Blueprint for the States,” concluded that leadership was the key factor for expanding prevention and treatment. The report, compiled by a nationwide policy panel whose chairman was former Massachusetts Governor Michael Dukakis, noted a key step for a governor interested in enhancing substance abuse as an issue is to form a high-level policy council that can cut across government agencies and coordinate efforts to address alcohol and drug problems.¹²²

In 2003, the Little Hoover Commission recommended the same thing, calling for a multidisciplinary council of representatives from various state and local agencies to help policy-makers align the multitude of efforts fighting addiction. The Commission said the state needed a mechanism for different agencies and stakeholders to create policies to integrate treatment and provide leadership.

California has not done this because its top leaders have not made it happen.

In her testimony to the Commission, Department of Alcohol and Drug Programs Director Zito told the Commission that she believed one council would be overwhelmed by the vast number of issues facing the alcohol and drug treatment field. Instead the department has formed or is part of various groups that address specific topics. The groups range from the Director’s Advisory Council, which includes judges, treatment providers and county officials and provides advice to the department, to the Rural Health Policy Council, which includes the directors of six departments within the Health and Human Services Agency. Zito listed seven different groups, councils and commissions in which the department was involved. Under questioning from Commissioners, however, department officials acknowledged that there was no mechanism to ensure that the various groups’ actions and recommendations were coordinated.

To date, many of the meetings, reports and recommendations are not engaging the top leaders who can turn advice into policy. The department has been busy, without question, but its account of its activity shows a failure by state leaders to appreciate the Commission's intent in calling for a high-level council: Reducing the harms caused by substance abuse and dependence is not solely the job of the state Department of Alcohol and Drug Programs.

Because substance abuse is a complex issue that touches many areas, and because it is beyond the department's scope to analyze such issues as how addiction relates to the child welfare system, or to review the effectiveness of law enforcement responses to illegal drugs, a diverse council comprised of several agencies is needed.

Other states have used broad-based, collaborative councils to make significant strides in helping state and local agencies abandon antiquated protocols and combine efforts to treat individuals based on their individual needs.

The Texas Correctional Office on Offenders with Medical and Mental Impairments, which is advised by a 31-person committee comprised of gubernatorial appointees, advocacy groups and state agencies, helped Texas develop a data-sharing agreement that allows various state agencies to share information about offenders and clients to better treat people with multiple disorders both within and outside the criminal justice system.

Using a federal grant, New Mexico created the New Mexico Behavioral Health Collaborative, which consists of 17 state agencies. Funding for virtually all of the state's social services is distributed through the collaborative to better treat individuals with multiple problems. The collaborative developed a supportive housing plan which provides multiple services to those in need of housing, and also has helped create 15 local collaboratives to allow each region of the state to help guide the state's planning process.

A substance abuse advisory council is essential to leveraging the benefits of substance abuse treatment across the programs of other state departments fueled by the consequences of addiction. Such a council is critical as well to transforming California's substance abuse treatment system from the state level down to the local level.

Any such council, however, will be meaningless without strong leadership from the top, communicating clearly and forcefully the state's substance abuse strategy and taking steps to execute that strategy. This is a role for the governor, as well as for the agency secretaries and

directors of the departments involved. They must embrace this role and lead the transformation.

The Legislature must provide oversight to the treatment system and remove legislative barriers to transformation. The creation in 2007 of the Assembly Select Committee on Alcohol and Drug Abuse is an important step toward that oversight role. The committee, created by Assemblyman Jim Beall, D-San Jose, has held important hearings on topics such as the dearth of adolescent treatment in the state and substance abuse issues relating to pregnant or post-partum women.

This committee should be expanded to include members of the Senate, and its role should be strengthened to ensure its continuation in the future. To ensure legislative understanding and oversight of substance abuse issues, the Legislature should make the Assembly Select Committee on Alcohol and Drug Abuse a permanent, joint committee.

State Key to Embedding Quality into New System

The state is not in the business of providing direct treatment, but it can establish standards of care and incentives for improving quality and successful treatment outcomes. It can insist on performance measurement as a requirement for treatment funding, and it should standardize the counselor certification process.

Instead of distributing limited funding for alcohol and drug treatment programs based solely on population levels and historic patterns, the state should require performance measurement and introduce incentives for counties to improve outcomes. In this way, the state can direct money to the providers who demonstrate they create value for taxpayers' dollars and stop funding programs that do not.

To create better outcomes, the state must address high turnover among the treatment workforce by increasing salaries and certification standards.

Move toward performance measurement and continuous quality improvement. With the installation of the CalOMS data collection system, the state can begin to track counties' ability to improve outcomes.

"ADP and county staff are using the CalOMS data to understand and report changes in client changes during treatment," Director Zito told the Commission. "This data will be used for ongoing quality improvement and the establishment of standards of care."¹²³

Though some states have passed laws requiring the use of evidence-based practices, California's large population, diversity and decentralized treatment delivery – in which counties and non-governmental agencies provide the services instead of the state – requires that local governments and providers be allowed to determine the best practices to treat their clients. The state should not legislate or regulate practices but instead require improving outcomes and then provide incentives and penalties to achieve those goals.

“The key danger is the ‘pick from this list only’ approach,” Joan Zweben, executive director of The East Bay Community Recovery Project and The 14th Street Clinic & Medical Group and a professor of psychiatry at the University of California San Francisco, told the Commission. Zweben was co-author of a 2005 paper that noted the differences in opinions on what constitutes an evidence-based practice and the pitfalls for policy-makers in dictating specific practices used by clinicians.¹²⁴

Delaware provides an important example of a state that replaced cost-reimbursement policies for alcohol and drug treatment with performance-based measurements. Frustrated in attempts to encourage treatment providers to adapt specific evidence-based practices, the state instead chose to focus on outcomes. Delaware measured outpatient treatment providers on two issues critical to improving outcomes: increasing engagement with clients and increasing participation of clients in treatment. The state provided bonus payments to providers who kept patients actively attending treatment sessions and in treatment for longer periods, as well as a \$100 bonus to providers for every client who successfully completed treatment. The state financially penalized providers who do not meet expectations.

The penalties forced one provider out of its state contract, but other providers succeeded and expanded by adopting creative strategies such as keeping longer hours, offering incentives directly to counselors and adapting evidence-based practices on their own. Providers dramatically increased the number of clients in their programs at any given time – from a 54 percent utilization rate in 2001 to 95 percent in 2006 – and increased the participation rates of ongoing clients.¹²⁵

The governor and Legislature should pass legislation mandating that the Department of Alcohol and Drug Programs distribute some of its funding to counties based on performance, starting at 25 percent and escalating over time.

The department should allow counties that contract with providers to determine the outcomes they value – such as retention in treatment beyond 90 days, which has been determined to be the minimum amount

of treatment needed to show an effect – and then require that counties build performance measurements into their contracts. Counties that provide direct treatment to clients also should determine their target outcomes, and the state should hold the counties responsible for improving outcomes.

The goal for the state should not be to dictate which practices counties and providers utilize, but to require counties to identify priority outcomes and begin measuring performance. Demonstration projects could be created in each county to test how fiscal incentives and penalties work, allowing the state and counties to make adjustments and learn how to best implement performance management.

An additional step the state should take toward improving treatment quality without dictating specific practices is requiring treatment programs to adopt continuous quality improvement practices. These practices, which originated in the private sector but are now used in many public sector settings, help organizations create a culture centered on improving practices to meet client needs. The state should require all treatment programs in the state – including outpatient programs – to use continuous quality improvement practices.

Beginning in 2006, the federal Substance Abuse and Mental Health Services Administration began requiring states to provide more detailed data on the effects of treatment. SAMHSA's National Outcome Measures strategy requires states to collect information from treatment clients such as retention in treatment, housing situations and alcohol and drug use. At present, the federal block grants that provide much of the funding for treatment programs in California and other states remain tied to population and not results. In light of the federal push for more outcome measures, however, and its introduction of pay-for-performance in Medicare and Medicaid, many in the field believe it is only a matter of time before the federal government introduces outcome-based funding to substance abuse treatment as well.

Rather than wait until that future arrives, the state should begin to link funding to results for substance abuse treatment.

Better trained workers needed. As research grows and stimulates the use of evidence-based practices in treatment programs, the need for a better-educated and trained workforce increases.¹²⁶ A fundamental part of any transformation must include a strategy for increasing the training and competence of the workforce. To do this, the Department of Alcohol and Drug Programs must tighten up its flawed counselor certification process. The current system allows certifying agencies too much leeway in creating their own curriculum and examinations. The result leaves

consumers and providers who make hiring decisions with little ability to determine the value of a counselor's certification.

The Department of Alcohol and Drug Programs must rewrite regulations to standardize the counselor certification process.

The state should standardize the curriculum, code of ethics and examinations for counselors to ensure that each certifying agency requires the same core information and level of counselor competence. In this, the state can draw on the experience and examples of other states that already have standardized their certification procedures. Agencies still could have the flexibility to expand upon basic requirements and could require counselors to demonstrate additional expertise to address treatment needs for differing populations, such as adolescents. The department also should consider creating multiple levels of certification, similar to 2001 legislation¹²⁷ that called for the creation of three levels of counselor:

- Licensed Addiction Counselor I, which required a high school or equivalent degree, 2,080 hours of experience and 90 hours of classroom education.
- Licensed Addiction Counselor II, which required additional experience and more classroom education.
- Licensed Addiction Practitioner, which required a master's or doctorate degree.

This model could be altered – by creating a license for counselors who earn a bachelor's degree in behavioral health, for example – but setting different levels of licensure is a good strategy to allow peer counselors in recovery to remain an important part of the workforce while also encouraging professional development within the field. Such professional development is a key to achieving a higher salary and reducing turnover.

One important piece of the treatment workforce that requires more attention in California is clinical supervision of counselors. “Effective supervisors observe, mentor, coach, evaluate, inspire and create an atmosphere that promotes self-motivation, learning and professional development,” according to “Competencies for Substance Abuse Treatment Clinical Supervisors,” a manual published by the U.S. Substance Abuse and Mental Health Services Administration.¹²⁸

Treatment professionals provided the Commission with examples of their clinical supervision requirements: Santa Clara County requires all treatment programs to have a licensed clinical coordinator on staff.¹²⁹ Tarzana Treatment Centers in Southern California reported they typically

have about one supervisor for every 10 counselors.¹³⁰ There are no statewide requirements for clinical supervision within treatment programs, and only 11 other states regulate clinical supervision.¹³¹ But it is an issue the state should consider once it improves the counselor certification program. Supervisors are an important component in bringing evidence-based practices into everyday use.

As the counselor certification process improves, the state will confront a difficult tradeoff that comes with the professionalizing of substance abuse treatment: quality for quantity. In California, the emphasis of substance abuse treatment traditionally has been in providing services to as many people as possible, with extensive use of peer counselors. Using resources in this way, however, has meant low salaries for staff, as well as inadequate investment in well-educated clinical managers, staff training, or data collection systems and analysis. Quantity, not quality, has been the driving motivation.

Other counties should consider the route taken by Santa Clara County, which agreed to provide more funding to treatment providers to allow for higher salaries. In exchange, the county instituted performance-based contracts with its providers that included quality goals such as reducing turnover, increasing the number of certified counselors on staff, as well as outcome measures such as increasing the number of clients who are employed or considered job-ready when they leave treatment. To initiate the funding increase, the county asked its treatment providers to confer with each other and determine the cost of delivering a quality treatment program, including how much counselors should be paid and the cost of a licensed clinical coordinator to oversee treatment programs. The proposal led to a 10 percent increase in the amount the county paid for treatment programs.¹³² As a result of that increase, the county offers treatment to fewer people.

But turnover among counseling staff has dropped significantly – 13 providers reported a range of 6.7 to 14.3 percent turnover in calendar year 2006,¹³³ compared to turnover rates of 20 to 30 percent in 2001,¹³⁴ when the performance management program began. During the same period, the number of graduating clients who were either employed or considered job ready grew from between 60 and 80 percent to 90 percent.¹³⁵

Santa Clara County's experiment can be replicated. To start the transformation at the local level, the state should link part of each county's funding to developing estimates of funding levels required to deliver quality treatment.

Finding the Funding

California cannot ask counties and treatment providers to improve the quality of treatment without making changes to state-controlled funding streams. In addition, the state must maximize its use of funding that comes with a federal match to expand treatment in the state.

First, determine what we spend. The state must first start by understanding how much it spends on treatment. Currently, we do not know. The state can look to Arizona for a model in gathering data on spending: the Arizona Drugs and Gangs Policy Council has for 14 years compiled an annual inventory of spending on treatment that includes an analysis of what parts of the state receive the most and least amount of funding.

As the lead agency charged with treatment oversight, the Department of Alcohol and Drug Programs should be required to gather this information and to provide it annually to the Legislature, along with outcomes associated with the funding. This data would help policy-makers determine where, and in what systems, money is being spent, and would be a key step toward understanding the effect treatment has on individuals and systems. Policy-makers cannot spend limited resources wisely in the future without first knowing where money is going now, and what results it is producing.

Update regulations. States have leeway in how they use federal funding streams and should take advantage of this flexibility. State regulations surrounding funding streams such as Medi-Cal can be re-written.

There has been some discussion in California regarding changing Drug Medi-Cal from a clinical model to a rehabilitative model, as the state did in 1993 with Mental Health Medi-Cal. The Medicaid rehabilitative option allows more flexibility in services, and can include options such as case management that provide more services to help recovery. The change would increase short-term costs, however. An analysis of legislation introduced in 2002 to change Drug Medi-Cal to a rehabilitative model estimated it would add \$20 million annually to the state portion of the Drug Medi-Cal budget. The legislation failed passage in the Senate Appropriations Committee.

The state should reconsider this option, as it might cut costs in the long-run by allowing for the use of more evidence-based practices and, therefore, more effective treatment.

Even without adopting the rehabilitative model, the state should rewrite Drug Medi-Cal regulations to allow clinicians – not administrators in Sacramento – more flexibility in determining appropriate treatment for clients. Specific limits on the number or types of counseling sessions add complexity to the billing process and drive up administrative costs.

Other aspects of Medi-Cal must be changed as well. The state must do away with Medi-Cal regulations that prohibit billing for more than one service per day. This is a prohibition that flies in the face of recommendations by the Institute of Medicine to integrate substance abuse treatment with general health care services.

Change regulations to help fund co-occurring treatment. Because of the statistical likelihood that many mental health and substance abuse treatment clients suffer from both disorders, the state must seek ways to help pay for co-occurring treatment. For example, the statute describing treatment at residential facilities that prohibits medical services such as psychiatry is a barrier to treating co-occurring disorders.

There are difficulties in funding co-occurring treatment. The federal mental health block grant can only be used for those suffering from a diagnosed Severe Mental Illnesses, for example, which can exclude common co-occurring disorders such as depression and Post Traumatic Stress Disorder. Department of Alcohol and Drug Programs officials told the Commission they were concerned that any use of substance abuse treatment funding for mental health services might affect federal Maintenance of Effort rules, which require states to maintain their levels of state spending on substance abuse treatment to qualify for federal treatment funding.

But a federal official from the Substance Abuse and Mental Health Services Administration (SAMHSA) provided the Commission with a 1999 memo stating, “States may use the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and the Community Mental Health Services Block Grant (CMHSBG) funds to provide services for individuals with such co-occurring disorders. SAMHSA is very interested in working with States to identify ways to facilitate local provision of the full array of services needed by individuals with substance abuse and/or mental disorders, while assuring that the requirements are met for both block grants.”¹³⁶

Additionally, Ken Minkoff and Christie Cline, partners in a behavioral health consulting firm and the creators of the Comprehensive, Continuous, Integrated Systems of Care model for redesigning systems to better treat co-occurring disorders, told the Commission that federal funding streams earmarked for mental health or substance abuse can be

used for other types of treatment. They point to New Mexico, which has used mental health money for substance abuse treatment where it was deemed necessary to help a mental health client recover. Minkoff noted that states cannot use mental health funds to pay exclusively for substance abuse treatment, or vice-versa, but money can be used to pay for treatments necessary to help the client.¹³⁷

The state must work more closely with SAMHSA, which has made treating co-occurring disorders a national priority, to determine how federal funding sources could be used to provide treatment for co-occurring disorders. At the same time, the state should rewrite its Medi-Cal regulations to encourage treatment of co-occurring disorders at the county level. The regulations' current silence on the issue discourages providing appropriate treatment to a large number of clients.

Additionally, the state should take advantage of the Mental Health Services Act, or Proposition 63, to increase capability to treat co-occurring disorders. The act was marketed to voters as a way to provide innovative programs for the mentally ill that traditional funding sources were not providing. Co-occurring treatment is an ideal innovative service that could be bolstered by the act.

Some counties have spent Proposition 63 money for co-occurring services. Kern and San Mateo counties used money for planning purposes to redesign their county substance abuse and mental health systems to work together to treat co-occurring disorders. Santa Clara County is using funding to provide housing and case management services for some drug offenders in the criminal justice system who have both mental illness and addiction problems. Sonoma County is proposing to spend more than \$1 million to create the first co-occurring treatment program in the county, which would accommodate 125 people per year and combine county mental health staff and a community-based substance abuse treatment provider.

The Mental Health Services Oversight and Accountability Commission, the 16-member board that helps set policy direction for Proposition 63 funds, should adopt a policy that co-occurring disorders are a priority. Department of Mental Health officials told Commission staff that a statement from the Mental Health Services Oversight and Accountability Commission affirming that co-occurring disorders should be a priority would have impact on policy.¹³⁸

Recommendation 1: The state should transform substance abuse treatment into a performance-driven system based on a comprehensive model of care through the use of incentives and mandates to improve quality, transparency and outcomes.

- ❑ **Adopt a comprehensive model of care.** The new system should include an emphasis on screening and early intervention to get clients the most appropriate treatment at the earliest stage possible; integration of treatment with other health and human services; and, easily accessible information on outcomes. The system also should incorporate treatment strategies for life-long recovery.
- ❑ **Tie funding to outcomes. Counties that demonstrate quality and improved outcomes should be rewarded.**
 - ✓ **Require performance management.** The governor and Legislature should pass legislation giving the Department of Alcohol and Drug Programs the ability to distribute an annually increasing portion of funding to counties based on outcomes. The department should allow counties to determine their priorities and require that counties set performance goals. More funding should go to counties that meet their goals.
 - ✓ **Prioritize quality, not quantity.** The Department of Alcohol and Drug Programs should require counties to assess the cost of providing evidence-based practices and prioritize those practices in their funding distribution.
 - ✓ **Require Continuous Quality Improvement as a condition of program licensure.** The Department of Alcohol and Drug Programs should rewrite regulations regarding program licensure to include outpatient programs and should require all provider programs to adopt continuous quality improvement measures.
- ❑ **Standardize counselor certification and create tiered levels of certification.** The Department of Alcohol and Drug Programs should develop a code of ethics, curriculum and examinations that ensure uniformity in counselor education. The governor and Legislature should pass legislation creating graduated levels of counselor certification to encourage professional development and higher wages in the treatment workforce without excluding peer counselors.
- ❑ **Eliminate regulatory and statutory barriers that hinder counties from adopting a comprehensive model of care and a system that provides proven, cost-effective treatment.**
 - ✓ **Amend regulations for Medi-Cal and other funding streams to allow for best practices.** The governor and Legislature should rewrite Medi-Cal rules to allow primary care clinics to more easily offer substance abuse treatment and to allow substance abuse treatment clinics to more easily offer mental health and general health care services. The governor and Legislature should rewrite rules for treatment funding to allow providers

more flexibility to use best practices, such as recovery support services, and to cover U.S. Food and Drug Administration-approved medications, such as buprenorphine.

- ✓ **Prioritize co-occurring disorders.** The Department of Mental Health and Department of Alcohol and Drug Programs must work together and with the federal government to clarify regulations regarding funding streams and to encourage the treatment of co-occurring disorders. The Mental Health Services Oversight and Accountability Commission should adopt a policy urging counties to use Proposition 63 funding to expand county capacity to treat people with co-occurring disorders.
- ✓ **Activate reimbursement codes that allow billing for Screening and Brief Intervention programs.** The Department of Health Care Services and the Department of Finance should activate the reimbursement codes to allow billing for screening and brief interventions in both Medi-Cal and private health plan programs.
- ✓ **Repeal the Uniform Accident and Sickness Policy Provision.** The governor and Legislature should overturn this outdated law that discourages hospitals from screening patients for substance abuse problems.

Recommendation 2: The state should institutionalize understanding, leadership and oversight of substance abuse issues to provide a more cohesive, cost-effective statewide substance abuse policy. Specifically, the state should:

- ❑ **Create a substance abuse policy council.** The governor should convene a council of substance abuse experts to act as an advisor to the Department of Alcohol and Drug Programs and other state agencies on improving responses to substance abuse issues. The council should examine barriers to data collection and collaboration among systems as a first step.
- ❑ **Require annual substance abuse reports.** The Health and Human Services Agency should require departments within the agency that deal with substance abuse issues to collect standardized data on substance abuse within their system, create strategies for reducing alcohol and drug abuse and publish annual reports on their findings. The Department of Corrections and Rehabilitation should perform the same functions. The Department of Alcohol and Drug Programs should coordinate with other agencies to prepare an annual report as it is required to produce by Health and Safety Code Section 11755 (p) that also includes a comprehensive catalog of public spending on prevention and treatment, as well as outcomes of the treatment.

- ❑ ***Make the Assembly Select Committee on Alcohol and Drug Abuse a permanent, joint committee.*** The Legislature should signal its commitment to addressing substance abuse as a distinct policy issue by creating a permanent committee that includes members of both the Assembly and Senate. The committee should review all current laws regarding substance abuse treatment to ensure implementation and identify needed reforms to reflect the current understanding of substance abuse and addiction.

Proposition 36: Missed Opportunities

Proposition 36 marked a profound and positive shift in public policy by providing thousands of drug offenders with substance abuse treatment rather than a jail or prison sentence. But flaws in the initiative, compounded by poor implementation, have produced disappointing results.

At its core, Proposition 36 is a sentencing reform. The new law has major implications for many parts of government, thrusting new responsibilities onto systems that were ill-prepared to handle the task:

- A largely unregulated treatment system with little accountability became the focal point of a program with significant public safety consequences.
- Already overloaded probation departments were given significant new duties to monitor and drug-test offenders.
- The state’s judiciary faced a new task that altered a judge’s traditional role by requiring more court interaction with health and treatment officials as well as an ongoing relationship with offenders.

“It is easy for a judge to sentence someone to prison,” Santa Clara County Superior Court Judge Stephen Manley told the Commission. It is much more difficult, he noted, to work with offenders in the community, where they are prone to relapse and re-arrest.¹³⁹

In interviews and testimony to the Commission, virtually every stakeholder said the new law was an improvement over the status quo, in which most drug offenders either were sent to jail or prison or released on probation without oversight. In both cases, treatment was a rarity, and many offenders churned in and out of the criminal justice system.

And research conducted by UCLA evaluators demonstrates the cost-effectiveness of the new policy. Most of the benefit comes from the avoided costs of sending low-level, nonviolent offenders to jail and prison, an important consideration given the state’s prison overcrowding problem and the potential for a court-imposed population cap.

A Sound Investment

A cost-benefit analysis of Proposition 36 performed by UCLA researchers showed that the state's investment in the program saves money. The analysis looked at Proposition 36 offenders who entered the program between July 1, 2001 and June 30, 2002 and included a 30-month follow-up period that concluded on December 31, 2004. Proposition 36 offenders were compared to a group of offenders convicted between January 1, 1997 and June 30, 1998 that would have qualified for Proposition 36 had it been in effect. UCLA looked at the effect of Proposition 36 on prison and jail costs, probation and parole costs, arrest and conviction costs, treatment and health care costs, and taxes paid by offenders in determining the costs and benefits. UCLA concluded that the state saved \$2.50 for every \$1 invested in Proposition 36, largely due to the avoided jail and prison time by Proposition 36 offenders.

The findings included:

- Taxpayers saved \$312.8 million in jail and prison costs in one year.
- Arrest and conviction costs incurred by police and courts rose by \$81.7 million.
- Proposition 36 offenders contributed \$3.6 million more in taxes than the comparison group.
- Offenders who completed treatment saved the state \$4 for every \$1 invested, largely because they were less likely to be reincarcerated.

Source: Angela Hawken, Douglas Longshore, Darren Urada, and M. Douglas Anglin. University of California Los Angeles Integrated Substance Abuse Program. April 13, 2007. "Evaluation of the Substance Abuse and Crime Prevention Act Final Report." Chapter 7: SACPA Benefit-Cost Analysis.

The Commission heard from judges, treatment experts and law enforcement professionals that the system can and should be improved, but that acrimony generated by flaws in the proposition and disappointment in the results have prevented a serious and productive discussion about how to move forward. State leaders must start that discussion now and develop a statewide strategy that incorporates findings from UCLA's research and builds on the successes several counties are experiencing through their drug court programs.

Such a discussion also must include a realistic assessment of Proposition 36's flaws.

By guaranteeing treatment for more than 50,000 offenders a year based almost exclusively on one criminal charge, Proposition 36 wastes scarce treatment resources on offenders who may not have an alcohol or drug problem or who are unwilling to get help. Experts told the Commission resources could be better used if courts had more power to examine an offenders' entire criminal and personal history to determine whether treatment was the correct approach, and if so, what type of treatment was best.

Conversely, because the proposition mandates that resources must be spread among the entire offender population, many offenders need access to more treatment and other programs – such as mental health

care or job training – than are available.

More important than the proposition's design has been the state and counties' implementation of the new law. Proven practices for treatment programs in criminal justice settings have been ignored. Offenders often do not receive appropriate treatment or supervision, and non-compliant offenders face few penalties.

Above all, successful implementation of the new law depended on the effectiveness of the Department of Alcohol and Drug Programs in ensuring the quality and performance of treatment programs in California – a system that must be re-engineered before it can meet such expectations.

“Proposition 36 was grafted onto a weak infrastructure,” Elizabeth Stanley-Salazar, vice president and director of public policy for Phoenix House, a large treatment provider in California and a former administrator with the Department of Alcohol and Drug Programs, told the Commission.

Initiative Too Simplistic

Proposition 36, as marketed, leaned heavily on an overly optimistic view of what treatment could achieve: Most nonviolent drug offenders could get sober and abandon criminal lifestyles if offered the opportunity for treatment. The initiative was designed on the premise that many of the offenders in the state’s criminal justice system posed relatively little risk to public safety, and therefore did not need to be locked up; and that offenders had minor drug problems, and therefore could recover with a relatively small dose of treatment.

The reality was far more complex.

Experts told the Commission that drug offenders – even those charged with low-level crimes like drug possession – present wide-ranging risks and needs that should be addressed on an individualized basis. Some offenders are dependent on drugs and need a significant amount of treatment to address their illnesses. Other offenders may not have an addiction but may need more law enforcement supervision than treatment. As a probation official told the Commission, all Proposition 36 offenders are arrested for a nonviolent crime, but that does not necessarily mean they are a nonviolent offender.¹⁴⁰

UCLA’s data show the wide range in addiction severity within the Proposition 36 offender population.

About one-quarter of the offenders in 2004-05 reported daily use of drugs or alcohol, and are therefore likely to have a severe dependence problem that requires intensive treatment, perhaps in a residential setting. Conversely, 37.7 percent of offenders reported they had not used alcohol or drugs during the past month, and another 15.7 percent said they consumed alcohol or drugs one to three times per month. While the offenders reporting no use in the past month may have been incarcerated

or on probation and therefore had limited ability to use or abuse drugs, the data indicates vast differences among offenders' alcohol or drug use. Instead of placing heavy alcohol and drug users in intense treatment and providing more supervision for criminally-oriented offenders, Proposition 36 programs tend toward the same, one-size-fits-all treatment – outpatient therapy with little monitoring.

Of those offenders who made it into treatment, more than 84 percent were directed into outpatient treatment, while only 10.9 percent were placed in long-term residential treatment of more than 30 days. UCLA's data found that only 22 percent of Proposition 36 offenders who said they used alcohol or drugs every day received long-term residential treatment. Given limited resources and the high cost of residential treatment – which can be more than five times as expensive as outpatient programs¹⁴¹ – counties limit the number of offenders directed to residential programs in favor of cheaper outpatient programs in order to meet the proposition's requirement to provide treatment for all.

Eligibility criteria not flexible. Proposition 36's guidelines for program eligibility, based largely on the charging arrest, give criminal justice officials little leeway in determining who is appropriate for the program. While authorities can exclude some offenders based on their past history, such as those who have been convicted of a violent crime within the last five years, they are not free to consider an offender's entire drug use and criminal history before determining if the individual is a good fit for Proposition 36.

UCLA's research shows that a small group of Proposition 36-eligible offenders with extensive criminal backgrounds experience little reduction in crime after referral to Proposition 36 treatment, instead consuming resources that could be better used for others. Offenders with five or more convictions in the 30-month period before entering a Proposition 36 program cost the state and counties 10 times as much as a typical offender, due to significantly higher re-arrest and incarceration rates. The data suggest these offenders – 1.6 percent of the offender population – may not be suitable for Proposition 36. They receive treatment because according to the initiative, officials are not allowed to exclude offenders from program participation based on the number of prior convictions.

Limits judges' options. In addition, Proposition 36's prohibition on incarceration removes one tool that judges could use to compel offenders to complete treatment. Flash incarceration – a short term in jail for noncompliant offenders – is a typical sanction in most drug courts. While there have been few studies on the effects of flash incarceration on outcomes for offenders, Douglas Marlowe, director of law and ethics at the University of Pennsylvania's Treatment Research Institute, told the

Commission there is general consensus that it is a needed behavior-modification tool for judges as they work to help offenders overcome addiction.¹⁴² Many judges, law enforcement officials and treatment providers believe the initiative's prohibition on incarceration has led some offenders to take the program less seriously. "Word on the street is that Proposition 36 has no teeth," Lionel Chatman, president of the California Chief Probation Officers Association of California, told the Commission.¹⁴³

Judges do have other options to sanction non-compliant offenders – ranging from fines to community service to daily reporting to courts or probation officers – but those options have not been fully explored by the state or counties.

Poor Implementation Undermines Results

Despite the initiative's inherent flaws, many of the poor results stem from implementation problems. Proposition 36 is a sentencing law that calls for a prohibition on sending some nonviolent drug offenders to jail or prison and stipulates new funding for substance abuse treatment. The initiative does not spell out the specifics of new programs, however, and states only that offenders should receive "appropriate" treatment, which could range from education-based programs for non-dependent users to long-term residential care for those with severe dependence problems. Nor is how much contact an offender should have with judges or probation officers described in the initiative. It was up to the state and counties to use evidence-based approaches to handling drug offenders, and they often have not.

Implementation of the new law revealed some of the same flaws that weaken much of the state's alcohol and drug treatment system:

- The Department of Alcohol and Drug Programs has not taken a strong leadership role.
- No one is held accountable for poor outcomes – the money continues to flow to counties and providers regardless of results.
- Governors, lawmakers and county supervisors have not devoted enough attention – or made the budget choices – to ensure the initiative was as successful as it could be.

"... Proposition 36 has been handicapped over the last six years by the same problems that have long plagued the provision of treatment in California," Theshia Nadoo of Drug Policy Alliance, the sponsors of Proposition 36, told the Commission.¹⁴⁴

These problems persist and continue to undermine the goals of Proposition 36.

Proven practices ignored. Many studies show drug court models to be effective for reducing both recidivism and alcohol and drug use.¹⁴⁵ Key components of drug courts include collaboration among a judge, prosecutor, defense attorney, treatment provider and law enforcement, access to treatment, frequent drug testing, and ongoing interaction between the judge and offender.¹⁴⁶

Central to the drug court model is supervision – through the use of drug testing, for example, and regular contact with a judge – which allows for swift and consistent rewards and sanctions for good or non-compliant behavior. The supervision of Proposition 36 offenders, however, often is minimal.

Drug-testing can be infrequent in many counties. A Ventura County grand jury report in 2004 found that many Proposition 36 offenders in that county were tested less than once a month, for example. Weekly or twice-weekly drug testing is widely accepted as the appropriate drug testing frequency for offenders as they begin programs.¹⁴⁷

In many counties, judges have virtually no contact with an offender after they are sentenced to Proposition 36 treatment programs. Counties such as Ventura and Yolo report that offenders make no further regular appearances before a judge unless they face a non-compliance hearing. This infrequent contact makes it difficult to provide rewards for compliant behavior or sanctions for non-compliant behavior. Research has shown that small rewards, such as gift certificates, and sanctions, such as increased treatment requirements, court appearances, or even admonishment from the judge, can impact an offender's progress.¹⁴⁸

State Has Failed to Develop Guidelines

Proposition 36 was intended to be a county-run program: The initiative called for the state to send money to counties for treatment and law enforcement costs, allowing California's diverse counties to develop creative programs to best serve their offender populations and protect public safety.

Nonetheless, many stakeholders complained that the Department of Alcohol and Drug Programs, as the state agency charged with overseeing Proposition 36, has failed to provide sufficient guidance and leadership. A survey of Proposition 36 stakeholders in 10 counties listed more guidance and training from the department as a key to improving Proposition 36 outcomes.

The department holds an annual Proposition 36 conference that includes information on county programs that are showing promising results, but has created no other consistent venues to help counties use research and promising practices to develop successful programs. For example, the department created a Web site designed to promote best practices in Proposition 36 programs, but does not provide information for the site that it created. It instead relies on outside submissions. Currently, the only submission is from a health care advocacy group that has little to do with substance abuse treatment in the criminal justice system.

The department has created stakeholder committees to provide advice and develop guidelines, but few guidelines have been developed. The department has yet to develop guidelines on such important topics as:

- **Law enforcement costs versus treatment costs.** An early debate among stakeholders centered around how best to spend limited funding, with law enforcement officials pressing for more money for probation supervision and drug testing and treatment supporters seeking more money for treatment. The Statewide Advisory Group, created to help the department develop Proposition 36 regulations, discussed this issue frequently, according to participants, but the department has yet to suggest to counties an appropriate ratio for allocating funds for courts, probation officers, treatment providers and other services.
- **Narcotic replacement therapy.** UCLA researchers have repeatedly noted that opiate users have the worst outcomes when comparing treatment completion rates for offenders in relation to their primary drug. The reason: only about 14 percent of opiate users are receiving narcotic replacement therapies such as methadone, which research indicates is the best and safest way to treat opiate users. UCLA has continually recommended increasing access to narcotic replacement therapies as they have noted that heroin and other opiate users who do receive such therapy have significantly higher treatment completion rates and lower re-arrest rates than do opiate users who receive other types of treatment. The department, to date, has not issued guidelines requiring that counties provide opiate users with access to the narcotic replacement therapies.
- **Co-occurring disorders.** Counties, treatment providers and law enforcement all have noted that a majority of Proposition 36 offenders have mental health issues that require treatment. There has been uncertainty about whether Proposition 36 funds could be used to provide mental health treatment along with addiction treatment. County administrators in Sacramento and Yolo counties told Commission staff they were instructed by the department to stop spending funds on mental health treatment. The department has not issued written guidelines on what is allowable, and has provided minimal guidance on how to find mental health treatment for Proposition 36 offenders who need it. Consequently, counties report considerable confusion about what is allowed. Additionally, the department has not issued guidelines or recommendations regarding screening for co-occurring disorders. Many providers are not taking the first steps in identifying potential co-occurring disorders and the state lacks data to understand the extent of co-occurring disorders among Proposition 36 offenders.

Sources: Suzanne Gelber and David Rinaldo, the Avisa Group. April 2005. "Proposition 36 Today: A Study of Stakeholders in 10 California Counties." Page 18. Berkeley, CA. Also, Department of Alcohol and Drug Programs. Best Practices. http://www.adp.ca.gov/SACPA/P36_BestPractices.shtml. Also, University of California Los Angeles Integrated Substance Abuse Programs. April 13, 2007. "Evaluation of the Substance Abuse and Crime Prevention Act Final Report." Page 92.

Parolees' Success Rates Lower

Parolees comprise a small percentage of Proposition 36 offenders, but their success in the program could provide relief for the state's prison overcrowding crisis. Parolee success rates, however, are lower than for people on probation.

UCLA's research on Proposition 36 has found that between 8 and 11 percent of the Proposition 36 population are parolees in the four years studied. Only 25.6 percent of parolees who entered treatment successfully completed their treatment program in 2003-2004, however, compared to 32.8 percent of those on probation. Additionally, only 35.6 percent of parolees were in treatment for 90 days or more. Research suggests that 90 days of treatment is the minimum threshold for treatment to show positive effects.

UCLA also found that 56 percent of parolees were returned to prison within 12 months of being referred to Proposition 36 in its report released in 2005.

Several factors may explain negative outcomes for parolees. According to UCLA's data, parolees were older, reported using drugs for longer periods, had longer criminal histories and were more likely to report daily use than Proposition 36 offenders on probation. All of these factors have been shown to lower treatment success rates. Additionally, heroin use was more common among parolees than probationers, with 13.9 percent of parolees listing heroin as their primary drug, compared to 7.8 percent of those on probation. Heroin users have lower success rates in Proposition 36, in part because a majority of heroin users are not referred to narcotic replacement therapy, which has shown to be the most effective way to treat opiate addiction.

Additionally, due to the nature of parole, Proposition 36 is set up differently for parolees and it may be more difficult to employ best practices for treatment within the criminal justice system. Parolees are not under the jurisdiction of a judge and instead are supervised by the state Board of Prison Terms. Parole agents, instead of a judge, are the primary contact for assessment centers and treatment providers.

Stakeholders suggested that communication between assessment centers, treatment providers and parole agents was weak in many areas. The state Department of Corrections and Rehabilitation has only 14 parole agents who handle specialized Proposition 36 caseloads, even though between 750 and 1100 parolees are enrolled in Proposition 36 at any given time.

UCLA has suggested a need for the state to devote more supervision and more intensive treatment programs for parolees to improve outcomes.

Sources: Douglas Longshore, et. al. July 22, 2005. "Evaluation of the Substance Abuse and Crime Prevention Act 2004 Report." Also, University of California Los Angeles, Integrated Substance Abuse Programs. April 13, 2007. "Evaluation of the Substance Abuse and Crime Prevention Act Final Report."

Treatment does not fit need. UCLA's research indicates many offenders are not receiving the substance abuse treatment needed to produce the best outcomes.

Only about 14 percent of Proposition 36 offenders who listed heroin or other opiates as their primary drug received opioid replacement therapy, such as methadone, according to UCLA's research, despite evidence showing it is the safest and best way to treat opiate addiction.¹⁴⁹ Thirty of the state's 58 counties do not offer narcotic replacement therapy.¹⁵⁰ Many counties are rural and do not have enough opiate users to make a methadone clinic financially viable. Stakeholders also told the Commission there is a bias among some judges and county alcohol and drug administrators against methadone.¹⁵¹ Thus, whether an offender

receives appropriate treatment for opiate addiction most often is determined by where the offender lives. UCLA researchers have suggested inappropriate treatment for heroin users may explain why they have such poor outcomes among Proposition 36 offenders.

Due to funding constraints and priorities set by counties, many offenders with severe drug problems are assessed as needing residential treatment programs but are instead assigned to outpatient programs. UCLA's data show that only 22 percent of Proposition 36 offenders who reported using alcohol or drugs daily before entering treatment – most of whom would be described as in the dependent phase of addiction – were referred to residential treatment. Nearly 6,000 people statewide were assessed as needing residential care but did not get it, according to a survey of county alcohol and drug administrators conducted by the County Alcohol and Drug Program Administrators Association of California.

Denying residential treatment to offenders who need it may be short-sighted. UCLA found that 40 percent of daily drug and alcohol users who went to residential treatment completed their treatment program, while only 19 percent of daily users who went to outpatient treatment completed their program. Because treatment completers cost the system less due to fewer re-arrests and incarceration rates, counties should consider placing more offenders who need residential treatment in residential programs. Good risk and needs assessment tools are critical to making better determinations on how to spend limited money and would allow counties, for example, to assign low-need, low-risk offenders to brief interventions that are relatively inexpensive, freeing money for higher-need offenders.

Too much lag time between adjudication and treatment. Too many Proposition 36 offenders drop out of the program before even entering treatment. A Commission review of UCLA's research found that in 2003-04, 27 percent of the 51,033 offenders referred to Proposition 36 did not enter a treatment program. In many counties, the process from sentencing to assessment and then entrance to a treatment program takes several days or weeks. In a survey of Proposition 36 stakeholders in 10 counties conducted in 2005, some stakeholders suggested that the time between court adjudication and treatment entry can be more than a month.¹⁵² Los Angeles County had more than 800 people on a waiting list for assessment, according to a statewide survey conducted this year by the County Alcohol and Drug Program Administrators Association of California. Research suggests that offenders on waiting lists are less likely to enter treatment.¹⁵³ This slow journey from the courthouse to treatment is a key reason for the high no-show rates, experts told the Commission.

Rather than treatment failure, this lag illustrates the failure of a system in which no one – not judges, probation, treatment, or even the offender – is held accountable for ensuring that offenders begin treatment.

New law not a priority for policy-makers. County supervisors and the governor and Legislature have made other spending choices than Proposition 36, despite evidence that Proposition 36 is a cost-effective way to reduce crime. The governor and lawmakers agreed in 2007 to spend more than \$8.3 billion to build more prisons, for example, while cutting funding for Proposition 36, despite evidence that the new law could reduce the number of inmates.

Probation departments in most counties are struggling with large caseloads. While the proposition allows counties to use initiative money to pay probation costs, it is not enough to increase the amount of interaction between officers and offenders. Alameda County probation officers overseeing Proposition 36 offenders have so many offenders on

their caseload that it is considered “banked” – there is virtually no interaction between offender and probation officer.¹⁵⁴ Some Kern County probation officers oversee more than 300 offenders.¹⁵⁵ Many stakeholders have suggested more probation officers are needed to monitor Proposition 36 offenders, particularly offenders with long criminal histories.

UCLA researchers in their 2007 report outlined five strategies to improve Proposition 36, including more residential treatment, increased use of opioid replacement therapies, longer treatment programs, and more probation supervision. Implementing those improvements, which would require hiring more probation officers, for example, or keeping people who needed residential treatment in treatment for at least 90 days, would require the state to spend an estimated \$228 million annually on Proposition 36,¹⁵⁶ compared to the fiscal year 2007-08 funding level of \$120 million, down \$25 million from the previous year, UCLA found. The administration is proposing even less – about \$108 million – for fiscal year 2008-09.

The state should be more entrepreneurial in using other funding sources to help improve Proposition 36 programs, such as the Mental Health Services Act, or Proposition 63. The act could be tapped to

LAO Recommends Sustained Funding For Proposition 36, Drug Courts

Responding to Governor Arnold Schwarzenegger’s plan to cut funding for the Substance Abuse and Crime Prevention Act and drug courts in the 2008-09 budget, the Legislative Analyst’s Office notes that both programs save money by reducing costs in the state’s criminal justice and child welfare systems and it would not be cost-effective to make the cuts. Instead of cutting the programs, the LAO recommends sustaining funding at 2007-08 levels by shifting funds from two other programs:

- ***California Methamphetamine Initiative.*** The LAO recommends redirecting \$9.6 million from methamphetamine prevention advertising funds from the California Methamphetamine Initiative to substance abuse treatment provided by Proposition 36 and drug courts.
- ***Forfeiture Proceeds.*** The LAO recommends modifying state law to shift between \$4.5 and \$10 million generated by seizures of assets related to illegal drug-trafficking activities toward substance abuse treatment.

Source: Legislative Analyst’s Office. February 20, 2008. “Analysis of the 2008-09 Budget Bill.” Health and Social Services. Page C-23.

provide mental health treatment for Proposition 36 offenders who have both mental health and substance abuse disorders. One Proposition 63 funding stream, the Community Services and Supports fund, is being used in Santa Clara County for Proposition 36 offenders with mental health problems who need case management or housing services.¹⁵⁷ Other counties should consider this option.

Reform Attempts at State and Local Levels

Counties, providers making changes. In an effort to respond to poor results, counties and providers have developed creative solutions to improve outcomes.

Several providers that serve Proposition 36 offenders in Los Angeles County participated in a pilot project built around principles developed by NIATx, the Network for the Improvement of Addiction Treatment, that were designed to improve no-show and retention rates. One such provider, Social Model Recovery Systems, Inc., reduced the number of no-shows to treatment to 1.1 percent from 37 percent by providing bus tokens and pamphlets to the county's assessment centers, which in turn gave them out to offenders who were referred to Social Model Recovery Systems, Inc. The provider also implemented a policy requiring offenders

Drug Court Model Effective

El Dorado County redesigned its Proposition 36 program in 2005 to embrace drug-court principles. The change improved outcomes and made a dramatic difference in families' lives.

Before the change, offenders sentenced to Proposition 36 only appeared before a judge when they were failing the program. The court offered no reward to those who were succeeding and staying sober. The county's probation office had no specialized plan for Proposition 36 offenders – each probation officer mixed Proposition 36 offenders in with their regular caseload, which amounted to about 120 offenders each. Drug tests were administered sporadically.

Now, Proposition 36 offenders appear before the same judge, Douglas Phimster, at least once a month. Offenders doing well are offered simple rewards, such as a gift card to Starbuck's. Two county probation officers work exclusively with Proposition 36 offenders. Random drug tests are conducted weekly, and every Proposition 36 offender also is required to take a drug test every Monday morning. Weekly meetings allow Phimster, probation officers, the district attorney's office, treatment providers, county alcohol and drug officials, and defense attorneys to discuss each offender's case and develop a unified strategy. The collaboration has helped develop individualized and wide-ranging plans for each offender. Phimster, for example, makes calls to local dentists on behalf of offenders who need significant dental work stemming from methamphetamine abuse.

The results in El Dorado County are dramatic: 54 percent of Proposition 36 offenders completed treatment in the 2005-06 fiscal year, the first year after the county changed its approach, up from a 34 percent treatment completion rate the year before.

Every Thursday, the importance of recovery unfolds in Phimster's courtroom. At an August hearing, a woman graduating from the program told other Proposition 36 participants that she recently helped plan her daughter's wedding. "I'm valued and respected, and I'm going to stay that way," she said. Another female graduate smiled through tears as her 8-year-old daughter handed her a bouquet of flowers as she received her certificate of completion. And Mike Hooper, a Proposition 36 alumni, told offenders he slept in a tent during his first 30 days in treatment, but recently bought his first house.

Reconsider Treatment Completion

Many stakeholders suggested that the state's use of treatment completion as the primary measurement of counties' effectiveness is flawed. Treatment completion is defined as a "participant has successfully completed his/her recovery plan and has met the major goals set forth in that plan." Counties have created their own programs and may differ greatly on such standards as the amount of drug testing and amount of sessions required, as well as the different needs of individual offenders. Treatment completion alone, therefore, is not an accurate or fair way to compare counties.

UCLA's research shows that offenders described as completing treatment spent significantly different amounts of time in treatment in different counties: Offenders who completed treatment in 20 counties spent a median length of time of between 101 to 200 days in treatment, for example, while treatment completers in 11 other counties spent a median length of time of more than 300 days in treatment. The state should consider using other information to compare outcomes, such as the number of offenders who enter treatment after referral or retention in treatment for more than 90 days, in addition with treatment completion as it compares counties.

This discussion could be an important method for developing statewide goals for Proposition 36. By highlighting which counties are doing the best at improving employment rates, and adding incentives to encourage employment among offenders, for example, the state could encourage counties and treatment providers to work more closely with vocational training programs or other job services.

to come to the treatment program within one day of assessment.¹⁵⁸

San Joaquin County Judge Richard Vlavianos told the Commission about his county's new requirement that forced offenders to make a return appearance before a judge to prove they have entered treatment, holding offenders more accountable for beginning their treatment program. Vlavianos said the required appearance in front of a judge was reducing the number of no-shows in the county, although a thorough review of outcomes has not yet been conducted.¹⁵⁹

El Dorado County created a drug court for all Proposition 36 offenders at its Placerville courthouse.

At the program level, Tarzana Treatment Centers in Southern California created a new counselor position that works with offenders during their first 30 days of treatment to keep them in the program. This "retention" counselor was created in response to data showing that offenders who stay in treatment for the first 30 days have a better chance of completing the program.¹⁶⁰

Statewide reform efforts attempted. Policy-makers have made a number of efforts to improve Proposition 36.

Senate Bill 1137, authored by Senator Denise Ducheny, D-San Diego, was signed into law in 2006 by Governor Arnold Schwarzenegger. The legislation contained provisions backed by a majority of the stakeholders that steered the program toward a drug-court model. The bill required treatment providers to share information on offenders with probation departments, suggested that counties have dedicated court calendars for drug offenders and gave judges more discretion to modify treatment plans. SB 1137 also allowed judges to impose jail sanctions as a consequence of probation violations. Proposition 36 proponents sued, arguing the new law was unconstitutional because it contradicted the non-incarceration provision in Proposition 36. They won a preliminary injunction preventing

SB 1137 from taking effect, and the case is expected to go to trial later this year.

In addition to SB 1137, lawmakers and the governor created a new funding stream, the Substance Abuse Offender Treatment Program (OTP), to aid Proposition 36 programs. OTP allotted \$25 million in the first year to counties, which were required to put up a 10 percent match. OTP money can be used to enhance treatment services, reduce delays in receiving treatment services, or institute drug courts. OTP, which was created in a budget trailer bill and enacted without legislative hearings, incorporated some of the recommendations made by UCLA in its annual evaluations of Proposition 36, such as distributing funds to counties on a competitive basis, requiring counties to implement drug court models, and requiring counties to develop better assessment procedures. Only 39 of the state's 58 counties received OTP dollars in fiscal year 2006-07.

Deeper problems not addressed. While both SB 1137 and the OTP program included important reforms, Proposition 36's disappointing results also can be attributed to weaknesses within the alcohol and drug treatment system that the Commission outlined in its 2003 report. Proposition 36 placed important new responsibilities on a system that was unaccustomed to accountability and unprepared to handle an influx of new clients with complicated addiction, health and legal problems.

Reforms recommended by the Commission in 2003, had they been adopted, could have helped counties roll out Proposition 36 more effectively and produced better outcomes for the dollars spent.

The multi-disciplinary council the Commission called for could have helped develop a state-level strategy that unified prevention, treatment and law enforcement, and guided the integration of substance abuse treatment with other services needed by Proposition 36 offenders, such as education, job-training and mental health. The state could have developed broad goals for treatment programs and helped counties prioritize treatment resources to those who needed it most. The state could have implemented outcome-based quality control standards for treatment personnel, programs and facilities.

To the extent the state failed to make reforms that would have bolstered a treatment system now charged with a major public safety and public health responsibility, it shares a large part of the blame for Proposition 36's disappointing outcomes. To improve Proposition 36 outcomes, policy-makers should first make badly-needed reforms for the treatment system.

Set Goals, Require Better Outcomes

Just as substance abuse treatment as a whole needs to shift to a new model, the criminal justice system must adopt a model that meets both the requirements of public safety and substance abuse treatment. Areas of the state already are making headway in this direction through drug court programs, but these programs can be improved and expanded. Efforts to improve both the treatment and criminal justice systems to better handle drug offenders will require the support and guidance of the state.

There also are specific reforms that can be made at the same time to the way Proposition 36 is implemented.

UCLA has provided multiple recommendations for improvements that have not been enacted. Some, such as increasing the use of residential treatment for those with severe alcohol and drug dependence, would require a greater financial investment. However, UCLA notes that research has shown that clients placed in the appropriate level of care can cost less than clients placed in inappropriate care who end up churning in and out of treatment.¹⁶¹

The Department of Alcohol and Drug Programs should create statewide goals for Proposition 36, rewrite funding regulations to create incentives for good performance, and help counties and providers develop creative approaches to address different offender subgroups. The state should not dictate specific programs or approaches for all offenders, but could, for example:

- Reward counties that improve the number of offenders who stay in treatment for 90 days or longer.
- Reward counties that improve the number of offenders who enter treatment after referral.
- Develop protocols for delivering rewards and sanctions to offenders.
- Require that counties develop ways for opiate-using offenders to receive opioid replacement therapy.
- Require that counties use drug court models for offenders when appropriate.

The Offender Treatment Program is well intentioned, but unnecessary. OTP is a separate funding stream to treat the same offender population, requiring counties to submit two separate plans for their Proposition 36 programs. While counties are required to submit their annual

Proposition 36 county plans and bi-annual and annual expenditure reports via the on-line Substance Abuse and Crime Prevention Act Reporting Information System, OTP fiscal information must be submitted by paper once every quarter.

The state should embrace OTP's purpose – to steer counties toward proven practices through financial incentives – within the Proposition 36 framework. The author of Proposition 36, David Fratello, told the Commission that most of the provisions within OTP did not conflict with Proposition 36, and could have been created within the new law without the need for separate funding.¹⁶²

Use drug court model. One of OTP's requirements is that counties develop a drug court model for some drug offenders. California has extensive experience with drug courts – there were 203 operating in the state as of December 2006.¹⁶³

Many drug courts are reserved for serious offenders who do not qualify for Proposition 36 due to their criminal history, and because the intensity of services and supervision can be costly.

A 2005 study of drug courts in nine California counties showed, however, that while drug courts can add up-front costs to courts and other health and human service systems, they save money by reducing costs elsewhere. "... often drug court participants have fewer business-as-usual costs (e.g. court hearings, bench warrant costs) than the drug court eligible clients who do not participate in drug court..." the report found.¹⁶⁴ It concluded that for every \$1 spent on drug courts, taxpayers saved \$3.50.¹⁶⁵

Based on the data generated by UCLA regarding the characteristics of Proposition 36 offenders, it appears the drug court model is needed within the Proposition 36 program. While initial cost per offender may be higher in a drug court model than counties are currently spending on Proposition 36 offenders, the higher intensity levels of treatment and supervision might pay off.

Clearly not all Proposition 36 offenders require a drug court model, but the state should require most counties – small population counties excluded – to implement a drug court model for at least some of their Proposition 36 offenders.

While the use of one component of most drug courts – flash incarceration – is under legal review, the treatment and law enforcement communities should not use the pending court case as an excuse to delay reforms to Proposition 36. Judges can implement creative, less-expensive sanctions

now that will allow courts to hold non-compliant offenders more accountable. Options include community service, day reporting to courts or probation offices, or fines and restitution.

Judges must take leadership role. No one group has a more important role in Proposition 36's success than the judiciary. A judge has the power to bring all parties to the table and act as a case manager for offenders. Yet too often, the Commission heard that Proposition 36 offenders rarely have contact with judges.

The state's judges – perhaps through the Judicial Council – must work more closely with the Department of Alcohol and Drug Programs to improve Proposition 36. Judges must heed the voters' wishes and become a key driver in searching for better outcomes.

Santa Clara County Superior Court Judge Stephen Manley told the Commission that judges should be held more accountable for outcomes, and suggested the entire Proposition 36 program should be based on improving results.

“Put the onus on the judges,” Manley said. “Why should we walk away and not be responsible? If we were driven to all of us work together and get better outcomes, and if we didn't get better outcomes and there was some kind of response we didn't like, we would get better outcomes.”¹⁶⁶

UCLA Recommends Changes

Proposition 36 required the state to hire an independent evaluator to gather data on the outcomes of the proposition and make recommendations for changes to improve outcomes. The University of California at Los Angeles' Integrated Substance Abuse Programs was hired to evaluate the program. Its 2007 report, the fourth such report, included several recommendations for improving Proposition 36. Some changes might require voters' approval. The recommendations included:

- ***Modify placement criteria.*** Offenders with high rates of prior non-drug convictions should be placed in more controlled settings, such as prison- or jail-based programs, or drug courts with intense probation supervision.
- ***Increase treatment engagement, retention and completion.*** Because offenders who stayed in treatment longer had better outcomes, the state and counties should focus on strategies that increase the number of offenders who show up to treatment, stay in treatment and complete their treatment.
- ***Increase collaboration.*** Court, probation, parole officers and drug-treatment systems should continue to work together to get offenders into the appropriate treatment as quickly as possible, while providing appropriate oversight.
- ***Create incentives.*** Counties and providers should be rewarded for demonstrating success on objective measures, such as reducing the length of time between court appearance and treatment entry.
- ***Increase supervision.*** Research suggests that outcomes would be improved by increasing oversight from probation and parole officials and a greater use of random drug testing.
- ***More residential treatment.*** Heavy-using offenders are often only sent to residential treatment after failing outpatient programs. Residential treatment should be available as a first option to avoid wasting resources.
- ***Narcotic replacement therapy.*** Narcotic Replacement Therapies (NRT) such as methadone or buprenorphine are considered the best and safest way to treat heroin or other opiate users. NRT should be provided.
- ***Decrease no-shows.*** The state and counties should incorporate evidence-based practices designed to improve the number of offenders who enter treatment, such as locating assessment offices within the courthouse and allowing walk-in assessments without appointments.
- ***Define treatment completion.*** There is no statewide definition for treatment completion, making it difficult to compare counties.

Beyond Proposition 36

Proposition 36 was born of frustration by voters at policy-makers' inability to develop programs that addressed drug offenders' needs at a reasonable cost to taxpayers. While flawed, the initiative signals state leaders that the public wants innovative options to "War on Drugs" rhetoric and policy.

Testimony to the Commission indicated many leaders have heard the message. Stakeholders representing widely divergent viewpoints sounded a similar theme: community-based treatment, not long-term

incarceration, is the appropriate policy for many drug offenders. Even the California State Sheriff's Association, which opposed the initiative in 2000, told the Commission it supported the general idea behind the initiative.¹⁶⁷ Returning to the pre-Proposition 36 status quo because of early disappointing results is senseless and counter to voters' intentions.

California's leaders need to engage in a much broader discussion about the best way to handle addiction – and mental illness – within the criminal justice system.

Such a discussion was underway before Proposition 36. Recognizing the futility of sending drug offenders to jail or prisons without addressing their addiction, the state, counties and judges developed sentencing alternatives. They ranged from county-run diversion for first-time, low-level offenders to felony drug courts for people with long criminal histories who are facing prison time. A discussion of judges' current options for nonviolent drug offenders is included as Appendix G.

State funding for a drug court program designed for adult felons facing potential prison time has grown from about \$16 million in 2005-06 to more than \$24 million in 2007-08. These specialized courts have shown some success: a study of drug courts in nine California counties showed the courts saved the state more than \$9 million in criminal justice and treatment costs by lowering offender recidivism rates.¹⁶⁸

These various programs for drug offenders, however, are used differently by different judges and vary widely in the number of offenders they serve, the types of treatment provided and even how offenders are monitored. Such programs have been created with little coordination or consistent attention to which practices provide the best outcomes. An initiative that may appear on the November 2008 ballot that seeks to better coordinate options for handling drug offenders is described in Appendix H.

The state is in a unique position to bring all of these concepts together and drive the change toward a smarter and more sophisticated system for handling drug offenders. Risk-and-needs assessment tools before sentencing are fundamental to determining appropriate treatment and supervision needs of individual offenders. Programs can be better tailored to individuals' risks to public safety and treatment needs, using such tools as a matrix developed by the Treatment Research Institute at the University of Pennsylvania. The matrix can be used to match offenders with correct programs, ranging from drug courts for high-risk, high-needs offenders, to minimal reporting probation for low-risk, low-needs offenders who would receive prevention and education programs.

Additionally, data should be used to spot trends and develop appropriate responses. UCLA researchers published findings in 2007 showing that daily methamphetamine users who entered Proposition 36 residential treatment programs had significantly fewer arrests after treatment than did daily methamphetamine users who received outpatient treatment.¹⁶⁹ Given the predominance of methamphetamine in the state, policy-makers should analyze this data and consider the cost effectiveness and public safety benefits of an investment in residential methamphetamine treatment programs.

California also should look for other promising programs to serve as a model in handling various types of offenders. In Hawaii, for example, the HOPE program is showing good results for probationers by using frequent drug testing and short stints of incarceration for those who fail tests.

HOPE is less treatment-centered – probationers in the program include sex offenders and others not convicted specifically of drug crimes – and more focused on accountability. A HOPE-style pilot project is being considered by the Department of Corrections and Rehabilitation for use with parolees in California. That project should be encouraged. A description of the HOPE program is included as Appendix I.

Voters' approval of Proposition 36 and the increasing use of drug courts throughout the state indicate a willingness to try new strategies to deal with the drug offenders who crowd jails and the prison system. But these advances have developed piecemeal, and the state lacks an overall strategy, with coherent policies, to handle different types of offenders with varying risks and needs.

To serve the goals of public safety and public health, and to reduce the burden on the state's social services, California must systematically coordinate courts, mental health, substance abuse and law enforcement to provide a continuum of services that combine treatment and supervision.

Components of A Model System for Drug Offenders

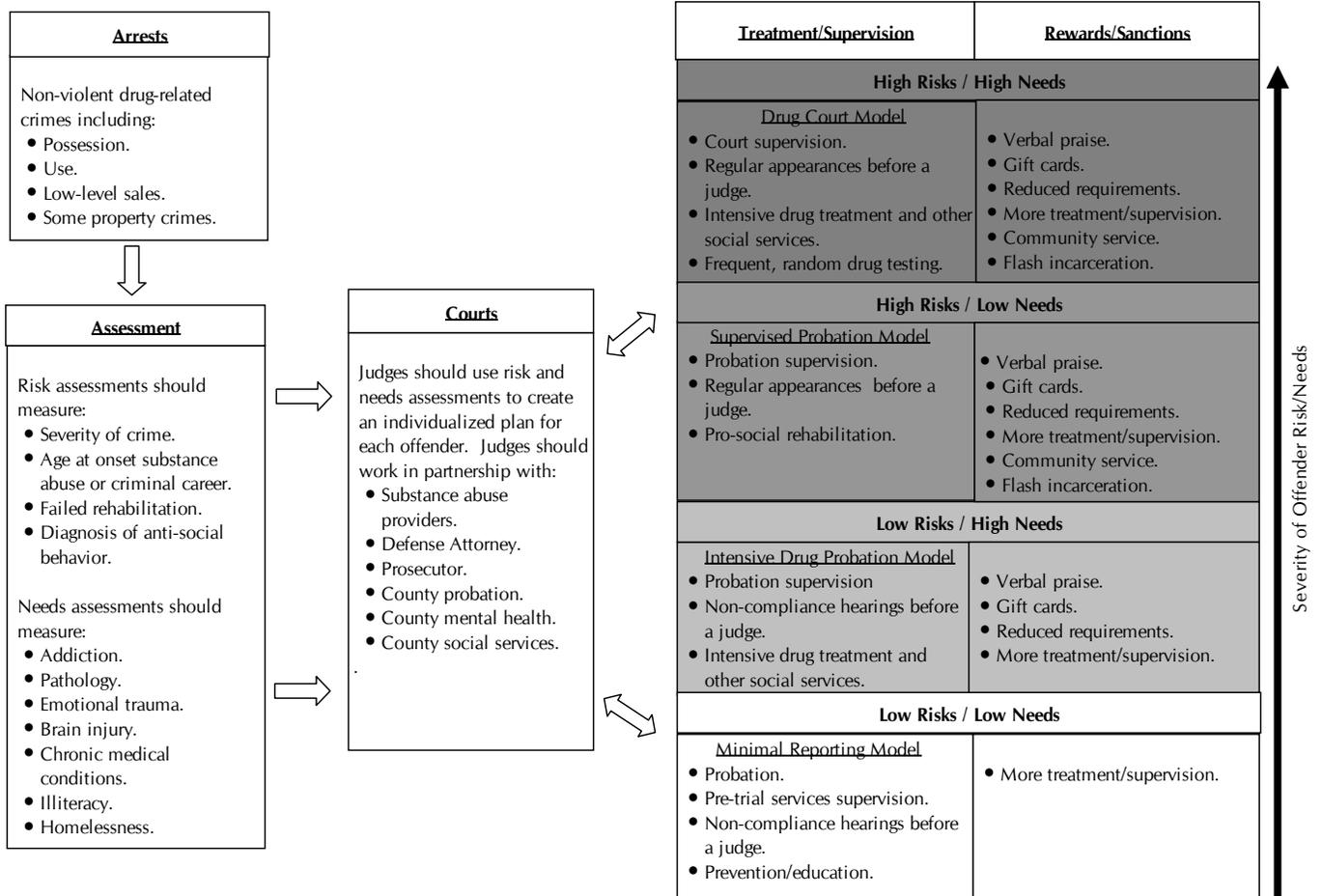
The Treatment Research Institute’s recommendations for a model continuum of services system for nonviolent drug offenders include:

- Valid, reliable and timely risk-and-needs triaging of drug offenders at the point of arrest.
- Ensuring the assessment results are available in real time for disposition.
- Targeting of individuals into appropriate and cost-efficient programs.
- Statutory provisions enabling seamless and rapid transfers of individuals from one program to another in light of demonstrative evidence of a need to alter the care plan.
- Careful and continuous measurement of performance and outcomes not for the purpose of proving that a particular program “works” but rather to show for whom it works, under what circumstances, at what cost, and who it harms.
- Adequate funding – perhaps derived, in part, from cost savings realized by other state agencies such as corrections or child welfare – to support both the services and the research evaluations.

Source: Douglas B. Marlowe. Treatment Research Institute. August 23, 2007. Written testimony to the Commission. Page 11.

A System for Drug Offenders

The state’s approach to nonviolent drug offenders should be designed with the assumptions that offenders have individualized and multiple risks and needs, treatment and supervision plans should fit those risks and needs, offenders should be moved between programs by the courts based on performance, and rewards and sanctions should be delivered swiftly and with consistency.



Recommendation 3: The state should transform programs for nonviolent drug offenders by tying funding to outcomes, requiring drug court models where appropriate, and requiring counties to tailor programs to offenders' individual risks and needs. Specifically, the state should:

❑ **Work with judiciary to develop standards for a continuum of services.**

The state should work with the judiciary to develop guidelines for best practices for diversion, Proposition 36 and felony drug court programs, including models for screening and assessment, treatment practices and supervision practices, as well as guidelines for moving offenders from program to program, based on their success or failure. Each county should be required to develop a Proposition 36 drug court to handle the offenders who need more intensive treatment and supervision.

❑ **Adapt the goal of the Offender Treatment Program – incentivizing best practices – into Proposition 36 and use guidelines to define success.**

The state should merge the Offender Treatment Program and the Proposition 36 program into a single program and rewrite funding regulations to allow the state to reward or penalize counties based on performance. The state should set priorities, tie funding to those priorities and annually publish data rating the counties on how well they meet these outcomes. The priorities could include:

- ✓ Lowering re-arrest rates of Proposition 36 offenders.
- ✓ Lowering the number of offenders who fail to enter treatment.
- ✓ Increasing the number of offenders who stay in treatment for at least 90 days.
- ✓ Using a drug court model for at least some offenders.

❑ **Coordinate Proposition 36 and Proposition 63.** The Mental Health Services Oversight and Accountability Commission should encourage counties to use Proposition 63 money for Proposition 36 offenders. Proposition 63 funding streams, such as the Community Services and Supports fund, should be used to provide mental health services to Proposition 36 offenders who suffer from co-occurring disorders. The state Department of Alcohol and Drug Programs must first require counties to conduct screening for co-occurring disorders – paid for by Proposition 36 funds – to fully understand the number of offenders with co-occurring disorders.

❑ **The Department of Corrections and Rehabilitation should place more focus on parolees in Proposition 36 programs.** The state should assign more parole agents to specific Proposition 36 caseloads, and design space in planned re-entry facilities for Proposition 36 programs for parolees. To reduce recidivism and prison costs, the

state should create financial incentives for providers who develop successful Proposition 36 programs for parolees.

- ***Redesign the contract between the Department of Alcohol and Drug Programs and UCLA to allow UCLA to publish reports independently of the department.*** The current relationship allows the department too much authority over evaluations of a program that it runs, setting up an inherent conflict of interest.

Conclusion

California has a substance abuse problem. Alcohol and substance abuse are a burden not only to the state's economy, but to its way of life. The state spends more than \$1 billion on substance abuse treatment and billions more on the consequences of failing to treat addiction.

The consequences of the disease are not small. Alcohol and substance abuse and addiction impact our health care, social services and criminal justice systems, but more importantly, they harm the lives of individuals and families. Fortunately, we know that with appropriate and sufficient treatment, recovery is possible. Unfortunately, we have not yet taken the steps to adequately and systematically address this disease.

The conclusions reached by the Commission in 2003 still apply today: California must focus efforts and resources on programs and services that are effective at reducing the costs and misery of substance abuse and addiction. We know what programs work, we know what it takes to treat the disease, yet we continue to work without a true plan in place, with little leadership and little reliance on evidence-driven practices. It is not a system, it is an un-system without priorities or oversight.

In terms of cost avoidance, research makes a powerful case that more money spent on proven treatment practices could save the state money it spends elsewhere, such as foster care and corrections, where substance abuse drives the need for state services.

In this instance and in many others the Commission has examined in the past, the Commission concluded that the state must first transform the way it pays for services. The state must insure that scarce and limited dollars are put to their best use, as measured by improvements in outcomes. This is essential to achieving the goals of helping people get better and making communities safer. This also is essential stewardship of taxpayer dollars.

Every day, the state must earn its legitimacy to govern – to take money from taxpayers and to make choices in how programs spend that money. Every day that the state does not earn its legitimacy, the state risks losing it.

California must measure the results it gets for the money it now spends. The state is rich in other assets it can deploy that also will improve outcomes: leadership, expertise, research on results, and the passion and idealism of state substance abuse and mental health workers. Mobilized efficiently, these assets have the potential to improve outcomes far more than simply spending more money.

Within the substance abuse treatment system, the state has the data system in place to begin linking funding to results. This will take a cultural change, and the Department of Alcohol and Drug Programs must take a much larger leadership role in the treatment field by setting standards and directing funding to effective programs.

California must rethink substance abuse treatment. Addiction is a disease that requires a public health response.

Treatment cannot remain an isolated piece of the health care system, reserved only for the sickest addicts. Health care providers and other human service systems should screen for alcohol and drug programs, provide brief interventions where appropriate, and make referrals to specialized treatment providers if necessary.

The treatment system must better incorporate proven practices into everyday use, and the state should reward providers who produce good results.

Within the criminal justice system, Proposition 36 must be reformed to follow some of the same tenets as the treatment system: Proven practices should be required and good results should be rewarded. Counties must adapt better risks-and-needs assessments, use drug court models where appropriate, and forge true working partnerships among judges, law enforcement, treatment providers, attorneys and other health and human services.

Much of the advice the Commission delivered in 2003 was ignored by policy-makers. To disregard the issue of substance abuse once again, California would miss a key opportunity to make the state safer, healthier and more financially sound.

The Commission's Study Process

The Commission previously examined alcohol and substance abuse addiction in its 2003 study, "For Our Health & Safety: Joining Forces to Defeat Addiction." It also has conducted decades of work on various aspects of the state's mental health, public health and public safety systems.

The Commission initiated this study in the summer of 2007 to review the state's alcohol and drug programs and to evaluate the state's progress in implementing recommendations the Commission made in 2003. This study also served as an opportunity for the Commission to review the state's implementation of the Substance Abuse and Crime Prevention Act of 2000, or Proposition 36, which was just underway at the time of the 2003 study.

In pursuing its study, the Commission convened two public hearings, two advisory committee meetings and one site visit.

The first public hearing, held in June 2007, experts discussed the Department of Alcohol and Drug Programs' progress in implementing the Commission's recommendations. The Commission also heard from researchers who evaluated the effectiveness of Proposition 36, a sponsor of the initiative and two stakeholders

The second hearing, in August 2007, brought together a drug court judge, substance abuse treatment researchers, treatment providers, law enforcement officers and Proposition 36 graduates to discuss the successes and challenges in implementing Proposition 36.

In addition to the public hearings, the Commission's advisory panel meetings provided the opportunity to meet with experts and practitioners. In August 2007, the Commission held two advisory panel meetings in Sacramento. The first meeting focused on the successes and challenges of Proposition 36 and the Offender Treatment Program, and the opportunities to increase the number of offenders who successfully complete alcohol and drug treatment. At the second meeting, advisory members discussed the status of the state's implementation of selected recommendations from the Commission's 2003 report, barriers to implementation, and potential opportunities for improvement of the state's substance abuse treatment system.

Additionally, the Commission visited a Proposition 36 Drug Court in El Dorado County in August 2007. Commission staff also received valuable feedback from a number of experts representing various components of the substance abuse treatment system through a series of e-mail discussions and a culminating conference call.

Hearing witnesses are listed in Appendix A and advisory committee members are listed in Appendix B. The Commission greatly benefited from the contributions of all who shared their expertise, but the findings and recommendations in this report are the Commission's own.

All written testimony submitted electronically for each of the hearings, and this report is available online at the Commission Web site, www.lhc.ca.gov.

Appendices & Notes

- ✓ *Public Hearing Witnesses*
- ✓ *Advisory Committee Members*
- ✓ *Guide to Selected Alcohol and Drug Acronyms*
 - ✓ *Proposition 36*
 - ✓ *Proposition 36 Offenders Pipeline*
 - ✓ *Advice to States*
- ✓ *Options for Nonviolent Drug Offenders*
- ✓ *Nonviolent Offender Rehabilitation Act of 2008*
 - ✓ *Positive Outcomes in Hawaii*
 - ✓ *Notes*

Appendix A

Little Hoover Commission Public Hearing Witnesses

Witnesses Appearing at Little Hoover Commission Public Hearing on Alcohol and Drug Treatment Programs, June 28, 2007

Lionel Chatman, Chief Probation Officer,
Contra Costa County Probation
Department, representing the Chief
Probation Officers of California

Angela Hawken, Economist and Policy
Analyst, UCLA Integrated Substance Abuse
Programs

Theshia Naidoo, Staff Attorney, Drug Policy
Alliance

Thomas Renfree, Executive Director,
County Alcohol and Drug Program
Administrators Association of California

Darren Urada, Principal Investigator, UCLA
Integrated Substance Abuse Programs

Renée Zito, Director, Department of Alcohol
and Drug Programs

Witnesses Appearing at Little Hoover Commission Public Hearing on Alcohol and Drug Treatment Programs, August 23, 2007

Peter Banys, Director, Substance Abuse
Programs, Veterans Administration San
Francisco Medical Center, representing the
California Society of Addiction Medicine

Mark Iwasa, Chief Deputy, Investigative
Services, Sacramento County Sheriff's
Department, representing the California
State sheriff's Association

Stephen V. Manley, Judge, Santa Clara
County Superior Court

Douglas Marlowe, Director, Section on Law
and Ethics, Treatment Research Institute,
University of Pennsylvania

Lou Martinez, Proposition 36 Graduate and
Counselor, The Effort, Inc.

Richard A. Rawson, Associate Director,
UCLA Integrated Substance Abuse
Programs

Elizabeth Stanley-Salazar, Vice President
and Director of Public Policy, Phoenix
Houses of California, Inc.

Richard Word, Chief, Vacaville Police
Department, and President, California
Police Chiefs Association

Appendix B

Little Hoover Commission Advisory Committee on Alcohol and Drug Treatment Programs

Susan Blacksher, Executive Director,
California Association of Addiction Recovery
Resources

Cathy Coyne, Legislative Analyst, California
State Sheriffs' Association

Michael Cunningham, Chief Deputy
Director, California Department of Alcohol
and Drug Programs

Warren Daniels, Director, California
Certification Board of Alcohol and Drug
Counselors & Community Recovery
Resources, Grass Valley

Dave Fratello, Political Director, Campaign
for New Drug Policies

Robert Garner, Director, County of Santa
Clara Department of Alcohol and Drug
Services

Suzanne Gelber, Partner, Avisia Group

Milicent Gomes, Deputy Director, California
Department of Alcohol and Drug Programs

Brian Greenberg, Addiction Specialist,
Shelter Network of San Mateo

Bill Harper, President, State Coalition of
Probation Organizations

Mark Iwasa, Chief Deputy, California State
Sheriffs' Association

Jeff Jeffery, Proposition 36 Graduate and
Substance Abuse Counselor, Stepping
Stone Residential Treatment

The Honorable Linda Lofthus, Judge, San
Joaquin County Superior Court

Jody Martin, Consultant, Senate of Office
Research

Rhonda Messamore, Executive Director,
California Association of Alcoholism and
Drug Abuse Counselors

Theshia Naidoo, Staff Attorney, Drug Policy
Alliance

Patrick Ogawa, Director, Los Angeles
County Alcohol and Drug Program
Administration

Tom Renfree, Executive Director, County
Alcohol and Drug Program Administrators
Association of California

The Honorable David Richmond, Judge,
Amador County Superior Court

Albert Senella, Chief Operating Officer,
Tarzana Treatment Centers

Trisha Stanionis, Executive Director,
Project Help

Sushma Taylor, Chief Executive Officer of
Center Point, Inc. and Co-Chair of
California Perinatal Treatment Network

The Honorable Richard Vlavianos, Judge,
San Joaquin County Superior Court

Joan Zweben, Director, East Bay
Community Recovery Project and 14th
Street Clinic

Appendix C

Guide to Selected Alcohol and Drug Acronyms

ADP or DADP – California Department of Alcohol and Drug Programs. The organization that leads the state’s efforts to reduce alcoholism, drug addiction and problem gambling by developing, administering and supporting prevention, treatment and recovery programs.

AOD – Alcohol and Other Drugs. A phrase used to describe controlled addictive substances, as in, the AOD treatment field.

CAADAC – The California Association of Alcoholism and Drug Abuse Counselors. The largest alcohol and drug counseling certification organization in California, also known as the California Certification Board of Alcohol and Drug Counselors (CCBADC). An affiliate of the National Association of Alcoholism and Drug Abuse Counselors (NAADAC).

CAADPE – The California Association of Alcohol and Drug Program Executives. A non-profit professional association of alcohol and other drug abuse program directors.

CAARR – The California Association of Addiction Recovery Resources. A membership-based organization which supports the development of organizations benefiting alcoholics, addicts, their families and the community.

CADPAAC – The County Alcohol and Drug Program Administrators Association of California. A non-profit organization comprised of the designated county alcohol and drug program administrators representing each county in California. Thomas Renfree, the executive director of CADPAAC, testified at the Commission’s June 28, 2007 public hearing.

CalOMS – The California Outcomes Measurement System. A database managed by ADP that collects county data on AOD treatment outcomes.

COD – Co-Occurring Disorder. A dual diagnosis of both a mental illness and alcohol or drug addiction.

COJAC – The Co-Occurring Joint Action Council. Created by the state to work on bettering treatment for people suffering from co-occurring disorders.

COSSR – The Continuum of Services System Re-Engineering Task Force. Created by ADP to help reorganize the department to insure system accountability, efficiency and effectiveness.

CSAM – California Society of Addiction Medicine. A group of doctors who treat addiction, also a political advocacy group.

DAC – Director’s Advisory Council. Includes the director of ADP, judges, treatment providers and constituency groups (such as the Lesbian, Gay, Bisexual and Transgender Constituent Committee). Works to address barriers to treatment.

GPAC – Governor’s Prevention Advisory Council. Comprised of heads of various state agencies, designed to recommend ways to increase programs to prevent alcohol and drug use.

NCCA – National Commission for Certifying Agencies. Commission that sets standards for accrediting agencies. Substance abuse counselors in California must now be certified by an agency that is accredited by NCCA.

NIATx – Network for the Improvement of Addiction Treatment. A partnership between the federal government, the Robert Wood Johnson Foundation and several addiction treatment organizations, NIATx works with treatment providers to improve business practices and client engagement and retention.

NOMS – National Outcome Measures. Created by the federal Substance Abuse and Mental Health Services Administration. This is a list of criteria used by the federal government to measure AOD treatment outcomes.

OTAG – Offender Treatment Advisory Group. Convened in 2006 to help implement the Offender Treatment Program. Includes all stakeholders except the groups who sued the state over implementing SB 1137, which would allow judges to impose jail sanctions for Proposition 36 offenders.

OWPS – The Office of Women’s and Perinatal Services. An entity within the California Department of Alcohol and Drug Programs which strives to ensure that all women have access to comprehensive, gender-responsive substance abuse treatment.

OTP – Offender Treatment Program. Created in 2006 as a funding augmentation to Proposition 36.

PSN – California Perinatal Services Network. A system of services designed to help women who are abusing alcohol or drugs and are pregnant or a parent of children under 17.

SACPA – The Substance Abuse and Crime Prevention Act of 2000. Enacted by Proposition 36.

SAG – State Advisory Group. Was convened to enact Proposition 36, included all stakeholders. The group was disbanded by ADP in 2006 and replaced by the Offender Treatment Advisory Group.

SAMHSA – The Substance Abuse and Mental Health Services Administration. The federal agency overseeing alcohol and drug treatment programs.

SAPBGT – Substance Abuse Prevention and Treatment Block Grant. The federal grant that provides the state with the largest portion of its funding for AOD treatment.

SBIRT – Screening, Brief Intervention and Referral to Treatment. A comprehensive, integrated public health approach to the delivery of early intervention and treatment services to people with substance abuse disorders or those at risk for developing such disorders.

SIT – The State Interagency Team for Children and Youth. Comprised of deputy directors from state agencies and departments, charged with bettering services and strategies for children, youth and families in California.

TIP – Treatment Improvement Protocol. Created by the federal Center for Substance Abuse Treatment, TIPs are best practice guidelines for the treatment of substance abuse.

Appendix D

Proposition 36 Ballot Initiative - 2000 General Election

DRUGS. PROBATION AND TREATMENT PROGRAM

This initiative measure is submitted to the people in accordance with the provisions of Article II, Section 8, of the California Constitution.

This initiative measure adds sections to the Health and Safety Code and the Penal Code; therefore, new provisions proposed to be added are printed in *italic type* to indicate that they are new.

PROPOSED LAW: SUBSTANCE ABUSE AND CRIME PREVENTION ACT OF 2000

SECTION 1. Title. This act shall be known and may be cited as the “Substance Abuse and Crime Prevention Act of 2000.”

SECTION 2. Findings and Declarations. The People of the State of California hereby find and declare all of the following:

(a) Substance abuse treatment is a proven public safety and health measure. Nonviolent, drug-dependent criminal offenders who receive drug treatment are much less likely to abuse drugs and commit future crimes, and are likelier to live healthier, more stable and more productive lives.

(b) Community safety and health are promoted, and taxpayer dollars are saved, when nonviolent persons convicted of drug possession or drug use are provided appropriate community-based treatment instead of incarceration. (c) In 1996, Arizona voters by a 2–1 margin passed the Drug Medicalization, Prevention, and Control Act, which diverted nonviolent drug offenders into drug treatment and education services rather than incarceration. According to a Report Card prepared by the Arizona Supreme Court, the Arizona law: is “resulting in safer communities and more substance abusing probationers in recovery,” has already saved state taxpayers millions of dollars, and is helping more than 75 percent of program participants to remain drug free.

SECTION 3. Purpose and Intent. The People of the State of California hereby declare their purpose and intent in enacting this act to be as follows:

(a) To divert from incarceration into community-based substance abuse treatment programs nonviolent defendants, probationers and parolees charged with simple drug possession or drug use offenses;

(b) To halt the wasteful expenditure of hundreds of millions of dollars each year on the incarceration—and reincarceration—of nonviolent drug users who would be better served by community-based treatment; and

(c) To enhance public safety by reducing drug-related crime and preserving jails and prison cells for serious and violent offenders, and to improve public health by reducing drug abuse and drug dependence through proven and effective drug treatment strategies.

SECTION 4. Section 1210 is added to the Penal Code, to read:

1210. Definitions As used in Sections 1210.1 and 3063.1 of this code, and Division 10.8 (commencing with Section 11999.4) of the Health and Safety Code. (a) The term “nonviolent drug

possession offense” means the unlawful possession, use, or transportation for personal use of any controlled substance identified in Section 11054, 11055, 11056, 11057 or 11058 of the Health and Safety Code, or the offense of being under the influence of a controlled substance in violation of Section 11550 of the Health and Safety Code. The term “nonviolent drug possession offense” does not include the possession for sale, production, or manufacturing of any controlled substance.

(b) The term “drug treatment program” or “drug treatment” means a licensed and/or certified community drug treatment program, which may include one or more of the following: outpatient treatment, half-way house treatment, narcotic replacement therapy, drug education or prevention courses and/or limited inpatient or residential drug treatment as needed to address special detoxification or relapse situations or severe dependence. The term “drug treatment program” or “drug treatment” does not include drug treatment programs offered in a prison or jail facility.

(c) The term “successful completion of treatment” means that a defendant who has had drug treatment imposed as a condition of probation has completed the prescribed course of drug treatment and, as a result, there is reasonable cause to believe that the defendant will not abuse controlled substances in the future.

(d) The term “misdemeanor not related to the use of drugs” means a misdemeanor that does not involve

(1) the simple possession or use of drugs or drug paraphernalia, being present where drugs are used, or failure to register as a drug offender, or

(2) any activity similar to those listed in paragraph (1).

SECTION 5. Section 1210.1 is added to the Penal Code, to read:

1210.1. Possession of Controlled Substances; Probation; Exceptions. *(a) Notwithstanding any other provision of law, and except as provided in subdivision (b), any person convicted of a nonviolent drug possession offense shall receive probation. As a condition of probation the court shall require participation in and completion of an appropriate drug treatment program. The court may also impose, as a condition of probation, participation in vocational training, family counseling, literacy training and/or community service. A court may not impose incarceration as an additional condition of probation. Aside from the limitations imposed in this subdivision, the trial court is not otherwise limited in the type of probation conditions it may impose. In addition to any fine assessed under other provisions of law, the trial judge may require any person convicted of a nonviolent drug possession offense who is reasonably able to do so to contribute to the cost of his or her own placement in a drug treatment program.*

(b) Subdivision (a) does not apply to either of the following:

(1) Any defendant who previously has been convicted of one or more serious or violent felonies in violation of subdivision (c) of Section 667.5 or Section 1192.7, unless the nonviolent drug possession offense occurred after a period of five years in which the defendant remained free of both prison custody and the commission of an offense that results in (A) a felony conviction other than a nonviolent drug possession offense, or (B) a misdemeanor conviction involving physical injury or the threat of physical injury to another person.

(2) Any defendant who, in addition to one or more nonviolent drug possession offenses, has been convicted in the same proceeding of a misdemeanor not related to the use of drugs or any felony.

(3) Any defendant who:

(A) While using a firearm, unlawfully possesses any amount of (i) a substance containing either cocaine base, cocaine, heroin, methamphetamine, or (ii) a liquid, non-liquid, plant substance, or hand-rolled cigarette, containing phencyclidine.

(B) While using a firearm, is unlawfully under the influence of cocaine base, cocaine, heroin, methamphetamine or phencyclidine.

(4) Any defendant who refuses drug treatment as a condition of probation.

(5) Any defendant who (A) has two separate convictions for nonviolent drug possession offenses, (B) has participated in two separate courses of drug treatment pursuant to subdivision (a), and (C) is found by the court, by clear and convincing evidence, to be unamenable to any and all forms of available drug treatment. Notwithstanding any other provision of law, the trial court shall sentence such defendants to 30 days in jail.

(c) Within seven days of an order imposing probation under subdivision (a), the probation department shall notify the drug treatment provider designated to provide drug treatment under subdivision (a). Within 30 days of receiving that notice, the treatment provider shall prepare a treatment plan and forward it to the probation department. On a quarterly basis after the defendant begins the drug treatment program, the treatment provider shall prepare and forward a progress report to the probation department.

(1) If at any point during the course of drug treatment the treatment provider notifies the probation department that the defendant is unamenable to the drug treatment being provided, but may be amenable to other drug treatments or related programs, the probation department may move the court to modify the terms of probation to ensure that the defendant receives the alternative drug treatment or program.

(2) If at any point during the course of drug treatment the treatment provider notifies the probation department that the defendant is unamenable to the drug treatment provided and all other forms of drug treatment, the probation department may move to revoke probation. At the revocation hearing, unless the defendant proves by a preponderance of the evidence that there is a drug treatment program to which he or she is amenable, the court may revoke probation.

(3) Drug treatment services provided by subdivision (a) as a required condition of probation may not exceed 12 months, provided, however, that additional aftercare services as a condition of probation may be required for up to six months.

(d) Dismissal of charges upon successful completion of drug treatment

(1) At any time after completion of drug treatment, a defendant may petition the sentencing court for dismissal of the charges. If the court finds that the defendant successfully completed drug treatment, and substantially complied with the conditions of probation, the conviction on which the probation was based shall be set aside and the court shall dismiss the indictment or information against the defendant. In addition, the arrest on which the conviction was based shall be deemed never to have occurred. Except as provided in paragraph (2) or (3), the defendant shall thereafter be released from all penalties and disabilities resulting from the offense of which he or she has been convicted.

(2) Dismissal of an indictment or information pursuant to paragraph (1) does not permit a person to own, possess, or have in his or her custody or control any firearm capable of being concealed upon the person or prevent his or her conviction under Section 12021.

(3) Except as provided below, after an indictment or information is dismissed pursuant to paragraph (1), the defendant may indicate in response to any question concerning his or her prior criminal record that he or she was not arrested or convicted for the offense. Except as provided below, a record pertaining to an arrest or conviction resulting in successful completion of a drug treatment program under this section may not, without the defendant's consent, be used in any way that could result in the denial of any employment, benefit, license, or certificate.

Regardless of his or her successful completion of drug treatment, the arrest and conviction on which the probation was based may be recorded by the Department of Justice and disclosed in response to any peace officer application request or any law enforcement inquiry. Dismissal of an information or indictment under this section does not relieve a defendant of the obligation to disclose the arrest and conviction in response to any direct question contained in any questionnaire or application for public office, for a position as a peace officer as defined in Section

830, for licensure by any state or local agency, for contracting with the California State Lottery, or for purposes of serving on a jury.

(e) Violation of probation

(1) If probation is revoked pursuant to the provisions of this subdivision, the defendant may be incarcerated pursuant to otherwise applicable law without regard to the provisions of this section.

(2) Non-drug-related probation violations If a defendant receives probation under subdivision (a), and violates that probation either by being arrested for an offense that is not a nonviolent drug possession offense, or by violating a non-drug-related condition of probation, and the state moves to revoke probation, the court shall conduct a hearing to determine whether probation shall be revoked. The court may modify or revoke probation if the alleged violation is proved. (3) Drug-related probation violations

(A) If a defendant receives probation under subdivision (a), and violates that probation either by being arrested for a nonviolent drug possession offense or by violating a drug-related condition of probation, and the state moves to revoke probation, the court shall conduct a hearing to determine whether probation shall be revoked. The trial court shall revoke probation if the alleged probation violation is proved and the state proves by a preponderance of the evidence that the defendant poses a danger to the safety of others. If the court does not revoke probation, it may intensify or alter the drug treatment plan.

(B) If a defendant receives probation under subdivision (a), and for the second time violates that probation either by being arrested for a nonviolent drug possession offense, or by violating a drug-related condition of probation, and the state moves for a second time to revoke probation, the court shall conduct a hearing to determine whether probation shall be revoked. The trial court shall revoke probation if the alleged probation violation is proved and the state proves by a preponderance of the evidence either that the defendant poses a danger to the safety of others or is unamenable to drug treatment. In determining whether a defendant is unamenable to drug treatment, the court may consider, to the extent relevant, whether the defendant (i) has committed a serious violation of rules at the drug treatment program, (ii) has repeatedly committed violations of program rules that inhibit the defendant's ability to function in the program, or (iii) has continually refused to participate in the program or asked to be removed from the program. If the court does not revoke probation, it may intensify or alter the drug treatment plan.

(C) If a defendant receives probation under subdivision (a), and for the third time violates that probation either by being arrested for a nonviolent drug possession offense, or by violating a drug-related condition of probation, and the state moves for a third time to revoke probation, the court shall conduct a hearing to determine whether probation shall be revoked. If the alleged probation violation is proved, the defendant is not eligible for continued probation under subdivision (a).

(D) If a defendant on probation at the effective date of this act for a nonviolent drug possession offense violates that probation either by being arrested for a nonviolent drug possession offense, or by violating a drug-related condition of probation, and the state moves to revoke probation, the court shall conduct a hearing to determine whether probation shall be revoked. The trial court shall revoke probation if the alleged probation violation is proved and the state proves by a preponderance of the evidence that the defendant poses a danger to the safety of others. If the court does not revoke probation, it may modify probation and impose as an additional condition participation in a drug treatment program.

(E) If a defendant on probation at the effective date of this act for a nonviolent drug possession offense violates that probation a second time either by being arrested for a nonviolent drug possession offense, or by violating a drug-related condition of probation, and the state moves for a second time to revoke probation, the court shall conduct a hearing to determine whether probation shall be revoked. The trial court shall revoke probation if the alleged probation violation is proved and the state proves by a preponderance of the evidence either that the defendant poses a danger to the safety of others or that the defendant is unamenable to drug treatment. If

the court does not revoke probation, it may modify probation and impose as an additional condition participation in a drug treatment program.

(F) If a defendant on probation at the effective date of this act for a nonviolent drug offense violates that probation a third time either by being arrested for a nonviolent drug possession offense, or by violating a drug-related condition of probation, and the state moves for a third time to revoke probation, the court shall conduct a hearing to determine whether probation shall be revoked. If the alleged probation violation is proved, the defendant is not eligible for continued probation under subdivision (a).

SECTION 6. Section 3063.1 is added to the Penal Code, to read:

3063.1. Possession of Controlled Substances; Parole; Exceptions. (a) Notwithstanding any other provision of law, and except as provided in subdivision (b), parole may not be suspended or revoked for commission of a nonviolent drug possession offense or for violating any drug-related condition of parole.

As an additional condition of parole for all such offenses or violations, the Parole Authority shall require participation in and completion of an appropriate drug treatment program. Vocational training, family counseling and literacy training may be imposed as additional parole conditions.

The Parole Authority may require any person on parole who commits a nonviolent drug possession offense or violates any drug-related condition of parole, and who is reasonably able to do so, to contribute to the cost of his or her own placement in a drug treatment program.

(b) Subdivision (a) does not apply to:

(1) Any parolee who has been convicted of one or more serious or violent felonies in violation of subdivision (c) of Section 667.5 or Section 1192.7.

(2) Any parolee who, while on parole, commits one or more nonviolent drug possession offenses and is found to have concurrently committed a misdemeanor not related to the use of drugs or any felony.

(3) Any parolee who refuses drug treatment as a condition of parole.

(c) Within seven days of a finding that the parolee has either committed a nonviolent drug possession offense or violated any drug-related condition of parole, the Parole Authority shall notify the treatment provider designated to provide drug treatment under subdivision (a). Within 30 days thereafter the treatment provider shall prepare a drug treatment plan and forward it to the Parole Authority and to the California Department of Corrections Parole Division agent responsible for supervising the parolee. On a quarterly basis after the parolee begins drug treatment, the treatment provider shall prepare and forward a progress report to these entities and individuals.

(1) If at any point during the course of drug treatment the treatment provider notifies the Parole Authority that the parolee is unamenable to the drug treatment provided, but amenable to other drug treatments or related programs, the Parole Authority may act to modify the terms of parole to ensure that the parolee receives the alternative drug treatment or program.

(2) If at any point during the course of drug treatment the treatment provider notifies the Parole Authority that the parolee is unamenable to the drug treatment provided and all other forms of drug treatment, the Parole Authority may act to revoke parole. At the revocation hearing, parole may be revoked unless the parolee proves by a preponderance of the evidence that there is a drug treatment program to which he or she is amenable.

(3) Drug treatment services provided by subdivision (a) as a required condition of parole may not exceed 12 months, provided, however, that additional aftercare services as a condition of probation may be required for up to six months.

(d) Violation of parole

(1) *If parole is revoked pursuant to the provisions of this subdivision, the defendant may be incarcerated pursuant to otherwise applicable law without regard to the provisions of this section.*

(2) *Non-drug-related parole violations If a parolee receives drug treatment under subdivision (a), and during the course of drug treatment violates parole either by being arrested for an offense other than a nonviolent drug possession offense, or by violating a non-drug-related condition of parole, and the Parole Authority acts to revoke parole, a hearing shall be conducted to determine whether parole shall be revoked. Parole may be modified or revoked if the parole violation is proved.*

(3) *Drug-related parole violations*

(A) *If a parolee receives drug treatment under subdivision (a), and during the course of drug treatment violates parole either by being arrested for a nonviolent drug possession offense, or by violating a drug-related condition of parole, and the Parole Authority acts to revoke parole, a hearing shall be conducted to determine whether parole shall be revoked. Parole shall be revoked if the parole violation is proved and a preponderance of the evidence establishes that the parolee poses a danger to the safety of others. If parole is not revoked, the conditions of parole may be intensified to achieve the goals of drug treatment.*

(B) *If a parolee receives drug treatment under subdivision (a), and during the course of drug treatment for the second time violates that parole either by being arrested for a nonviolent drug possession offense, or by violating a drug-related condition of parole, and the Parole Authority acts for a second time to revoke parole, a hearing shall be conducted to determine whether parole shall be revoked. If the alleged parole violation is proved, the parolee is not eligible for continued parole under any provision of this section and may be reincarcerated.*

(C) *If a parolee already on parole at the effective date of this act violates that parole either by being arrested for a nonviolent drug possession offense, or by violating a drug-related condition of parole, and the Parole Authority acts to revoke parole, a hearing shall be conducted to determine whether parole shall be revoked. Parole shall be revoked if the parole violation is proved and a preponderance of the evidence establishes that the parolee poses a danger to the safety of others. If parole is not revoked, the conditions of parole may be modified to include participation in a drug treatment program as provided in subdivision (a). This paragraph does not apply to any parolee who at the effective date of this act has been convicted of one or more serious or violent felonies in violation of subdivision (c) of Section 667.5 or Section 1192.7.*

(D) *If a parolee already on parole at the effective date of this act violates that parole for the second time either by being arrested for a nonviolent drug possession offense, or by violating a drug-related condition of parole, and the Parole Authority acts for a second time to revoke parole, a hearing shall be conducted to determine whether parole shall be revoked. If the alleged parole violation is proved, the parolee is not eligible for continued parole under any provision of this section and may be reincarcerated.*

SECTION 7. Division 10.8 (commencing with Section 11999.4) is added to the Health and Safety Code, to read:

DIVISION 10.8. SUBSTANCE ABUSE TREATMENT FUNDING

11999.4. Establishment of the Substance Abuse Treatment Trust Fund. *A special fund to be known as the "Substance Abuse Treatment Trust Fund" is created within the State Treasury and is continuously appropriated for carrying out the purposes of this division.*

11999.5. Funding Appropriation. *Upon passage of this act, \$60,000,000 shall be continuously appropriated from the General Fund to the Substance Abuse Treatment Trust Fund for the 2000–01 fiscal year. There is hereby continuously appropriated from the General Fund to the Substance Abuse Treatment Trust Fund an additional \$120,000,000 for the 2001–02 fiscal year, and an additional sum of \$120,000,000 for each such subsequent fiscal year concluding with the 2005–06 fiscal year. These funds shall be transferred to the Substance Abuse Treatment Trust*

Fund on July 1 of each of these specified fiscal years. Funds transferred to the Substance Abuse Treatment Trust Fund are not subject to annual appropriation by the Legislature and may be used without a time limit. Nothing in this section precludes additional appropriations by the Legislature to the Substance Abuse Treatment Trust Fund.

11999.6. Distribution of Monies from Substance Abuse Treatment Trust Fund Monies deposited in the Substance Abuse Treatment Trust Fund shall be distributed annually by the Secretary of the Health and Human Services Agency through the State Department of Alcohol and Drug Programs to counties to cover the costs of placing persons in and providing (a) drug treatment programs under this act, and (b) vocational training, family counseling and literacy training under this act. Additional costs that may be reimbursed from the Substance Abuse Treatment Trust Fund include probation department costs, court monitoring costs and any miscellaneous costs made necessary by the provisions of this act other than drug testing services of any kind. Such monies shall be allocated to counties through a fair and equitable distribution formula that includes, but is not limited to, per capita arrests for controlled substance possession violations and substance abuse treatment caseload, as determined by the department as necessary to carry out the purposes of this act. The department may reserve a portion of the fund to pay for direct contracts with drug treatment service providers in counties or areas in which the director of the department has determined that demand for drug treatment services is not adequately met by existing programs. However, nothing in this section shall be interpreted or construed to allow any entity to use funds from the Substance Abuse Treatment Trust Fund to supplant funds from any existing fund source or mechanism currently used to provide substance abuse treatment.

11999.7. Local Government Authority to Control Location of Drug Treatment Programs. Notwithstanding any other provision of law, no community drug treatment program may receive any funds from the Substance Abuse Treatment Trust Fund unless the program agrees to make its facilities subject to valid local government zoning ordinances and development agreements.

11999.8. Surplus Funds. Any funds remaining in the Substance Abuse Treatment Trust Fund at the end of a fiscal year may be utilized to pay for drug treatment programs to be carried out in the subsequent fiscal year.

11999.9. Annual Evaluation Process. The department shall annually conduct a study to evaluate the effectiveness and financial impact of the programs that are funded pursuant to the requirements of this act. The study shall include, but not be limited to, a study of the implementation process, a review of lower incarceration costs, reductions in crime, reduced prison and jail construction, reduced welfare costs, the adequacy of funds appropriated, and any other impacts or issues the department can identify.

11999.10. Outside Evaluation Process. The department shall allocate up to 0.5 percent of the fund's total monies each year for a long-term study to be conducted by a public university in California aimed at evaluating the effectiveness and financial impact of the programs that are funded pursuant to the requirements of this act.

11999.11. County Reports. Counties shall submit a report annually to the department detailing the numbers and characteristics of clients-participants served as a result of funding provided by this act. The department shall promulgate a form which shall be used by the counties for the reporting of this information, as well as any other information that may be required by the department. The department shall establish a deadline by which the counties shall submit their reports.

11999.12. Audit of Expenditures. The department shall annually audit the expenditures made by any county that is funded, in whole or in part, with funds provided by this act. Counties shall repay to the department any funds that are not spent in accordance with the requirements of this act.

11999.13. Excess Funds. *At the end of each fiscal year, a county may retain unspent funds received from the Substance Abuse Treatment Trust Fund and may spend those funds, if approved by the department, on drug programs that further the purposes of this act.*

SECTION 8. Effective Date. Except as otherwise provided, the provisions of this act shall become effective July 1, 2001, and its provisions shall be applied prospectively.

SECTION 9. Amendment. This act may be amended only by a roll call vote of two thirds of the membership of both houses of the Legislature. All amendments to this act shall be to further the act and shall be consistent with its purposes.

SECTION 10. Severability. If any provision of this act or the application thereof to any person or circumstances is held invalid or unconstitutional, such invalidity or unconstitutionality shall not affect other provisions or applications of this initiative that can be given effect without the invalid or unconstitutional provision or application, and to this end the provisions of this initiative are severable.¹⁷⁰

Appendix E

Proposition 36 Offenders Pipeline Fiscal Year 2003-04

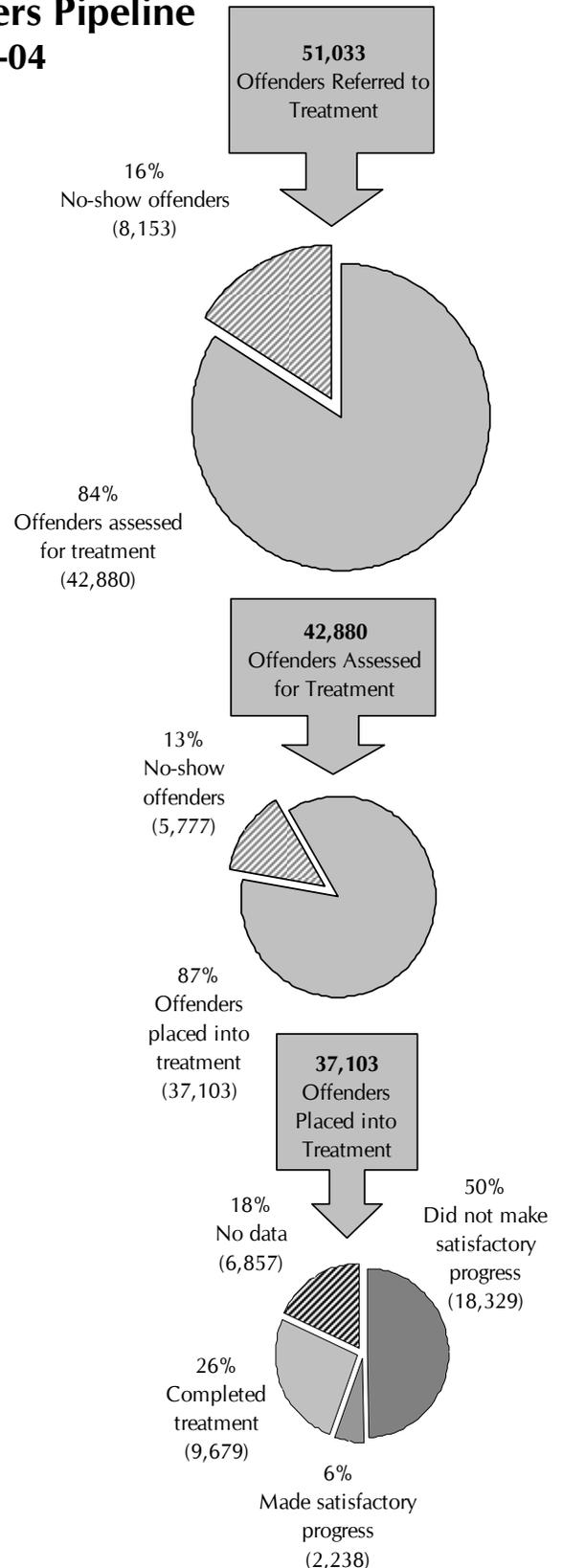
Process Leaks Participants:

- 27% of all 51,033 offenders referred to treatment were “no-shows” and either declined Proposition 36 participation, absconded, died or committed crimes or parole violations that preclude their participation in Proposition 36 treatment.
- Another 13% of all 51,033 offenders referred to treatment were assessed for and placed into treatment, but either transferred to another treatment provider or had no record of discharge (“no data”).

Successful Completion:

- 19% of all 51,033 offenders referred to treatment were assessed for, placed into and successfully completed treatment.
- 26% of all 37,103 offenders placed into treatment successfully completed treatment.
- An additional percentage of offenders who were transferred to another treatment provider or who have no record of discharge (“no data”) may have either successfully completed a treatment program or made satisfactory progress. The extent to which these offenders could increase the total rate of completion is unknown.

Sources: Douglas Longshore, et. al. University of California Los Angeles, Integrated Substance Abuse Programs. July 22, 2005. “Evaluation of the Substance Abuse and Crime Prevention Act 2004 Report.” Pages 8-9. Also, University of California Los Angeles, Integrated Substance Abuse Programs. April 13, 2007. “Evaluation of the Substance Abuse and Crime Prevention Act Final Report.” Page 39. Also, Darren Urada. University of California Los Angeles, Integrated Substance Abuse Programs. Personal communication. December 13, 2007.



Appendix F

Advice to States

Two recent national reports offer advice to state policy-makers on improving substance abuse treatment. The Institute of Medicine released a report in 2006 entitled “Improving the Quality of Health Care for Mental and Substance-Use Conditions” as part of a series of reports on improving health care in the United States.¹⁷¹ Also in 2006, a national policy panel convened by Join Together, a program of the Boston University School of Public Health that provides information, strategic planning assistance and leadership development to advance effective substance abuse policies, released a report, “Blueprint for the States: Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment.”¹⁷²

The Institute of Medicine report offered these recommendations:

- Make coercion policies transparent, use information on comparative quality of providers and evidence-based treatment, and afford consumers choice.
- Revise laws and other policies that obstruct communication between providers.
- Create high level mechanisms to improve collaboration coordination across agencies.
- Use purchasing practices that incentivize use of evidence-based practices and information technology.
- Enact parity for coverage of mental health and substance abuse treatment.
- Reorient state procurement processes toward quality.
- Reorient state purchasing to give more weight to quality and reduce emphasis on grant-based mechanism.

The Join Together national policy panel included these recommendations:

- Governors, legislative leaders and chief judges must provide personal, continuous leadership to prevent and address alcohol and drug problems.
- Incorporate responsibility for statewide strategies to address substance abuse and related problems in an entity at the highest level in state government that reports directly to the governor.
- Identify all resources directed to substance abuse issues and comprehensively plan and coordinate the use of these resources to maximize their overall effectiveness.
- Gather data on prevention and treatment outcomes, publish information on outcomes and provide rewards for improved outcomes and penalties for failure to meet targets.
- Review and update core legislation authorizing prevention, treatment and recovery services to reflect current understanding of addiction.

- Community leaders and people in recovery should work to educate state leaders and provide them with support to sustain effective action on substance abuse issues.

Appendix G

Options for Nonviolent Drug Offender

California judges have options for drug offenders short of jail:

Deferred Entry of Judgment. Deferred Entry of Judgment (DEJ) is available for nonviolent drug offenders accused of use or possession of illegal substances, based on Penal Codes 1000-1000.8. Offenders must plead guilty to their charge and are then required to participate in education and treatment programs determined by the judge. If the participant is performing unsatisfactorily in the assigned program or is convicted of another crime, the participant may lose his/her eligibility for DEJ which could result in a different sentence. Successful completion can lead to a dismissal of charges. According to the Administrative Office of the Courts, approximately 40,000 individuals are eligible for DEJ each year.¹⁷³

Probation. Drug offenders in California can be sentenced to two types of probation, depending on the severity of the charge and their criminal history.

Nonviolent adult drug offenders accused of use, possession or transport of illegal drugs for personal use may qualify for treatment under the Substance Abuse And Crime Prevention Act of 2000, or Proposition 36, which is Penal Codes 1210-1210.1 and 3063.1. Offenders must plead guilty or no contest to their charge. Eligible offenders may receive up to one year of drug treatment and six months of aftercare. Vocational training, family counseling, literacy training, and other services also may be provided. The court may impose a variety of sanctions for non-compliance, but a jail sentence is not an allowable sanction. Upon completion of successful drug treatment, participants may petition the sentencing court for dismissal of charges. Approximately 48,000 individuals participate in Proposition 36 each year.

Drug offenders not eligible for participation in Proposition 36 or another type of drug treatment program may be sentenced, at the court's discretion, to probation rather than directly to jail or prison, under Penal Code 1203. In these cases, the judge may include terms and conditions that the defendant must complete, including drug treatment. Failure to complete probation could result in a jail sentence.¹⁷⁴

Drug Court. Drug courts are a program, not a sentencing statute. The state began encouraging counties to create drug courts through funding allocated by the Comprehensive Drug Court Implementation (CDCI) Act of 1999, which is Health and Safety Codes 11970.1 – 11970.4. Because the CDCI emphasizes treatment for adult felons facing prison sentences, drug courts are most commonly used for felony offenders who have abused alcohol and other drugs for 10 years or more and have received little or no substance abuse treatment. The drug court model also can be applied to a range of nonviolent drug offenders, including adults, juveniles and the parents of children at risk of losing their kids due to substance abuse issues. Some counties use a drug court model for Proposition 36 offenders, and many send offenders who fail Proposition 36 programs to more restrictive and intensive drug courts. Drug courts

typically provide intensive levels of services and supervision for offenders, and sanctions for felony drug courts can include jail time.

There are no state guidelines regarding how drug courts should be run, so there is variation in drug court programs throughout the state. Under the CDCI-funded courts, judges and county alcohol and drug program administrators develop plans for drug courts, and judges have significant leeway in determining program requirements.

Program requirements vary depending on the type of drug court, but many drug courts allow successful participants the chance to expunge the arrest. According to the Department of Alcohol and Drug Programs, 9,451 people participated in CDCI-funded drug courts between January 1, 2001 to June 30, 2004.¹⁷⁵

Appendix H

Nonviolent Offender Rehabilitation Act of 2008

The Nonviolent Offender Rehabilitation Act, or NORA, a ballot measure intended for the November 4, 2008, ballot, would organize programs for drug offenders, partially reorganize the Department of Corrections and Rehabilitation and guarantee that money from the state's General Fund be spent on adolescent and adult drug substance abuse treatment programs.

Sponsored by the Drug Policy Alliance and the Campaign for New Drug Policies, the same organizations that authored Proposition 36, NORA would reform Proposition 36 and targets three populations:

- Youth. NORA would spend \$65 million per year to build drug treatment programs for people under the age of 18. Additional money for youth treatment would come from fines paid for low-level marijuana possession offenses.
- Adult drug offenders. NORA would spend \$385 million per year to develop a unified, multi-track system of treatment-centered programs for adult drug offenders. Track I, similar to Penal Code 1000, would provide treatment to offenders charged with nonviolent drug possession. Those offenders who failed to complete Track I would move to Track II. Track II, a modified version of Proposition 36, would provide post-conviction treatment, with sanctions, for offenders up to 24 months. Failure to complete Track II could result in a jail sentence or transfer into Track III. Track III would expand current drug court programs for adult felons. Additionally, Track III would allow a judge to sanction a nonviolent offender whose crimes were primarily motivated by substance abuse problems with a partial jail sentence before beginning treatment.
- Prisoners and parolees. NORA would add a Secretary of Rehabilitation and Parole to the California Department of Corrections and Rehabilitation to oversee all current and future divisions and programs related to parole, recovery, rehabilitation and re-entry. CDCR would be required to pay for rehabilitation programs for all current and former parolees who could request services for up to one year after discharge. NORA would give an independent oversight panel authority over key aspects of CDCR implementation.

Additionally, NORA would require prisons to provide rehabilitation programs to all existing inmates not less than 90 days before release. Prison inmates, whose crimes were nonviolent and who had no prior strikes or sex offenses that required registration, would be able to earn time off their sentences with good behavior and participation in rehabilitation programs. NORA would limit parole periods for qualifying nonviolent offenders to between six to 12 months, rather than up to three years under current law, with earlier discharge upon completion of a rehabilitation program.¹⁷⁶

Appendix I

Positive Outcomes in Hawaii

Hawaii's Opportunity Probation with Enforcement (HOPE) program, created by Judge Steven S. Alm in Hawaii's First Judicial Circuit, uses frequent drug testing and swiftly-delivered and brief jail sanctions to keep probationers sober and compliant with the terms of their probation. The results are promising and could be implemented in California.

The HOPE formula is simple: At a group hearing, the judge warns probationers that they will face frequent, random drug tests, and failed drug tests or missed appointments will result in jail time. Jail sentences are typically one week but can be as short as a weekend.

The key to the program is the warning hearing, in which offenders are told that the conditions of probation will be strictly enforced, and swift and certain consequences for non-compliance. A failed drug test or admission of drug use can result in immediate arrest.

Offenders who miss appointments with probation or fail to attend substance abuse treatment sessions if they are ordered to attend treatment face a bench warrant, quick arrest, and a court hearing within 48 hours.

The program, launched in October 2004, targeted sex offenders, domestic violence offenders and offenders who, failing regular probation, risked prison time. Most of the offenders are involved with drugs, but have varying degrees of addiction severity. Some are required to attend substance abuse treatment.

Probation and court officials have worked together to reduce paperwork and ensure that those who fail drug tests are brought into court within one or two days. The Federal Fugitive Task Force within the U.S. Marshall's Office and the Honolulu Police Department serves all warrants.

Probationers who failed 49.2 percent of their drug tests before being enrolled in HOPE failed only 5.8 percent of their drug tests after enrollment, according to data compiled by the Hawaii Attorney General's Office and researchers with the University of California Los Angeles Integrated Substance Abuse Programs. Missed appointments dropped to 2.4 percent from 12.9 percent.

HOPE's focus on swift and certain sanctions for offenders who violate conditions of their probation offer a stark contrast to California's criminal justice systems for probationers and parolees, who often receive little punishment, if any, for failing to comply with the terms of their probation or parole. Prop. 36 offenders rarely receive swift consequences for a failed drug test, for example.¹⁷⁷

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