

California Department of Alcohol and Drug Programs



Proposition 36

“Making It Work!” 2002

a statewide technical assistance conference



THE CALIFORNIA ENDOWMENT

Sponsored by:
The California Department of
Alcohol and Drug Programs
and
The University of California, San Diego
Department of Psychiatry
Addiction Training Center

Funded by The California Endowment

Hilton San Diego Resort
March 25-27, 2002

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

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Re: "Proposition 36 – Making It Work 2002"

Dear Participant:

The attached proceedings of the "Proposition 36 -- Making It Work 2002" conference are sent to assist you in your ongoing efforts toward successful implementation of this pioneering initiative.

This second annual "Making It Work" conference brought together judges, district attorneys, public defenders, parole agents, probation officers, treatment providers, county alcohol and drug program administrators, state agency officials, and others to highlight our collective successes and provide opportunities to discuss strategies for improvement. The proceedings in large part reflect the successful collaborations among counties and state agencies and the innovative approaches and creative solutions they are developing.

The Department of Alcohol and Drug Programs (ADP) and other agencies are designing technical assistance efforts that reflect challenges and opportunities identified at this conference. An example is the creation of mechanisms for getting new clients through assessments and into treatment. There are many notable successes on which to build in our ongoing implementation effort.

We would again like to thank The California Endowment for their sponsorship of this conference and especially for their commitment to work with the Department to improve public health by reducing drug abuse in our communities.

Handwritten signature of Kathryn P. Jett in black ink.

Kathryn P. Jett
Director
Department of Alcohol
And Drug Programs

Handwritten signature of David A. Deitch in black ink.

David A. Deitch, Ph.D.
Clinical Professor of Psychiatry
Director, Addiction Training Center
University of California, San Diego



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Proposition 36 – “Making It Work!”

A statewide technical assistance conference

San Diego, March 25-27, 2002

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Proposition 36 - Making It Work! 2002

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Proceedings

Proposition 36 — Making It Work! 2002 A statewide technical assistance conference San Diego, March 25-27, 2002

Executive Summary

The conference brought together judges, district attorneys, public defenders, parole agents, probation officers, treatment providers, county alcohol and drug program administrators and officials of state agencies to review their experience in implementing the Substance Abuse and Crime Prevention Act of 2000 (SACPA) and discuss issues yet to be resolved. Kathryn Jett, Director of the California Department of Alcohol and Drug Programs (ADP), in introductory remarks, described the attendees as “pioneers” in an endeavor attracting national attention and warned against a “rush to judgment” about its success. **Robert Ross, M.D.**, President and Chief Executive Officer of the California Endowment, one of the sponsors of the conference, said that, as those at the conference demonstrate their ability to work together in this endeavor, “The resources will begin to flow.”

Members of a panel led by **Judge Stephen Manley** of the Santa Clara County Superior Court described innovative approaches to procedural problems in implementing SACPA. Humboldt County has developed a method of “dual assessment” bringing probation officers and treatment counselors together to determine treatment options for SACPA clients. Riverside County is conducting assessments in courtrooms to expedite the process. An “Interagency

Consultation Committee” in Imperial County meets weekly to evaluate cases. Sacramento County has established “benchmarks of success” in analyzing data on SACPA cases from multiple sources. Orange County overcame initial problems with client compliance by setting up a centralized clinical assessment program to speed up entry into treatment.

Videotaped enactments of problems with SACPA cases in courtrooms formed the basis for a panel presentation. Judicial, public defender and district attorney panelists commented on how conflicts among participants in hearings could be resolved through collaboration by the principal players. Judge Manley noted that “...the adversarial system in which attorneys, probation and the judge play their traditional roles does not work with substance abusing clients.”

In the first of three lectures on assessment and treatment issues, **A. Thomas McLellan, Ph.D.**, Director of the Treatment Research Institute at the University of Pennsylvania, compared addiction with other “chronic conditions” such as hypertension, diabetes and asthma. He pointed out that many patients with the latter conditions fail to make lifestyle changes that would address their problem, just as many addicts fail at first to “follow doctor’s orders” in their recovery. He described various components of treatment, as well as strategies for monitoring and coordinating substance abuse treatment with health care and social systems to improve outcomes.

Marc Schuckit, M.D., Director of the Alcohol Research Center of the Veterans Affairs San Diego Health Care System, explored the issue of dual diagnosis. He discussed how to distinguish between symptoms of mental disorder that are associated with alcohol or other drug use and those which are an underlying problem predating substance abuse in the patient’s life. He reviewed case histories to show how treatment for a psychiatric disorder can be separated from treatment for a substance abuse disorder once it is determined that they are two separate problems.

In the third presentation, **Henry Richards, Ph.D.**, of the University of Washington Institute for Mental Illness and Training, dealt with risk assessment. He explained the difference between actuarial risk assessment, based on sex, age or other characteristics, and an assessment based on a structured clinical assessment of an individual. “The new thinking is that actuarial prediction along with structured clinical assessment may be better than either one by itself,” he said. He discussed various theories that can be applied to background information about an individual to arrive at an estimate of risk.

Representatives of the California Department of Corrections (CDC) Parole and Community Services Division, the California Board of Prison Terms (BPT), and ADP made up a panel looking at emerging directions in state policy with regard to the implementation of SACPA. Areas addressed included the auditing of county programs, reporting by counties to ADP, and the interface between parole agents and members of local teams handling SACPA cases. A Parolee Subcommittee of the SACPA Statewide Advisory Group has been looking at issues such as the scope of information about parolees provided to assessment centers, dual supervision of persons subject both to probation and parole, and the cross-training of SACPA teams.

Brokering and procuring ancillary services was the subject of another panel presentation. Sacramento County provided examples of how screening tools can be used to identify ancillary services needed by clients, including a dual diagnosis screen that may point to a need for mental health services. San Joaquin County has taken advantage of federal housing grants to help provide living quarters for otherwise homeless addicts. San Mateo County has created “family self-sufficiency teams” and one-stop service centers to expedite various services. It was noted that SACPA clients might be eligible for services under other programs such as CalWORKs.

Speakers emphasized that adequate ancillary services may make the difference between success and failure in drug treatment.

Attendees at the conference were divided into seven groups based on the size and geographic location of their counties and engaged in an exchange of ideas and conducted problem-solving. Each group delivered a report to the general session, bringing many issues which counties have in common to the surface. Among them were cross-jurisdictional questions involving clients living in one county being subject to the courts of another county; problems associated with creating and locating new residential treatment facilities; the provision of mental health services to dual diagnosis clients; the need for more communication among stakeholders; and the general problem of financing the array of needs arising under SACPA.

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DAY ONE

Welcome and Introductions

Kathryn P. Jett, Director of the California Department of Alcohol and Drug Programs (ADP), and **David A. Deitch, Ph.D.**, Director of the Addiction Training Center at the University of California, San Diego opened the conference with introduction of special guests.

The first speaker, **Sheriff Bill Kolender** of San Diego County, said his years in law enforcement and as Director of the California Youth Authority had made him familiar with the challenges implementation of SACPA presents. He praised the degree of collaboration evident in San Diego County among the district attorney's office, the probation department, and the sheriff's department, stating that even before SACPA, there was also a good relationship with the county's drug courts. Sheriff Kolender stated that drug abuse is perhaps the biggest problem in San Diego County, and he believed the demonstrated philosophy of cooperation would result in many drug users getting into treatment through SACPA.

Hector Sanchez, Western States Team Leader for the federal Center for Substance Abuse Treatment (CSAT), told the group there are potential funding sources in the federal government that can help with implementation of SACPA. He said that ADP would be receiving more than \$250 million in ongoing federal block grant funds this year. The money will be distributed to all of California's 58 counties to support alcohol and drug treatment and prevention. CSAT also funds the Addiction Technology Transfer Centers (ATTC). The proposed CSAT budget for Federal Fiscal Year (FFY) 2003 includes \$175 million allocated to

reducing waiting lists and creating new drug treatment slots in communities. He called attention to the many publications from CSAT that include tips on grant writing and ways to improve treatment methodologies. He invited those in the audience to visit the CSAT home page at www.samhsa.gov.

Robert K. Ross, M.D., President and Chief Executive Officer of The California Endowment, said the support of this conference by the Endowment was based on the view that making SACPA work is both a public health issue and a prevention issue. He recalled a line from the movie “Apollo 13” when a National Aeronautics Space Administration (NASA) official told his mission control crew that “failure is not an option” as efforts were being made to deal with a crisis threatening the lives of Apollo astronauts. The same could be said about SACPA, he said. He reviewed the reasons why some people fear that SACPA will not work:

- The proposition was written in a way that a lot of us did not agree with.
- There was not enough money provided for treatment services.
- The various entities responsible for implementation cannot work together: There is no way to get judges, law enforcement, the doctors, the social workers, and the treatment providers at one table at one time to figure out to how to make SACPA work.

Just as with Apollo 13, Dr. Ross said, the SACPA endeavor cannot be allowed to fail. “If this initiative is viewed by the public in California and nationally by policymakers as not having worked, it will be a devastating blow for drug treatment services. That will happen not just in the California but nationally, because the taxpayers will have concluded that ‘we gave you people a chance to figure out a way to make this work and you did not make it work’.” He acknowledged concerns about the adequacy of resources for implementing SACPA, but said that, as those at this conference demonstrate their ability to work together, more resources would begin to flow.

“Your success will have a pivotal, telling impact on reforming not just drug treatment services but our criminal justice system, so I no longer have to read a statistic telling me that an African-American young male has a better chance of spending time in the criminal justice system than in a four-year college. That is unacceptable in America and all of you know that.”

The next speaker, **William Vickery**, Director of the Judicial Council of the California Administrative Office of the Courts, praised all those in the executive, legislative and judicial branches of state government who were cooperating in the SACPA effort. He said the judicial branch is building on the successes of California’s drug courts, which have set an example of how different agencies can work together on complex and difficult issues. There are 158 drug courts in 50 counties. About 13,000 individuals have gone through the drug courts, and drug use and incarceration rates are down. “SACPA provides another challenge and another opportunity for us to work on this extraordinarily difficult problem in our society and build on the success of the drug court model. We have had a transition that has been more effective than anyone would have guessed a year ago, and that is a result of the collaboration, partnership and dedication of everybody working in this area.” He said working with drug offenders was a “labor intensive activity” and there was a need to ensure stabilized funding as the effort moves ahead. “We are going to have to assure that funding remains a priority in bad times as well as in good times.”

He said SACPA poses a number of questions:

- Do we simply replicate the drug court programs?
- What kind of staffing within the judicial branch is needed?
- How do we ensure that the unique characteristics that have made this effort so successful to date can be preserved as we move ahead?
- How can we more effectively integrate all of the concepts to ensure that we have a continuum of treatment and care within our criminal justice system for all offenders?

- How can we integrate this with all of the other problem-solving or collaborative justice approaches, such as the dependency courts, mental health courts, teen courts, domestic violence courts, and so forth?

SACPA Update

ADP Director Jett continued the opening session by recalling that many participants in this conference had also attended a statewide technical assistance conference in May 2001 when the deadline for implementing SACPA was approaching. “SACPA was a pioneering effort, the first of its kind in the nation, and all of us in this room are in fact pioneers,” she noted. Individuals are entering treatment in all 58 counties. Counties are talking and collaborating on problem solving. Since July 1, 2001, it has been demonstrated that this pioneering approach can be made to work.

She said ADP and other state agencies would be designing technical assistance approaches that reflect the challenges emerging from this conference and the experience of the counties in the past year. A variety of mechanisms for getting new clients through assessments and into treatment have been put in place. She invited like-size counties to compare their different approaches during this conference and to learn from each other. She pointed out that the trust funds set up for counties for implementing SACPA are interest-bearing accounts. “A lot of held the money in reserve so they will have funds for treatment three, four or five years down the line. So our counties are being somewhat fiscally conservative with those funds,” she said. She also pointed out that \$600,000 had been set aside annually for evaluation of the SACPA effort. ADP has contracted with the University of California, Los Angeles to carry out a five-year evaluation.

Jett described the SACPA Statewide Advisory Group as “a dedicated group of professionals” who have helped problem-solve from the outset. “This group did a very, very

diligent and difficult job of advising ADP as it put together all the rules on SACPA and all the guidance that is given to the counties on how to spend their money,” she reported. Jett also reviewed the responsibilities given to ADP as the lead agency for SACPA at the state level, but pointed out that ADP has had the support of other state agencies and the lead agencies in the counties. She praised the “dedicated willingness” at the local level for teams to meet and problem-solve, and declared that what has been accomplished in the past year is “extraordinary.” She called attention to the enactment in October 2001 of Senate Bill 223, which made \$8.4 million available for drug testing as a part of treatment.

Preliminary data is revealing issues that need to be addressed, Jett continued. “What we are seeing in SACPA are clients who have severe drug histories, serious physical health problems, and extensive criminal justice backgrounds. To some people this is a surprise; to others it was fully expected.” She noted there has been much discussion about whether SACPA teams would be dealing mainly with felons or with misdemeanants and first offenders. Early experience is indicating that more felons are participating in the program than were expected. She observed that some offenders are choosing to enter into the least demanding course for treatment. “Diversion laws are still on the books,” she said, and it is unlikely that a misdemeanant would want to plead guilty to a felony and sign up for a year and a half of SACPA treatment that is court and probation-supervised when a less demanding alternative is open. “So, yes, individuals who are eligible are opting for lesser programs. I do not think there is a judgment to be made on that other than an understanding that there are other laws on the books.”

Speaking of judgments, she noted that on a recent trip to Washington, D.C., she encountered people who asked her how it felt to be in a state that had “legalized drugs.”

“I spent a long time talking to them about how the courts, probation and treatment were working together. When I left, I think they saw a different picture of what we are doing—that we are really trying to work collaboratively and build on the success of the drug court model.”

Jett spoke of the “rush to judgment” about the success of SACPA. Very often, reports on preliminary results in some counties highlight that 30 percent of eligible offenders are not entering treatment, instead of the 70 percent who are. She said ADP adopted three guiding principles as it approached SACPA. “The first was to use the first year as a baseline, realizing that we had to make a lot of very quick decisions and that we would have to evaluate those decisions and make adjustments as the year went on. The second was to honor local control, realizing the diversity of the state and the 58-county system. And third that we continue to work on fostering collaboration at both the state and local levels. The one additional principle I might add at this stage of implementation would be: Do not rush to judgment. SACPA is really only nine months old. It has been operational for only nine months. That is far too soon to say whether the implementation has been successful or not.”

SACPA Success Stories from Around the State

Moderator: The Hon. Stephen Manley, Judge of the Superior Court, County of Santa Clara. Panelists: Sandy Jordan, Supervising Probation Officer, County of Humboldt; Alfred Bell, Supervising Substance Abuse Counselor, County of Riverside; John Grass, Clinical Service Manager, County of Imperial; Toni Moore, Administrator, Alcohol and Drug Services, County of Sacramento; Jerry Evans, Coordinator, Alcohol and Drug Services, County of Amador; Sandra A. Fair, Division Manager, Health Care Agency, Alcohol and Drug Abuse Services, County of Orange.

Judge Stephen Manley moderated the panel that brought together representatives of six counties to report on their experiences with SACPA. He opened by quoting headlines from news stories describing early experiences with SACPA implementation such as, “Officials are ‘baffled’ by the task,” “Counties need more money,” and “Failure rate is high.” Said Manley, “I

think everyone in this room knows that we do not need others to define success for us. Each and every county in the state has worked very hard to meet the unique challenges posed to us by SACPA, and we do not need to be compared to perfection.”

Sandy Jordan then described how probation and treatment are working closely together in Humboldt County. She pointed out that the Probation Department and the Alcohol and Drug Department in Humboldt have a long history of working together, giving them a head start on collaborating to implement SACPA. Since last July, both have learned much about the inner workings of the other department. “If we do not understand another agency’s practices and procedures, it becomes easy for us to assume that the other agency is not doing things the right way. We have very different operating systems, but by taking the time to explain each other’s processes and procedures, it makes it easier to understand why we do things the way we do.”

A compelling example of interagency collaboration is the system for “dual assessment” of SACPA clients. Both the probation officer and the substance abuse counselor are present at the assessment, a process that provides for greater accuracy in gathering information about the individual. “Much of the information gathered in the assessment process is based on the client’s self-reporting. By conducting dual assessments, the probation officer is able to provide criminal history that often paints a much more accurate picture of the client’s past,” Jordan stated. “Meanwhile, the substance abuse counselor makes observations about the client’s treatment plan.” This is a time-consuming process, Jordan said, but it reduces “turf wars.” Failure to make accurate assessments and develop plans that bring about change in the client would amount to “dropping the ball.” Jordan also praised the willingness of the local judge to make herself available to clear up procedural problems that often arise. “We can pick up the phone and call her or we can go to her chambers and talk to her,” Jordan said.

Alfred Bell described how Riverside County is conducting assessments of SACPA clients in the courtroom. Historically, participation in other diversion programs had averaged about 50 percent, and it was hoped the rate of participation would improve under SACPA. The county assigned six assessment counselors to work in seven courts throughout Riverside County, which covers 7,000 square miles and spans 200 miles between its western and eastern borders. “We found we could do the assessments in the courtroom by moving the client to an isolated section of the courtroom or to one of the screening booths or areas that attorneys use,” he said. Issues of confidentiality and the presence of attorneys are overcome by concern for the offender on the part of all the parties, said Bell. “The judge and the various attorneys encourage the offenders to participate in SACPA and to enroll in treatment...this allows the clients to ask questions about their sentencing and treatment prior to accepting a SACPA sentence. The clients also understand the level of care they will be assigned to and can ask the judge or defense attorney about their best option.” An added benefit of this system is that it is unnecessary to make appointments for assessment and the no-show problem is eliminated.

John Grass described the development of an “Interagency Consultation Committee” in Imperial County. He said the county team recognized that treatment is “a living and dynamic process” that needs to be monitored along the way. The county’s Consultation Committee includes representatives of the alcohol and drug treatment staff, behavioral health staff, probation, parole, residential treatment providers, and methadone programs. The committee meets on a weekly basis and evaluates an average of 25 cases every week, reviewing and modifying treatment plans and dealing with compliance problems. “One of the beautiful things about this committee is that we are able to bring clients into the room and have a face-to-face with them. We try to encourage motivation. We explore different ways to get them to buy in to treatment. We explore what is obstructing their treatment and modify the treatment plan to make

it more successful.” Grass said the judge might get involved when there is a recommendation for parole revocation or violation of probation. “The judge will know right away that a team has evaluated the case thoroughly so he is not trying to sort out the facts by himself,” Grass continued. “We have reviewed the facts an average of three or four times before a revocation is recommended so the judge is getting a case that has been very well evaluated.”

Toni Moore told the group how Sacramento County collects and uses data to modify programs and procedures. She described the various common-sense “benchmarks of success” based on numbers-- numbers of clients completing treatment, eliminating drug use, reducing recidivism, and getting jobs. Judge Manley asked about what happens when the alcohol and drug people add up their numbers and get one total while the criminal justice people add up their numbers and get a different total. Moore said the data were taken from multiple sources and then reconciled. Even within treatment, there may be discrepancies. The county uses its Social Services Department to help with an overall evaluation so a single set of numbers will flow out.

The numbers have been used to compile a four-month report and an eight-month report and will be used for a final one-year report. “The interim reports are mostly process oriented, but we are using them to modify our program. We are hoping that in the one-year report we will actually see some outcomes.” The county had predicted that 25 percent of offenders would not make it from the courthouse to the assessment, but the dropout rate was actually higher—about one-third. “We rearranged our staffing pattern at assessment so that everyone could be accommodated on a drop-in basis,” Moore said. The county has created user-friendly written materials to explain its program, along with a specialized orientation that helps bring people in. The county found that fewer people than anticipated were coming into the SACPA program, but those who did come in required higher levels of treatment and supervision than were predicted. This experience is being used to modify the mix of treatment services.

Jerry Evans said Amador County, with its population of about 34,000, belongs to an association of 19 small counties each ranging in population below 70,000. “You would think there would be similarities, but there are great differences dictated by size, funding, resources, and geography,” Evans said. The challenge for Amador was to build a program meeting the dictates of the limited SACPA funding available to the county. The solution was to develop outpatient day treatment as the most efficient, cost-effective method.

The county found it had only about half as many offenders as anticipated entering its SACPA group, and most of them were poorly motivated to treatment. The unused space in the group was filled with men whose mates had been receiving drug treatment under the county’s perinatal program, which did not cover males needing treatment. Many of these men had been waiting for years to find a treatment opportunity, and they were highly motivated when they joined the SACPA group. Said Evans, “They are the same kind of people who are being referred by SACPA, but they just do not have the criminal history. When the group first started, the Prop. 36’ers sat on one side and the motivated clients sat on the other. They now sit together and work together. The motivated clients are breaking down the denial of our SACPA group. They are showing them that there are ways to engage in recovery or at least consider it. They are challenging them to pick up the pieces and put their lives back together.”

Finally, **Sandra Fair** described how Orange County overcame an early failure in the design of a program for offenders. Clients had been allowed to self-select their treatment providers. This created problems in tracking their enrollment and getting progress reports promptly from the providers. It turned out that about 57 percent of the clients were not showing up in court, failing to show up at their treatment provider, or failing to participate actively in their treatment. Among the changes was immediate access to risk assessment and setting up a centralized clinical assessment. The aim was to assure that offenders were assessed and referred

to the appropriate level of care immediately. Clients also were required to attend support groups such as Narcotics Anonymous (NA) or Alcoholics Anonymous (AA) during the interim period between signing up for treatment and enrolling in a program. Progress review periods also were shortened.

The new tracking system made it possible to get clients back into court promptly when appropriate and to intensify treatment if necessary. “Now we have about 83 percent of the eligible population being assessed and enrolled into treatment,” Fair said. “We have well over 1,000 men and women participating in treatment right now.”

Meeting Challenges in the Courtroom: The Team Model

Panelists: Cynthia Buren, Supervising Probation Officer, County of San Bernardino; Rachel Carey, Deputy Public Defender, County of San Diego; Peter Gallagher, Deputy District Attorney, County of San Diego; the Hon. Darrell Stevens, Judge of the Superior Court, County of Butte.

Judge Stephen Manley introduced the theme of the next panel discussion as collaboration. “We believe that the adversarial system in which attorneys, probation and the judge play their traditional roles does not work with substance abusing clients,” he said. “When the attorneys are gladiators, and probation stands in the middle, and treatment counselors are under attack, and the judge makes decisions, the focus is not on solutions, not on better treatment plans, but on who wins and who loses.” Instead, the Administrative Office of the Courts (AOC) Workgroup has developed a *team model* for SACPA cases based on drug court procedures that have been followed for a number of years. He referred to statistics indicating that violations of probation or treatment non-compliance usually occur in the first six months. “Our challenges begin when clients do not get into treatment or fail in treatment,” asserted Manley.

A video enactment showed how attorneys might clash when they consider themselves adversaries with a substance-abusing defendant in court. **Peter Gallagher** explained how the team model for SACPA would work in such a case. “What you have in the team approach is

various disciplines working together. They are cross-trained, and everybody understands each other's roles." He said prosecutors need to understand treatment, to distinguish between what is a public safety risk in allowing a person to stay in treatment after a failure and the public benefit of allowing him or her to continue in treatment. Attorneys and probation work together to understand what each individual client needs.

Rachel Carey said experience with SACPA is showing "what most of us in the criminal justice system have known for a long time—that the majority of clients who are committing crimes have some sort of drug problem." She sees her job as a public defender to broker a solution to the problem rather than take an adversarial course. "I think a key element is a basic trust, and it goes both ways," she stated. The trust level has risen between Peter Gallagher and her during 12 years of working opposite each other. She agreed with Judge Manley that a defense attorney would be looking for an enlightened district attorney who would assign deputy district attorneys who knew something about substance abuse to SACPA cases.

Gallagher added that he would expect the defense attorney not to "blow smoke" if a client is not amenable to treatment or if it is obvious that treatment is not working. "If there is no solution, then maybe the best thing for the client is a soft landing into a program where incarceration is part of the program." Carey added that she is not bothered by the fact that the client is not present while attorneys are discussing the case. "Clients often say things that are not helpful at all," she said. "They are often unaware of the issues that we really need to talk about. My role is to provide a buffer between them and the system and make sure they are presented in the best possible light."

Cynthia Buren pointed out that probation officers serve as a "liaison" between the court and treatment providers. "Collaboration with treatment is important because we are both working toward the same goal, and that is engaging the client in treatment."

Judge Darrell Stevens said he believes judges should call a halt to adversarial confrontations if they occur in SACPA cases. “We need to say, ‘Wait a minute, people, this is not what we are here for. This is a treatment court and we are going to all work together. And we are going to understand each other.’” If there are people in the picture who do not understand addiction, it is part of the role of the judge to explain what addiction is. When there are disagreements among attorneys, it is important that strife does not occur in front of the defendant. “The defendant has to feel and know that he or she has a whole group of people who are working together, who care about his or her success.”

Judge Manley then described the details of a challenging case. A judge had told SACPA defendant “Steve” to go to probation, get assessed, start treatment and come back to the court to show what he had done. But Steve did not return to court and a bench warrant was issued. Now he is back in jail. The treatment provider reported that Steve showed up for his assessment appointment, but then never went to treatment. Probation people report that he never came to their office to get guidance. What should the judge do next?

Judge Stevens said he would try to find the positive somewhere in all that negative and find a way to motivate the defendant. “We have to realize we may be dealing with people who are totally new to the idea of treatment. So the entire treatment team would collaborate and determine what is going on with this man and see that he understands that if he keeps this up, he will end up in jail or state prison. We need to dispel the idea many of them have that the worst that can happen is 30 days in jail. We still have people who believe that coming into the process.” In the case described, Judge Stevens said that, as the judge, he probably would let the person begin again but under very quick review by the court—“come back and see me in one week, two weeks, three weeks—not three months down the line.”

Gallagher said he believed the team needed to “get this person’s attention” and perhaps scale up the level of treatment and set up a mechanism to make sure he complies. “What we have to do is coerce this person into treatment at the appropriate level.” He said that at this stage he would not go through a full evidentiary hearing just because the defendant failed to report.

Carey said she would try to find out why the client failed to show up. “Why did he go through a 45-minute assessment and fall off after that?” She would try to find out what is going on in the person’s life. “Often people start hanging out with their regular crowd and they just cannot get back on track. The point is, I would ask my client a lot of questions and try to find out what the real problem is that is preventing him from going into treatment. I would offer solutions to the team and see if there was an idea we can all agree on.”

Buren said the probation officer would make the same kind of effort to find out why the defendant failed to follow through and would look for answers with the treatment people who did the assessment. “Are there issues that we need to look at that we did not consider previously? Does this person have a dual diagnosis? What was in that assessment that may be an indicator of why this person is not engaged?” She added that while Gallagher wanted to “coerce” the person into treatment she would rather say the effort should be to “entice” the person into treatment. She also said it might be necessary to increase probation supervision, letting the person know he was going to be monitored on a more frequent basis. Judge Stevens said this kind of team effort is key to successful results. “We do not want just to churn people through the system but to get them into full-blown recovery.”

Another video was shown, this time with a client who has begun treatment but the treatment provider told the district attorney that the client has a poor attitude, had missed three treatment sessions, and has tested positive for drugs. The client’s lawyer says he tested positive because he had eaten a poppy seed muffin. Carey commented that, as a defender, “I would try to

find out more information. What does the treatment provider mean by a poor attitude? That term alone does not tell me a lot about what my client is or is not doing in treatment.” She pointed out that a bad attitude is typical of people at the beginning of treatment. “So why penalize them for acting like we expect them to?”

Buren said she too would gather more information. “I would find out if the treatment provider thinks the client would be amenable to an alternative form of treatment rather than what he is in.”

Judge Stevens said he would make it clear to this client that “we expect him to be accountable to the court and we are not going to put up with his nonsense any more. He would be told to ‘get with the program’ and ‘if you do not want treatment, that is up to you.’”

Gallagher said he thought the client “is starting down a slippery slope” and he would try to get the judge, defense and probation to agree on a course of action such as an admission to a violation of probation and then reinstatement with some additional conditions, such as community service. He compared it to a plea bargain. “I am getting a violation and a revocation, but I am not terminating treatment.”

Carey said she probably would agree to this formula. Having entered treatment and missed only three sessions shows something positive in the client’s behavior, and a probation violation might get him moving in the right direction.

The next challenge involved a defendant with prior probation violations who had entered residential treatment under SACPA but was then asked to leave the facility when it was learned that he had a prior record for arson and other offenses. Gallagher questioned whether the treatment people acted properly in this case. “Do they want only the easy cases?”

Carey said she would talk to Gallagher about whether the client should remain in the SACPA program or not and what the sentence would be if he left it. “How much time is he

looking at? Since everyone had decided he needed residential treatment and the treatment provider kicked him out after 15 days, he has not yet violated the terms and conditions of his SACPA probation because it was not his fault that he was terminated from that program.” As to a probation complaint about his failure to cooperate, she pointed out that people with a long history in the criminal justice system may feel “adversarial” toward probation people because they “carry guns and badges and they arrest you.” The probation officers she has worked with, however, are caring and very interested in working with clients and helping them out. “So if there is no residential program that will take him because of his arson history, I would try to get everyone to come up with a plan, perhaps an intensive outpatient plan.”

Buren said she thought it significant that the treatment program expelled him only because of the safety issue involved in his history of arson, and would otherwise take him back into treatment. One possibility might be an increase in probation supervision. “Let us try something creative,” she continued. “If you give him an intensive outpatient or day-treatment program where he has to be more often, perhaps the probation officer can go to that facility. Let us look at some ancillary services, maybe anger management. We may want to see if he needs literacy. As long as he is not a threat to the community, I do not foresee a problem in letting them try one more time with a new and unique option.”

Concluding the panel session, Judge Stevens said he believed this case showed the importance of working out such problems before entering the courtroom. If not, the district attorney and public defender will begin to battle and “will just want to make their point and win.”

What Works: Models of Successful Treatment and Outcomes

A. Thomas McLellan, Ph.D.
Director, Treatment Research Institute
University of Pennsylvania

A. Thomas McLellan, Ph.D., discussed addiction as a “chronic” condition and reviewed research that has shown what works in treatment. He pointed out that drug use is involved in 60 percent of adult arrests, 50 percent of domestic violence incidents, 67 percent of probation cases, 75 percent of parole incidents, and as many as 80 percent of child abuse and neglect cases. He said tension has been going on for decades over whether to lock up drug users as an obligation to society or treat them out of compassion for their plight. Another statistic points to the best choice: of the addicts who go to jail, 70 to 90 percent come out and resume their use of drugs. “They get re-incarcerated, and in record numbers.”

He went on to compare addiction with such chronic illnesses as hypertension, diabetes and asthma, pointing out that they cannot be “cured” and are influenced by a number of factors—“genetic, metabolic and, very importantly, behavioral.” He reviewed evidence that there is a genetic factor in the likelihood of being afflicted with these conditions. Similarly, there are genetic factors in the likelihood that a person will become addicted to drugs or alcohol while others who try using those substances do not. While some people have resisted the notion that there are similarities between addiction and such illnesses as diabetes and asthma, research is proving otherwise. “The Swedes are treating many cases of diabetes without insulin. They are training people who are diabetic to change their diet, change their exercise level, and change the way they live. They are changing their behaviors and they are finding that many, but not all, are able to get off of what seems like a drug that they otherwise would have to be on for the rest of their lives, merely because of voluntary efforts.” Addicts often do not do what you ask them to do and they relapse after treatment. But the same is true of people with other chronic illnesses. “If you tell hypertensive persons that they must stay on their medication or they will get a stroke, 60 percent or fewer will actually do that. Less than 30 percent changes their diet and does exercise. They relapse, too. Their blood pressure goes up so much that 50 to 60 percent have to

be treated again in a hospital or an emergency room setting.” Asthma patients have a similar pattern. People relapse because they do not do what the doctor tells them to do.

Dr. McLellan pointed to the relationship of these factors with the relapse of drug addicts. “I am not trying to tell you that addiction is an illness. I cannot prove that. I am telling you that like those illnesses, many of the same factors that are involuntary and voluntary appear to contribute to the course and the outcomes of treatment for addiction.” In spite of this similarity, people are applying a different test to decide whether addiction treatment is worthwhile. A successful outcome does not depend on the “dose” of treatment and what happens after treatment is completed. There are three stages to be considered in treatment for addiction. Stage one is detoxification, which removes toxins and prepares the client for the next stage, which is rehabilitation. Rehabilitation is designed to teach a person the skills needed to reduce the threat of relapse and prepare for the third stage, which is continuing care. “These efforts are to try to remove barriers to behavioral change and prevent backsliding into detoxification.” He cited four predictors of relapse that are true for chronic illness as well as addiction:

- Failure to follow doctor’s orders.
- Low socio-economic status.
- Low family support.
- Psychiatric problems.

He went on to describe the shortcomings evident in treatment programs around the country, starting with professional staff and services. Physicians are typically only 20 percent of full-time equivalency in a treatment program. Psychologists and social workers are typically no more than 25 percent full-time equivalency. “There is no standard management information system, and only about 60 percent of treatment programs we see even have a computer available for their staffs.” Staff turnover rate is also a problem, approaching the same rates as those in the

fast food industry. There is not a single treatment approach that has been shown to be universally effective for everyone, but more than 90 percent of treatment programs have only one approach to treatment, typically a 12-step program approach. “That is at least a good thing because that is one of the approaches that has been shown to be effective.” In a recent year, Philadelphia spent 38 percent of its alcohol and drug budget on detoxification, which is not an effective treatment. In a seven-year period, one individual was detoxed 365 times. Access to care and its duration are other factors predicting success. “The faster you get in, the more likely you are to engage. The longer you stay, the better your outcomes are likely to be, and after-care or continuing care is one of the major keys to success. But most places have waiting lists, and most care is for less than 30 days. The only aftercare really available now is AA or NA, which are great, but how about a little more variety?” He went on to discuss the kinds of medication that are useful in treating alcoholism and addiction and types of therapy that can be used. The problem is that therapies, which have been studied and found to be effective for cocaine and opiate users, are all individual therapies. “There is no study of group-based treatment, and that is a problem in our field because essentially all care is delivered in a group format.”

Dr. McLellan described cognitive behavioral therapy and said many treatment people claim to be using that therapy when actually they are not. The most popular treatment is “12-step facilitation” which is designed to prepare patients to do something they are often unlikely to do. It appears to work but its effectiveness has never been formally studied. A major question is how addicts can be moved from a “pre-contemplation” stage to an “active” stage--from denying a problem to deciding to do something about drug use and signing up for treatment. It has been found that “active confrontation”--demanding that a person recognize the problem--does not work in getting a drug user to take this step. He said there are therapies and techniques in manuals that actually do move people in this way, especially the technique of motivational

interviewing. Another technique is couples therapy. “No, this is not family night. This is a very precise kind of therapy done by trained people who can work through the conflicts that are typical in couples where one or both are using substances. It has been very effective not just in reducing alcohol or cocaine use but also in reducing family violence.” He went on to list some therapies that have been studied and proven to be ineffective in addiction treatment. Heading the list is detoxification by itself. Others on the list are acupuncture, biofeedback, and aversion therapy. As for group counseling, there is no evidence for or against its effectiveness. “I am not telling you that group counseling does not work. I am telling you that it has not been evaluated and it is the biggest component of almost every form of treatment.” Finally, he said that support services—things like housing, child care, employment counseling, parenting skill training, family therapy and psychiatric treatment—all have been found to make a significant contribution to the effectiveness of addiction treatment. He said some studies show that “case management” works, but only if there are services to be provided.

Dr. McLellan emphasized that what he had been discussing were “components of care—not modalities of care, not programs of care, not facilities. I am talking about components and where they might fit in that list of things you are trying to do to stabilize clients, to teach them new skills, to help them reduce the threats of relapse. These components can help. But we need more of them and we need for them to be more attractive. That is what they do in the treatment of chronic health conditions. They know that most patients drop out, most patients do not engage, most patients do not do what they are supposed to do. So instead of saying, well, they will be back when they have a heart attack, they say ‘let us see if we can get more attractive means of delivering these kinds of care.’” Effective components of drug treatment would include attractive options for treatment, effective strategies to improve compliance, coordination with health and social systems, and good monitoring strategies.

He urged the audience to consider results of a treatment study published in the December 1999 issue of *Prison Journal* following the fate of drug-related felons in prisons in three different states. The follow-up showed that those who received therapeutic community treatment before their release were as likely to be re-arrested as those who received no treatment were. Recidivism rates declined for those who received therapeutic community treatment and also received continuing care after they left prison. They remained in an environment with treatment components that reduced the likelihood of relapse.

There was a question from the floor about contingency management programs. Dr. McLellan said these programs call for giving addicts a voucher good for \$10 or \$15 worth of community goods or services if they pass a urine test. “The treatment field has justifiably laughed at it and for one reason. They do not have \$10 or \$15 dollars in their budget to give to this person. And they question whether they really want to set a precedent of paying someone for doing the right thing.” Nevertheless, he said, there have been cases where people with apparently uncontrollable cocaine use have been brought under control by the promise of money. Another question pointed out that prisoners having dual diagnosis problems or being sex offenders could have affected outcomes in the three state studies Dr. McLellan cited. Dr. McLellan agreed, but pointed out that people were randomly assigned in all three studies, so there would be an equal proportion of people with these problems in all three groups.

Another question raised the issue of when treatment should be terminated. Dr. McLellan said, “Any time I make a statement about substance abuse treatment, I ask myself if the statement still works if I substitute diabetes or hypertension for substance abuse. So let us say a patient is doing well on insulin after 18 months, is that evidence they have learned their insulin lesson and we should stop their treatment? No. Not a good idea. With addiction, if somebody is doing well under monitoring and supervision, and especially if there is a public safety

consideration involved, I have problems stopping it. Just the opposite. It is working, so let us keep it up.”

To another question, Dr. McLellan responded that he knew of no relapse prevention benefit from diet and exercise. But if a patient in an aftercare program focuses on diet and exercise and any other lifestyle feature that is inconsistent with a return to drug use, it is a good thing. When another questioner asked if there were any aftercare programs other than 12-step programs, Dr. McLellan said he does not know of any. He said AA, NA and Cocaine Anonymous amount to “the most effective monitoring and maintenance strategies ever conceived for a chronic disorder. It would be hard to build a machine that would be better than that. It is free. It is everywhere. It is all the time.” But he added that two-thirds to three-quarters of people referred to a 12-step program do not like it, and there is nothing else available.

BREAKOUT SESSIONS

The breakout sessions led by experts in various fields included:

- *Methadone Maintenance Treatment for Heroin Addiction: How They Work, For Whom They Seem to be Useful, and Strengths and Liabilities*, led by Joan Zweben, Ph.D., University of San Francisco, Executive Director of the 14th Street Clinic and East Bay Community Recovery Project.
- *Residential and Daycare Therapeutic Communities: How They Work, For Whom They Seem to be Useful, and Strengths and Liabilities*, led by David A. Deitch, Ph.D., Director, Addiction Training Center, University of California, San Diego.
- *Outpatient Therapies, With and Without Medications: How They Work, For Whom They Seem to be Useful, and Strengths and Liabilities*, led by Richard Rawson, Ph.D., Associate Director, Integrated Substance Abuse Programs, University of California, Los Angeles.
- *Short Term Inpatient and Continuing Care: How They Work, For Whom They Seem to be Useful, and Strengths and Liabilities*, led by Marc A. Schuckit, M.D., Director, Alcohol Research Center, Veterans Affairs San Diego Healthcare System; Professor of Psychiatry, University of California, San Diego.
- *Assessment: Current Knowledge and Key Items Linked to Good Outcomes*, led by A. Thomas McLellan, Ph.D., Director, Treatment Research Institute, University of Pennsylvania.
- *Creative Strategies in the Courtroom: Probation, Non-compliance, Relapse, and Recidivism*, led by the Honorable Stephen Manley, Judge of the Superior Court, Santa Clara County; the Honorable Darrell Stevens, Judge of the Superior Court, Butte County; the Honorable Ana Maria Luna, Judge of the Superior Court, Los Angeles County; the Honorable Patrick J. Morris, Judge of the Superior Court, San Bernardino County.
- *Proposition 36: Managing the Media*, led by Lynne Doll, President/Partner, Rogers & Associates, and Dotty Diemer, Vice President, Rogers & Associates.

Dual Diagnosis: Programmatic Recommendations

Marc A. Schuckit, M.D.
Director, Alcohol Research Center
Veterans Affairs San Diego Healthcare System
Professor of Psychiatry
University of California, San Diego

Marc A. Schuckit, M.D., reviewed issues raised by dual diagnosis—“how co-occurring disorders sometimes mean two separate disorders that are going to require referral to both a substance disorder treatment program and referral to a psychiatric program or to a single program that does both.” He said the task is to identify such separate disorders when they occur and to “disentangle” their effects.

He explained that patients who have problems related to their dependence on alcohol or drugs are relatively easy to treat. “But if they meet the criteria for a psychiatric disorder as well as substance dependence, which one do I treat? Do they really have two disorders? Does the treatment of one interfere with the treatment of the other?” Two out of three patients with a substance use disorder also have a second diagnosis, but that statement may be misinterpreted. “Half the time, the other diagnosis is another substance use disorder or an anti-social personality disorder.” The other half appear to have schizophrenia or mania or major depressive disorders and may require long-term treatment. He went on to explain how the use of various drugs can lead to symptoms similar to psychiatric disorders, but the symptoms disappear after a few days of treatment. “The problem is that drugs of abuse can mimic psychiatric syndromes but those psychiatric syndromes will go away and clear spontaneously with abstinence.”

Dr. Schuckit described problems that could be induced by substance use and could be confused with long-term psychiatric disorders such as anxiety, depressive disorders, mania, and schizophrenia. He said use of two types of drugs, stimulants and depressants, can mimic almost any psychiatric disorder. Those who use stimulants such as cocaine and amphetamines may

show symptoms of anxiety and psychosis that resemble panic disorders but disappear when use of the drug is stopped. With depressants, including alcohol, tranquilizers and sleeping pills, heavy use can cause hallucinations, delusions, severe jealousy and other symptoms that look like schizophrenia, but they too go away with detoxification. Dealing with these patients can be confusing if only symptoms and not diagnosis are looked at, since mild symptoms are common in intoxication and withdrawal. It is also important to determine whether the drug being used is capable of causing psychiatric symptoms. If patients ever met the criteria for a psychiatric disorder at a time that cannot be explained by the drug, then they probably have a psychiatric disorder. This leads to the important point that clinicians must explore the history of the patient to determine whether a psychiatric symptom existed before or after the development of a substance abuse problem. Dr. Schuckit described the technique of using a “timeline” to help patients recall events in their lives that provide clues to separating psychiatric problems from substance use problems.

He explained how treatment differs depending on whether symptoms are substance-induced or reflect a pre-existing disorder. He gave an example of a patient with an alcohol dependence that said, “I have always been depressed, and I drink because I am depressed.” While only 15 percent of women and eight percent of men in the population have major depressive episodes in their lives, 40 percent of alcohol-dependent men and women describe such depression. “But two out of three times it is substance-induced and temporary, and it will disappear.” Again, it is necessary to find out when the depression problem began in relation to the history of substance dependence. Use of both stimulants and depressants can lead to symptoms that look like depressive disorders. “When people who are on depressants or stimulants come into an alcohol or drug treatment program, 80 percent of them have some level of depression, and about 40 percent look like they have severe depression. But only about 5 to

15 percent really need anti-depressant medications.” He described cases where depressive symptoms disappeared in patients who stayed sober but recurred when they resumed drinking after discharge from treatment. He said relatively few patients who come into treatment for alcohol or drug dependence need to be put on anti-depressant medication after withdrawal from the substance use.

Dr. Schuckit then turned to symptoms of psychotic disorders that are associated with drug use. “I have a feeling that in most jail-type settings and most criminal justice and SACPA referrals, this may be one of the major issues you face,” he said. He referred to diagnostic criteria for various conditions, noting that anxiety disorder, panic disorder, social phobia, agoraphobia, and obsessive compulsive disorder have some things in common. “They have an onset usually in the late teens to early 20’s, almost always prior to age 30. The bad news is that once you have one of these syndromes, you probably will always have it. The good news is that there are many treatments for these disorders and they will help you minimize the symptoms and lead a normal life.” He reviewed some case histories illustrating how treatment for psychiatric disorders can be separated from treatment for a substance use disorder once it is determined that they are two separate problems. “If you are a judge or are in probation or parole, you may have in front of you two patients who look exactly alike. Both are alcohol dependent, both are showing panic attacks. By using the timeline, you can conclude that the panic attacks for one of them are not going to go away. I am going to detox the person, and he may need longer-term treatment for panic attacks, maybe even medication. The other person looks identical, but from his history I know he does not have panic disorder. The panic will go away and the major emphasis will be treating him for alcohol or drug dependence and making him feel comfortable with abstinence.”

He described how this approach is put to work in evaluating patients coming into the San Diego Veterans Affairs Hospital. “It involves cross-talk between people in the alcohol and drug field and people in psychiatry and psychology and is something that constantly needs attention. We try to teach this material to residents and medical students and other emergency room personnel—how to determine whether it is a substance-induced or an independent disorder.” He said patients who are severely depressed or suicidal may be sent to a locked psychiatric ward. About 90 percent, however, are referred to alcohol and drug treatment. The history of a patient who uses stimulants and has symptoms of schizophrenia may lead to referral to the psychiatric unit because the psychosis existed independently of the drug use. “Our goal is to have these schizophrenic individuals, for whom stimulants or alcohol or other drugs are making things worse, become totally, forever alcohol and drug free. But they do not have a lot of good judgment because of their underlying disorder and I am not sure we are going to get there. So maybe our secondary goal is to try to have longer and longer periods of time between psychiatric emergencies. And maybe one of these times, the patients with schizophrenia are going to latch on to something that is involved in the treatment of alcohol and drug dependence and we are going to keep them engaged with us over a period of time.”

He went on to describe the behavior of patients with manic depressive disease—they have not been sleeping, they are talking very fast—and noted that such patients have double the rate of substance dependence disorders. “I think they get into alcohol and drugs and then the alcohol and drugs run their course. I believe that is why there is a high rate of true manic depressive disease having substance dependence as a secondary consequence much more than you would expect by chance alone.” He told how medication is used in inpatient and outpatient treatment for manic depression. “If they get into alcohol or drugs again, it is going to precipitate manic attacks if they are predisposed, especially if they get into stimulants. If they wish to live a

fairly normal life and have their medications at the lowest level possible, they have got to work with us to stay clean and sober.”

Elise Lenox of Marin County opened the question period asking for advice about how to deal with the cost of medications used in treating psychiatric disorders. Dr. Schuckit said medications have to be used regardless of their cost in cases of manic depressive disease and schizophrenia. “If a county or other government agency is having trouble with the cost of medications, usually you can find off-label generic drugs that will work as well although they may have a higher level of side effects than some of the newer medications that are more expensive and have no generics.” He pointed out that for treating users of stimulants such as amphetamines and cocaine there are no medications of value in the rehabilitation phase. He also described some of the difficulties in judging the efficacy of medications in substance abuse cases because of other circumstances affecting alcohol or drug dependence. For heroin addicts, the cost of methadone is “pennies per day,” and opioid blockers such as Naltrexone also can be used. He pointed out that failing to use expensive medications for major psychiatric disorders can be more costly in the long run because of the troubles the patients will have without the use of the medications.

Etta Robin of Kern County asked what to do about a person who has been using methamphetamine for 15 years and is having panic symptoms when going into treatment under SACPA. Dr. Schuckit doubted if a person could use methamphetamine for 15 years and still be alive, so there must have been periods of abstinence. The panic symptoms should drop below the threshold of full-blown panic disorder within a month if they are connected with stimulant use, he said. “I can almost always get someone to work with them as an outpatient and give them enough support to stay clean and sober for a month.”

Mark Bono of Contra Costa County raised the point that assessments need to be made without waiting a month. Dr. Schuckit said the diagnosis as to whether the person has a psychiatric disorder is based on history, not symptoms. “I will take the time to gather the history and determine whether this will clear up with abstinence or it will not. Of course, I could be wrong. The next step is to get the patient some help in trying to stay clean and sober for a month, and during that month I am guessing that the symptoms will disappear or they will not disappear, depending on the prior history.”

Kirk Haynes of Fresno County asked if any drugs of abuse can cause permanent psychiatric disorders. Dr. Schuckit said the only drug that is known to cause permanent brain damage is alcohol. On the other hand, some drugs like amphetamines, cocaine and ecstasy can have effects seen on brain imaging for three to six months; but usually there is no diagnosable psychiatric disorder. If psychiatric symptoms persist for a month to six weeks, it will be necessary to look for a history of psychiatric disorders in the person or the person’s family. Finally, Dr. Schuckit pointed out that he had seen people who were heavily into hallucinogens, such as LSD and mescaline, and they are “a little odd.” But rather than having a psychiatric disorder, they were simply a little odd to be getting heavily into hallucinogens in the first place.

Proposition 36 - Making It Work! 2002

A statewide technical assistance conference

DAY TWO

ADP Director Kathryn Jett opened the second day of the conference with a brief description of the scope of activities of the Department of Alcohol and Drug Programs (ADP), which funds prevention and treatment services in California's 58 counties. On any given day, there are around 100,000 persons in alcohol and drug treatment in the state. The state supports 148 narcotic treatment programs, 468 driving-under-the-influence programs, 732 residential treatment programs, and well over 600 outpatient programs. Programs are supported primarily by federal funds.

Director Jett reported that there are efforts moving forward to require certification of substance abuse counselors. For prevention, an ADP work group will recommend steps for strengthening programs at the community and family levels.

The Director identified the 10 "focus counties" that will be studied in a formal evaluation of SACPA implementation. They are Alameda, Kern, Los Angeles, Orange, San Diego, San Joaquin, San Mateo, Santa Barbara, Santa Clara and Shasta.

Director Jett introduced **Carol Daly**, newly appointed chair of the California Board of Prison Terms (BPT), who said her experience in collaborative efforts in community-oriented policing when she was Undersheriff in Sacramento County helped prepare her for the kind of collaborative effort needed to make SACPA successful. Daly introduced members of her staff attending the conference, and said that BPT is committed to making substance abuse treatment available to offenders. She pointed out that the BPT and the Parole and Community Services

Division of the Department of Corrections (CDC) are separate entities. She emphasized the importance of communication among various agencies in making SACPA work.

Sharon Jackson introduced staff members from the CDC Parole and Community Services Division. She recalled that at the meeting a year ago, it was estimated that 7000 to 8000 parolees would be referred by parole to the SACPA program, with different estimates for different counties. "It's too early to say that SACPA is a success, but so far it is going pretty well with the parole division." She said the mission of the division is not only to protect the community but also to reintegrate parolees into the community. "If we do a good job with our supervision and in matching people up with services, we diminish the desire of parolees to commit crimes. SACPA is another tool for us to work with parolees." She said it was hoped that in the next few years California can reduce its recidivism rate, which at 63 percent now is the highest in the nation. The national rate is 35 percent.

Mike Brady, a recovering addict and a member of the staff of State Senator John Burton, said he knows the criminal justice population because he was a defense attorney for 15 years. He knows the prisoner and parolee population because he was a prisoner for two years and on parole for a year and a half. He knows that treatment does work for people who want to help themselves. He declared that addiction is "no longer a shame-based disease," pointing out that 18 percent of the professional population--including lawyers and doctors--have a chemical dependency problem or a mental health problem. Brady also pointed out that not all drug users are a criminal justice problem. For instance, many heroin addicts function well in their jobs. Brady added that the 58 counties in California have different personalities and different programs to implement SACPA. He called attention to the fact that in Kern County, 70 percent of the offenders eligible for SACPA are in treatment due to the county's broad and inclusive policies, and cited other counties that have impressive rates of participation. The challenge, he

concluded, is to open the "many doors to recovery" and also to continue protecting the public from crime.

State Policy Directions

Moderator: David A. Deitch, Ph.D., University of California, San Diego; Director, Addiction Training Center. Panelists: Sharon Jackson, Assistant Deputy Director, California Department of Corrections/Parole and Community Services Division; Joseph D. Ossmann, Manager, Proposition 36 Unit, California Board of Prison Terms; Del Sayles-Owen, Deputy Director, Office of Criminal Justice Collaboration, California Department of Alcohol and Drug Programs; Craig Toni, Parole Agent III, California Department of Corrections/Parole and Community Services Division.

Del Sayles-Owen, Deputy Director of ADP's Office of Criminal Justice Collaboration, introduced members of the ADP staff in the audience and called attention to ADP's technical assistance table in the lobby. She said regulations have been finalized and cover such areas as county allocation methodology, allowable costs, data reporting and county plan requirements. "We have broadened our policies regarding stakeholder involvement in county planning, and have expanded the definition of who can perform family counseling," she said. "We made clarifying changes in such areas as client fees and out-of-state services." The Department has just issued preliminary allocations of funds for Fiscal Year 2002-2003. "The allocation formula is based on population, arrest rates and caseloads. As those things change, so do allocations. In the upcoming year, some counties will get a little more money and some will get less." She added that the Legislature had asked for a report on how the allocation methodology was developed, and this report has been delivered.

Sayles-Owen went on to discuss the reporting procedures to be used by counties in providing data to ADP. The Department will be working with other state agencies to do comparisons with the data that come through their systems. ADP expects to have a formal report on the SACPA program ready for release this summer.

The auditing of county programs also is in progress, she continued. To date more than 20 counties had been audited to assure that funds are adequately accounted for and expenditures are documented in accordance with SACPA. ADP also has carried out training and technical assistance. She reported that a grant from The California Endowment to the University of California, San Diego would support development of a comprehensive plan for providing technical assistance for the counties.

Senate Bill 223 was enacted in October 2001 and made \$8.4 million in federal funds available for drug testing of SACPA clients. The legislation included a provision that testing can be used only as a treatment tool and the results can be given no greater weight than other aspects of the client's treatment program. ADP is promulgating regulations covering drug testing.

Sayles-Owen recalled that in the first round of county planning for implementing SACPA, the counties estimated that there would be a total of 71,000 participants in the first year. Now, the Department will be comparing those estimates with the actual number of cases. She added that the Department will be giving time and energy to problems arising from dual diagnosis, along with cross-jurisdictional issues. "We know that we have challenges in terms of monitoring failures-to-appear and looking for ways to engage clients and ensure that they progress through treatment."

Sharon Jackson described how BPT and CDC have been collaborating on the implementation of SACPA. "We have met once a week for the last year, if not more often, to make sure we stay on track and work out the policy and procedures to make it work best." In preparation, CDC asked parole agents to review all their case files to determine which cases were eligible for SACPA. Those with a prior history of a serious violent felony conviction are not eligible if they are on parole. CDC also created a process in which a report is sent to BPT when a person commits a qualifying parole violation—generally a simple drug use violation. "The

process is fairly simple. Agents just refer the case once there is a dirty [drug test] or other related drug violation.”

Craig Toni of CDC Parole and Community Services Division explained the process further. He said he has been helping parole agents in the field find answers to SACPA questions as they arise. There have been occasions when procedures needed to be revised. “The Board of Prison Terms, the CDC Institution Division, the CDC Parole and Community Services Division, and Mike Brady from Senator Burton’s office work together to identify areas where improvement is needed.” He said some of the procedures are awaiting approval by the parole agents’ union. One task is to establish a procedure for providing county probation departments with information about parolees arriving at assessment centers. It is hoped this information can be provided without increasing the parole agent’s workload.

Joe Ossmann from BPT explained that there are three different ways by which parolees are placed in the SACPA process. Most commonly, the parolee is referred directly by the CDC Parole and Community Services Division on the basis of a violation report. A paper review of the charges determines whether the parolee will be offered an opportunity to participate in SACPA. A second process involves a hearing. If a parolee is found to be ineligible for SACPA based on the charges, the parolee can contest the decision and take it to a hearing. The charges may be reduced or dismissed to make the parolee eligible. The third method deals with parolees who fall under SACPA when local charges bring them into courts. In these cases, they are subject to both the court process and the BPT process. “We have set up a system under which courts can request the Board of Prison Terms to drop the hold that we have on [the parolee] and allow the court to place [the parolee] in SACPA. A number of counties are participating in this.”

Ossmann also described a process in which parolees are served with SACPA paperwork in advance, allowing them to get out of custody more quickly and participate in alternative

programming before entering treatment. Also, BPT is working with counties to develop a process whereby parolees can go to assessment centers on a walk-in basis rather than requiring appointments. “Typically the assessment center notifies the Board of Prison Terms about what days and hours that they are willing to accept parolees. Then we simply notify the parolee that he must report to the county assessment center on such-and-such a day at such-and-such hour no later than the second day after his release from custody.” The assessment centers either do the assessment immediately, or schedule it for a later date.

In conclusion, Ossmann said the Parolee Subcommittee of the SACPA Statewide Advisory Group is attracting wide participation. He outlined various issues the subcommittee has been studying, including the scope of information about parolees provided to assessment centers, dual diagnosis problems, cross-training of members of SACPA teams, dual supervision of offenders subject to both probation and parole. Additionally, the subcommittee has been studying the interface between SACPA and the Substance Abuse Services Coordination Agencies, or SASCA’s, which coordinate continuing care for parolees who have been in therapeutic community programs in prison. One question is whether SASCA should be utilized first for these parolees, to be followed by SACPA, or whether referral to SASCA would be in lieu of a referral to a county SACPA program.

Lily Alvarez of Kern County opened the question period, asking whether there is any discussion about having specialized SACPA caseloads for parole agents, and about the frequency of drug testing. Sharon Jackson responded that specialized caseloads for SACPA are not being considered at this time for budgetary reasons.

John Larson of Santa Clara County asked whether parolees in the Bay Area Services Network (BASN) are eligible to remain with the BASN treatment providers if they become eligible for SACPA under a violation. Jackson said that once a person in BASN meets SACPA

criteria, he or she would be switched over to a SACPA program. **Leslie Kirkpatrick** of Mendocino County raised the issue of placing parolees who have done their time in prison in SACPA treatment programs after their release. Jackson explained that the CDC has been investing heavily in programs to provide in-prison drug treatment and a continuity of treatment in the community after release. For parolees eligible for SACPA, the aim is to get them involved. Joe Ossmann added that the SACPA language pertaining to such cases may be misunderstood. “One of the differences [in SACPA] for parolees and for defendants coming through the courts is that when they come through the court their charges may remain open, and if they fail under SACPA, they can be re-sentenced on those charges. With parolees who are charged before the Board of Prison Terms with a non-violent drug possession offense, if they accept placement in SACPA, that is the final disposition of the charges and they cannot be reopened. Any subsequent violations, such as failure to complete a SACPA program, are new and discrete violations and that starts a whole new chapter.”

Garrick Byers, a public defender of Fresno County, asked whether something might be done to minimize the confusion between the responsibilities of the CDC Parole and Community Services Division and the BPT in implementing SACPA. Jackson said the new procedures, which were still being ironed out, will probably remove a lot of that confusion. One major step will be to shift more responsibility to the local level.

Brokering and Procuring Ancillary Services

Panel moderator: William Demers, President, County Alcohol and Drug Program Administrators Association of California. Panelists: Toni Moore, Administrator of Alcohol and Drug Services, County of Sacramento; George Feicht, Alcohol and Drug Program Administrator, County of San Joaquin; Larry Bogatz, Human Services Manager, County of San Mateo.

Toni Moore pointed out that ancillary services such as vocational services, mental health services, or family counseling services, could have as much or more to do with a client’s success

as treatment services. This has been kept in mind in providing ancillary services in Sacramento County. “Often we fall down when we use quality assessment tools but do not really use the results of these assessments by incorporating ancillary services into a treatment plan.” The ancillary services can be provided directly, as part of the treatment plan, or through a case management process that assures they are provided by other agencies. It is also important that clients be informed about the availability of ancillary services, as Sacramento County does in its orientation for new clients. The county has published a pamphlet outlining such services, and uses a screening tool at assessment to determine various needs. Other counties are welcome to use the two-page screening tool or modify it for their own use, she said. Re-screening for service needs is also carried out regularly. As for staffing, anyone can be trained to do it.

Moore reviewed the contents of the screening tool that focuses on such areas as education, literacy, physical health, emotional health and family relations. “We like the term emotional health. It sounds more user-friendly than mental health.” Sacramento County also has developed a two-day training in motivational interviewing for county staff. “We ask people what they need and how we can help provide it. If they have a voice in how that service delivery comes together, it is a wonderful tool to engage them in services. So I strongly recommend motivational interview training to be used around ancillary service training.” She went on to describe how the county utilizes subcontracted services that can be provided both at the core outpatient service sites and at other sites. Those who provide services are aware of other available services throughout the community so they can refer clients to them. She also explained how linking eligible clients to the CalWORKs program opens the door for various support services available through that program. The county public health nurse also reviews initial health screening forms to see if there are additional, individual needs. For instance, when

issues involving prescription drugs arise, the nurse helps coordinate their use with other health professionals.

Sacramento County also has developed a dual diagnosis screen. “As many of you know, a lot of folks got started in their alcohol or drug history by self-medicating around a psychiatric problem and we see that frequently in our day-to-day experience. So we do an in-depth assessment there.” Some services are provided by county staff and others are contracted with psychiatrists linked to the University of California, Davis Medical Center. “A lot of our SACPA population often suffer from what I call ‘everyday’ mental health needs, things related to stress, lack of life skills, disorganization, anger, [and] self-esteem; and they may not reach the threshold where they would qualify for mental health system services.” She went on to explain how a client who becomes clean and sober in treatment may be confronted with mental or emotional problems that are not addressed, and will be a candidate for relapse.

Moore went on to discuss the question of paying for ancillary services under terms of SACPA. “The kind of things we can pay for are very broad and wide open. The primary restriction is that you cannot use the money for drug testing.” While recommended services are literacy training, vocational training and family counseling, she would look beyond those to physical and mental health components. “There is proposed legislation to focus specifically on mental health, but you really do not have to wait for that to get started.” County staff provides family counseling, but the services are linked with a broader array of community services.

Where Sacramento County is lacking, she concluded, is in housing resources. The county does not fund clean and sober living facilities, but hopes to do so after statewide licensing and certification standards are adopted. Meanwhile, the federally financed Shelter Plus Care program may provide housing that SACPA clients are eligible for.

George Feicht said that SACPA has forced San Joaquin County to look beyond alcohol and drug counseling to the additional needs of people going into treatment. Assessment instruments identified a client's additional needs but not much had been done to provide for them. This is changing with SACPA. He said that about 70 percent of the addicts seen in San Joaquin County have few skills, low self-esteem, and an average 7th or 8th grade education. "Confronted with that, we see that it takes a lot of services to get people up to the level that they can compete in the employment market." He said the motivation of addicts in treatment depends on developing a sense of success, so the county is seeking to develop services that contribute to that goal. Not only do 75 percent lack a high school diploma; many have a learning disability. The county went to the local community college for help with that problem, and funds were donated to pay for special training for teachers to help people with learning disabilities.

"Clients who come into our program may be functioning as best they can, given all the tools they have learned, but they do not have many of the basic tools," Feicht continued. The county's literacy program handles 20 people at a time and soon will be expanded to handle 40. He suggested that counties look to their local community colleges for programs that are readily available and not very expensive. The CalWORKs program is another source of services. Feicht pointed to a union-sponsored "construction technology" program that teaches basic carpentry, plumbing and electrical skills. Goodwill Industries and the Salvation Army are other sources of training, including on-the-job experience in thrift stores.

Dual diagnosis issues can present problems in getting SACPA clients into training programs. About one-third of the people coming into the program have a mental health problem that may not be acute but still gets in the way of progressing in treatment and getting employment. He described how WorkNet (the California One-Stop Career Center System) can provide training in job skills, but emphasized that it may be difficult for addicts to avail

themselves of such assistance if left to their own initiative. “It is really scary to go into something you’ve never done before when you are in somebody else’s territory. So addicts need that extra little help to get themselves involved.”

Feicht said his county has received significant grants for services to the homeless from the federal Department of Housing and Urban Development (HUD). “Just about every drug addict is technically homeless,” he said. HUD funds might be available, for example, for fixing up an old hotel to house SACPA clients and other recovering people with substance abuse problems.

Larry Bogatz pointed out that his county and some others are fortunate in having their alcohol and drug services located within a human services agency that can provide the kind of ancillary services that SACPA clients may need. Because of the geographic nature of San Mateo County, there has been an effort to “regionalize” services, coping with the fact that a mountain range divides the county into two parts. “We have one-stop centers that are open pretty much from 7:00 in the morning until 8:00 at night. People can come in for job training, or to see if they qualify for public assistance, or to access other services.” Since many people have to cross over the mountain range to look for jobs, the county invests funds in auto repair and subsidized housing. Services needed for SACPA clients may also be available through programs originally created to deal with welfare reform, such as family counseling centers. The county has created “family self-sufficiency teams” that receive referrals from a variety of agencies and help people navigate a system that may be confusing to them. He recalled how some people coming for help to a family self-sufficiency team were uncommunicative and never smiling, but after it was learned that they needed dental work and that was provided, they began to smile and speak up about their problems. “I think there is a symbiotic relationship between treatment and these

ancillary services,” he said. “I think they feed off each other, and I think that once it starts, people will really engage in their own process of healing and remain drug-free.”

Bogatz explained how his county uses one question on the ASI assessment instrument to identify people who may need mental health services. Social workers can see the possibility of an immediate crisis in the way people answer certain questions, such as “Have you had any feelings of depression in the last 30 days?” These questions help triage people into the mental health system. The SACPA team is creating links with regional health clinics to provide counseling, medication management and other services. “All in all, I think there are a number of challenges in our county, but we have been fortunate in having an existing infrastructure to draw on so we can provide services for a lot of our clients.”

William Demers opened the discussion period by raising the question of timing. “When do you make the referral to ancillary care? If clients have multiple issues coming up in their assessment, at what point do you try to broker those ancillary needs and services?” Moore responded that the timing varies in Sacramento County. If there is an immediate need, then the service should be provided immediately. Otherwise, a service might be folded into the treatment plan to be addressed at a later point. For example, she suggested that for a person entering a six-month treatment program who is in need of vocational or literacy services, it might be wise to start folding in those services after the first three months or so of treatment. Feicht said he agreed, pointing out that addicts usually are “working” 24 hours a day to deal with their drug needs, and when the addiction is taken away, they have time on their hands. “You don’t want to overload them with something that is heavy, but you want them to get involved quickly. You have to have it structured, but not overly structured.” If a person is in outpatient treatment three times a week for an hour, the extra time can be plugged with 12-step program meetings, or some appointments connected with a particular goal. “We try to give a client something to do within

one week after they come in, something they have the ability to do.” A client who wants to get a high school diploma, which might take six months, can be told to make an appointment to talk to someone about how you get a GED. “What we try to do is give them what they need in order to do something that they have the ability to do within a short time so they can get a success right out of the gate. But it is individual, so you sort of tailor it according to where the person is, based on your assessment.”

Garrick Byers of Fresno County said he wondered if the ancillary services being discussed are provided to probationers generally or just to drug offenders. If they are not provided to probationers generally, would it be a good idea to do so? Bogatz responded that in his county, services are offered to all probationers, and it has turned out that a lot of the needs of SACPA clients are first identified by the probation department. “They have the contact with people, and it’s not unusual for them to call and say so-and-so needs job training or may need to see a therapist. We have developed a nice relationship.”

Demers then turned to questions that had been submitted on cards from the audience. Can ancillary funds be used to purchase tools for a client who has successfully participated in SACPA treatment and is ready to enter the work force? Feicht responded that his county does. “If job training or a job requires a certain number of tools, we are trying to equip people to go to work, and I think that is an appropriate expenditure of funds.” Another questioner raised the issue of “integrated services”—treating the whole person through services covering mental health, vocational training, education, and housing. Moore said all three presentations had touched on this question, and it was clear that people needed to be viewed in a holistic way. “Ask them what they need so you engage them in the process. Make sure you have user-friendly screening tools and use motivational interviewing techniques to help draw out individuals so they are really engaged in helping develop a service plan that is going to meet their needs.”

Sue Weisenhaus-Braz of Kings County added further comment about paying for ancillary services. She said that if clients are eligible for welfare-to-work assistance under the Workforce Investment Act (WIA), their services and other needs may be covered by funds other than those designated for SACPA. Moore said she agreed. “I’ve been told that most all of our SACPA participants qualify for WIA funding, so you would not have to use your allocation to pay for those kinds of things.”

Jerónimo Breen of San Bernardino County noted that real progress will have been made when the services now considered “ancillary” are considered an essential components of treatment. In response, Moore discussed how Sacramento County is providing for continuation of ancillary services throughout the treatment period and beyond. “The individual can continue during the aftercare mode or while they are continuing to be supervised by parole or probation,” she said. “I think this is something you should consider when you support someone petitioning the court to have charges dismissed.” She pointed out that part of the completion criteria of the Sacramento program requires that a person be in a job or an education or job-training program. Feicht said that in San Joaquin County they prefer to use the term “continuing care” rather than aftercare. “You do not graduate from programs. You are in a different stage of recovery, and it is the rest of your life.” Clients do not necessarily come back for formal counseling but are urged to return to get annual sobriety pins. “Part of that is to give us feedback on how well they are doing. The longer you keep someone actively engaged in recovery, the better the outcome and the less chance they are going to relapse.”

Demers offered another written question: “Who tracks the client’s ancillary services, the county team or the treatment provider?” Bogatz said the best answer was both. He said there is a need to develop a dialogue between the treatment provider and the team members as services are provided. Demers raised another issue regarding the impact of SACPA on the delivery of county

mental health services. Moore observed that it was so hard to access mental health services that it would be surprising if SACPA had any impact on them at all. She said many in the mental health field need more information about the value of providing mental health services to clients entering alcohol and drug treatment in order to identify psychiatric symptoms and overcome the “revolving door dynamic” that would otherwise prevail. Bogatz said that in San Mateo County 15 to 20 percent of the people coming into the program already were connected to the mental health system “so the problem we have is more one of getting information rather than coordinating the treatment.”

Addiction and Crime: Risk Assessment and Public Safety

Henry Richards, Ph.D.
Assistant Research Professor
University of Washington
Washington Institute for Mental Illness Research and Training

Henry Richards, Ph.D., began his presentation by stating that anyone working with addicted offenders is making "risky decisions" even when making day-to-day decisions regarding treatment or disposition of a case--whether it is safe for the offender, for his or her peers, or for the public at large. If in the criminal justice system, it is "heavy duty risk assessment" because it requires taking all of these factors into consideration and being responsible for the decisions. He discussed systematic approaches to risk assessment and the hazards involved if it is not done well.

The best metaphor for risk assessment is weather forecasting. "We trust or distrust the weather people based on past history, whether the things that they say will happen do happen, or what they say will not happen do not happen." If parole officials tell the public that bad things will not happen when an offender is released, and bad things do happen, then their credibility goes down. The reverse is also true. "When we tell the people bad things are going to happen, and bad things do not happen, it also affects credibility. We have the heavy responsibility to get both ends of it right when we do risk assessment."

Dr. Richards recalled his experience in doing risk assessment while working with offenders in federal and state institutions. His work has pointed to the need to make an accurate match between those offenders who will profit by substance abuse treatment both as a crime prevention strategy and as a public health strategy. "If the crime prevention does not happen, then what happens to the funds available for treatment? They dry up and disappear."

One of the first issues to be addressed is whether a person really has substance dependency that calls for treatment. How are substances affecting the person's life? What is the

relationship between the person's criminality and substance use? Other issues having a direct bearing on risk include anger, a sense of entitlement, criminal attitudes, impulsivity, boredom and self-esteem. He emphasized that risk assessment should start at the beginning of the screening process. "We should not wait until the offender is ready for release or ready to enter a program." The next step is classification--where the person fits, how he or she will be managed, what management and containment strategies are required. Issues to be considered are the risk of self-harm, dependence, vulnerability to coercion or persuasion, and the risk for being intimidated or exploited by others. He noted that "followers" tend to be at higher risk than "leaders." A follower tends to do what someone else tells him or her to do. A leader wants things done, so it is important to know the leader's agenda.

He emphasized that all drug offenders are not the same. Some do not use drugs themselves, but may be principally involved with drugs as a dealer. Some currently identified as non-violent offenders may have histories of violent offenses. In response to a question from the floor, Dr. Richards said he would define a "violent" offense as one in which someone has been hurt. Those with alcohol problems have a higher risk for recidivism and violence. Generally speaking, low-risk drug offenders are people for whom substance abuse treatment can reduce the risk to society even more. "In risk assessment, it is the exceptions that we are worried about." As with weather, people are not worried about tornadoes most of the time, but when one comes along, it is important to be aware of it and issue a warning.

Dr. Richards cited a study of offenders in a drug court program which showed that 75 percent had at least one violent crime in their past with the records showing a versatility in the types of crime. This points to the question that when a drug court defendant is identified as "low risk," it is important to know *when*--i.e., they had not had a violent offense in the *recent past*. It was found that those drug court defendants with multiple offenses in the past were more likely to

have a negative outcome. Another study, in Baltimore, found that among heroin addicts involved in criminal activity there was a subgroup whose criminal behavior did not decrease during periods when they were not using drugs. These individuals have been described as "violent generalists." While these offenders represented only 7 percent of narcotics users, they accounted for over half of the violent crimes among the group as a whole and for three-quarters of the car thefts. This indicates that 93 percent of the heroin users were not particularly involved with violent crimes or car thefts. "If you identified those 7 percent in a city, and increased their monitoring and supervision, and perhaps provided some form of treatment intervention, you would probably have a pretty heavy impact on crime in that city." An attempt to do that has been undertaken in Maryland.

The "violent generalists" have a high overlap with psychopathic drug offenders who tend to get worse with treatment rather than better, and who often sabotage the treatment of others in a group. Some studies show that psychopathic offenders make up from 15 to 25 percent of the maximum-security prison population. At lower security levels, there should be a lower percentage of psychopaths. The prisoner assessments he did in Maryland indicated that about 11 percent of offenders met the criteria for severe psychopathy. Only those who were considered very dangerous were excluded from a treatment program, however. Dr. Richards recalled the case of a prisoner who filed a lawsuit contending that his rights were violated under the Americans with Disabilities Act (ADA) because he was a psychopath and was denied entry into a program for that reason. His extreme behavioral characteristics excluded him from coverage under the ADA. "But he was making the point that he had these problems and if you handled him the same way as others you were overlooking a major need he had."

Research has shown that psychopaths do poorly in a therapeutic environment in both prisons and hospitals. In methadone maintenance programs, they are more likely than others to

be found using other drugs. Treated psychopaths recidivate more rapidly and more violently than those who are not treated. Recent research shows this is true not only for treatment in a therapeutic community but also for cognitive behavioral therapies and several other treatments. New research is attempting to discover why this is the case. Psychopaths represent a relatively small percentage of the total population, but account for a “huge amount of serious crime,” Dr. Richards said. Fortunately, it appears that offenders found to have a drug dependence are less likely to be psychopaths.

Dr. Richards used images of the human brain to demonstrate how psychopaths process emotional experience differently than non-psychopaths. He pointed out that differences in the brain functions of persons who have some kinds of mental illness due to social deprivation or abuse can be overcome through psychotherapy, but this does not appear to be the case with psychopaths.

Turning to the process of risk assessment, Dr. Richards used the metaphor of a lens. He suggested there are three different lenses representing different ways of looking at things, each with its own logic and methods. This can help resolve the conflict between actuarial risk assessment—such as risks based on sex, age or other characteristics—and clinical predictions based on characteristics of the individual. The new thinking is that actuarial prediction along with structured clinical assessment may be better than either one by itself. Typically, an assessment is based on interpretation and judgment of what is discovered about an individual. The assessment may be based on the combination of background information and a theory of what makes people risky. The big question is whether substance users who are at risk for committing substance use crimes are also at risk for committing non-substance use crimes.

He explained how a study of parolees in Arizona showed that the same data about offenders could lead to different risk assessments depending on what theory is used. One theory

is that risk of committing violent crimes is higher for competitively disadvantaged males, those with poor social skills and low achievement status. Another holds that the key issue is impulse control—that the most dangerous offenders are those with very poor self-control. The study found that the model or theory based on low self-control as the key factor was more reliable in assessing risk.

Dr. Richards listed several risk indicators to be considered:

- Violence history
- Actuarial predictors
- Psychopathy checklist (the best indicator)
- Mental disorders and states
- Strengths and ameliorating factors

These indicators can be combined with situational or circumstantial factors such as where the person lives, whether he or she is married or in a long-term relationship, and whether the person is employed.

A major question is how various indicators are combined to produce an assessment. The “Violence Risk Assessment Guide” (VRAG) for male offenders combines psychopathy; elementary school maladjustments; age at offense; personality disorder; separation from parents prior to age 16; failure on prior release; property offenses; marital status; a diagnosis of schizophrenia (a factor reducing risk); victim injury in the offense; history of alcohol abuse; and whether a male was the victim in the offense. (Men who hurt other men are more dangerous because they are willing to confront men). Dr. Richards pointed out that substance abuse other than alcohol is not an item on the VRAG. He discussed ways that various risk factors can be combined and weighted to arrive at an assessment. Another approach is the History Clinical Risk 20 or HCR20, looking at the history of the individual and clinical factors systematically and

allowing the person doing the assessment to exercise more judgment than would be the case with the VRAG assessment. The history items include previous violence, age at first violence, relationships and stability, employment problems, substance abuse, major mental illness, psychopathy, early maladjustments, and prior supervision failure. Clinical items include lack of insight regarding the individual's own problems, negative attitudes, impulsivity, unresponsiveness to treatment, and behavior in treatment. Other factors look at the future: does the person have feasible plans; exposure to destabilizing influences; lack of personal support; and have a history of noncompliance with remediation attempts?

Some researchers in the State of Washington are looking at how the risk factors from mentally ill offenders differ from those of offenders who are not mentally ill. The answer based on the current state of knowledge is almost not at all. Factors most affecting risk of recidivism included a first offense prior to age 25 and in-prison infractions.

On average, Dr. Richards concluded, the best that risk assessment can do in predicting who will commit new crimes is being correct about 75 percent of the time. "You can consider that pretty bad or pretty good, but it is a great improvement over where we were just a few years ago." He pointed out that the person receiving the results of an assessment needs to have some information about what it is based on and how long it can be relied upon. The limitations should be stated, such as saying the assessment is good for the next 90 days. "If you say a person is at high risk, does that mean forever? Or he is at low risk—forever?" Assessments, like weather forecasts, are based on probabilities. Weather forecasters become reliable when they are engaged in their activity full time for a long time. Ideally, risk assessments would be made the same way weather forecasts are made. They would be made by persons who are specialists in the field, who work in teams, and base their assessments on base rates and actuarial factors.

They know how the information they use was collected. They have continuing education so they are up-to-date. And they have feedback to measure the accuracy of their assessments.

Dr. Deitch then pointed out that much of the “feedback” on assessment and treatment flowing to the criminal justice system and the courts is distorted because it consists mainly of people who are failing and coming back into the system. “They do not see the many people who as a result of treatment are *not* returning to the courtroom. They are only seeing what is not successful, and they begin to make conclusions based on those return visitors.”

Proposition 36 - Making It Work! 2002

A statewide technical assistance conference

DAY THREE

Showcasing Success and Identification of Issues by Like-Size Counties

Opening the final day of the conference, ADP Director Jett said emerging from small group sessions was the need to adopt statewide policies clarifying several issues and that these policies will be forthcoming. She also pointed out that some counties have created SACPA informational materials in languages other than English. She urged counties wishing to share such materials with others provide copies to the ADP Resource Center, which can make the texts available via its web site. She said she was pleased that so many counties had indicated a willingness to share what they have learned and created as the implementation process goes on.

Dr. Deitch said the conference sessions had made it apparent that certain problems are unique to counties of similar size. In the final hours of the conference, like-size counties gathered to address problems they had identified in a previous meeting and report back to the final plenary session on the results of their work.

Medium-size Counties in the Bay Area: Marin, San Joaquin, San Mateo, Santa Cruz, Solano, Sonoma, and Stanislaus Counties

Bill Manov of the Santa Cruz County Alcohol and Drug Program and **Jose Varela** of the Marin County Public Defenders Office delivered the report for the group.

Manov said the group identified a problem in providing services to dual diagnosis clients whose mental problems are not severe enough to place them in the county mental health system.

“Some counties have been able to get mental health [staff] to the table for the screening process and case consultations but others have not,” he said. One possibility is to provide alcohol and drug treatment providers with enough training to do a preliminary screening. “There was also discussion around public and private participation with local non-profits and mental health care providers to fund them to provide dual diagnosis services.”

Varela said the group discussed participation by the Board of Prison Terms (BPT) and the Parole and Community Services Division of the California Department of Corrections (CDC) on county implementation committees and suggested that counties try to add parole representatives to their committees. San Joaquin County, for example, has a parole representative at the table on its implementation committees. Such participation can be valuable because of the knowledge of the client base and structural problems that the BPT and parole can provide in getting statewide information down to the local level, Varela said.

The group also discussed the problem of caseload sizes. One solution is not to put every client on formal probation, but to use a screening process to assign higher-risk clients to probation and put others either in a banked caseload or under judicial supervision. “Some counties are doing case conferences with the team prior to the status review court hearings and this provides a mechanism for a lot of input to the supervision aspects as well as the clinical aspects,” Manov said. Some counties have clarified the role of probation in supervision and monitoring, and the role of alcohol and drug treatment providers as case managers, reducing duplication of effort by the two entities.

Varela said the group also touched on cross-jurisdictional supervision issues among counties. He pointed out that San Mateo County was hosting a meeting of representatives of like-size or contiguous counties in the Bay Area to focus on such issues. Data on cross-jurisdictional issues could reveal funding questions regarding which county should pay for

services. The group suggested that other like-size or contiguous counties hold similar meetings to provide the Legislature with data on any funding issues.

Manov said other subjects discussed included the lack of residential treatment beds, affected both by funding and community resistance issues; and how to sustain funding for facilities during periods of high vacancy rates. “Some counties are developing small, six-bed licensed treatment facilities which may be a little less cost-efficient but are a lot easier to get up and running. Other counties are using a combination of clean and sober housing with intensive outpatient or day treatment programs which are much easier and quicker to scale up and scale down as caseloads may require.”

Bringing homeless programs into SACPA also was discussed. It was pointed out that grant programs to deal with homelessness, such as those providing funds for housing or medical and mental health treatment, might serve as a source of funds when homeless individuals become SACPA clients.

The group also discussed the fact that the most impaired clients—often those with a dual diagnosis of mental health or physical health problems—tend to take up the most resources. One solution is to divert minor first-offense clients into programs other than SACPA such as Penal Code 1000 diversion programs. Educating the public and policymakers about the value of treatment could also lead to a greater investment in resources for implementing SACPA. “As we come up against resource limitations we are going to have to develop policies saying what we will do when we have helped someone as much as we can, given the amount of resources we can put into that person. We are going to be facing some tough value judgments.”

Communication and conflict resolution also were discussed. In many counties, people who did not support Proposition 36 are not coming to the table to help in its implementation. They need to be encouraged to recognize that SACPA is what California voters wanted. “The

way it is going to work is through meaningful collaboration, not just warm bodies taking up space.”

Finally, the group talked about continuous and sufficient funding for SACPA. Some counties will be able to make it through the coming year with what they saved from start-up funding this year; but by the end of next year many counties could be running out of money. A lot can be accomplished through best practices, but at some point the money will run out. One solution is to build cross-jurisdictional coalitions at the local level to lobby for more resources. Since SACPA is an entitlement, there is a potential for lawsuits if the resources are not at hand to provide entitled services.

Medium-size Counties including Kern, Monterey, Placer, San Luis Obispo, Santa Barbara, Tulare, and Ventura

Judge Rogelio Flores of the Superior Court of Santa Barbara County reported that the theme of his meeting might be described as “purpose colliding with destiny.” There is a need for more information sharing among like-size counties, which might be accomplished through regional conferences, he said.

One county in the group offered an idea for meeting the challenge of dual-diagnosis clients. A part-time psychiatrist or psychologist would be hired to provide services to those clients who do not meet the criteria for the county mental health program. In Santa Barbara County, Flores said, a SACPA client found to have a dual diagnosis is moved to the county’s mental health court.

The group also hopes the state will provide guidance for the jurisdictional transfer of cases and how the 58 counties relate to each other in that respect.

The group discussed at length the need to enhance communication among SACPA stakeholders. One idea is to have a “policy committee” and an “implementation committee” within the counties, embracing not only SACPA teams, but also drug courts, mental health

courts, domestic violence review courts, and juvenile drug courts. The stakeholders in different therapeutic models need to communicate with each other because at times their workloads interact.

Smaller Counties including Alpine, Amador, Calaveras, Inyo, Mariposa, Modoc, Mono, Plumas, San Benito, Sierra, and Tuolumne

William Demers, President of the County Alcohol and Drug Program Administrators Association of California and Administrator of the Sierra County Alcohol and Drug Program, delivered the report for this group, emphasizing at the beginning that their county collaboratives were working well—“not perfect, but working well.”

Jurisdictional transfers also concerned this group, and an administrative “fix” is needed. Chief probation officers in northern California have developed policies and procedures to handle cases in which a person arrested in one county continues to be supervised by that county’s court even though he or she lives in another county. This is a public safety issue that should be addressed throughout the state, Demers said.

As for parole issues, the group suggested that a list of regional parole contacts be mailed to the SACPA lead agencies in each county. There also needs to be more outreach and contact with local probation and parole officers to improve communication involving SACPA implementation.

In many counties, delivering ancillary services has raised concern about what happens when their programs are audited. On the one hand they are urged to be innovative in meeting client needs, but they may not match an auditor’s “parameters of purchase.” It is often not clear what a program can and cannot do in providing ancillary services. There is also an issue of duplication of purchase, when services being bought from another agency are permissible purchases under SACPA but are already being funded by another source. The rules of flexibility

for purchase of services should be as flexible as the rules applying to the CalWORKs program. Auditors should be educated about and brought into the innovative spirit of SACPA.

The group also discussed the challenge of workforce development. Among the issues are salary differences among counties and a lack of certified counselors in rural areas, especially bilingual counselors. One solution would be paid scholarships to encourage choice of a career in alcohol and drug counseling. Another idea is for the state to hire staff as is done for staffing in local public health programs.

Rural areas also have client transportation problems. Ideas for relieving those problems include setting up appointments in clusters, bringing counselors to the clients, leasing vehicles, providing gasoline vouchers, or utilizing “telemed” services to link clients at remote locations.

Finally, Demers said the rural counties see a need for a full-blown educational program about SACPA to make county supervisors more familiar with SACPA’s provisions and goals.

Smaller Counties including Butte, Colusa, El Dorado, Glenn, Lake, Mendocino, Napa, Nevada, Sutter, Yolo, and Yuba

Lisa Cox of Butte County said the group had talked about four main issues—residential treatment, funding, cross-jurisdictional issues, and communication and teamwork.

One problem is getting residential treatment facilities to accept dual diagnosis clients. Intensive outpatient treatment might be an alternative if proper housing for these clients can be found. Another avenue would be to use SACPA funds to send the clients to private mental health providers. Butte County, for instance, hired a clinician to be part of the SACPA team and connect dual diagnosis clients with behavioral health agencies. Further, alcohol and drug staff could have meetings with mental health staff. The lack of connection between alcohol and drug services and mental health services in some counties is one of the issues that SACPA has brought to the surface.

One county came up with an \$18,000 subsidy to provide additional clean and sober housing. Funding for homeless programs also can be utilized for dual diagnosis clients. Butte County is amending contracts with residential treatment facilities to provide alcohol- and drug-free housing for these clients. Providing residential treatment for women with children is another big problem. One county has a therapeutic learning center allowing children to be on the site when their mothers are in treatment. Counties also can use Medi-Cal and CalWORKs funds for clients with children.

Another problem cited was inadequate funding for probation departments to make probation officers part of SACPA teams. The funding of district attorneys and public defenders for SACPA cases also is an issue. Counties need to re-evaluate how SACPA funds are spent and create priorities since no additional funding from the state is coming.

Cox said that in states bordering California no treatment facilities have applied for California licensing in order to treat SACPA clients. As a result, some small counties on the edges of California are having trouble finding treatment opportunities for some individuals. These counties are asking that the Legislature address the “tourist offender” issue. Also, within California, not every county accepts “courtesy supervision” of probation cases. Some believe cases should be transferred to the county in which the client lives in order to assure accountability. The arrangement described earlier involving probation chiefs in northern California is not the same throughout the state, she added.

Members of the group also expressed some confusion over the difference between the “Drug Court” model and the “Probation Model” of handling cases. Various counties are making progress in improving communication and collaboration among various departments involved in SACPA cases. In one county, all of those involved meet once a month to discuss issues that are not client-specific, and subcommittees are created to deal with specific issues. Having an analyst

connected with the program also helps keep track of new rules and regulations that come up. One county has the auditor as a member of the work group and this was seen as an excellent idea. Another county uses a basic spreadsheet for intake and collects data on a daily basis as clients come into the program. In Butte County, the team has a weekly meeting with probation and treatment people to discuss cases, and meets weekly with the judge, district attorney and public defender to “hash out” difficult cases. Finally, the group agreed there was a need to set up regular small county regional meetings.

Smaller Counties including Del Norte, Humboldt, Imperial, Kings, Lassen, Madera, Merced, Shasta, Siskiyou, Tehama, and Trinity

David Lee, a Deputy District Attorney in Merced County, said the group looked at issues in five areas: treatment, staffing, funding, criminal justice questions and parole. It was obvious that finding and funding qualified staff were issues across the board.

The group felt that a good team approach was essential to success. With dual diagnosis cases, there should be room for “creativity” in using community physicians. State assistance should be sought to provide for more professional training of staff people, cross-training of team members, and more residential treatment resources. The group believed that sharing the information given to this conference by Dr. Schuckit would help make the case for more cross-training. There is also a need for more resources for “sober living environments.” On the local level, there is a need to improve the process for certification of sober living environments. Santa Clara County was cited as an example of how this can be done. Better case management is another approach that can be pursued at the local level, but it would create additional costs.

The group discussed possible local solutions to transportation problems, such as having the courts and treatment providers become more creative in their scheduling. Cooperation with neighboring counties could also solve some problems, along with using fleets of vehicles and bus

passes as transportation resources. Another measure would be the development of satellite treatment sites, which also would require additional state funding.

The counties feel that not enough ancillary services are available, and that there is a need for mobile services to conduct outreach and for provision of child care as an adjunct to treatment services. There were suggestions for seeking help from the private sector, and for using county resources for grant writing to seek additional funds.

On the staff training issue, it was suggested that such training might be made available on a regional basis, including an opportunity for continuing education units. Low salaries in smaller counties also make it difficult to attract and retain trained staff.

Lee listed five problem areas that came up within the group but could not be addressed with problem solving during their session. These were: lack of commitment by courts and the district attorney's office in some counties; the need for a dedicated court; defining cross-jurisdictional processes; parole concerns; and district attorney filings.

Larger Counties in the Bay Area including Alameda, Contra Costa, Sacramento, San Francisco, and Santa Clara

Stan Weisner of Alameda County said a number of success stories had surfaced at the session--the assessment center in Santa Clara, the dual diagnosis expertise in Contra Costa, pre-treatment groups developed in several counties, and the range of outpatient services available in Alameda. The problem areas discussed were: mental health resources, continuing care in the context of ancillary services, defining success, and tracking and coordination.

The group saw a need for statewide definitions regarding dual diagnosis; a need for day to day mental health services as well as formal treatment. There is also a need for early identification of mental health problems in clients and for incremental health services while the individual is being linked to more formal services. There is also a need to look at new models for interventions. Workplace issues include a need for more training, with scope-of-practice

issues emerging as more mental health needs are found in delivery of alcohol and other drug services. The group saw all of these things as “doable.” Legislation might help resolve many problems by folding mental health services into SACPA.

John Ramos, program coordinator for San Francisco, reported on the discussion of collaboration at the local level, especially involving parole and BPT. He explained that the CDC Parole and Community Services Division is the supervisory agency that does the monitoring of offenders while BPT is a referral source acting as the authority for the parolee population. He praised BPT for its response to the need to work with all 58 counties on SACPA cases, and suggested that county agencies familiarize themselves with parole and BPT, as well as their local probation agency, to improve their collaboration. The collaboration problems differ from county to county because lead agencies in each county may be different. “We can’t put a stamp on a certain model,” he said. “We all, in a sense, are hybrids.”

Bruce Occena, San Francisco Department of Public Health, said the group discussed ancillary services in the broader context of continuing care. All counties are trying to understand what should be included in ancillary services, how they should be provided, and when they should be considered completed. The term itself makes clear that it is considered ancillary to substance abuse treatment, and there must be a balance between ancillary services and primary substance abuse services. It is a zero-sum situation. One question is what happens when substance abuse treatment is considered to be completed, but ancillary services are still needed. “A lot of us are grappling with that issue,” he said. San Francisco County is asking providers of ancillary services whether their mission and funding would allow them to continue providing their services even after people have completed SACPA in terms of probation and parole.

Lenny Williams of Contra Costa County’s Alcohol and Drug Services and supervisor of its Gateway Recovery Unit reported on the group’s consideration of tracking issues. These

include how people can be tracked after they go to court and enter treatment, and how to get information from the treatment provider to parole and probation and the courts. No two counties seem to be doing this in the same way. He said Contra Costa uses its Gateway Unit as a central funnel for all information. “Treatment providers tell us how a client is doing. We give the information to probation. And probation gives it to the court.” He said San Francisco does something similar, but in Santa Clara County such information goes from the treatment provider directly to the judge the day before the client has to appear in court. Contra Costa developed a computerized form to be used by treatment providers so that the same information about each client would be provided to probation. “It is difficult when probation has to go to each provider to get such information,” Williams said.

Southern California Counties including Fresno, Los Angeles, Orange, Riverside, San Bernardino and San Diego

Judge Richard Field, Riverside Superior Court, said this group talked about investing resources in dual diagnosis programs. It was suggested that SACPA treatment providers be required to bring mental health treatment into their programs. There is also a need to have assessors capable of making dual diagnosis assessments at the initial assessment stage.

Discussion of funding centered on the need for funds for dual diagnosis treatment, with a proposal that federal block grant funds for mental health be earmarked for dual diagnosis SACPA clients, and that block grant funds be flexible enough to cover ancillary services. He noted that Director Jett had advised the group that ADP is discussing this issue with the California Department of Mental Health.

The group talked about collecting fees for services to recover some expenses, and how fees could be collected without an adverse effect on the recovery of clients who cannot afford to pay. There was also concern expressed about diverting federal block grant funds to drug testing, citing a need to find new sources of funds for drug testing. In the funding discussions, there was

a tendency to talk in terms of individual defendants rather than a “systems approach” to obtain sufficient funds on a statewide basis.

The group suggested one way to help make a case for more SACPA funding is to take the number of non-prison days and non-county-jail days resulting from SACPA and calculate how much is saved for each of the days that those clients are not in jail or prison. The amount of money saved for each non-prison and non-jail day should be applied to drug treatment.

Finally, Judge Field said that some time should be spent becoming familiar with the requirements for entering the programs of various social service agencies that may be able to provide ancillary services for SACPA clients. The Workforce Investment Act provides funds for educational services in the community. Grants for housing needs may be available from the federal Housing and Urban Development Agency (HUD) if experienced grant writers are available to draft proposals.

Success Unfolding and Closing Comments

Director Kathy Jett praised participants for sharing their ideas and assured them that those ideas would be conveyed to the State Advisory Group for Proposition 36. She introduced Tom W. of San Diego who described his experience staying clean and sober as a client in treatment under Proposition 36. She said he represents tens of thousands of others who are having similar experiences as they move through the system.

The Director closed the conference with a call to all SACPA stakeholders to join ADP in a commitment to continuing collaboration that ensures that all Californians are offered an opportunity for healthy lives and safe communities.

