

**CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS**

**MAKING IT WORK! CONFERENCE**

October 10-12, 2007

**COUNTY BREAKOUT SESSION QUESTIONS**

The California Department of Alcohol and Drug Programs (ADP) in conjunction with stakeholders is required under the Offender Treatment Programs (OTP) to report at budget hearings performance based allocations and sources of key data for measurement competitive approaches on other program and service improvements including allocation and funding. Pursuant to the requirements under the Substance Abuse Crime Prevention Act (SACPA), ADP continues to report annually on the effectiveness and financial impact of the act.

(1) The OTP goals are to Improve Outcomes, Programs and Services.

a. In addition to the “show” and “completion” rates, what other data elements is your county using to document that you are meeting these goals?

MBA Counties	Small Counties	Medium Counties	Large Counties
<ul style="list-style-type: none"> <li>- How to get courts to track clients that refuse the program. Data base for C.J. – court must do entry</li> <li>- Tracked by probation/parole – referral tool</li> <li>- DA/ Court do not forward those who refuse treatment</li> <li>- Individuals will “opt-out” for 30 days of serving time vs. Prop 36 program (lack of support from Pub Def. to motivate client for tx)</li> </ul>	<ul style="list-style-type: none"> <li>- Quality of life survey adapted from mental health.</li> <li>- Data elements captured</li> <li>- Violations data tracked</li> <li>- Retention – county has info</li> <li>- Track graduation &amp; jurisdiction</li> <li>- Longitudinal data-post graduation data</li> <li>- Electronic ASI</li> <li>- Graduation, jurisdictional transfers</li> </ul>	<ul style="list-style-type: none"> <li>- CalOMS</li> <li>- Ability for Stake holders/Partners Reporting Systems have the ability to talk to each other.</li> <li>- Standardize definitions</li> <li>- ID Course of treatment</li> <li>- Employment (Sonoma)</li> <li>- Housing</li> <li>- Refusal of Treatment</li> <li>- UCSB – Statistic break down by sex/age/education (Santa Barbara)</li> </ul>	<ul style="list-style-type: none"> <li>- Do assessment same time, compare show rates from prior years to those after co-location (probation and parole), % of clients placed in treatment at the assessed level, program retention rates on monthly basis. For D.C.'s, recidivism rate after 2 years completion. (Orange)</li> </ul>

b. What is the most effective way your County presently collects this data or plans to collect it in the future from all stakeholders, in order that it may be presented to the Legislature in a timely and effective manner by March of 2008?

MBA Counties	Small Counties	Medium Counties	Large Counties
<ul style="list-style-type: none"> <li>- Smart System (San Joaquin)</li> <li>- Swits – New data, web page information data system, also handles CalOMS, billing. (Sonoma)</li> <li>- CalOMS – Quarterly basis, ASI (Santa Barbara)</li> </ul>	<ul style="list-style-type: none"> <li>-at assessment</li> <li>- have staff meet w/ clients to collect by hand</li> <li>- computerized data</li> <li>- provider level</li> <li>- electronic medical record</li> <li>- # of admissions</li> <li>- progress notes, assessment and treatment records tracked electronically</li> </ul>		<ul style="list-style-type: none"> <li>- Use Daisy system and RANT (San Mateo)</li> <li>- LAPARS, internal system (Los Angeles)</li> <li>- shared system between departments (Orange)</li> </ul>

c. Are you confident that the data provided by each of your stakeholders is valid, timely and consistent? If not, what steps do you intend to take to reach this goal?

MBA Counties	Small Counties	Medium Counties	Large Counties
<ul style="list-style-type: none"> <li>- No, we are not confident in data collection –</li> <li>- Criminal Justice Reporting System needs to be incorporated throughout as a way to track “refusals”</li> <li>- Insufficient minimum funding to even meet legislative mandates</li> <li>- Probation reports do not match treatment numbers submitted in CALOMS</li> <li>- All clients should be placed on “formal” probation in an attempt to <u>track</u> all referrals. Utilize Birthdates as a “unique” identifier</li> </ul>	<ul style="list-style-type: none"> <li>- Collecting info regarding parole referrals</li> <li>- Concerns around the refusal rate (when client say’s “I change my mind”)</li> <li>- In CalOMS there is no box that states the client had “no prior drug history”</li> <li>- Validity of Data</li> <li>- Lack of coordination between data services</li> <li>- Counties can not count refusals</li> <li>- Difficult to spend down OTP money when it is so late in the FY when they find out what their allocations will be.</li> </ul>	<ul style="list-style-type: none"> <li>- They want to see contracts done in a timely manner by providers. (San Joaquin)</li> <li>- Training treatment providers (Solano)</li> </ul>	<ul style="list-style-type: none"> <li>- Yes with internal shared data base. No with out of county placements. 50/50 sure/unsure about their data system. Need county training. Want common definition of completed treatment from ADP recommended by UCLA. (Orange)</li> </ul>

	<ul style="list-style-type: none"> <li>- Accountability</li> <li>- Cross-training PO in orientation</li> <li>- Quick return dates &amp; progress reports in the court</li> <li>- Open communication on no shows</li> <li>- Reminder telephone calls the day before appt</li> <li>- Ongoing readiness group – mandatory 3x wk meeting – extended evaluation random testing is utilized dirty test while in readiness group will result in immediate short-term residential-detox.</li> </ul>		
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(2) There are obvious gaps in services that lead to waiting lists in many counties. With a mandate to improve outcomes, what contributes to the counties' inability to spend all funding within the prescribed timeframes resulting in funding being returned to the State or request for rollover? What can be done to ensure that all funding is spent within the fiscal year

MBA Counties	Small Counties	Medium Counties	Large Counties
<ul style="list-style-type: none"> <li>- Increase Residential beds</li> <li>- Use OTP funds first</li> <li>- Start up Cost-New Projects</li> <li>- Lack of multi year stable funding</li> <li>- Increase treatment slots</li> <li>- Eliminate waiting list</li> <li>- Afraid to staff up when funding may not be there next year.</li> <li>- OTP and design to be up certain places but they were stuck depending on third party delays. (Building permits) Santa Barbara</li> <li>- They advised providers to hold a bunch of beds so they bought</li> </ul>	<ul style="list-style-type: none"> <li>Issue to spend funds</li> <li>- Difficult to spend money when it is so late in the FY when they find out what their allocations will be.</li> <li>- Trying to hire staff when it was budgeted in the application</li> <li>- There is a lag time</li> <li>- With OTP the rules changed. Initially the funding was for 2 years, and then the rules changed again to reduce funding. It takes time to start up a new program. Some counties did not have a prior drug court model.</li> <li>- Have multiple year funding instead of one year</li> </ul>	<ul style="list-style-type: none"> <li>- Need more referrals from DA</li> <li>- DA is an obstacle because they don't believe in Prop 36</li> <li>- Prefer drug court because of sanctions</li> </ul>	<ul style="list-style-type: none"> <li>- Problems – late notice of OTP funding and late budget news = lack of time to spend money. Extended deadlines would be helpful. Difficulty filling CJ positions timely. Local approved and Board of Supervisors approval time.</li> <li>- Funding three months after FY, then BOS procedure, then no time to spend. Treatment providers (outside providers) don't spend. Courts need to collaborate more with funding sources. Local approved process 8-10 weeks after budget signed plus developing contracts. Deal with at State level with bureaucratic level.</li> </ul>

<p>residential beds. Tulare</p> <ul style="list-style-type: none"> <li>- Providers were not telling them about no shows for treatment. They requested providers to give information so they could track slots. Sonoma</li> </ul>	<ul style="list-style-type: none"> <li>- Issue for counties is that the small counties are unable to spend the funds quickly.</li> </ul>		<ul style="list-style-type: none"> <li>- Solutions – monitor providers on monthly basis. Work with State regarding any monetary approval. Work with BOS on Amendments or shifting line items, shift dollars to where needed. Spend Prop 36 first. More flexible residential treatment, extending days for people who work.</li> <li>- Master agreement fee for service. Can't overspend so they don't end up with extra funds. As much designated authority from Board as possible. Board authority to amend contracts. More flexible in contracts with length of stay. Move between providers. (Orange)</li> </ul>
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(3) Under the existing law, how do you hold defendants accountable to enter participate in and complete treatment? What specific actions have you taken to improve show rates, ongoing participation rates and completion rates?

MBA Counties	Small Counties	Medium Counties	Large Counties
<ul style="list-style-type: none"> <li>- Intake/Assessment is setup within close proximity to the courts to facilitate probationer ability to "report" after sentencing</li> <li>- Evening "tracks" are available for probationers who work during the day.</li> <li>- Intensive six month program</li> <li>- Participate in group &amp; orientations while waiting to be placed.</li> <li>- Utilize Counselor to call and follow up with "no-show" &amp; consistent communication/collaboration between entities has improved outcomes.</li> </ul>	<ul style="list-style-type: none"> <li>- Cross training DPO's so whatever staff will be available to any walk ins</li> <li>- Cross training PO in orientation</li> <li>- Quick return dates and progress reports in the court</li> <li>- Open communication on no shows</li> <li>- Quick turnaround dates</li> <li>- Let DPO's know who is showing up, when they need to</li> <li>- Communication with clients</li> <li>- As soon as sentenced enrolled into readiness group</li> <li>- Reminder telephone calls the day</li> </ul>	<ul style="list-style-type: none"> <li>- Interim Groups to hold accountable</li> <li>- Increased Reviews – Progress</li> <li>- More bilingual providers</li> <li>- Assessment appointments made in Court</li> <li>- Drug Testing</li> <li>- Assessment in court and in custody- make appointment for treatment</li> <li>- Transportation needed</li> <li>- Standardized intake counselors</li> <li>- To improve show rates they implemented an interim group at least once a week and then stay in that group until a slot opens up. (Humboldt)</li> </ul>	<ul style="list-style-type: none"> <li>- Co-location of services (assessment and the courts).</li> <li>- Assessment teams at probation and parole.</li> <li>- Immediate contact with treatment.</li> <li>- Frequent reviews in court.</li> <li>- Increase/decrease drug testing.</li> <li>- Incentives for wait list participants/clients.</li> <li>- Resources and referral follow through with court.</li> <li>- Participation = Supervision.</li> <li>- Pretreatment process before intake.</li> </ul>

	<p>before app.</p> <ul style="list-style-type: none"> <li>- Ongoing readiness group-mandatory</li> <li>- Three week treatment meetings-extended evaluation</li> <li>- Dirty test white in readiness group will result in immediate short term residential detox</li> </ul>	<ul style="list-style-type: none"> <li>- Doing same (interim groups), Marin County Probation attends orientation groups. (Marin)</li> <li>- Designated phone line and Prop 36 information flyer. They noticed a big improvement since the implementation of system. They also offer rides to and from location. (Santa Barbara)</li> <li>- Probation officer outreach. Welcoming environment-bring their kids; it's not the typical court environment. (San Luis Obispo)</li> <li>- Providers are required to contact probation and Prop 36 if no show. Personal engagement for fear reduction- JUST SHOW UP! (San Joaquin)</li> <li>- Providers offer transportation to and from location instead of probation officers. (Monterey)</li> <li>- Medication in custody.</li> </ul>	<ul style="list-style-type: none"> <li>- eight week intake model before assessment to save money on participants who actually make it.</li> <li>- Reduce time from assessment to treatment.</li> <li>- Counselors at court, bus passes, and other incentives haven't helped.</li> <li>- Co-located assessment with probation and parole. If increase show rate, can't afford to treat them. Upgrade or downgrade supervision based on engagement, same with drug testing. Probation waiting list for treatment team – Check in more frequently (Orange)</li> <li>- Eight week program/orientation before treatment. (Riverside)</li> </ul>
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(4) What is the most effective change or innovation that you have made in the six years that SACPA has been in existence to improve outcomes, programs and services? How have you measured that change or innovation to demonstrate its effectiveness?

MBA Counties	Small Counties	Medium Counties	Large Counties
<ul style="list-style-type: none"> <li>- Have established a three phase program (up to 12 months)</li> <li>- Dedicated "treatment" calendar has enhanced completion rates and retention.</li> <li>- Intensive outpatient program</li> <li>- Consistent &amp; routine monitoring of treatment plan goals</li> <li>- Increase communication with the courts on the need for adjustments</li> </ul>	<ul style="list-style-type: none"> <li>- Drug court model for Prop 36</li> <li>- increased drug testing – instant</li> <li>- increased residential treatment times</li> <li>- changed the way in patient is managed</li> <li>- parolees go through same process as all in P36</li> <li>- communication with parole agents</li> <li>- full time counselor in jail</li> </ul>	<ul style="list-style-type: none"> <li>- Mental Health as a SACPA Provider, Monthly private reports</li> <li>- Immediate Reporting on testing and attendance</li> <li>- Pre treatment Groups (if there's a waiting list)</li> <li>- Income show rate</li> <li>- Increased reviews. Providers not only give them monthly reviews but also</li> </ul>	<ul style="list-style-type: none"> <li>- Co-occurring court for Prop 36 shelter for homeless MH/AOD SLE with outpatient = lower jail population.</li> <li>- Co-locate assessment, probation, parole, and health care.</li> <li>- Health care worker in court to screen for treatment and give referrals immediately (Orange).</li> <li>- Flexible residential 30, 60, 90.</li> </ul>

<p>to probationer's court order</p> <ul style="list-style-type: none"> <li>- Assessments to effectively place in 3-phase system-more structured treatment</li> </ul>	<ul style="list-style-type: none"> <li>- social day to celebrate recovery</li> <li>- all providers, faith based, AD,ND participate</li> <li>- developed a resource day for clients</li> <li>- vocational training</li> <li>- schools</li> <li>- maps</li> <li>- programs</li> <li>- one stop shop for clients at treatment</li> </ul> <p><b>Effective Innovations</b></p> <ul style="list-style-type: none"> <li>- Went to Drug Court Model</li> <li>- Instant drug testing results</li> <li>- Utilize Short term residential (90 days or 30 days &amp; 15 additional if needed)</li> <li>- Bring Parolee's into court so that they go through the same process as other participants</li> <li>- Dirty tests 1<sup>st</sup> on Court days-taken away in hand-cuffs=then those that are doing well receive kudos and are dismissed, the all others heard one at a time.</li> <li>- Recovery celebration held annually in the community</li> <li>- Full time counselor in jail</li> <li>- Developed resource day for clients-vocational training-schools fair-job fair</li> <li>- Interim education for folks on wait list-meet weekly</li> <li>- Integrated Services</li> </ul>	<p>weekly reports. Monterey</p> <ul style="list-style-type: none"> <li>- Daily reports (drug tests) via email by providers.</li> </ul>	<ul style="list-style-type: none"> <li>- Pro compliance checks at treatment.</li> <li>- Monthly meeting with each Probation Officer and treatment providers; split regionally (San Bernardino).</li> <li>- Liaison program with Probation Officer and providers (Fresno).</li> <li>- Mental health courts, but Prop 36 can attend.</li> <li>- Homeless court, Co-occurring disorder court and women's recovery court.</li> <li>- Measure the changes –</li> <li>- - Co-location (anecdotal) no shows have fallen; beginning to measure with data (Orange).</li> <li>- Moved assessment to court, went from 50% no show to 90-100% show rate (Ventura).</li> </ul>
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	<ul style="list-style-type: none"> <li>- Instead look at clients and see different programs for them</li> <li>- Went to BOS and got shortfall funding</li> <li>- Seek out other funds to assist w/paying for treatment</li> </ul>		
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(5) With decreased funding and increased expectations by policy makers for improved outcomes, programs and services, have you found it necessary to reduce or cut some aspects of your program, and if so, how did you determine where to cut?

MBA Counties	Small Counties	Medium Counties	Large Counties
<ul style="list-style-type: none"> <li>- Residential bed days should be standardized.</li> <li>- Have cut residential – unable to buy beds @ costs – can't compete with surrounding counties unable to use dedicated bed space. Brought up that surrounding counties can not charge variable rates and for county to check on. Cutting residential- not staff- staff already limited</li> </ul>	<p>Reductions</p> <ul style="list-style-type: none"> <li>- Staff cuts</li> <li>- Use of intern Programs</li> <li>- Cut residential</li> <li>- Cut counselors</li> <li>- Fee for service Probation Officers</li> <li>- Shortfall funding from BOS</li> <li>- Cut internal staff to keep from cutting Treatment contracts</li> <li>- Simplified entry forms</li> <li>- Increased Efficiencies</li> <li>- Decreased Funding, Increased Expectations</li> <li>- Use of alumni's to act as role models</li> <li>- Cut in counseling staff to add another paid Parole Officer</li> <li>- Simplify internal documents/forms</li> <li>- Increased Stakeholder Collaborations</li> <li>- Use of database systems between</li> </ul>	<ul style="list-style-type: none"> <li>- Yes, necessary to cut</li> <li>- Decrease residential most expensive</li> <li>- Broke down to hard core residential per person on 1<sup>st</sup> come 1<sup>st</sup> serve or this the group for more participants but less effective</li> <li>- Increase client fees</li> <li>- Decrease in Programs 1) Staff; 2) Treatment slots; 3) Time in treatment</li> <li>- Cut in all stakeholders across boards</li> <li>- Cut admin cost</li> <li>- Cutting SACPA Staff</li> <li>- Probation services cut</li> <li>- Cut frequency of testing</li> <li>- 25/28% goes to the court for probation they based on those #s to do the cuts. (Based on % allocations)</li> <li>- Probation versus treatment.</li> <li>- San Joaquin reduced the intensity of progress, Increased JLE/decreased on residential</li> </ul>	<ul style="list-style-type: none"> <li>- Cut residential (most expensive), decision made with collaborative.</li> <li>- Increase client fees.</li> <li>- Decrease bed days and length of treatment given.</li> <li>- Decrease court appearances and reviews.</li> <li>- Tailor court appearances with client.</li> <li>- Issues/problems.</li> <li>- Debated to give a few what they needed or give some treatment to everyone.</li> <li>- Bring 3 options of cuts to full board for decision.</li> <li>- Hotel space for clients waiting (San Francisco).</li> <li>- Raise client accountability.</li> <li>- Reduction in housing.</li> <li>- Took percentage cut across the board (Orange).</li> <li>- 30% cut across the board (Ventura).</li> <li>- 80% treatment, 20% other cost model</li> </ul>

	<p>the county and the Parole Officer (SMART Card, SMART System) (SMART Central Database System)</p>		<p>for LA stay close to that model – put maximum time frames for each treatment level (Los Angeles).</p> <ul style="list-style-type: none"> <li>- 5% treatment, 25% other (Alameda) did not cut treatment. Lost 4 Probation Officers – now only have 3 Probation Officers.</li> <li>- May only fund treatment providers with highest retention rate.</li> <li>- Less Probation Officers (Contra Costa) only at felony court misdemeanors done by AOD's. 9 to 4 Probation Officers with PO's a huge negative impact – less compliance with clients. First come first serve until money is gone.</li> <li>- Cut providers with low retention rates.</li> </ul>
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(6) What is the greatest challenge you face in reaching the goals of the OTP (e.g. creating dedicated calendars, difficulty in moving failing SACPA offenders into drug court, inability to site residential treatment, reluctance to place offenders in Narcotic Replacement Therapy, and inability to effectively utilize drug test results, etc.). What are you doing to resolve these challenges?

MBA Counties	Small Counties	Medium Counties	Large Counties
<ul style="list-style-type: none"> <li>- Ask state to change allocation methodology to provide great preparation of allocation.</li> <li>- Need clarity of definitions –i.e. completion- is it after minimum treatment, 3 mos. or 18 mos. standardize.</li> <li>- Not confident on SRIS, CalOMS data, due to varying interpretations of categories- referral, assessment, completion of treatment. Also, MBA's mostly "hand-count" numbers we do not have resources, equipment to automate.</li> <li>- Date requirements are overwhelming such that MBA can't observe clients– should be vice-versa.</li> <li>- Need very few, very defined date elements</li> <li>- Cut residential first, keep staff to survive. Tail is wagging the dog. Legislature is looking at absolutes. Can't measure success as an absolver. You have to look at incremental successes.</li> <li>- Judge needs to be convinced to: Implement Drug Courts, not require probation officers in court, free up to spend more time with clients in</li> </ul>	<ul style="list-style-type: none"> <li>- How do the providers settle their cost settlements by November 30, 2007?</li> <li>- Need more county General funding increase</li> <li>- Loss of Probation Officer due to decreased funding still expected to do more supervision and also do drug court model</li> <li>- Lack of internal personnel case load resources</li> <li>- Lack of internal personnel to handle waiting list and other internal everyday activities-not enough time and resources to conduct field work</li> <li>- Lack of data management and data collection processes: among the court, parolee and the providers</li> <li>- Consistent data elements among the different agencies to reflect accurate reporting.</li> <li>- Workforce issue of non qualified staff; lack of core competency skills</li> <li>- Current counselors are aging out thru retirements</li> <li>- Lack of competent staff because of low pay in rural counties-CDCR pays more money than small counties</li> <li>- More funding for Narcotic Treatment</li> </ul>	<ul style="list-style-type: none"> <li>- Increased caseloads</li> <li>- Lack of support from presiding judge</li> <li>- Judges not consistent or willing to move clients from 36 to Drug Court</li> <li>- 3<sup>rd</sup> violation- Drug Court intensive 12/10 program</li> <li>- Treatment providers don't want to use drug test as treatment tool.</li> <li>- Santa Barbara: Need for residential</li> <li>- Drug Court</li> <li>- Post-Plea Drug Court</li> <li>- Drug Court preview/observation</li> <li>- Provide counseling on site</li> <li>- ADP needs to find a monetary way to get new/additional Judges to come.</li> <li>- Residential treatment needed transportation/childcare outreach to target community leaders.</li> </ul>	<ul style="list-style-type: none"> <li>- Increased caseloads.</li> <li>- Lack of support from presiding judge.</li> <li>- No drug court.</li> <li>- Unwilling to move Prop 36 clients to DC's (Judges).</li> <li>- Drug treatment providers won't use drug test results.</li> <li>- Huge challenge to move clients from Prop 36 to DC, difficult with so many judges handling the cases. If a client fails Prop 36, the judge does not want to move them to Drug Court. Not working. All DC clients are Prop 36 failures (Orange).</li> <li>- Little to no DC clients are prop 36 failures (San Francisco).</li> <li>- 80% of all DC clients are P36 failures (Fresno).</li> <li>- Need to have collaborative see the CJ continuum of care. DC has heavier clients than P36 (San Francisco).</li> <li>- Public Defender does not want to move clients from P36 to DC. Some providers don't want to use drug testing results (Santa Clara).</li> <li>- NRT abstinence vs. using drugs. 6month methadone detox (Contra Costa).</li> </ul>

<p>the field, place everybody on formal probation to allow tracking</p>	<p>Programs;</p> <ul style="list-style-type: none"> <li>- Administrative Challenges with Private Physicians who uses a Medical Practice not reporting to-CalOMS (Narcotics)</li> <li>- Benefiting from the NTP</li> <li>- County is unprepared to give data by March 2008</li> <li>- Court system is still working DOS systems</li> <li>- Difference in the way treatment and criminal justice count clients</li> <li>- Not enough residential beds</li> <li>- Workforce issue-not enough skilled workers</li> <li>- County has 4 prisons in county and are unable to keep sheriffs because they cannot pay them enough</li> <li>- No provider for narcotic replacement therapy</li> <li>- Not enough funding for suboxone</li> <li>- Administrative challenges when it comes to NRT</li> <li>- Transportation-inadequate Public Regional Transit. Currently ask rides from folks attending NA</li> <li>- Nov. 30<sup>th</sup> deadline</li> <li>- County Match</li> <li>- Cut in P.O. case load of 200, 350</li> <li>- Data Management-using hand counts data systems can't interact DA, court probation, Behavioral Health</li> </ul>		<ul style="list-style-type: none"> <li>- Reluctance of tax providers to use drug testing. Maintain "1210" program. Mandatory drug testing imposed on providers. Segregated NRT programs.</li> </ul>
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	<ul style="list-style-type: none"><li>- Not enough beds</li><li>- Workforce-not skilled counselors &amp; other treatment workers</li><li>- Losing workforce to CDCR</li><li>- Access to NRT- no providers in counties</li><li>- Funding for suboxone</li><li>- Lack of transportation for clients- asking other staff to e transportation to those in recovery to get to their programs</li></ul>		
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