Evaluation of the Substance Abuse and Crime Prevention Act

2003 Report

Prepared for the Department of Alcohol and Drug Programs
California Health and Human Services Agency

By Douglas Longshore, Ph.D., Darren Urada, Ph.D.,
Elizabeth Evans, M.A., Yih-Ing Hser, Ph.D., Michael Prendergast, Ph.D.,
Angela Hawken, Ph.D., Travis Bunch, and Susan Ettner, Ph.D.

September 23, 2004

Integrated Substance Abuse Programs

Evaluation of the Substance Abuse and Crime Prevention Act

2003 Report

Prepared for the Department of Alcohol and Drug Programs
California Health and Human Services Agency

By Douglas Longshore, Ph.D., Darren Urada, Ph.D.,
Elizabeth Evans, M.A., Yih-Ing Hser, Ph.D., Michael Prendergast, Ph.D.,
Angela Hawken, Ph.D., Travis Bunch, and Susan Ettner, Ph.D.

September 23, 2004

Table of Contents

Preface 7

Executive Summary 9

Chapter 1: Introduction 13
Evaluation overview 13
Organization of the report 14

Chapter 2: Criminal Justice 15
SACPA-eligible offenses 15
Felony and misdemeanor convictions 19
Probation violations and revocations 21
Parolee recommitments to prison 21
Conclusion 23

Chapter 3: SACPA Offenders 25
SACPA pipeline 26
Characteristics of treatment clients 30
Characteristics of first-time clients 42
Conclusion 47

Chapter 4: Offender Management Strategies 49
Assessment procedures 50
Drug court procedures 50
Conclusion 50

Chapter 5: Offender Management Strategies and Show Rates 53
County variability 53
Show rates at assessment 53
Show rates at treatment 55
Conclusion 57

Chapter 6: Treatment Placement 59
Treatment modality 59
Placement of clients with high-severity drug problems 61
Conclusion 66

Chapter 7: Treatment Completion and Duration 69
Analytic issues 70
Treatment completion 73
Treatment duration among clients who completed treatment 80
Treatment duration among all clients 83
Conclusion 89

Chapter 8: Implementation 93
County implementation 93
Sector implementation 93

Conclusion **95**

Chapter 9: Evaluation Progress and Planning **97**
Research questions **97**
Upcoming products **101**
Stakeholder survey **101**
Focus counties **101**
Data access **106**

Glossary **109**

Appendices **111**
A. SACPA-eligible offenses **113**
B. 2003 SACPA stakeholder survey **115**
C. Pipeline analysis **127**
D. Multivariate analysis of treatment completion **131**
E. Treatment duration among non-SACPA clients **135**

References **143**

Preface

Proposition 36 was passed by the California electorate in November 2000 and enacted into law as the Substance Abuse and Crime Prevention Act (SACPA). SACPA represents a major shift in criminal justice policy. Adults convicted of nonviolent drug-related offenses and otherwise eligible for SACPA can now be sentenced to probation with drug treatment instead of either probation without treatment or incarceration. Offenders on probation or parole who commit nonviolent drug-related offenses or who violate drug-related conditions of their release may also receive treatment. An independent evaluation of SACPA's implementation, fiscal impact, and effectiveness was mandated in the initiative.

The Department of Alcohol and Drug Programs (ADP) was designated by the Governor's Office to serve as the lead agency in implementing and evaluating SACPA. In turn, ADP, through a competitive bid process, chose UCLA Integrated Substance Abuse Programs to conduct the independent evaluation of SACPA over a five and one-half year period beginning January 1, 2001 and ending June 30, 2006. The evaluation will include analyses of cost-offset, client outcomes, implementation, and lessons learned.

This report presents detailed findings on the implementation of SACPA during its second year (July 1, 2002 to June 30, 2003) and summarizes key findings across SACPA's first and second years. Findings describe the types of crime committed by offenders entering SACPA and subsequent probation violations and revocations and parolee recommitments to prison. Also described is the flow of offenders through the SACPA "pipeline" starting with referral of the offender to SACPA and continuing through assessment and treatment entry. In addition, the report covers offender management strategies employed by the counties; the relationship between offender management strategies and the flow of offenders through the SACPA pipeline; treatment placement, completion, and duration; and a review of evaluation progress and planning. Reports issued in 2004 will update findings on implementation; describe crime trends before and after SACPA began; analyze criminal recidivism, drug use, and other outcomes among SACPA offenders; and include an in-depth analysis of SACPA's fiscal impact.

For an on-line copy of the 2002 and 2003 reports, see http://www.uclaisap.org/prop36/reports.htm. For more information about the evaluation, see http://www.uclaisap.org/Prop36/Prop36.htm or contact:

Douglas Longshore, Ph.D.
UCLA Integrated Substance Abuse Programs
1640 S. Sepulveda Blvd., Suite 200
Los Angeles, CA 90025
Tel: (310) 445-0874 ext. 231
Email: dlongsho@ucla.edu

Larry J. Carr, Ph.D.
California Department of Alcohol and Drug Programs
1700 K Street
Sacramento, CA 95814
Tel: (916) 327-8965
Email: lcarr@adp.state.ca.us

Executive Summary

This is the second in a series of annual reports from the independent statewide evaluation of the Substance Abuse and Crime Prevention Act (SACPA). Prepared by UCLA Integrated Substance Abuse Programs for the California Department of Alcohol and Drug Programs, the report covers the second year of SACPA (July 1, 2002 to June 30, 2003) and compares findings across the first and second years.

Offenders eligible for SACPA

A statewide total of 54,140 offenders were found in court to be eligible for SACPA in its second year. This total included offenders already on probation or parole as well as new offenders. Most eligible offenders who did not choose to participate in SACPA opted for routine criminal justice processing.

Among 50,335 offenders who agreed to participate in SACPA in its second year, 35,947 (71.4%) entered treatment. This show rate was slightly higher than the rate in SACPA's first year (69.2%) and compares favorably with show rates in other studies of drug users referred to treatment by criminal justice.

There was variability in SACPA eligibility across counties. For example, persons convicted of drug possession and being under the influence of drugs were SACPA-eligible in all counties, while persons convicted of possession of drug paraphernalia and driving under the influence were eligible in some counties but ineligible in others.

Characteristics of offenders in treatment

Characteristics of SACPA treatment clients were stable across its first and second years. In its second year, about half of those entering treatment reported methamphetamine as their primary drug (53.0%), followed by cocaine/crack (13.2%), marijuana (12.1%), and heroin (10.2%). Most SACPA clients (72.7%) were men. About half (48.0%) were non-Hispanic Whites, while 31.4% were Hispanics, 13.8% African Americans, 2.6% Asian/Pacific Islanders, and 1.7% Native Americans. Their average age was 35. SACPA treatment clients had longer drug use histories than clients referred to treatment by criminal justice sources other than SACPA.

About half of SACPA clients in each of the first two years were entering drug treatment for the first time. The effect of SACPA on first-time treatment exposure was most apparent for Hispanics, men, younger drug users, and methamphetamine users. Many first-time clients had a lengthy drug use history.

Treatment placement

Treatment placements were similar across SACPA's first two years. Most clients were placed in outpatient drug-free programs (84.1% in the second year) or long-term residential programs (10.9%).

In a sample of SACPA and non-SACPA clients with high-severity drug problems, placement in outpatient rather than residential treatment was more common for SACPA clients. To expedite treatment for SACPA clients, counties may be placing them in outpatient programs

able to take them immediately. However, as a result, clients with high-severity drug problems may not be getting the level of treatment they need.

Within SACPA, outpatient placement of high-severity clients was more common for African Americans. Race/ethnic differences may be due to the geographic dispersion of residential programs supplying treatment for SACPA clients. There were no differences in placement of high-severity clients by age, sex, or primary drug.

Treatment completion and duration

About one-third (34.4%) of offenders who entered treatment in SACPA's first year completed treatment. Data were not yet available on completion in SACPA's second year.

Overall, about one-quarter (23.8%) of offenders who agreed to participate in SACPA in its first year completed treatment (based on a 69.2% treatment entry rate among all SACPA offenders and a 34.4% completion rate among offenders who entered treatment). This rate is typical of drug users referred to treatment by criminal justice.

A majority of SACPA outpatient drug-free clients (54.9%) received at least 90 days of treatment, as did 42.8% of long-term residential clients. These rates are typical of drug users referred to treatment by criminal justice. A period of 90 days is widely cited as the minimum length of stay before treatment is likely to have a beneficial effect.

Treatment completion and 90-day duration were less likely for African Americans, Hispanics, and Native Americans than for Whites and Asian/Pacific Islanders. Race/ethnic differences in treatment completion occurred among non-SACPA clients as well and may reflect broad societal conditions that are difficult to change. However, differences in placement (noted above) and 90-day duration occurred only among SACPA clients. It may therefore be possible to address race/ethnic differences in SACPA at the "front end" (placement and early retention) more readily than disparities at the "back end" (completion). For example, existing residential capacity might be redistributed within counties and day treatment capacity might be expanded.

Asian/Pacific Islander clients in SACPA were mostly Filipino and South Asian (Cambodian, Laotian, and Vietnamese). Treatment duration and completion for these clients were relatively good despite possible cultural barriers to treatment access.

Treatment completion and 90-day retention were better for users of methamphetamine, cocaine/crack, and marijuana than for heroin users. Concern has been raised regarding the treatment system's ability to meet clinical challenges presented by methamphetamine users. Findings suggest that treatment providers in SACPA have handled these challenges effectively. Treatment completion and duration would likely improve for heroin-using clients if methadone maintenance were available to all who wish to receive it.

Criminal justice

Most SACPA clients (90%) were placed on probation when sentenced or were already on probation. The remaining 10% were parolees with a new offense or a drug-related parole violation. SACPA probationers and parolees were similar in race/ethnic composition. Men comprised a larger proportion of the parolee group. Compared to probationers, parolees

were older, had longer histories of drug use, and were more likely to cite heroin as their primary drug.

One in five probationers (20.0%) had their SACPA probation revoked. This rate is lower than revocation rates typical of offenders on probation.

SACPA parolees had lower rates of treatment completion and 90-day duration than probationers. Over half (60.0%) of SACPA parolees were recommitted to prison in the one-year period after referral to SACPA. This rate is typical of drug users who receive treatment while on parole. The recommitment rate may improve if more parolees reach the 90-day mark for treatment duration.

Offender management

Counties employed a variety of strategies to manage the flow of offenders into SACPA. These strategies included: locating assessment centers in or near the court, co-location of probation and assessment staff, allowing assessment by walk-in as well as (or instead of) appointment, allowing a longer time (number of days) for offenders to report for their assessment, completing assessment in one visit, and adoption of one or more drug court procedures. The assumption underlying each strategy was that it might help to maximize the show rate at assessment, treatment, or both. Offender management strategies varied across counties for reasons such as availability of office space, expected volume of SACPA offenders, and number of assessment staff available.

Assessment show rates were higher in counties where assessment took place in or near the court and where offenders were allowed more days to report for assessment. Assessment and Treatment show rates were higher in counties using one or more drug court procedures to handle SACPA offenders. These findings were stable across SACPA's first two years and may represent important aspects of effective management of the flow of offenders into SACPA.

Implementation

County representatives reported "very good" quality of SACPA implementation across both years. SACPA required substantial collaboration among service sectors at the county level. These sectors include county administrators, treatment providers, judges and court administrators, district attorneys, defense attorneys, and probation and parole representatives.

Future reports

Reports issued in 2004 through 2006 will update findings on implementation; describe crime trends before and after SACPA began; analyze criminal recidivism, drug use, and other outcomes among SACPA offenders; and include an in-depth analysis of SACPA's fiscal impact.

Chapter 1: Introduction

In November 2000, California voters passed Proposition 36, which was enacted into law as the Substance Abuse and Crime Prevention Act (SACPA).

UCLA Integrated Substance Abuse Programs was chosen by the California Department of Alcohol and Drug Programs (ADP) to conduct an independent evaluation of SACPA.

This report describes the second year of SACPA implementation and summarizes key findings across SACPA's first and second years.

In November 2000, California voters passed Proposition 36, which was enacted into law as the Substance Abuse and Crime Prevention Act (SACPA). SACPA represents a major shift in criminal justice policy, inasmuch as adults convicted of nonviolent drug-related offenses in California and otherwise eligible for SACPA can now be sentenced to probation with drug treatment instead of either probation without treatment or incarceration. Offenders on probation or parole who commit nonviolent drug-related offenses or who violate drug-related conditions of their release may also receive treatment. Modalities include drug education, regular and intensive outpatient drug-free treatment, short- and long-term residential treatment, and pharmacotherapy (typically methadone for clients dependent on heroin). Offenders who commit non-drug violations of probation/parole may face termination from SACPA. Consequences of drug violations depend on the severity and number of such violations. The offender may be assigned to more intensive treatment, or probation/parole may be revoked.

The California Department of Alcohol and Drug Programs (ADP), through a competitive bid process, chose UCLA Integrated Substance Abuse Programs to conduct an independent evaluation of SACPA over a five and one-half year period beginning January 1, 2001 and ending June 30, 2006. This report describes findings on the implementation of SACPA and evaluation progress and planning during SACPA's second year (July 1, 2002 to June 30, 2003) and summarizes key findings across SACPA's first and second years.

Evaluation overview

Along with evaluations of drug courts and drug policy initiatives in other states (e.g., Arizona's Drug Medicalization, Prevention, and Control Act of 1996), the SACPA evaluation is providing state and national policymakers with information needed to make decisions about the future of SACPA in California and similar programs elsewhere. The evaluation covers four domains: cost-offset, client outcomes, implementation, and lessons learned. Data are being collected in surveys of county representatives and offenders; focus groups (semi-structured in-depth discussion) with county representatives; observation (e.g., recording of issues raised, perceptions noted, decisions and agreements reached) at meetings, conferences, and other events; county records; and statewide datasets maintained by human services and criminal justice agencies.

Douglas Longshore, Ph.D., is principal investigator. Other UCLA researchers leading the SACPA evaluation are Yih-Ing Hser, Ph.D., and Michael Prendergast, Ph.D. Susan Ettner, Ph.D., an economist at UCLA, will lead the cost-offset analysis. Also involved are M.

Douglas Anglin, Ph.D., serving as science advisor; and A. Mark Kleiman, Ph.D., as policy advisor.

Organization of the report

This report addresses research questions in the implementation domain of the evaluation (a full list of research questions appears in Chapter 9). Those questions are:

- How many SACPA-eligible offenders enter and complete treatment?
- What procedures are used for assessment, placement, and supervision of SACPA offenders?
- How do sectors of the criminal justice and treatment systems respond to SACPA?
- What problems occur in implementing SACPA, and how are those problems addressed?

Chapters 2 through 5 are concerned with criminal-justice and treatment aspects of SACPA implementation. Chapter 2 identifies the types of crime committed by offenders entering SACPA and subsequent probation violations and revocations and parolee recommitments to prison. Chapter 3 describes the flow of offenders through the SACPA "pipeline" starting with referral of the offender to SACPA and continuing through assessment and treatment entry. The chapter includes a comparison of pipeline findings from the second year and the first. Chapter 4 reports offender management strategies employed by counties in the second year of SACPA, and Chapter 5 reports the relationship between these strategies and the flow of offenders through the SACPA pipeline.

Chapters 6 and 7 further examine the treatment aspect of SACPA. Chapter 6 describes the types of treatment in which SACPA's second-year offenders were placed and analyzes the prevalence of outpatient treatment for offenders whose drug problem severity was high enough to indicate a likely need for residential treatment. Chapter 7 reports treatment completion and duration for SACPA's first-year offenders. The focus is restricted to SACPA's first year because it is too soon to determine how SACPA's second-year population will fare after entering treatment.

Chapter 8 reviews the quality of SACPA implementation during its first and second years, as perceived by county representatives. Finally, Chapter 9 reviews evaluation progress and planning.

Key findings are highlighted at the outset of each chapter.

Chapter 2: Criminal Justice

There was variability in SACPA eligibility across counties. Drug possession, being under the influence of drugs, and drug transportation for personal use were treated as SACPA-eligible offenses in all counties in SACPA's second year. While drug possession and being under the influence were SACPA-eligible in all counties in SACPA's first year as well, drug transportation was treated as an eligible offense in most but not all counties in SACPA's first year. Possession of drug paraphernalia and other drug-related offenses were treated as SACPA-eligible in most but not all counties in SACPA's first and second years. A minority of counties treated vehicle offenses, such as driving under the influence of drugs, as SACPA-eligible in both years.

Cases involving some of these offenses—including transportation of drugs, cultivating marijuana, and driving under the influence—were on appeal as of December 31, 2003. Treatment of these offenses may become more consistent across counties as cases now pending are decided at the appellate level.

During SACPA's second year 60.7% of probationers entered SACPA on felony as opposed to misdemeanor convictions. There was wide variation across counties in the percent of offenders with felony convictions.

After entry into SACPA, 50.0% of offenders on probation had no drug violations recorded; 27.0% had one drug violation, and 24.0% had two or three.

One in five probationers (20.0%) had their SACPA probation revoked. This rate may increase as offenders' time on probation grows longer, but currently it is lower than revocation rates typical of offenders on probation.

Over half (60.0%) of SACPA parolees were recommitted to prison in the one-year period after having been referred to SACPA. This rate is typical of drug users who receive treatment while on parole.

This chapter begins with findings on variability across counties in the specification of SACPA-eligible offenses. Also presented is an analysis of the proportion of felony versus misdemeanor convictions in the SACPA population. The chapter concludes with findings on drug-related violations and drug- and nondrug-related revocations among SACPA offenders on probation as well as recommitments to prison among SACPA parolees.

SACPA-eligible offenses

SACPA defines "nonviolent drug possession offense" as unlawful possession, use, or transportation for personal use of any controlled substance identified in Section 11054, 11055, 11056, 11057, or 11058 of the Health and Safety (H&S) Code or being under the influence of a controlled substance in violation of Section 11550 of the H&S Code. An exhaustive list of offenses meeting this definition is not provided in SACPA. Thus, eligibility to participate in SACPA may, for some offenses, be subject to interpretation.

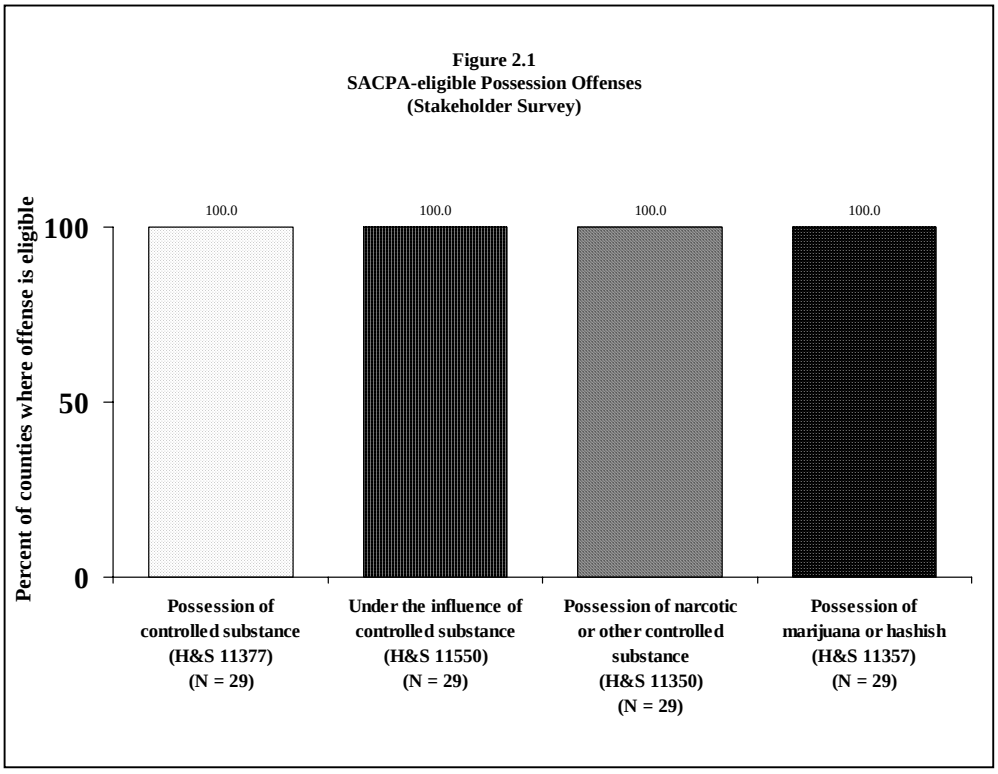
UCLA consulted a variety of knowledgeable sources to compile a list of offenses for which an offender might be deemed eligible for SACPA (see Appendix A). Sources included

specifications in the SACPA legislation, analyses by the California Public Defenders Association (2001) and the California District Attorneys Association (2001), criminal justice experts on ADP's Statewide Advisory Group and Evaluation Advisory Group, and the Parole and Community Services Division of the California Department of Corrections.

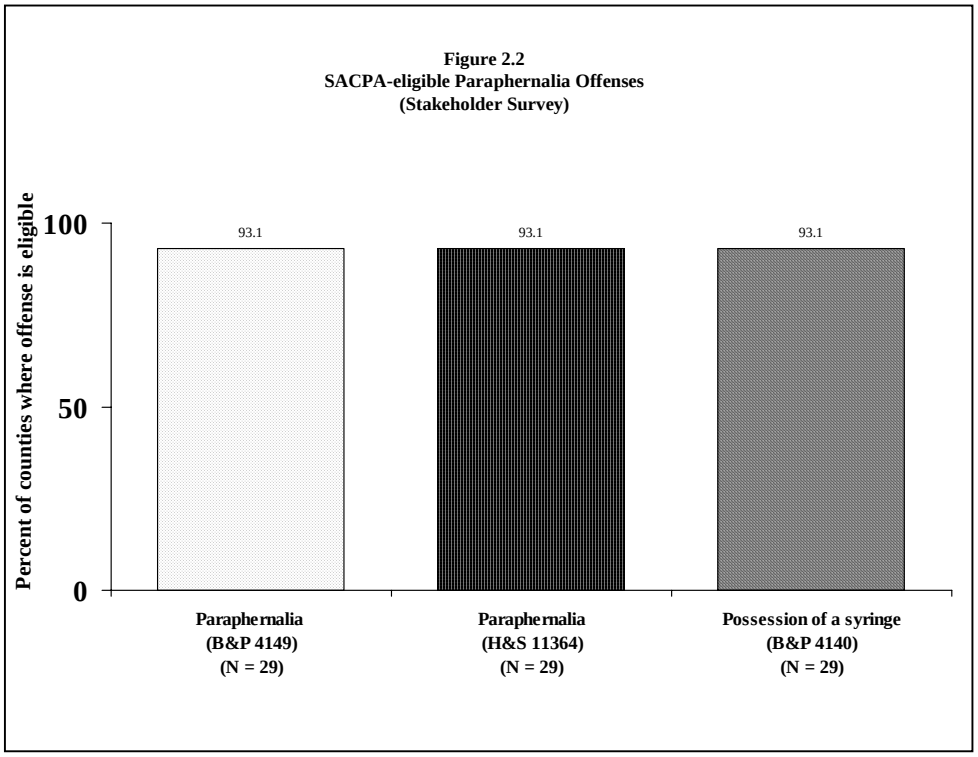
The list of offenses was included in the stakeholder survey sent to court administrators in each county during SACPA's first and second years. They were asked to identify offenses regarded as SACPA-eligible in their county (Court Administrator section of stakeholder survey in Appendix B). The primary purpose of this inquiry was to gauge variability in the offenses for which a person might be deemed eligible for SACPA. (To serve that purpose, it was not necessary to ask respondents *how many offenders* entered SACPA upon conviction for each eligible offense, and such a request would have added unduly to respondent burden.) A secondary purpose was to inform the procedure for selecting the matched pre-SACPA comparison group needed for future analyses of SACPA costs and outcomes. Court administrators in 29 counties responded to the question on SACPA-eligible offenses. Over half (60.0%) of the state's SACPA offender population resided in these 29 counties. Thus they provide a reliable indication of the extent of variability in offenses regarded as SACPA-eligible across counties.

Three offenses were universally cited by reporting counties as SACPA-eligible in the program's second year: possession of a controlled substance (H&S 11377), being under the influence of a controlled substance (H&S 11550), and possession of a narcotic or other controlled substance (H&S 11350). See Figure 2.1. One additional possession offense, possession of marijuana/hashish (H&S 11357), was cited by almost all counties in the first year and by all counties in the second.

Figure 2.1
SACPA-eligible Possession Offenses
(Stakeholder Survey)



Paraphernalia offenses appear in both the Business & Professions Code (B&P 4149) and the Health and Safety Code (H&S 11364). Possession of a syringe is covered separately (B&P 4140). These offenses were cited as eligible in SACPA's second year by a large majority of reporting counties but not all. See Figure 2.2. This was true also in SACPA's first year.



There was considerable variability across counties with respect to Vehicle Code (VC) offenses. See Figure 2.3. Under half of the reporting counties indicated that an open container offense (VC 23222 (b)) was SACPA-eligible. In addition, some counties reported that persons convicted of driving under the influence (VC 23152 and VC 23153) were SACPA-eligible. This pattern—eligibility under vehicle offenses in some counties but not in a majority—pertained in SACPA's first year as well.

Figure 2.4 shows findings on drug transportation for personal use. All counties reported that drug transportation offenses were eligible. In contrast, drug transportation offenses were reported to be eligible in SACPA's first year by most counties but not all.

The percent of counties citing other drug-related offenses as SACPA-eligible varied from 44.8% for public intoxication (PC 647 (f)) to 82.8% for being present when drugs were used (H&S 11365), cultivating marijuana (H&S 11358), and illegally obtaining prescription drugs (H&S 11368). See Figure 2.5. Findings regarding these offenses were very similar in the first year of SACPA.

Cases involving some of these offenses—including transportation of drugs, cultivating marijuana, and driving under the influence—were on appeal as of December 31, 2003. Treatment of these offenses may become more consistent across counties as rulings are made at the appellate level.

Figure 2.3
SACPA-eligible Vehicle Code Offenses
(Stakeholder Survey)

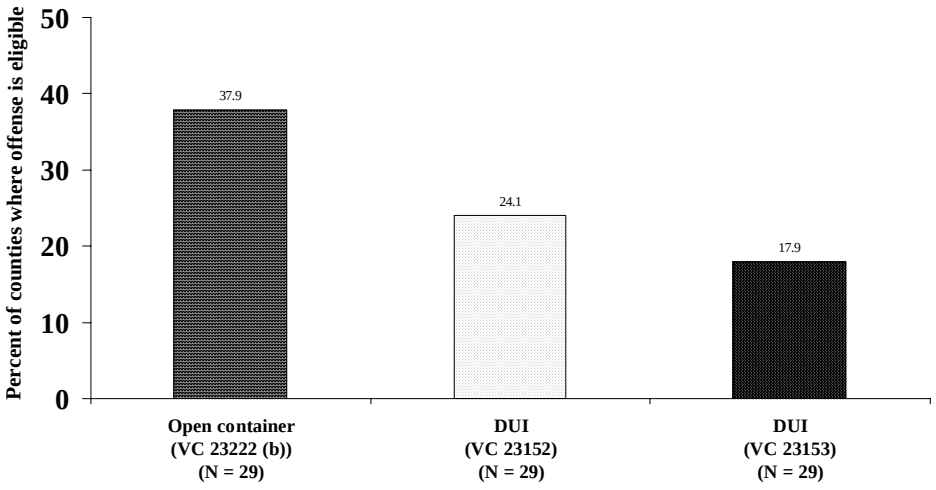
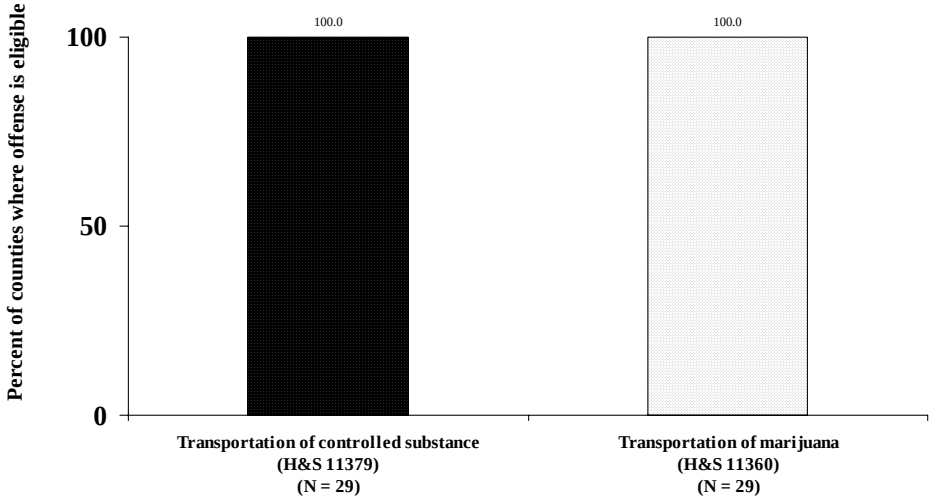
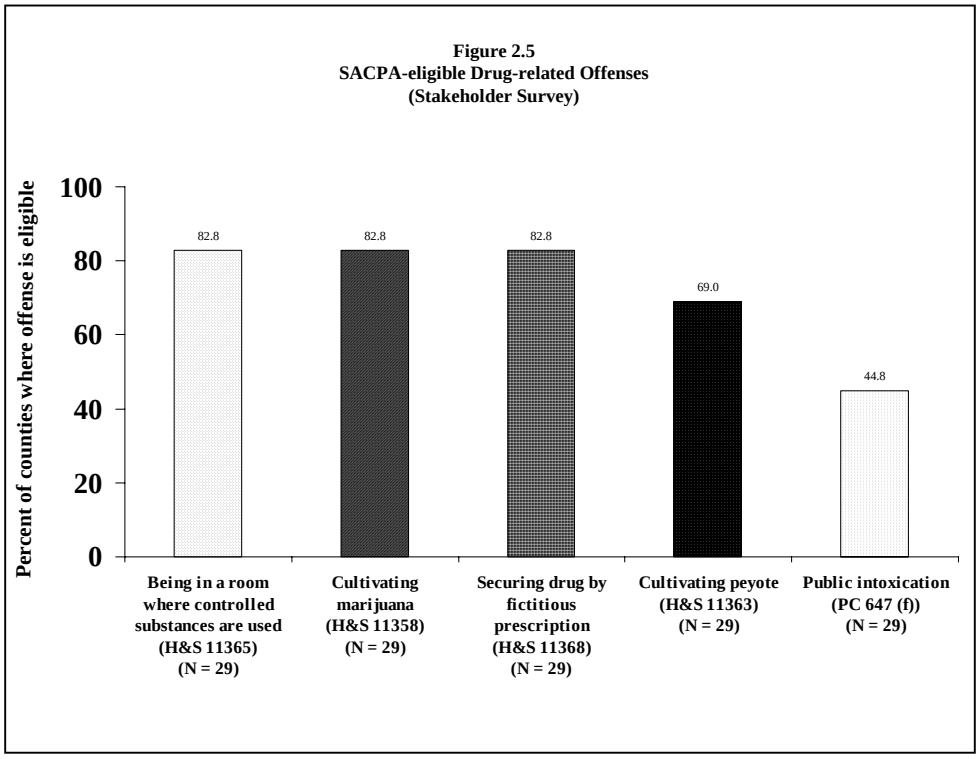


Figure 2.4
SACPA-eligible Drug Transportation Offenses
(Stakeholder Survey)





Felony and misdemeanor convictions

Offenses leading to felony convictions are generally but not necessarily more severe than offenses leading to misdemeanor convictions, and some offenses might be handled either as a felony or as a misdemeanor. However, studies of criminal offending in California and elsewhere (e.g., Chaiken and Chaiken, 1982; Gray et al., 2001; Petersilia et al., 1986; Wolfgang et al., 1972) have shown that felony offenders typically require closer supervision in the community and are more likely to re-offend. Hence, the proportion of offenders entering SACPA on felony versus misdemeanor convictions may have important implications for downstream costs and outcomes.

County representatives were asked to report the number of offenders entering SACPA on felony or misdemeanor convictions in SACPA's second year (County Probation Department section of stakeholder survey in Appendix B). Figure 2.6 shows the percent of felony and misdemeanor convictions. Across 36 counties reporting this information, a majority (60.7%) of probationers had felony convictions. The remainder had misdemeanor convictions. These counties cover 45.3% of the state's SACPA offender population.

There was considerable variability across counties. As shown in Figure 2.7, a majority of SACPA probationers in 21 counties had felony convictions. Misdemeanor convictions were predominant in almost as many counties.

Figure 2.6
SACPA Offenders by Conviction Level
July 1, 2002 to June 30, 2003
(Stakeholder Survey)
(N of counties reporting = 36)

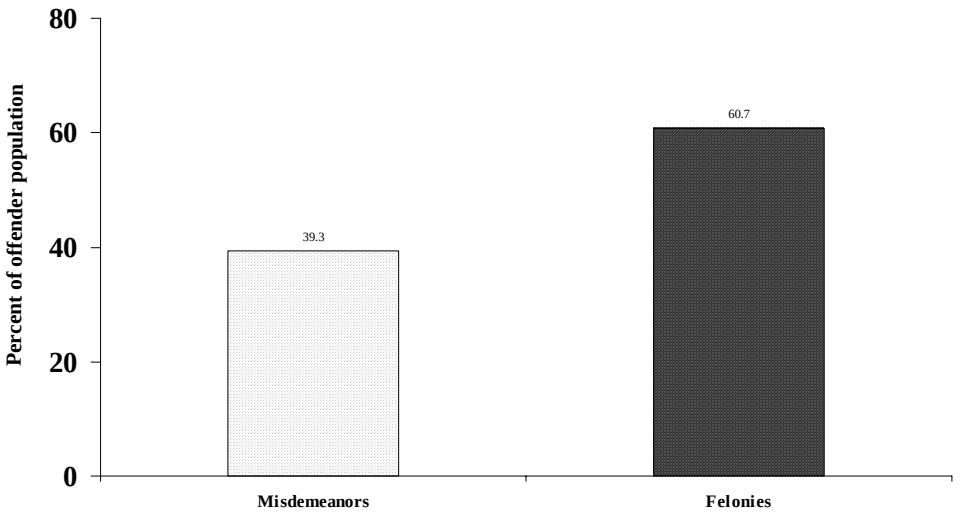
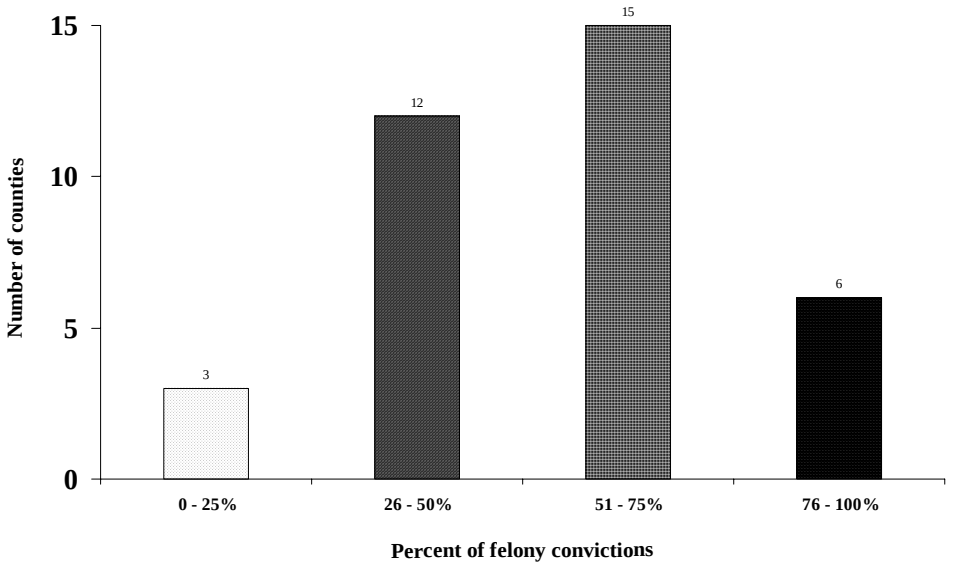


Figure 2.7
SACPA Offenders with Felony Convictions
July 1, 2002 to June 30, 2003
(Stakeholder Survey)
(N of counties reporting = 36)



Probation violations and revocations

The stakeholder survey asked probation department representatives to report the number of SACPA offenders on probation in their counties during SACPA's second year (County Probation Department section of stakeholder survey in Appendix B). Offenders may have entered SACPA anytime during the first or second year. As a result, time spent on probation varied widely across offenders. The survey also asked how many of these offenders had one or more drug violations (e.g., drug possession or use) and how many had their SACPA probation revoked for either drug or nondrug violations during SACPA's second year. Questions pertained to violations on record. Additional violations may have been detected but, at the discretion of the probation officer, not entered into the offender's record.

As shown in Figure 2.8, half (50.0%) of SACPA offenders on probation in the counties reporting this information had no drug violations recorded. About one-fourth (27.0%) had one violation; 14.3% had two violations; and 9.7% had three. Drug and nondrug violations of probation are treated differently in SACPA. Any nondrug violation may result in revocation of SACPA probation. A second or third drug violation, but not the first, may result in revocation. Figure 2.9 shows revocations for offenders on probation in the reporting counties during SACPA's second year. A total of 20.0% had their SACPA probation revoked during SACPA's second year and were subject to re-sentencing. Revocations can be divided into 11.5% for drug violations and 8.5% for nondrug violations. Thus, a majority of revocations (57.5%[1]) among these offenders occurred in response to drug violations.

These findings provide a one-time snapshot of the population of offenders who were on probation for all or any part of SACPA's second year in counties reporting this information. Some may have entered SACPA as early as July 1, 2001; others, as recently as June 30, 2003. Accordingly, "time at risk," or the length of time during which violations and revocations could have occurred, varied widely across offenders. In addition, reporting counties cover only 30.6% of the state's SACPA offender population. Drug violation and probation revocation findings may change with the passage of additional time and inclusion of more counties.

Parolee recommitments to prison

The Parole and Community Services Division (P&CSD) of the California Department of Corrections was able to provide information on recommitments to prison among 2,423 parolees referred to SACPA by P&CSD and the Board of Prison Terms (BPT) during a portion of SACPA's second year (July 1, 2002 to December 31, 2002). The follow-up period for each parolee was 12 months after SACPA referral.[2]

[1] .115 /.200 = .575.

[2] Information was provided by Bubpha Chen and Joseph Ossmann at P&CSD.

Figure 2.8
Drug Violations Recorded for SACPA Offenders on Probation
July 1, 2002 to June 30, 2003
(N of counties reporting = 25)

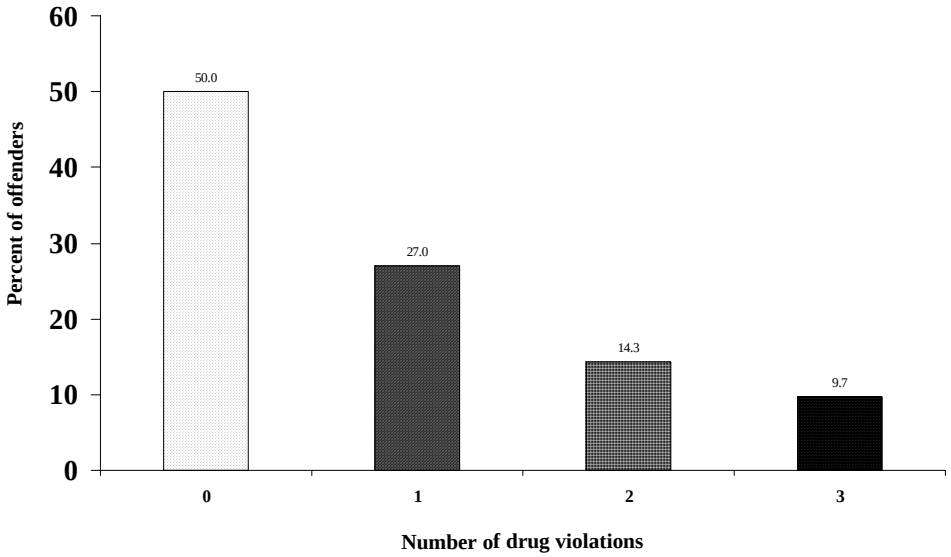
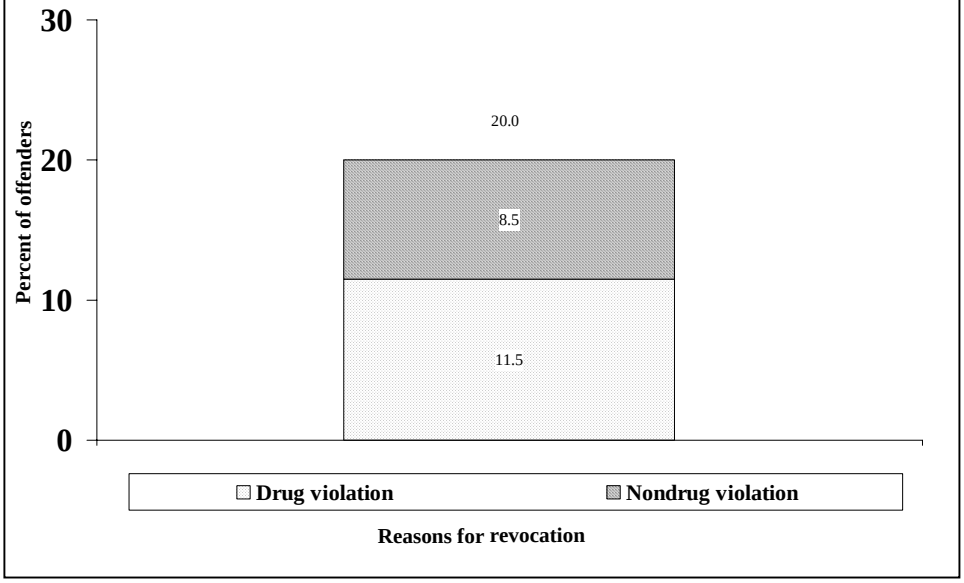
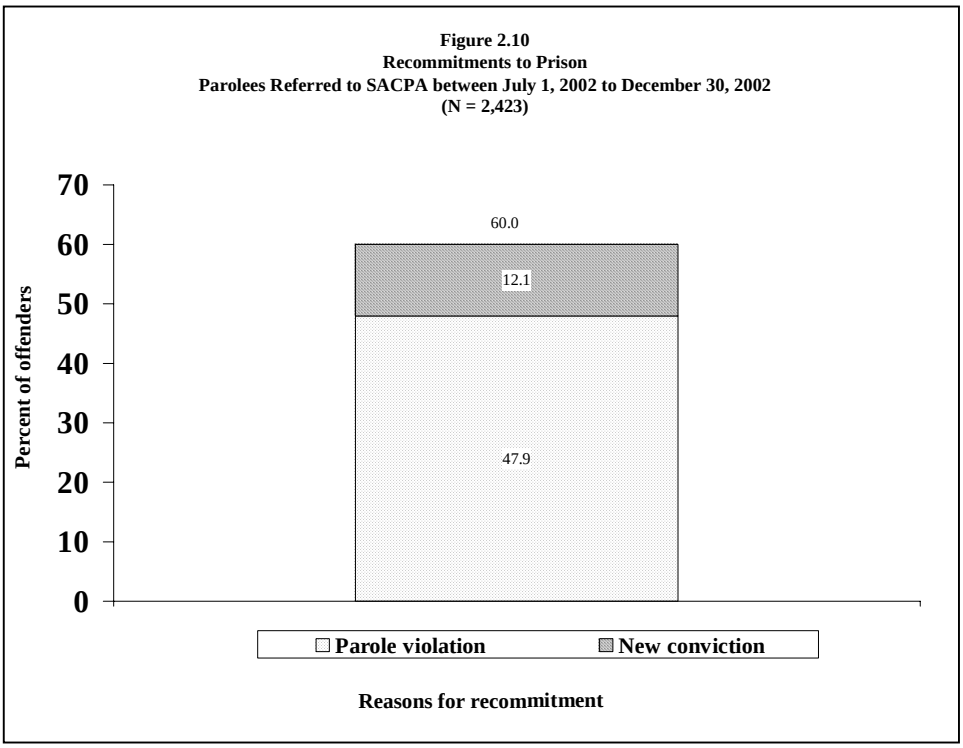


Figure 2.9
SACPA Probation Revocations
July 1, 2002 to June 30, 2003
(N of counties reporting = 27)



As shown in Figure 2.10, 60.0% were recommitted during the 12-month period. This total includes parolees returned to prison for violating the conditions of their parole (47.9%) and those sentenced to prison on a new conviction (12.1%). Data were not available to indicate how many violations and new convictions were drug-related or nondrug-related. Parolee revocation rates cannot be compared to probation revocation rates reported above because the follow-up cannot be compared to probation revocation rates reported above because the follow-up period was the same for each parolee (12 months) but varied widely among probationers.



For two reasons, revocation rates for these parolees may not be typical of all parolees placed in SACPA. First, they entered SACPA during a period of administrative transition. Through September 30, 2002, placement of parolees in SACPA was the responsibility of the BPT. The P&CSD took on that responsibility for parolees arrested on or after October 1, 2002, while the BPT retained responsibility for those arrested previously. As of January 1, 2003, the P&CSD assumed responsibility for all parolees. Revocation rates occurring before or after the analytic timeframe might therefore be different. Second, the analysis did not include parolees referred to SACPA by the court.

Conclusion

There is variability in SACPA eligibility across counties. Drug possession, being under the influence of drugs, and drug transportation for personal use were treated as SACPA-eligible offenses in all counties in SACPA's second year. While drug possession and being under the influence were SACPA-eligible in all counties in SACPA's first year as well, drug transportation was treated as an eligible offense in most but not all counties in SACPA's first year. Possession of drug paraphernalia and other drug-related offenses were treated as

SACPA-eligible in most but not all counties in SACPA's first and second years. A minority of counties treated vehicle offenses, such as driving under the influence of drugs, as SACPA-eligible in both years. Cases involving some of these offenses—including transportation of drugs, cultivating marijuana, and driving under the influence—were on appeal as of December 31, 2003. SACPA eligibility may become more consistent across counties as cases now pending are decided at the appellate level.

During SACPA's second year, 61% of probationers entered SACPA on felony as opposed to misdemeanor convictions. There was wide variation at the county level. Thus it will be important to determine whether county variation in SACPA costs and outcomes is related to the composition of the SACPA population by conviction level.

Half (50.0%) of SACPA offenders on probation during its second year had no drug violations recorded; 27.0% had one drug violation, and 24.0% had two or three (three is the maximum allowed by law).

One in five probationers (20.0%) had their SACPA probation revoked during SACPA's second year. In a recent national study, 29% of adult probationers had their probation revoked and were incarcerated (Bonczar, 1997; see also Mayzer et al., 2004). Comparison across studies is inexact because drug offenders comprised only 21% of the national probation population, whereas all SACPA probationers had been convicted for drug offenses. There may also have been differences in background characteristics of probationers and probation supervision policies. Finally, revocations of SACPA probation may increase as offenders' time on probation grows longer. Thus far, however, revocations are less common among SACPA probationers than among probationers overall, even though the risk of revocation is generally higher among probationers with a history of drug involvement (e.g., Gray et al., 2001).

Over half (60.0%) of SACPA parolees were recommitted to prison in the one-year period after referral to SACPA. Recommitment rates are 50-60% among parolees in California and the nation (California Department of Corrections, 2004; Hughes et al., 2001). In studies of non-SACPA parolees who received treatment, one-year recommitment rates were 55-66% overall but much lower (28-32%) among those in treatment for at least 90 days (Anglin et al., 2002; Fain and Turner, 1999; Longshore et al., 2004; Prendergast et al., 2003). The comparison between SACPA and non-SACPA parolees is inexact because parolees' background characteristics, the scope of their drug involvement, and parole supervision policies may differ across studies. Moreover, drug-involved parolees are at higher risk of arrest and recommitment; this difference in risk may explain why parolees who received treatment were no less likely to be recommitted than those who did not. Two conclusions can be reached. First, with respect to recommitment, SACPA parolees were typical of other drug-involved parolees in California who received treatment. Second, parolees are unlikely to benefit unless they receive treatment for at least 90 days. In the first two years of SACPA, most parolees did not reach the 90-day mark (see Chapter 7). This may help to explain why the recommitment rate was not lower in SACPA parolees than in the state's parolee population.

Chapter 3: Offenders in SACPA

A total of 54,140 offenders were found in court to be eligible for SACPA in its second year. This total includes offenders already on probation or parole as well as new offenders. Most eligible offenders who did not choose SACPA opted for routine criminal justice processing.

Among 50,335 offenders who chose to enter SACPA, 42,972 (85.4%) completed assessment.

Among assessed offenders, 35,947 (83.7%) entered the treatment program to which they were referred.

The number of offenders entering treatment increased by 18% (from 30,469) over the first year. The overall show rate of 71.4% in SACPA's second year was slightly higher than the 69.2% show rate in its first year.

About half (53.0%) of SACPA offenders in treatment reported methamphetamine as their primary drug problem, followed by cocaine/crack (13.2%). SACPA clients had longer drug use histories than non-SACPA clients referred to treatment by criminal justice.

Most SACPA clients (72.7%) were men. About half (48.0%) were non-Hispanic Whites, while 31.4% were Hispanics, and 13.8% were African Americans. About half (48.8%) had never been in treatment before.

This chapter describes the "pipeline" of offenders entering SACPA during its second year. Three steps in the pipeline are covered: referral of the offender to SACPA, completion of the assessment process, and entry into the treatment program to which the offender was assigned. Show rates at assessment and treatment are calculated and compared to show rates observed in SACPA's first year.

This chapter also reports characteristics of offenders who entered treatment during SACPA's second year with a special focus on offenders who had never been in treatment before.

SACPA pipeline

People convicted of a nonviolent drug-related offense or of being under the influence of a controlled substance are eligible for SACPA.[1] As shown in Table 3.1, there are differences in eligibility criteria for probationers and parolees.

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

Offenders who chose SACPA were ordered to complete an assessment and enter treatment. Assessment entails a systematic review of the severity of the offender's drug use and other problems, a decision regarding appropriate placement in a drug treatment program, identification of other service needs, and a determination of the appropriate level of community supervision. Upon completion of the assessment, offenders must report promptly to the assigned treatment program. Referral is the first step in the SACPA pipeline. Completion of assessment is the second step, and treatment entry is the third.

Information to describe the pipeline was compiled from three sources: the SACPA Reporting Information System (SRIS) maintained by ADP, the county stakeholder survey conducted by UCLA, and the California Alcohol and Drug Data System (CADDS). The first two of these sources were created specifically for SACPA monitoring and evaluation. The third, CADDS, predates SACPA, having been maintained by ADP since July 1991.

Each data source had unique value in the pipeline analysis but was also subject to limitations. To overcome these limitations, the analysis employed a mix of data taken directly from these sources along with estimates validated across multiple sources when possible. Appendix C enumerates the known limitations of data sources and explains the estimation procedure.

---

[1] There are some eligibility exceptions. SACPA does not apply to any offender previously convicted of one or more serious or violent felonies, unless the current drug possession offense occurred after a period of five years in which the offender remained free of both prison custody and the commission of an offense which resulted in (1) a felony conviction other than a non-violent drug possession offense or (2) a misdemeanor conviction involving physical injury or the threat of physical injury to another person. Also ineligible is any non-violent drug possession offender who has been convicted in the same proceeding of a misdemeanor not related to the use of drugs or any felony. SACPA does not apply to any offender who, while using a firearm, unlawfully possesses (1) a substance containing cocaine base, cocaine, heroin, or methamphetamine or (2) a liquid, non-liquid, plant substance, or hand-rolled cigarette, containing phencyclidine. SACPA does not apply to any offender who, while using a firearm, is unlawfully under the influence of cocaine base, cocaine, heroin, methamphetamine, or phencyclidine. SACPA does not apply to any offender who refuses drug treatment as a condition of probation or parole.

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

Table 3.1 Terms of SACPA Participation for Parolees and Probationers[3]		
Factor	*Parolees*	*Probationers*
Controlling law	Penal Code 1210, 3063.1, 3063.2	Penal Code 1210, 1210.1, 1210.5
Adjudication authority	Board of Prison Terms	Superior Court
Supervision authority	Parole and Community Services Division, California Department of Corrections	County probation department
Serious or violent background	Parolees who have ever been convicted of a serious or violent felony are ineligible.	Offenders with prior serious or violent felony convictions are eligible if the conviction is more than five years old and they have been free of both prison custody and non-drug possession felony or violent misdemeanor convictions during that five-year period.
Disposition of charges	Placement in SACPA is the final disposition. Failure to complete treatment must be charged as a new violation.	Original charges remain open for dismissal upon successful completion or re-sentencing upon failure to complete treatment.
Term of supervision	Placement on parole occurs before placement in SACPA and will terminate independently of parolees' progress in treatment.	If not already on probation, offenders are placed on probation as part of SACPA disposition, and probation will not terminate prior to completion of treatment.
Disposition of drug violations	Parolees become ineligible upon the second violation subsequent to placement (first violation for those on parole before July 2001).	Probationers become ineligible upon the third violation subsequent to placement (second violation for those on probation before July 2001).

Eligible offenders

The estimated number of offenders found in court to be eligible for SACPA in its second year is 54,140.

This may be an underestimate inasmuch as offenders facing SACPA-eligible charges may opt out of SACPA before sentencing. Other offenders who would have been eligible for SACPA may not have been counted as such because they did not enter SACPA when sentenced. In addition, there is no reliable estimate of the number of parolees eligible for

[3] Based on a table created by Joseph Ossmann, Parole and Community Services Division, California Department of Corrections.

SACPA because there are no formal records of the initial decision on how to handle violations of parole.

There is, however, information available on the options chosen by offenders who were eligible for but did not enter SACPA. These options include drug court, diversion, or routine criminal justice processing. On the stakeholder survey, 26 counties reported on offenders who took these other options (Lead Agency section of stakeholder survey in Appendix B). The overwhelming majority (91%) accepted routine processing, while 7% went to a diversion program and 2% entered drug court. These findings do not cover the entire state and may not include all eligible offenders in the reporting counties, but they suggest that most offenders were opting out of SACPA not in favor of any alternative special program but in order to accept routine sentencing.

Further information sheds light on one possible reason for choosing to accept routine sentencing. As reported in Chapter 2, a majority of offenders were in SACPA on felony convictions (61.6%) as opposed to misdemeanor convictions (38.4%). The breakdown of arrests for felony and misdemeanor drug offenses among California adults in 2001 (California Department of Justice, 2002) shows a roughly even split (51.0% and 49.0% respectively). Thus, misdemeanor convictions in the SACPA population (38.4%) were less common than misdemeanor drug arrests in the state overall (49.0%). These two findings are not strictly comparable because (1) some offenses counted in the total number of drug arrests may not have been SACPA-eligible, and (2) offense type at arrest is not necessarily the same as offense type at conviction. However, the difference suggests that offenders with misdemeanor convictions may be more likely than those with felony convictions to opt out of SACPA. Facing only a misdemeanor conviction, they may expect that the non-SACPA sentence will be less onerous than treatment and other requirements imposed upon offenders in SACPA.

Offenders referred

UCLA estimated that 50,335 offenders were referred to SACPA in its second year. This estimate includes offenders referred by the court and by parole agents.[4] See step 1 of the pipeline shown in Figure 3.1.

Offenders assessed

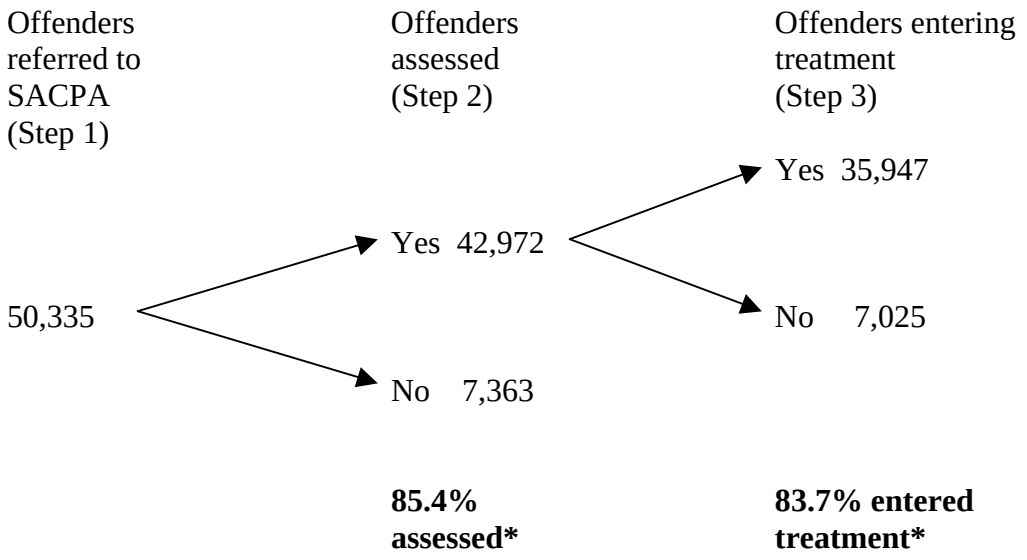
In the second year of SACPA, an estimated 42,972 offenders, including probationers and parolees, completed their assessment. That estimate is step 2 of the pipeline shown in Figure 3.1. The show rate at step 2 was 85.4%.

Offenders entering treatment

The estimated total of offenders placed in treatment in SACPA's second year is 35,947, shown as step 3 in the pipeline. This total includes probationers and parolees. The show rate at step 3 was 83.7%.

[4] The SRIS manual defines "referrals" as probationers and parolees sent from the court, probation department, or parole authority.

Figure 3.1 SACPA Offender Pipeline, July 2002 to June 2003
(SRIS)



*The overall percent of referrals entering treatment was .854 x .837 = 71.4%.

The estimated overall show rate (i.e., percent of offenders who were referred to SACPA and went on to enter treatment) in SACPA's second year was 71.4%, slightly higher than the estimated overall show rate (69.2%) in SACPA's first year.

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

No-show rates

State and county stakeholders have expressed interest in the no-show problem, i.e., offenders who chose SACPA but who did *not* complete an assessment or enter treatment. For a direct look at that problem, pipeline results can be converted to a no-show rate at assessment (step 2), a no-show rate at treatment (step 3), and an overall no-show rate.

Findings reported above were that 85.4% of offenders referred to SACPA in its second year went on to complete an assessment. Thus the estimated no-show rate at assessment was 14.6%. Similarly, 83.7% of assessed offenders went on to enter treatment. Thus the estimated no-show rate at treatment was 16.3%. Combining these two steps led to the conclusion that 71.4% of offenders referred to SACPA in its second year went on to enter treatment. The remaining 28.6% is the estimated overall no-show rate in SACPA's second year. No-show offenders include those who failed to complete assessment or enter treatment as well as those unable to do so because, after initial acceptance into SACPA, they

committed crimes or probation/parole violations that precluded further participation in SACPA. Data were not available to determine what happened to no-show offenders.

Characteristics of treatment clients

This section reports characteristics of SACPA offenders who entered treatment during SACPA's second year. SACPA probation and parole referrals are shown separately so that any differences within the SACPA client population will be apparent. Characteristics covered in the analysis include race/ethnicity, sex, age, primary drug, and drug problem severity.

Also reported are characteristics of clients who entered treatment during SACPA's second year but who were not part of SACPA. Non-SACPA clients are, moreover, divided into those referred by the criminal justice system but not by SACPA and those entering treatment by self-referral or other non-criminal justice referral from, for example, a health care provider, school, or employee assistance program. The purpose of comparing treatment clients by referral source is to determine the ways in which SACPA clients were similar to, or different from, other clients in the state's treatment population.[5]

Characteristics of the first year's clients were reviewed in the 2002 report and are reprised only briefly here. The purpose of a cross-year comparison is to show whether there has been any change in the characteristics of SACPA treatment clients thus far.

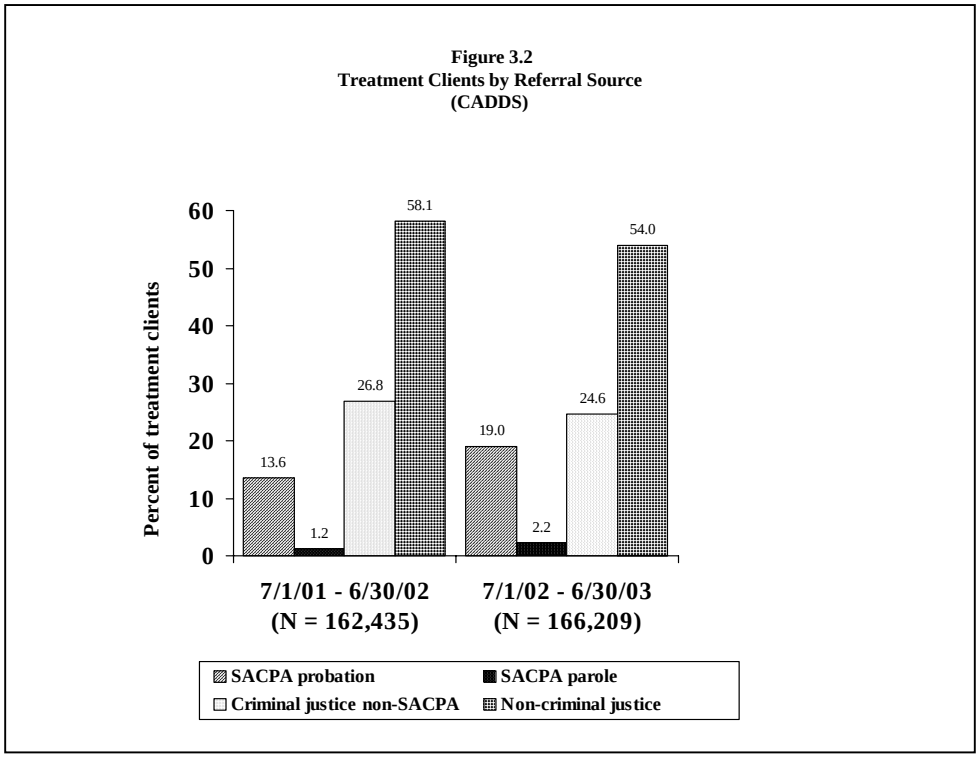
UCLA used CADDS data on race/ethnicity, sex, age, and primary drug. Most but not all SACPA clients received treatment at programs required to report into the CADDS database. Of the estimated 35,947 SACPA treatment clients shown in Figure 3.1, 35,401 appear in CADDS. Hence, characteristics of SACPA clients receiving treatment from CADDS providers are likely to be a close approximation of the characteristics of all SACPA clients in treatment.

Figure 3.2 shows the breakdown of clients entering treatment by the referral source indicated in CADDS. In its first year, SACPA accounted for 14.8% of clients entering treatment (13.6% were referred by probation; 1.2%, by parole). Thus, 8.1% of SACPA treatment clients in the first year were parolees entering SACPA on the basis of a new offense or a drug-related parole violation.[6] In SACPA's second year, 21.2% of clients entering treatment were identified in CADDS as SACPA referrals (probation accounted for 19.0%; parole, for 2.2%). Thus, 10.4% of SACPA treatment clients in the second year were parolees entering SACPA on the basis of a new offense or a drug-related parole violation.[7] The percent of treatment clients referred by SACPA appears to increase across the two years, but a large part of this increase may be due to improvement in the accuracy of CADDS data on referral source.

[5] The CADDS record for each incoming client indicates the referral source as either SACPA (court/probation or parole), non-SACPA court/criminal justice, or non-criminal justice. CADDS also indicates the client's legal status. Most clients (77%) sent from non-SACPA court/criminal justice were on probation or parole or were incarcerated. Among the remaining 23% were clients participating in a diversion program and others with no legal status on record. Thus, while a portion of the non-SACPA court/criminal justice population may actually not have been in the criminal justice system, the overall population can be characterized as non-SACPA criminal justice. Non-criminal justice clients were those referred by health care provider, employee assistance program, self, or other sources but not by criminal justice.

[6] 1.2/14.8 = .081.

[7] 2.2/21.2 = .104.



Race/ethnicity

The race/ethnic composition of SACPA treatment clients is presented in Figure 3.3. In SACPA's second year, about half of SACPA treatment clients were non-Hispanic Whites (48.0%). Hispanics (31.4%), African Americans (13.8%), Asian/Pacific Islanders (2.6%), Native Americans (1.7%), and other groups (2.2%) comprised the other half of the SACPA client population. Figure 3.3 also shows the race/ethnic composition of SACPA clients in the first year. There was virtually no change across years.

Figure 3.4 presents race/ethnicity for SACPA probationers and parolees separately and for clients referred by non-SACPA sources in SACPA's second year. The race/ethnic composition of all four groups was very similar.

Sex

Clients referred to treatment by SACPA in its second year were 72.7% men and 27.3% women. See Figure 3.5. This pattern almost exactly duplicates the breakdown in SACPA's first year.

Figure 3.6 shows the sex breakdown for SACPA clients referred by probation and parole and for non-SACPA criminal justice and non-criminal justice referrals. A majority of treatment clients in all groups were men, but this pattern is more pronounced among clients referred to treatment by SACPA and other criminal justice entities than among non-criminal justice referrals. The pattern is, moreover, most pronounced among offenders referred to SACPA by parole. These results are partly a reflection of the enduring difference between men and women in the seriousness of their criminal involvement (Blumstein et al., 1986; Gottfredson and Hirschi, 1990).

Age

In SACPA's second year, the average (mean) age among clients referred to treatment by SACPA was 34.5. The average age among SACPA probation referrals was 34.2 and among SACPA parole referrals was 36.8. Clients referred from criminal justice sources other than SACPA were 29.6 years old on average; non-criminal justice clients, 35.5. These findings are quite similar to those in SACPA's first year.

Figure 3.7 shows the distribution in age among SACPA clients. About one-fifth of SACPA clients (22.7%) were no older than 25 years old. Most (64.1%) were between 26 and 45 years old. Relatively few (13.1%) were 46 or older. These findings closely match the findings for SACPA's first year.

As shown in Figure 3.8, SACPA clients referred from parole were older than those referred from probation. Moreover, clients referred from criminal justice sources other than SACPA include a much higher percent between 18 and 25 years old than the percent seen among SACPA clients (44.2% versus 22.7%). Finally, while clients in this youngest age bracket are equally represented among SACPA and non-criminal justice referrals, the latter group includes more clients in the oldest age bracket. Because crime is less prevalent in older age-cohorts (Gottfredson and Hirschi, 1990; Hirschi and Gottfredson, 1983), it is to be expected that non-criminal justice referrals include a higher percent of older clients.

Primary drug

According to client self-report, methamphetamine (53.0%) was the most common drug type among SACPA clients in the second year, followed by cocaine/crack (13.2%), marijuana (12.1%), heroin (10.2%), and alcohol (9.8%). See Figure 3.9. These figures are virtually unchanged from SACPA's first year.

Primary drug by referral source is presented in Figure 3.10. As was true in SACPA's first year, methamphetamine continued to be a more common problem in SACPA clients than in the other two client groups. Within the SACPA treatment population, heroin use was twice as common among parolees (18.1%) as among probationers (9.2%). Heroin use was more prevalent among non-criminal justice clients (29.2%) than among criminal justice clients, possibly because heroin users may, on their own initiative (self-referral), seek methadone treatment to avoid the daily symptoms of heroin withdrawal. Reporting requirements may also help to explain the higher prevalence of heroin use on the non-criminal justice side. Private as well as publicly funded providers are required to report methadone treatment admissions to CADDS, whereas only publicly funded providers are required to report admissions to other types of treatment.

In Figure 3.9, alcohol was the self-reported primary problem for 9.8% of the SACPA group—even though SACPA targets offenders with drug problems. Heavy drinking is quite common among people also engaged in illegal drug use. Figure 3.11 shows the secondary drug problem recorded in CADDS for SACPA clients whose self-reported primary problem was alcohol. The distribution of secondary drug mirrors the distribution for primary drug. Methamphetamine was the most common secondary drug problem (35.3%). Marijuana (21.5%) and cocaine (21.5%) were also prevalent. No secondary drug problem was shown for 16.4% of SACPA clients whose primary problem was alcohol. These findings for SACPA's second year closely parallel those for its first.

Figure 3.3
Race/Ethnicity of SACPA Treatment Clients
(CADDS)

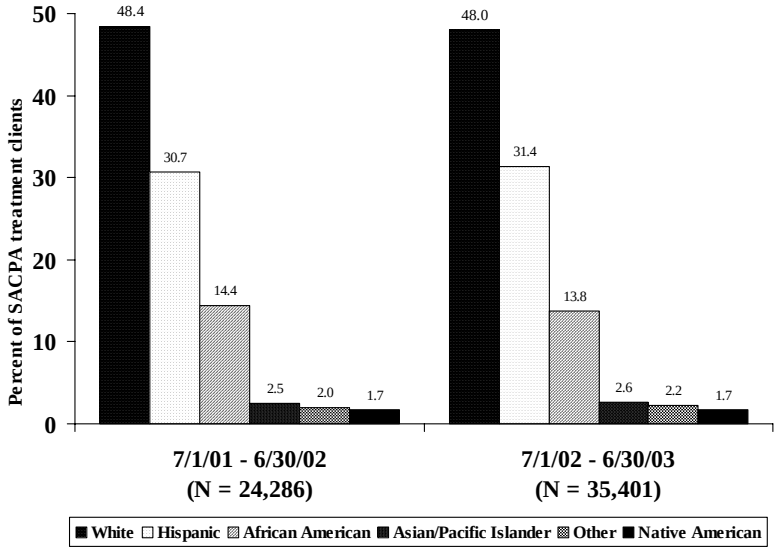


Figure 3.4
Race/Ethnicity of Treatment Clients by Referral Source
(CADDS), 7/1/02 - 6/30/03
(N = 166,209)

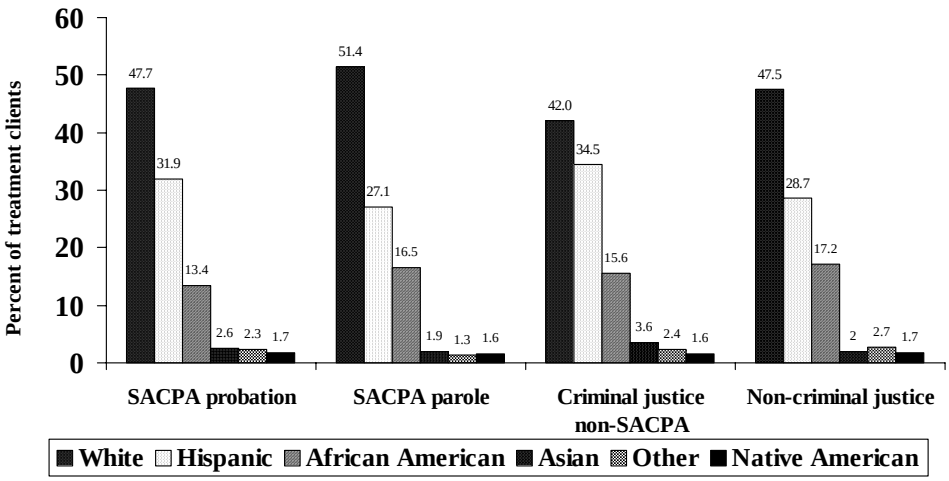


Figure 3.5
Sex of SACPA Treatment Clients
(CADDS)

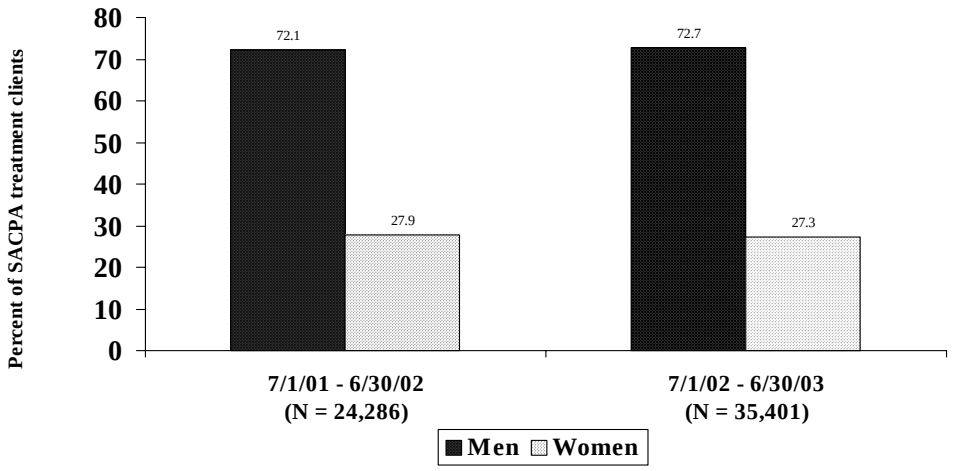


Figure 3.6
Sex of Treatment Clients by Referral Source
(CADDS), 7/1/02 - 6/30/03
(N = 166,209)

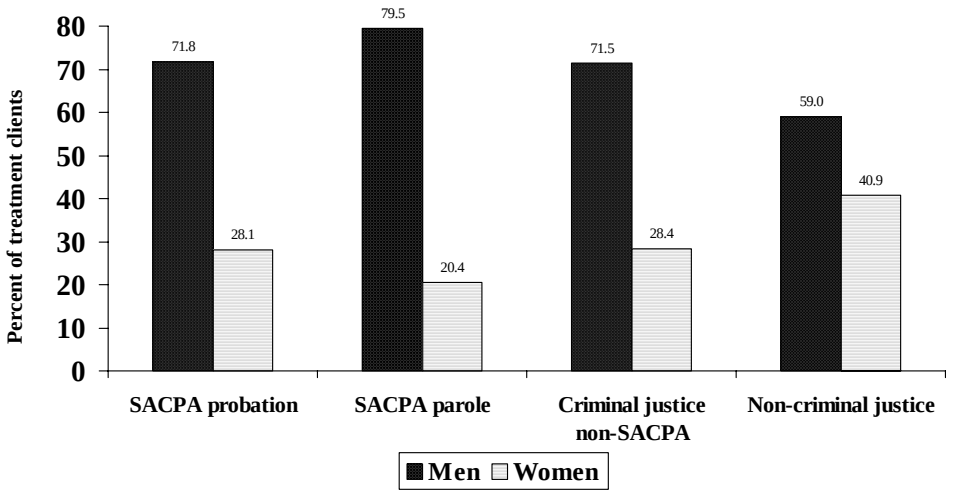


Figure 3.7
Age of SACPA Treatment Clients
(CADDS)

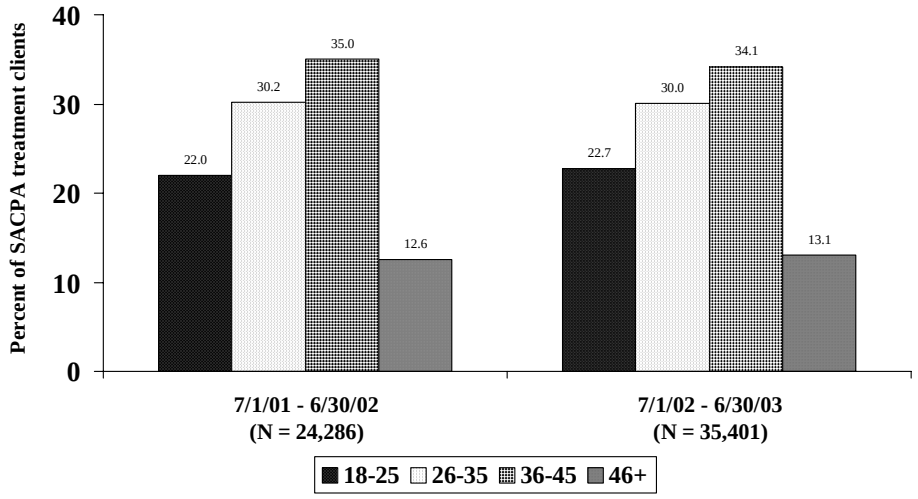


Figure 3.8
Age of Treatment Clients by Referral Source
(CADDS), 7/1/02 - 6/30/03
(N = 166,209)

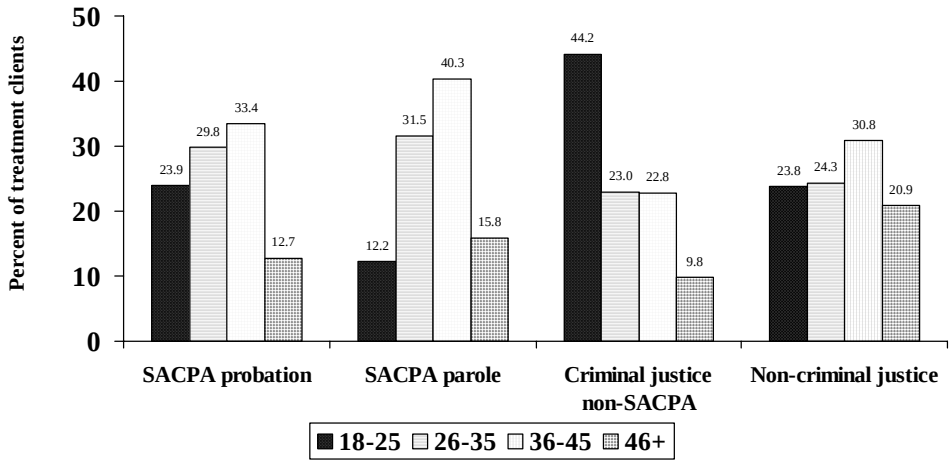


Figure 3.9
Primary Drug Among SACPA Treatment Clients
(CADDS)

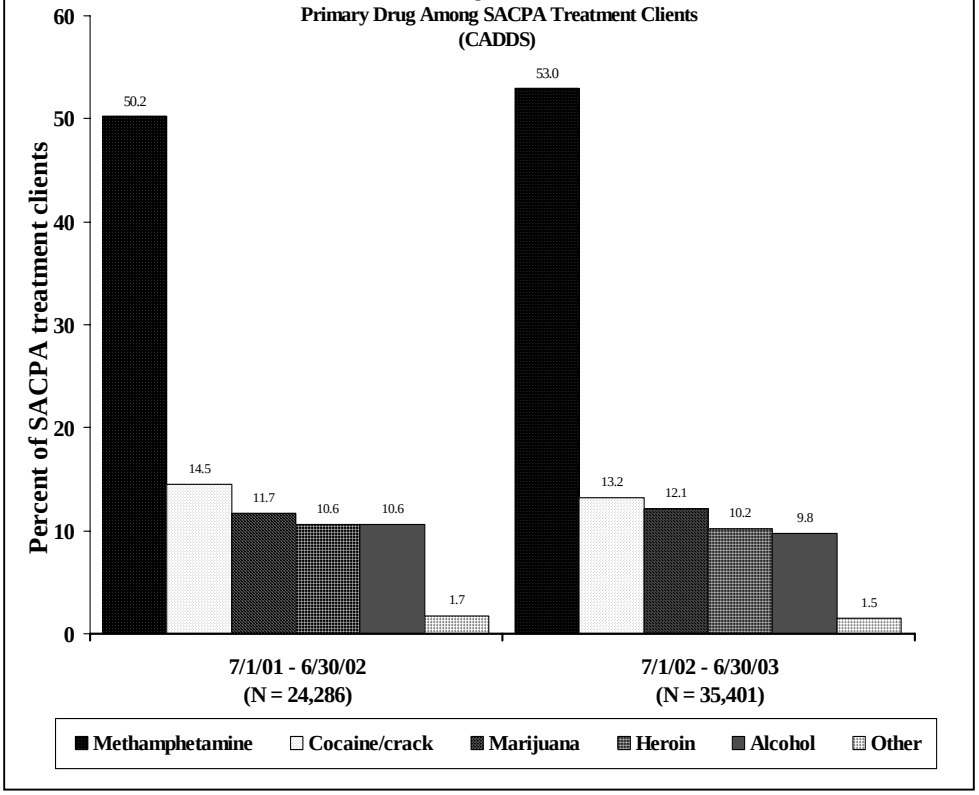
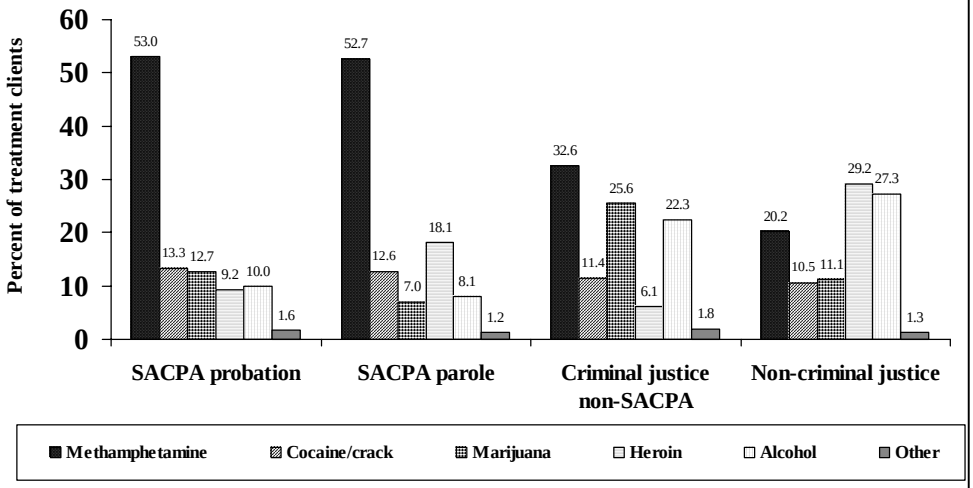


Figure 3.10
Primary Drug Among Treatment Clients by Referral Source
(CADDS), 7/1/02 - 6/30/03
(N = 166,209)



Clients with no secondary drug problem on record may have reported a secondary drug problem that was not entered into CADDS, or they may have failed to report a secondary drug problem despite having one. In any case, they comprised only 1.6% of the SACPA client population. Patterns observed here would not change significantly if data on problem drug were complete. Finally, although non-SACPA clients were more likely than SACPA clients to report alcohol as their primary problem (see Figure 3.10), the patterns for primary problem drug were not significantly affected when clients reporting alcohol as their primary problem were excluded from the analysis.

Drug problem severity

UCLA analyzed three indicators of drug problem severity: years of drug use, frequency of recent drug use, and prior treatment experience.

Figure 3.12 shows a split distribution of drug use histories among SACPA treatment clients. About one-fifth (20.7%) of SACPA clients in each of the first two years reported having used drugs for no more than five years. Slightly higher percents (23.7% in the first year and 23.9% in the second) reported drug use histories extending longer than 20 years.

Figure 3.13 shows years of drug use by referral source for the second year's treatment population. Non-SACPA criminal justice referrals reported shorter drug use histories. Over one-third (35.9%) reported having used drugs for no more than five years, compared to only 20.7% among SACPA referrals (shown in Figure 3.12). Although SACPA referrals were somewhat older than non-SACPA criminal justice referrals (see Figure 3.8), the age difference does not account for the shorter drug use histories of non-SACPA criminal justice referrals. In the youngest age group (18-25 years old), the average drug use history was shorter among non-SACPA criminal justice referrals (4.4 years) than among SACPA referrals (5.8 years).

Figure 3.13 sheds light on the split distribution in drug use histories shown in Figure 3.12. Almost half (44.3%) of SACPA clients referred from probation reported drug involvement for no more than ten years. In comparison, only 29.5% of SACPA's parole referrals reported drug use histories in that range, whereas about one-third (31.4%) of SACPA parolees had been using drugs for over 20 years.

Frequency of drug use by SACPA clients in the month prior to treatment admission is presented in Figure 3.14. About one-third of SACPA clients (34.1%) in the second year reported no drug use in the past month, possibly because they were coming to treatment directly from lock-up. This was also the pattern in SACPA's first year.

As shown in Figure 3.15, non-criminal justice clients were less likely than SACPA and non-SACPA criminal justice clients to report no drug use in the past month. Non-criminal justice clients were, conversely, more likely to report daily drug use in the past month. Again, this divergence may have arisen because some SACPA and non-SACPA criminal justice clients were incarcerated just before entering treatment. Alcohol was the primary problem for a greater proportion of non-criminal justice referrals, but the same pattern held true when clients with alcohol as a primary drug problem were excluded, therefore alcohol use does not account for the difference in daily use rates (data not shown).

The number of prior treatment admissions among SACPA clients is shown in Figure 3.16. About half of SACPA clients thus far (55.2% in the first year and 48.8% in the second) reported no prior experience in drug treatment.

Figure 3.17 compares treatment experience among clients from all referral sources. Slightly under half of the non-criminal justice referrals (46.5%) reported no prior treatment—a finding very similar to that for SACPA referrals on probation as well as parole. Over half of the non-SACPA criminal justice referrals (60.2%) reported no prior treatment. Thus, among criminal justice referrals, regardless of source, a greater portion were entering treatment for the first time.

Findings in Figures 3.16 and 3.17 are based on the CADDS record of client self-reports of prior treatment experience. Self-reports might under-represent actual experience if clients failed to mention or forgot prior admissions. As an alternative to self-reports, UCLA used CADDS client identification numbers (which remain the same for each client across all admissions) to count the number of prior admissions shown in CADDS for each SACPA client who entered treatment during SACPA's second year. This search spanned 1991 to 2003. The analysis counting prior admissions indicated that 46.7% of SACPA clients had no prior experience in treatment—a finding quite close to the 48.8% indicated by client self-reports. It remains possible that some clients with no prior treatment on record in CADDS received treatment from a non-CADDS provider in California or elsewhere. However, any such treatment should have been included in the self-report data, and those data tell a very similar story. Inconsistency in recording the client identification numbers might also affect the findings. But, given both the self-report data on prior admissions and UCLA's independent count of prior admissions, it appears that a large number of clients in the state's treatment population—and about half of those referred by SACPA—were entering treatment for the first time.

Figure 3.11
Secondary Drug when Alcohol is Primary Drug Among SACPA Treatment Clients
(CADDS)

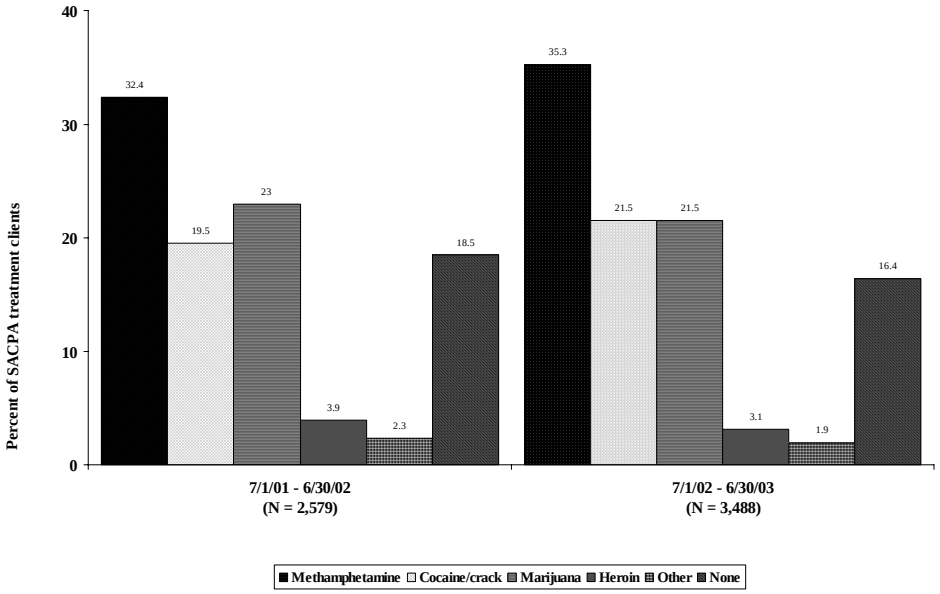


Figure 3.12
Years of Drug Use Among SACPA Treatment Clients
(CADDS)

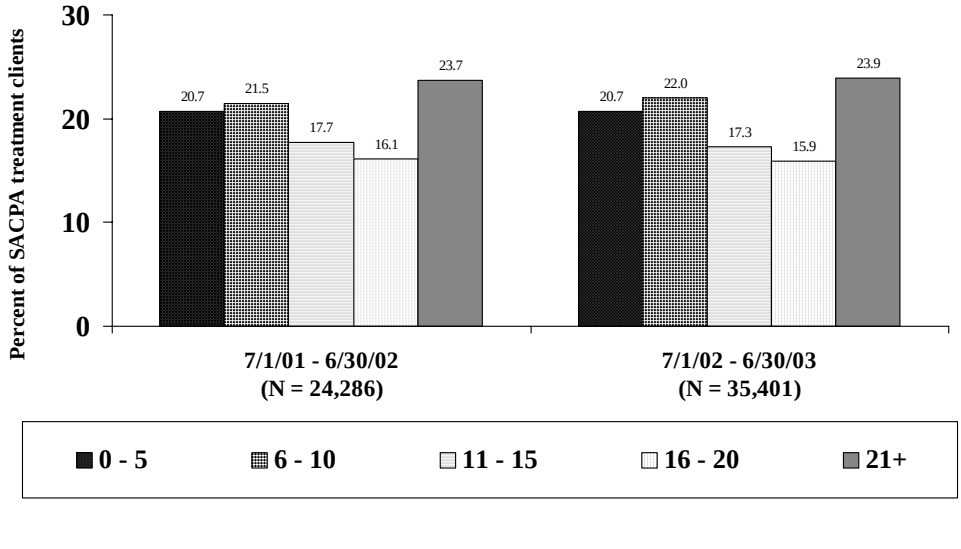


Figure 3.13
Years of Drug Use Among Treatment Clients by Referral Source (CADDS), 7/1/02 - 6/30/03
(N = 166,209)

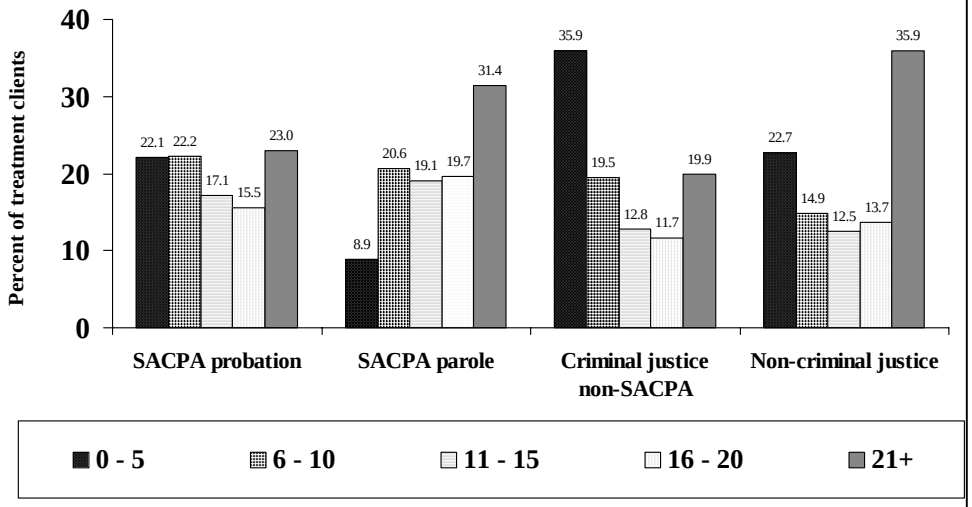


Figure 3.14
Frequency of Primary Drug Use in Past Month Among SACPA Treatment Clients (CADDS)

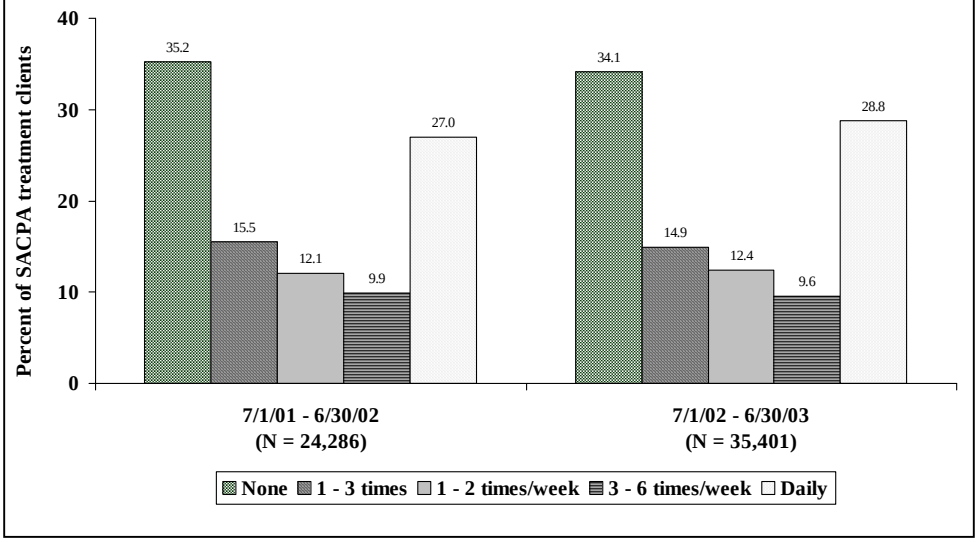


Figure 3.15
Frequency of Primary Drug Use in Past Month Among Treatment Clients by Referral Source (CADDS), 7/1/02 - 6/30/03
(N = 166,209)

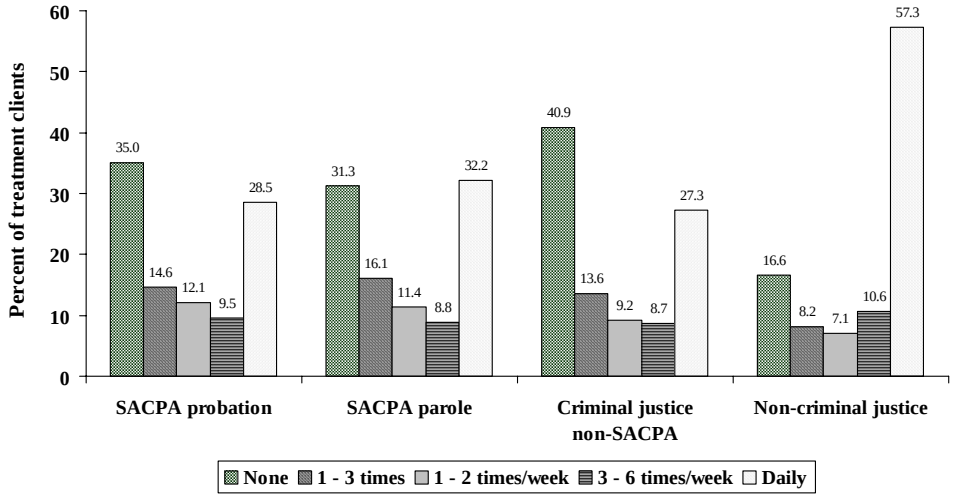


Figure 3.16
Number of Prior Treatment Admissions Among SACPA Treatment Clients (CADDS)

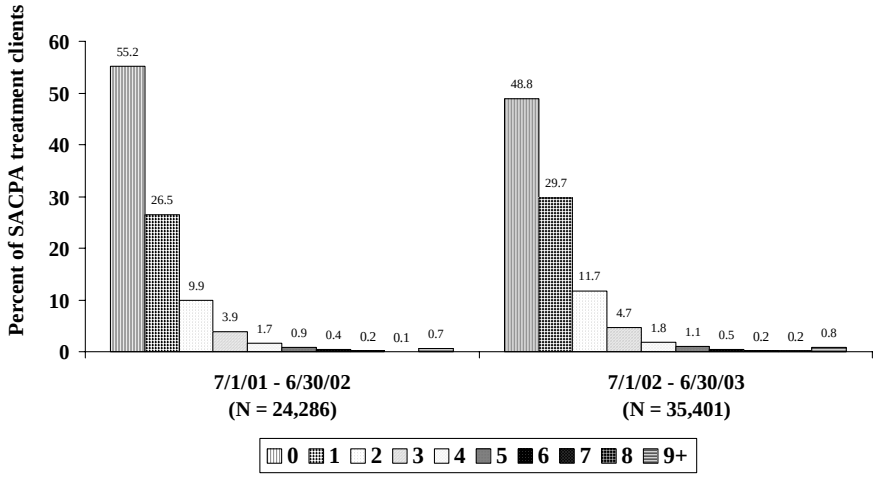
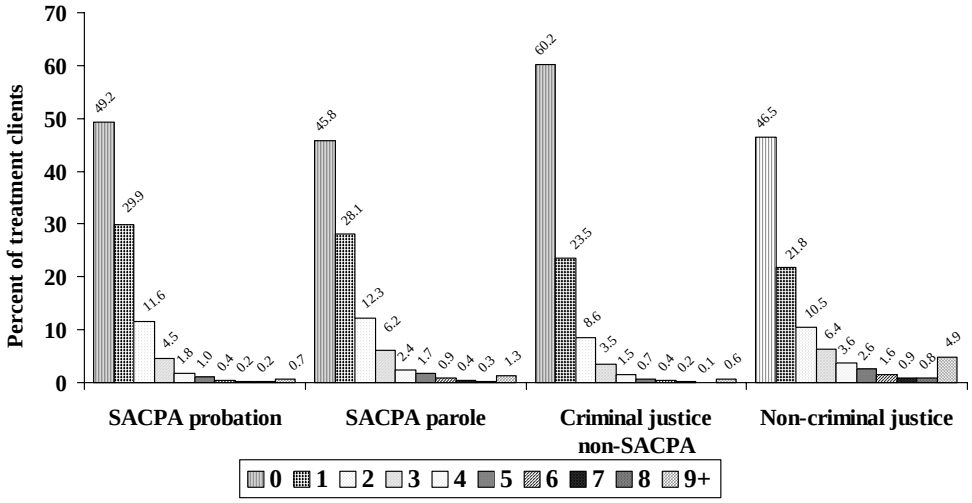


Figure 3.17
Number of Prior Treatment Admissions Among Treatment Clients by Referral Source (CADDS), 7/1/02 - 6/30/03
(N = 166,209)



Characteristics of first-time treatment clients

About half of SACPA clients in each of the first two years had no prior experience in drug treatment (see Figure 3.16 above). That finding was based initially on client self-reports and was verified through a count of the number of prior admissions shown in CADDS for each SACPA client. If SACPA is moving such a large number of first-time clients into the state's treatment population, it is important to understand how these clients compare with clients who did have prior treatment experience. In this section, SACPA's second-year clients with and without prior treatment experience are compared on these characteristics: race/ethnicity, sex, age, primary drug, and drug problem severity.

Race/ethnicity

The race/ethnic composition of SACPA clients with and without prior treatment experience is presented in Figure 3.18. Clients with prior experience were somewhat more likely to be non-Hispanic Whites (48.8% versus 46.6%) and African Americans (14.8% versus 12.4%). Hispanics were somewhat less likely to have had prior experience (30.1% versus 33.4%), as were Asian/Pacific Islanders (1.9% versus 2.7%).

Sex

Clients with prior treatment experience were somewhat less likely to be men; 71.1% of clients who had been in treatment before were men, compared to 75.2% of clients who had not. See Figure 3.19.

Age

SACPA clients with prior treatment experience were older than those with no treatment experience. See Figure 3.20. This difference was to be expected, but the magnitude of the difference is nevertheless striking. While 18.3% of clients with prior treatment experience were in the youngest age bracket (18-25 years old), 29.1% of clients with no such experience were in that age bracket. Conversely, over half of clients with prior treatment experience (51.7%) were 36 years of age or older, whereas only 40.8% of clients with no experience were in that age range.

Primary drug

As shown in Figure 3.21, methamphetamine users were less likely to have had prior experience in treatment (49.4% versus 55.8%), as were marijuana users (9.4% versus 16.5%). Heroin users were more likely to have had prior treatment (15.3% versus 3.8%).

Drug problem severity

UCLA analyzed two indicators of drug problem severity: years of drug use and frequency of recent drug use.

Figure 3.22 shows drug use histories among SACPA clients with and without prior treatment experience. As with age, it is not surprising that first-time clients had shorter histories of drug use. Over one-fourth (27.3%) of clients with no prior treatment experience, compared to only 16.3% of those with such experience, reported having used drugs for no more than five years. On the other hand, almost half (49.4%) of first-time clients had been using drugs for over 10 years, and almost one in five (19.9%) had been using drugs for over 20 years.

Frequency of drug use appears similar for SACPA clients with and without treatment experience. The one exception arises with respect to daily drug use. Only about one-fourth of clients with no prior treatment (24.1%) reported daily use the month prior to treatment admission, whereas almost one-third (32.2%) of clients with prior treatment did so. See Figure 3.23.

Figure 3.18
Race/Ethnicity of SACPA Treatment Clients with No Prior Admission Compared to SACPA Treatment Clients with a Prior Admission
(CADDS), 7/1/02 – 6/30/03

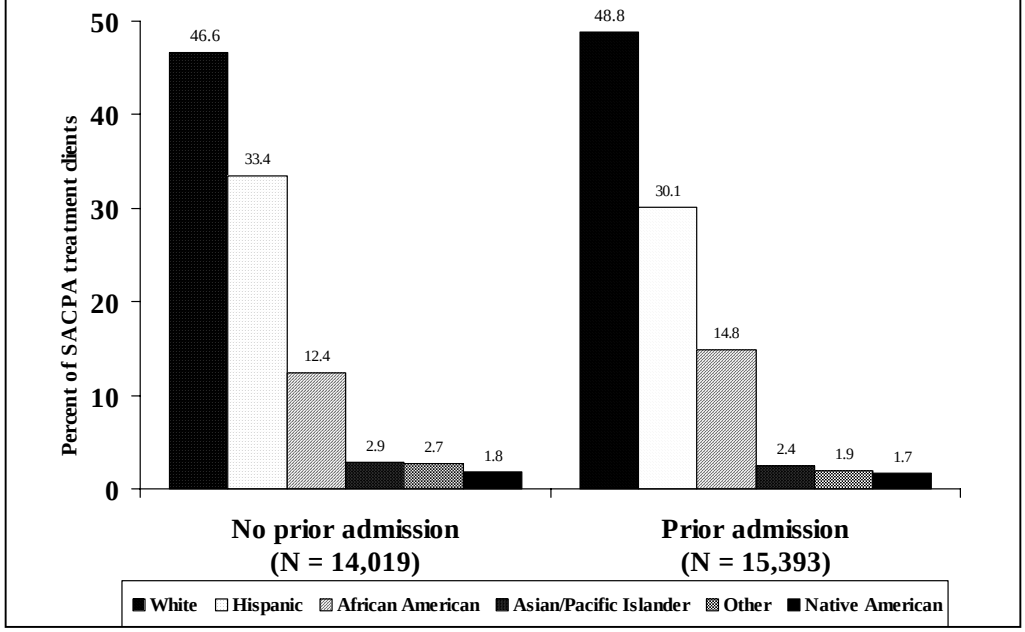


Figure 3.19
Sex of SACPA Treatment Clients with No Prior Admission Compared to SACPA Treatment Clients with a Prior Admission
(CADDS), 7/1/02 – 6/30/03

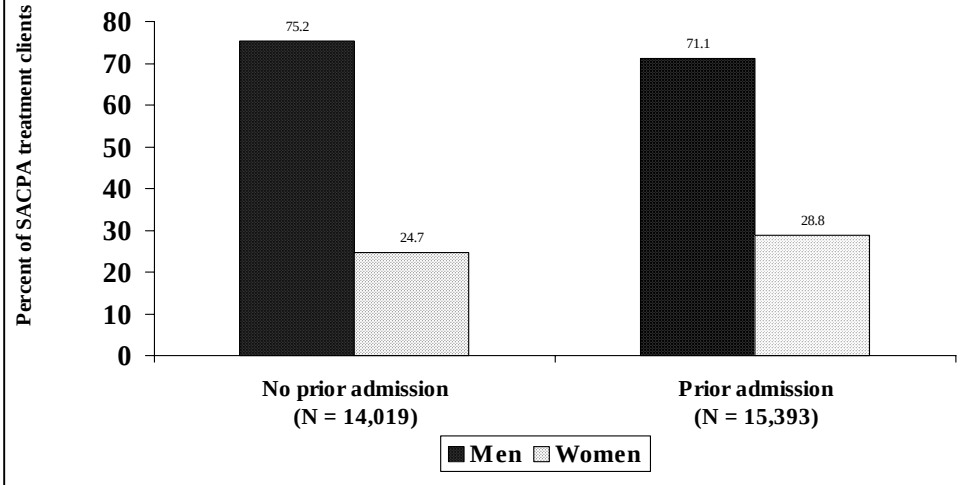


Figure 3.20
Age of SACPA Treatment Clients with No Prior Admission Compared to SACPA Treatment Clients with a Prior Admission
(CADDS), 7/1/02 – 6/30/03

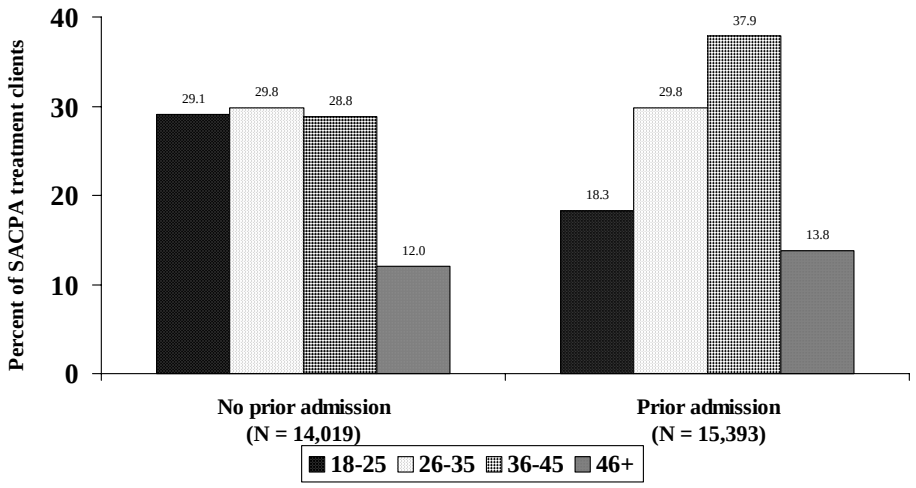


Figure 3.21
Primary Drug Among SACPA Treatment Clients with No Prior Admission Compared to SACPA Treatment Clients with a Prior Admission
(CADDS), 7/1/02 – 6/30/03

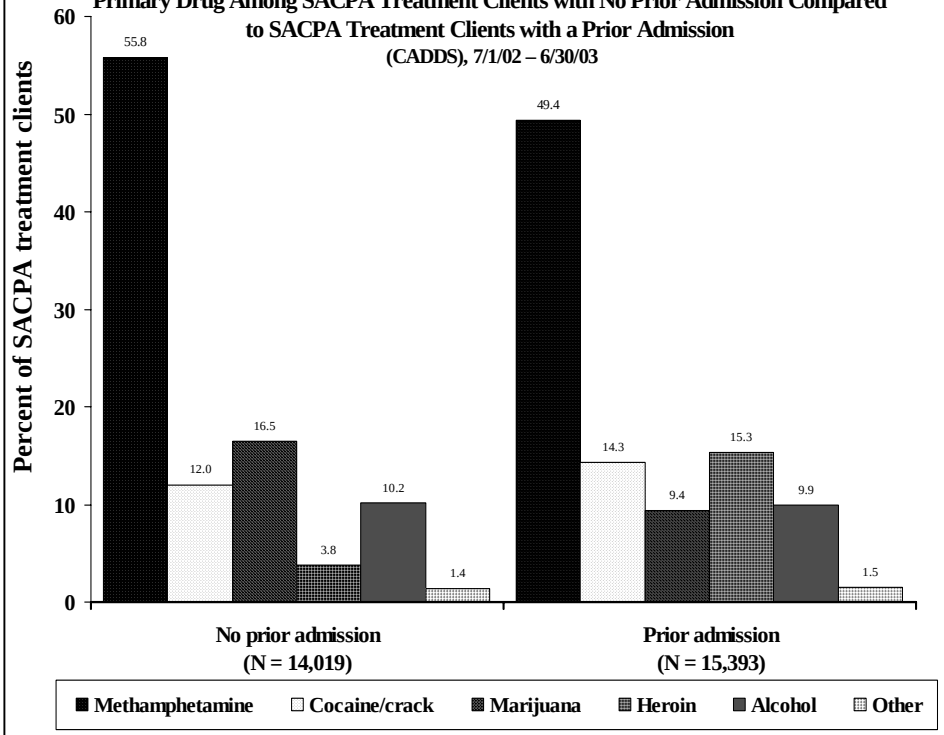


Figure 3.22
Years of Drug Use Among SACPA Time Treatment Clients with No Prior Admission Compared to SACPA Treatment Clients with a Prior Admission
(CADDS), 7/1/02 – 6/30/03

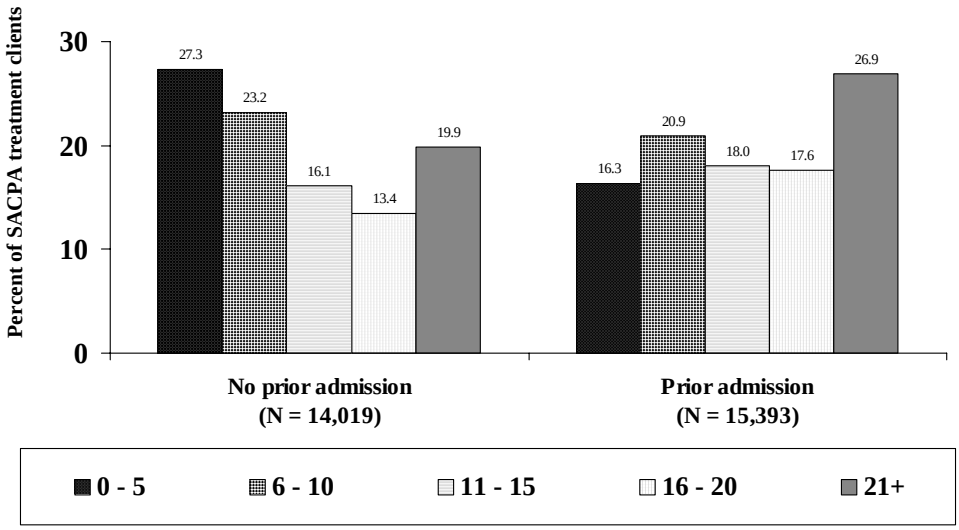
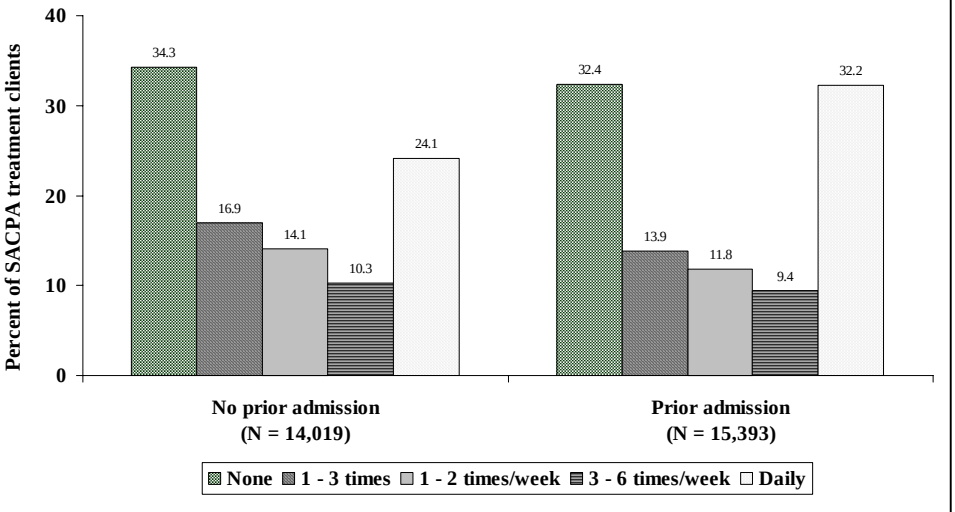


Figure 3.23
Frequency of Primary Drug Use in Past Month Among SACPA Treatment Clients with No Prior Admission Compared to SACPA Treatment Clients with a Prior Admission
(CADDS), 7/1/02 – 6/30/03



Conclusion

About 50,000 offenders were referred for treatment during SACPA's second year. Of this total, 71.4% went on to enter treatment. Most SACPA treatment clients were men. About half (48.0%) were non-Hispanic White, while 31.4% were Hispanic and 13.8% were African American. Their average age was 35. The primary drug problem for about half of SACPA's treatment clients was methamphetamine (53.0%), followed by cocaine/crack (13.2%), marijuana (12.1%), and heroin (10.2%). On all of these characteristics, SACPA's second-year clients were similar to its first-year clients. Thus far, in other words, client characteristics have been quite stable across the first two years.

About half of SACPA clients in each of the first two years had no prior experience in treatment. Compared to SACPA clients with prior treatment, those with no prior treatment were more likely to be Hispanic, male, and younger. They were also more likely to report methamphetamine as their primary drug problem. While first-time clients had shorter histories of drug use than repeat clients, almost half of the first-time clients nevertheless reported having used drugs for over ten years.

Differences between first-time and repeat clients were small with respect to race/ethnicity, sex, and primary drug. However, given the large number of Hispanics (31.4%), men (72.7%), and methamphetamine users (53.0%) in the SACPA client population, it is important that the effect of SACPA on first-time treatment exposure was most apparent in these groups. In addition, many first-time clients had a lengthy drug use history despite their relatively young age. Thus, SACPA has reached a large number of habitual drug users who needed treatment but had never received it. Only in hindsight will it be possible to know the impact of this first treatment experience on long-term drug use patterns of SACPA offenders. But it is clear that SACPA is a route into treatment for many young drug users—mainly users of methamphetamine—whose first treatment experience might otherwise have been delayed.

Chapter 4: Offender Management Strategies

Counties reported use of a variety of offender management strategies intended to raise show rates at assessment and treatment. In at least half of the counties, probation and assessment staff were co-located, walk-in assessments were allowed, offenders had more than one day to report for assessment, and the assessment protocol required only one visit.

Most counties adopted one or more drug court procedures to handle SACPA offenders.

UCLA reviewed county and state documents and observed hearings, advisory group meetings, and county implementation meetings to identify strategies employed by counties to manage SACPA offenders. These strategies were identified: locating assessment centers in or near the court, co-location of probation and assessment staff, allowing assessment by walk-in as well as (or instead of) appointment, allowing a longer time (number of days) for offenders to report for their assessment, completing assessment in one visit, and use of one or more drug court procedures (see below).

The assumption underlying each strategy was that it might help to maximize the county's show rate at assessment, treatment, or both. Offenders can be ordered directly from sentencing to assessment if the office where assessments are completed is only a few steps or minutes away from the courtroom. Also, assessments may take less time if probation officers and assessment staff are co-located in one office or if assessments are routinely completed in a single visit. Any of these three strategies might result in higher show rates because they make the assessment process more efficient. Two other strategies—allowing walk-in assessment and allowing more time to report—might result in higher show rates at assessment because they create some latitude for the offender; he/she is required to appear promptly but not on a specific date and time. Finally, using drug court procedures to manage offenders might lead to a higher show rate at either assessment or treatment because the judge, case manager, and probation officer are providing close supervision. Counties took different approaches to the assessment process for multiple reasons, such as availability of office space, expected volume of SACPA offenders, and number of assessment staff available.

Questions about use of these offender management strategies have been included in the annual stakeholder survey for both SACPA years (Lead Agency and Court Administrator sections of stakeholder survey in Appendix B).

Drug courts follow procedures promulgated by the National Drug Court Institute (NDCI) (Tauber & Huddleston, 1999). These include a court calendar devoted to drug offenders as well as open dialogue between judge and offender; close supervision by judge, case manager, and probation officer; and collaborative decision-making involving judge, prosecutor, defense attorney, probation officer, and treatment provider. The stakeholder survey asked court administrators to describe their SACPA courts in these terms, but it was impossible to determine whether courts fully reflected NDCI procedures. The term "drug court procedures" is used to describe courts in which these procedures were followed at least to some degree.

Assessment procedures

In the stakeholder survey, many counties reported use of offender management strategies intended to raise show rates at assessment. As shown in Figure 4.1, assessment centers were located in or near the court in 43.8% of responding counties. Most (69.7%) reported co-location of probation and assessment staff. About half (54.5%) of the counties allowed walk-in assessment. Most counties (77.8%) allowed offenders more than one day to report for their assessment. Half of the counties established an assessment protocol requiring only one visit (53.1%).

Drug court procedures

Most counties (80.8%) reported use of drug court procedures to handle at least some SACPA offenders. See Figure 4.2.

Conclusion

Many counties reported use of offender management strategies intended to raise show rates at assessment and treatment. In at least half of the counties, probation and assessment staff were co-located, walk-in assessments were allowed, offenders had more than one day to report for assessment, and the assessment protocol required only one visit.

Most counties used one or more drug court procedures to handle SACPA offenders.

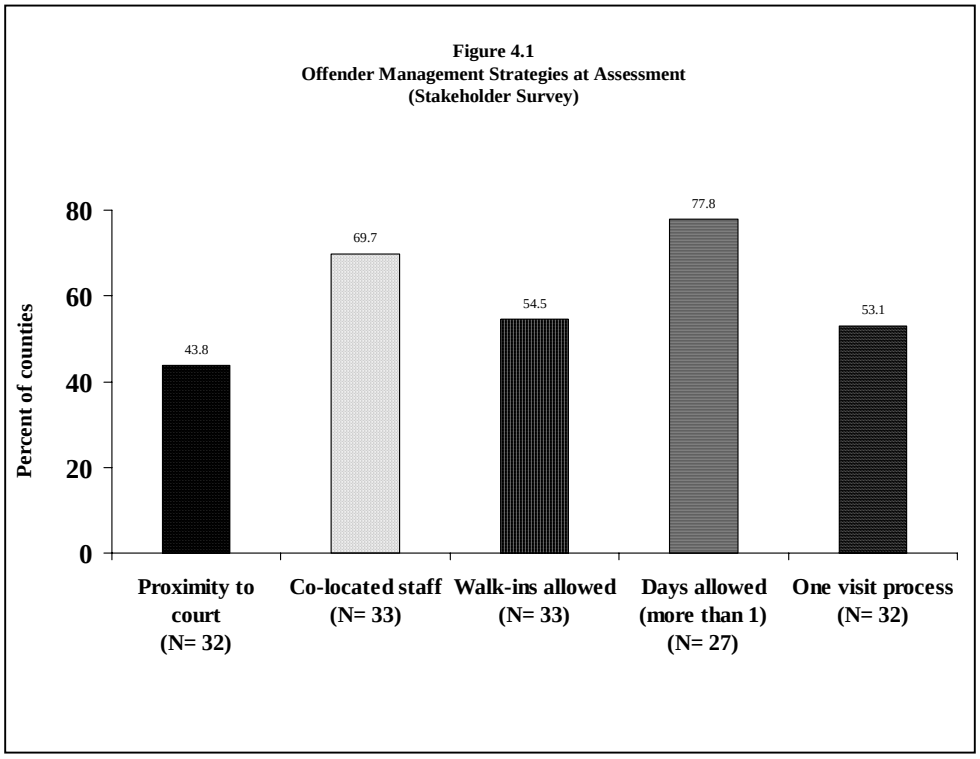
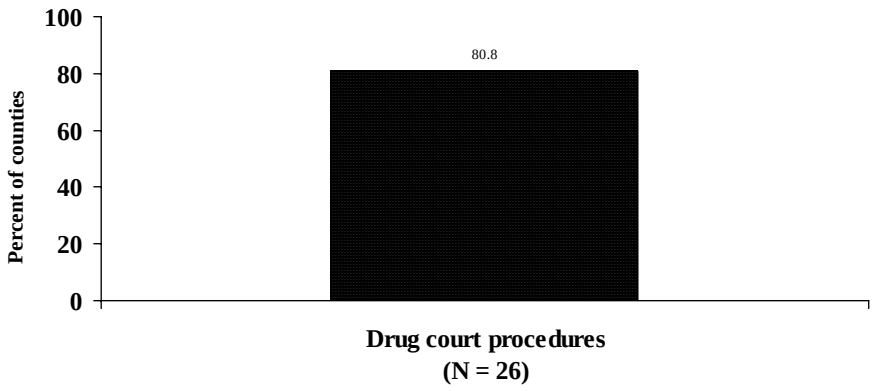


Figure 4.2
Management of SACPA Offenders with Drug Court Procedures
(Stakeholder Survey)



Chapter 5: Offender Management Strategies and Show Rates

Assessment show rates were higher in counties where assessment took place in or near the court and where offenders were allowed more days to report for assessment. Treatment show rates were higher in counties using one or more drug court procedures to handle SACPA offenders. These findings were stable across SACPA's first two years and may represent important aspects of offender management. Show rates may improve statewide if these strategies are adopted in additional counties.

Both assessment and treatment show rates were lower in counties where the proportion of SACPA offenders with felony as opposed to misdemeanor convictions was higher.

A major concern for SACPA administrators is to maximize the proportion of offenders who complete their assessment and enter treatment, i.e., the show rates. Statewide show rates at assessment and treatment were reported in Chapter 3. Strategies adopted by counties to maximize show rates were reported in Chapter 4. The analysis now turns to possible impact of these strategies on county show rates at assessment and treatment in SACPA's second year.

Initial focus is on the relationship between county show rates at *assessment* and these offender management strategies: locating assessment in or near the court, co-locating assessment staff, allowing assessment by walk-in or appointment, allowing offenders more days to report for assessment, completing assessment in one visit, and using one or more drug court procedures to handle SACPA offenders. Because the composition of SACPA offenders by conviction level—felony or misdemeanor—might affect show rates as well, the analysis includes conviction level.

Focus then turns to the relationship between county show rates at *treatment* and use of drug court procedures. The relationship between conviction level and treatment show rates is also examined.

County variability

Statewide show rates were 85.4% at assessment and 83.7% at treatment (see Chapter 3). Figure 5.1 shows county variability around those rates. Most counties (72.0%) reported assessment show rates over 80%. Assessment show rates were 50% or lower in 12.0% of the counties. About two-thirds of the counties (64.4%) reported treatment show rates over 80%. On the other hand, these rates were no higher than 50% in one-fifth of the counties (19.6%).

Show rates at assessment

Figure 5.2 shows the relationship between assessment show rates and strategies specifically intended to facilitate the step from referral to assessment. Rates were higher in counties where assessment occurred in or near the court and where offenders were allowed more days to report for assessment. There was no difference between counties with and without a co-located assessment process, between counties allowing walk-in assessment and those

Figure 5.1
County Variability in Show Rates for SACPA Offenders at Assessment and Treatment (SRIS), 7/1/02 - 6/30/03

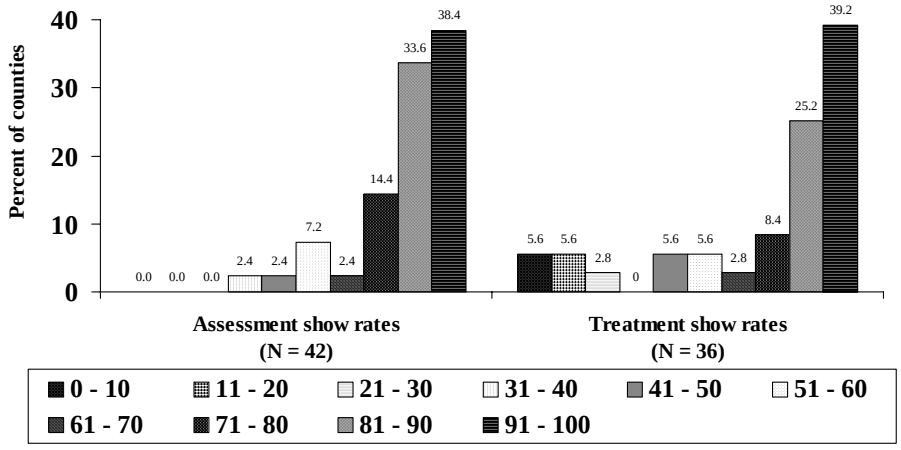
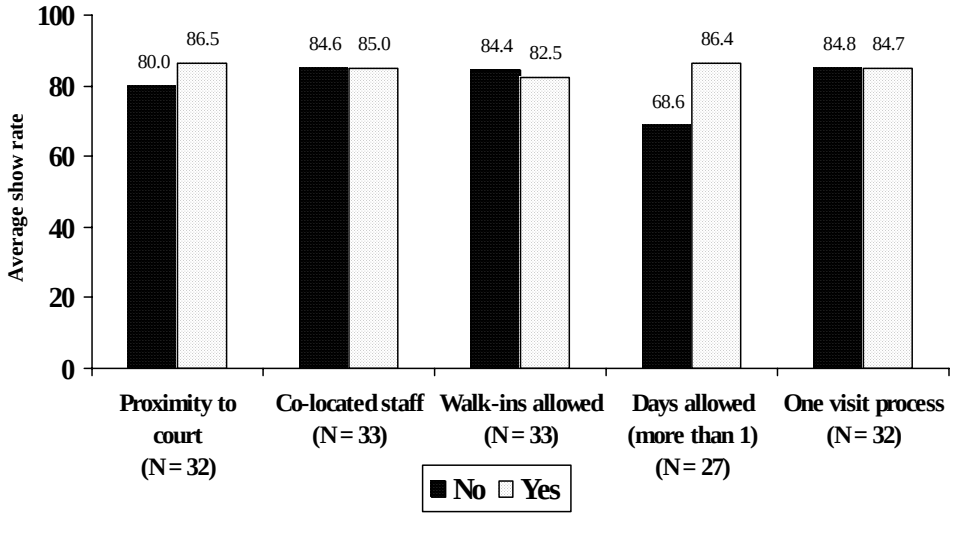


Figure 5.2
Average Assessment Show Rates by Offender Management Strategies at Assessment (SRIS and Stakeholder Survey)



requiring an appointment, or between counties where assessment required one visit and those requiring more than one.

Figure 5.3 shows the relationship between assessment show rates and use of drug court procedures. Counties using drug court procedures for SACPA offenders had higher show rates.

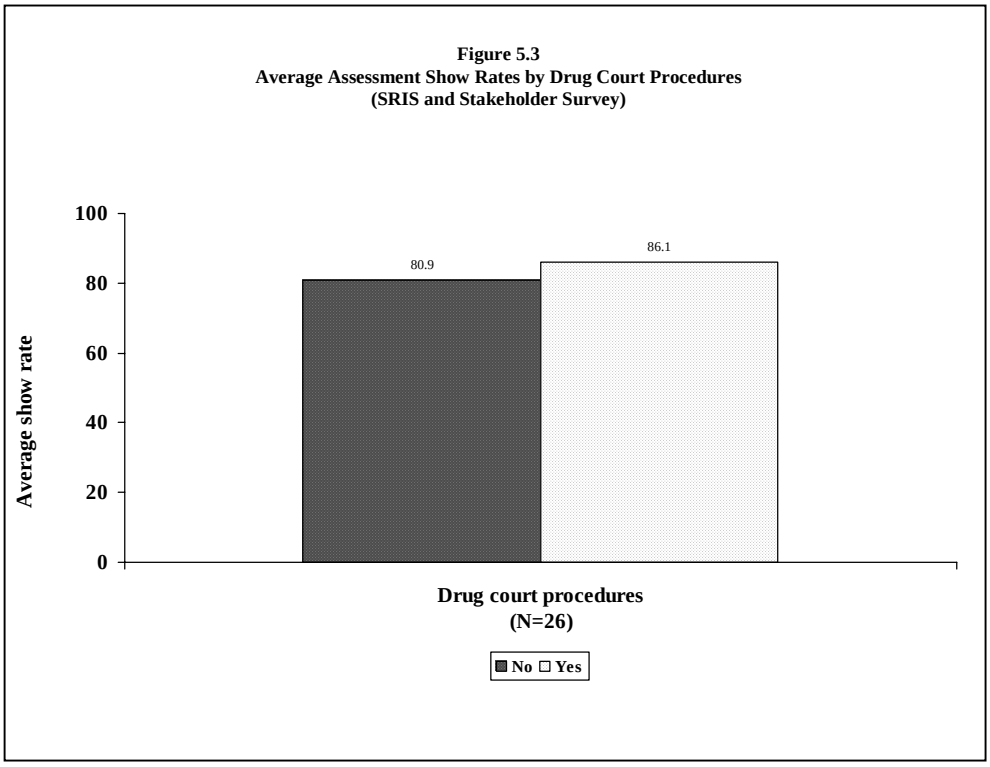
Figure 5.4 shows the relationship between assessment show rates and conviction level. Counties were asked to report the number of second-year SACPA probationers with felony convictions and the number with misdemeanor convictions. As indicated in Chapter 2, the percent of felony convictions varied widely by county. In counties where the percent of felony convictions was above the median,[1] assessment show rates were lower.

Show rates at treatment

Figure 5.5 shows the relationship between treatment show rates and use of one or more drug court procedures. Counties using drug court procedures for SACPA offenders had higher show rates at treatment.

Finally, Figure 5.6 shows that treatment show rates were lower in counties where the proportion of felony convictions in SACPA was higher.

Figure 5.3
Average Assessment Show Rates by Drug Court Procedures
(SRIS and Stakeholder Survey)



[1] The median county (56% felony convictions) is the "middle case" in the distribution from lowest to highest county percents.

Figure 5.4
Average Assessment Show Rates by Conviction Level
(SRIS and Stakeholder Survey)
(28 Counties Reporting)

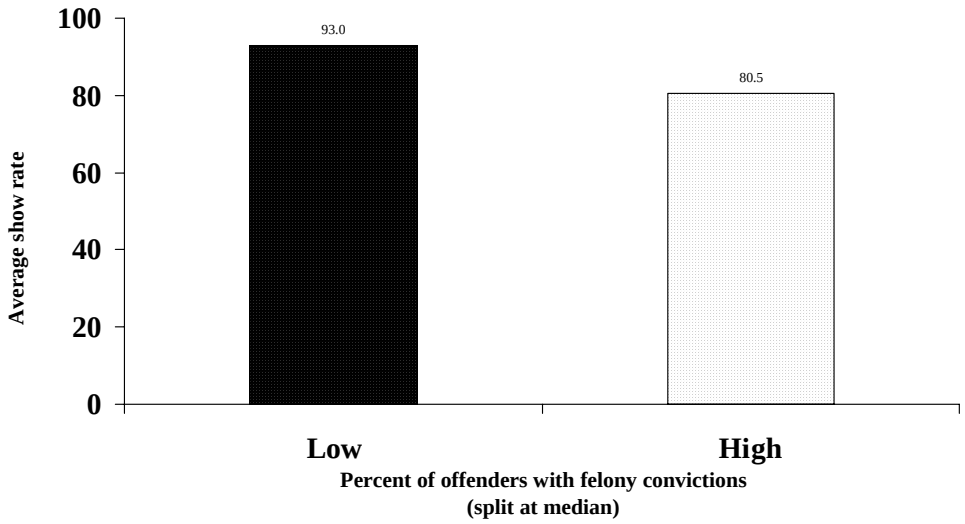


Figure 5.5
Average Treatment Show Rates by Drug Court Procedures
(SRIS and Stakeholder Survey)

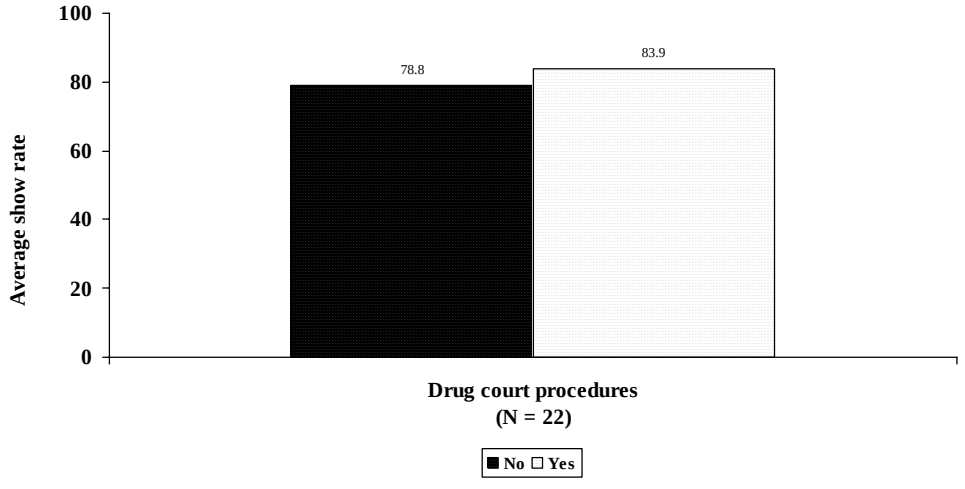
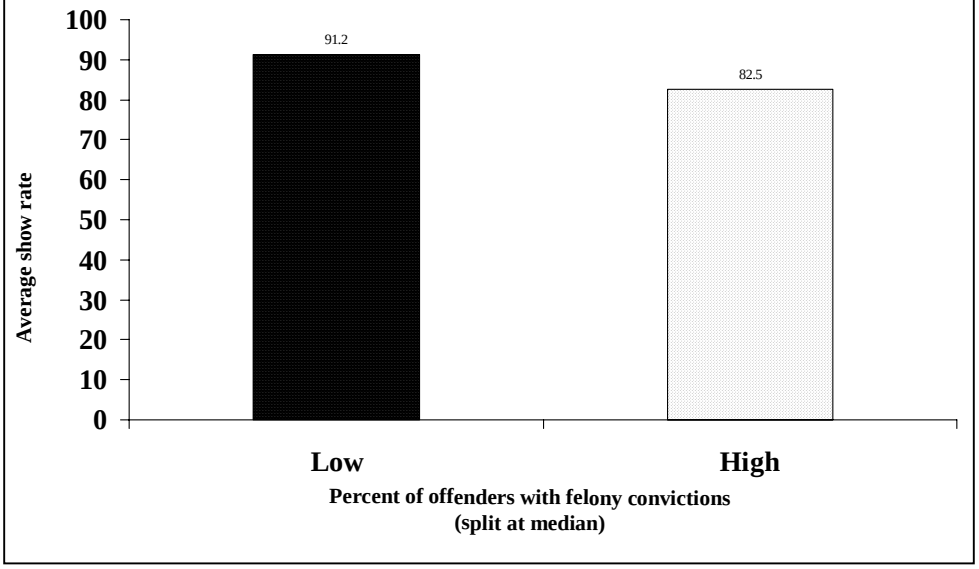


Figure 5.6
Average Treatment Show Rates by Conviction Level
(SRIS and Stakeholder Survey)
(18 Counties Reporting)



Conclusion

In SACPA's second year as well as the first, assessment show rates were higher in counties where assessment took place in or near the court and where offenders were allowed more days to report for assessment. Treatment show rates were higher in counties using one or more drug court procedures to handle SACPA offenders. These findings appear stable and may represent important aspects of offender management. Show rates may improve statewide if these strategies are adopted in additional counties.

Both assessment and treatment show rates were lower in counties where felony convictions predominated. Studies of criminal offending in California and elsewhere (e.g., Chaiken & Chaiken, 1982; Gray et al., 2001; Petersilia et al., 1986; Wolfgang et al., 1972) have shown felony offenders are more likely to re-offend than misdemeanants. Felons may be less likely to comply with SACPA requirements unless closely supervised and promptly returned to court for noncompliance. The cost of SACPA implementation could therefore be higher, on a per-client basis, in counties with a higher proportion of offenders in SACPA with felony convictions. Downstream program costs and outcomes may be affected as well. In the analysis of costs and outcome, it will be important to account for county variation in conviction levels represented in the SACPA population.

Chapter 6: Treatment Placement

The initial treatment placement for most of SACPA's second-year offenders (84.1%) was outpatient drug-free. Long-term residential treatment (planned duration exceeding 30 days) was the second most common placement (10.9%). Few heroin users (12.7%) were treated with methadone detoxification or maintenance programs despite the proven effectiveness of these programs. Treatment placement patterns in SACPA's second year were very similar to patterns found in the first year.

Although most treatment clients were placed in an outpatient program, many had drug problems severe enough to suggest a need for residential treatment. In a sample of SACPA and non-SACPA clients with high-severity drug problems, placement in outpatient rather than residential treatment was more common for SACPA clients.

Within the SACPA group, such placement was more common for African Americans. There were no differences in placement of high-severity SACPA clients by age, sex, or primary drug.

These findings indicate a need to assess the adequacy of treatment resources available to support appropriate placement of SACPA clients, especially those who are African American.

This chapter describes the types of treatment in which offenders were placed during the second year of SACPA and analyzes the prevalence of outpatient treatment for offenders whose drug problem severity was high enough to indicate a likely need for residential treatment. The placement issue is important because policymakers and county representatives have expressed concern regarding the degree to which SACPA offenders with severe drug problems are placed in a treatment program appropriate to their needs.

Treatment modality

CADDS data were analyzed to show the percent of SACPA offenders entering each treatment modality. As shown in Figure 6.1, outpatient drug-free was the initial treatment placement for most offenders (84.1%). Long-term residential treatment (planned duration exceeding 30 days) was the second most common placement (10.9%).

Figure 6.2 shows treatment modality by primary drug reported by the client. Outpatient drug-free was the predominant modality for clients reporting each primary drug. The next most common modality, again for each primary drug, was long-term residential.

Methadone maintenance is an effective treatment for heroin dependence (American Methadone Treatment Association, Inc., 2004; Mathias, 1997; National Institute on Drug Abuse, 1999; National Institutes of Health Consensus Conference, 1998). However, few heroin users in SACPA (12.7%) were treated with methadone detoxification or maintenance. Most were placed in outpatient drug-free programs, which do not provide medication to alleviate the symptoms of heroin dependence. Information was not available to determine the extent to which this finding reflects client preference versus SACPA policy.

Figure 6.1
SACPA Treatment Clients by Modality
(CADDS), 7/1/02 - 6/30/03
(N = 35,401)

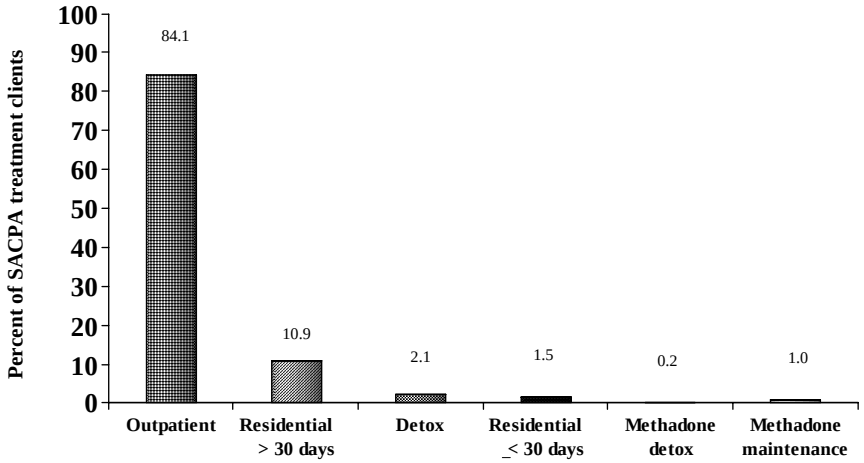
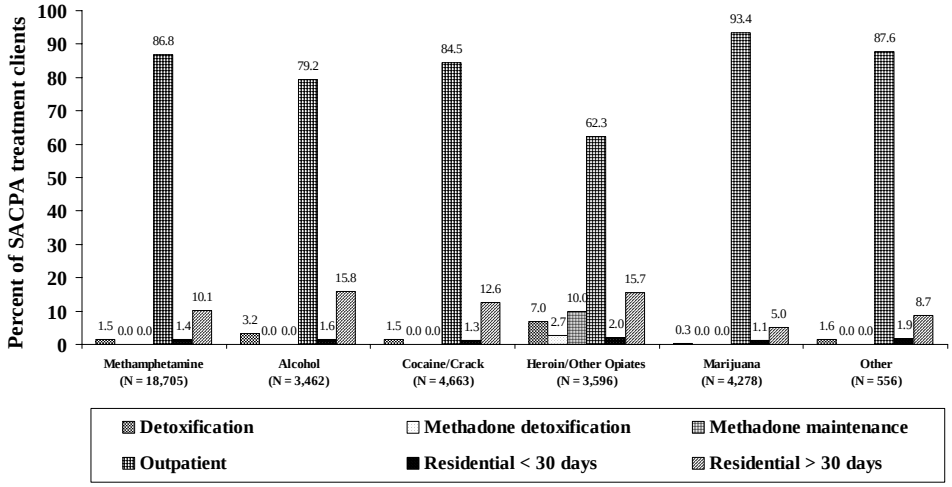


Figure 6.2
Primary Drug by Modality Among SACPA Treatment Clients
(CADDS), 7/1/02 - 6/30/03
(N = 35,401)



Treatment placement patterns in SACPA's second year were very similar to patterns found in SACPA's first year.

Placement of clients with high-severity drug problems

Policymakers and county representatives have expressed concern regarding the degree to which SACPA offenders with severe drug problems are being placed in a treatment program appropriate to their needs. More specifically, if an offender appears to need residential treatment, is the offender placed there? This concern has arisen because residential treatment is more costly than outpatient treatment. One recent study calculated per-episode costs of $838 for outpatient treatment and $2,791 for residential treatment in California (Ettner et al., 2003). Residential placements thus represent a particular drain on SACPA and other resources used by counties to pay for the treatment of SACPA offenders. Concern over the cost of residential treatment takes on additional urgency in the current climate of fiscal constraint.

From a cost-control point of view, residential slots must be used judiciously. If, for example, funds available for SACPA treatment in a given fiscal year are overspent, county administrators might be forced to scale back on residential placements. Also, if no residential slot is immediately available for a given offender, assessment staff may decide to place him/her in an outpatient program in order to avoid a long lag before the start of treatment. That is, promptness may be judged more important than modality.

UCLA examined the prevalence of placement in outpatient treatment among clients whose drug problem was severe enough to indicate a likely need for residential treatment. The analysis included non-SACPA as well as SACPA clients for two reasons. First, the available data on drug problem severity do not suffice to support a formal diagnosis of need for residential treatment. However, by comparing SACPA and non-SACPA clients, it is possible to determine whether SACPA clients with high-severity drug problems are any more likely, or any less likely, to be placed in a residential program in comparison to non-SACPA clients with high-severity drug problems. Second, placement of some high-severity clients in outpatient treatment may reflect sound clinical judgment, not captured in any formal diagnostic tool. A comparison of SACPA to non-SACPA clients does not eliminate the problem inasmuch as sound clinical judgment may lead to placement of high-severity clients in outpatient treatment more often for SACPA clients than for non-SACPA clients. But a higher prevalence of outpatient placement among SACPA clients would suggest that treatment resources may be inadequate to support appropriate placement of SACPA clients.

UCLA also checked for background characteristics that might be associated with treatment placement of SACPA clients.

Data sources

The California Treatment Outcome Project (CalTOP) was part of a multi-site project funded in 1998 by the U.S. Center for Substance Abuse Treatment. CalTOP's main goal was to create and test a system for monitoring treatment outcomes. The system included standardized assessments of client needs, services received, outcomes, and cost-offsets. At 44 treatment programs in 13 California counties, client self-report data were collected on drug problem severity and other problem severity at treatment intake, treatment discharge, a

three-month follow-up, and a nine-month follow-up. In addition, background and outcome data were collected via links to statewide criminal justice and social service databases. The California Department of Alcohol and Drug Programs led implementation of CalTOP with assistance from UCLA.

The CalTOP sample included 20,092 clients, enrolled between April 1, 2000 and December 31, 2002. Of this total, 3,748 were enrolled during SACPA's first year. Analysis of treatment placement compared three groups of clients enrolled in that timeframe: SACPA clients (N = 688), clients referred to treatment by criminal justice sources other than SACPA (N = 1,178), and non-criminal justice clients (N = 1,882).[2] Analysis of client characteristics associated with placement focused on the SACPA group.

CalTOP included only 13 of the state's 58 counties. Also, the analysis focused on clients enrolled in treatment during SACPA's first year. Findings may not be typical of placements occurring among SACPA clients statewide or beyond SACPA's first year. However, treatment clients in those 13 counties comprised fully half (50.3%) of the state's total treatment population during the CalTOP study, and clients in the CalTOP sample were quite similar to the total treatment population on a wide range of characteristics, e.g., race/ethnicity, sex, age, and primary drug (Hser et al., 2003). Patterns seen in CalTOP's counties are therefore important in their own right and are probably a reliable indication of patterns statewide.

CalTOP data collection included the Addiction Severity Index (ASI), a well-established and widely used assessment tool that collects standardized data on client status in seven domains: drug use, alcohol use, employment, family and social relationships, legal status, psychiatric status, and medical status (McLellan et al., 1980, 1992). Indicators of drug problem severity on the ASI include frequency of drug use in the past 30 days, incidence of problems related to drug use in the past 30 days, money spent on drug use, and the client view of his/her current need for treatment. For this analysis, clients with a composite drug problem score in the top one-third (.16 or more) were counted as high-severity drug users. In McLellan et al. (1992), the *average* score for clients in publicly funded residential treatment was .14, compared to .10 for clients in publicly funded outpatient treatment. Thus, if the top one-third of clients in this analysis had scores of .16 at *minimum*, most of them were likely to have needed residential treatment. Supplementary analyses using lower and higher cutoffs led to the same findings reported here.

UCLA used CADDS data to determine where clients were placed. There was only one placement for most SACPA offenders (84%). Among those who received two or more placements, the typical pattern (for 56%) was placement in a residential program followed by transfer to an outpatient program. Hence it was sufficient to focus on the initial placement. Finally, the analysis focused on long-term residential and outpatient drug-free treatment

[2] The CADDS record for each incoming client indicates the referral source as either SACPA (court/probation or parole), non-SACPA court/criminal justice, or non-criminal justice. CADDS also indicates the client's legal status. Most clients (77%) sent from non-SACPA court/criminal justice were on probation or parole or were incarcerated. Among the remaining 23% were clients participating in a diversion program and others with no legal status on record. Thus, while a portion of the non-SACPA court/criminal justice population may actually not have been in the criminal justice system, the overall population can be characterized as non-SACPA criminal justice. Non-criminal justice clients were those referred by health care provider, employee assistance program, self, or other sources but not by criminal justice.

because, as indicated above, placement of SACPA clients in modalities other than those two was rare. Other variables extracted from CADDS for this analysis include: referral source (SACPA, non-SACPA criminal justice, and non-criminal justice); client demographic characteristics (e.g., age and sex); primary drug of abuse; and occurrence of prior treatment.

Data on recent involvement in crime (number of arrests for violent, property, or drug offenses in the year before treatment intake) were extracted from records maintained by the California Department of Justice.

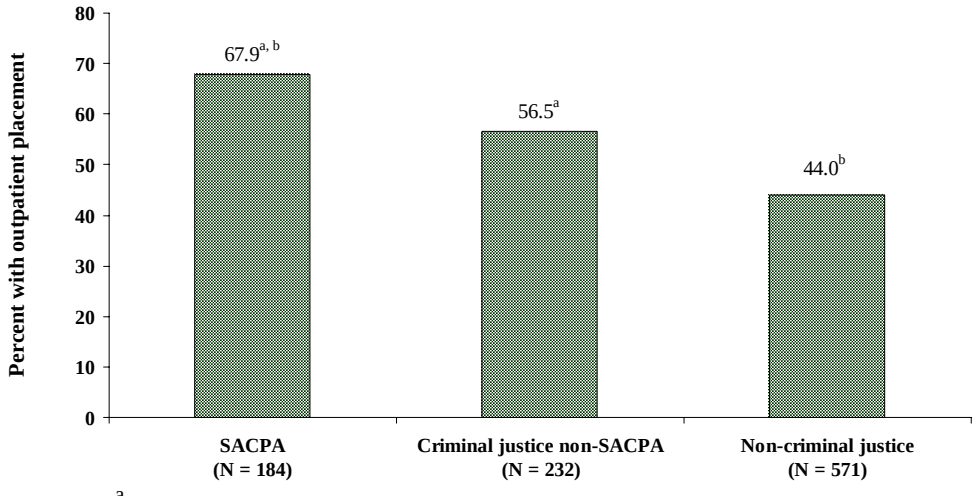
Because findings on treatment placement were based on a sample of clients rather than the entire population in treatment, UCLA determined whether these findings were statistically significant, i.e., likely to reflect reliable differences across groups rather than chance variation.

Placement of low-severity clients in residential treatment could be regarded as a problem because such clients may not need residential treatment. But the focus of this analysis was on under-treatment (i.e., placing high-severity clients in outpatient programs), not over-treatment (i.e., placing low-severity clients in residential programs). Moreover, only 18% of low-severity SACPA clients were over-treated (they comprised 13% of all SACPA clients). Under-treatment was far more common.

Placement of high-severity clients in outpatient treatment

As shown in Figure 6.3, 67.9% of SACPA clients with high-severity drug problems (N = 184) were placed in an outpatient program. The rate was lower (56.5%) for non-SACPA criminal justice clients with high drug severity (N = 232) and lowest (44.0%) for non-criminal justice clients with high drug severity (N = 571). The difference between SACPA and each of the non-SACPA groups was statistically significant.

Figure 6.3
Outpatient Placement of High-Severity Clients by Referral Source (CalTOP), 7/1/01 - 6/30/02
(N = 987)



[a] Difference is statistically significant, p< .001.

[b] Difference is statistically significant, p<.0001.

The composition of these groups may have differed in other ways that affected treatment placement. For example, drug problem severity is typically higher for clients who have psychiatric problems, which may necessitate a residential placement. UCLA adjusted the findings to account for severity of psychiatric problems as well as demographic characteristics (e.g., age and sex), primary drug problem, and recent involvement in property and violent crime. After this adjustment, placement in outpatient treatment was still significantly more common among high-severity clients sent to treatment by SACPA than among those sent by other sources (data not shown).

At least two factors may explain the rate of outpatient placement for high-severity SACPA clients. First, counties may conserve SACPA resources by restricting the number of residential placements. Depending on how restrictive the placement procedures are, SACPA clients could be "shut out" of residential treatment more commonly than others. Second, counties may emphasize expedited placement of SACPA offenders. Residential treatment capacity is limited, and clients requiring such treatment often must be assigned to a wait list until a slot is available. Counties may be sending them to an outpatient program able to take them immediately. In contrast, non-SACPA clients, especially those referred from sources other than criminal justice, may be placed on a wait list until the treatment program they need (or prefer) has an opening. It is quite possible that these two factors are both at work. That is, if high priority is placed on moving SACPA clients into treatment as promptly as possible, it may be especially difficult to place them in residential programs if resources for such placement are already very limited.

Because day treatment programs are less costly than residential treatment but more intensive than standard outpatient care, UCLA considered the possibility that high-severity SACPA clients in the CalTOP sample were being placed in day treatment as an alternative to residential treatment. However, only 3% of high-severity clients were placed in day treatment, compared to 24% in residential and 68% in outpatient. Placement in day treatment was too uncommon to affect findings.

Characteristics of high-severity SACPA clients with outpatient placement

UCLA examined background characteristics associated with placement in outpatient treatment for SACPA clients with high-severity drug problems in the CalTOP sample. The purpose was to identify any client group with a significantly higher rate of outpatient placement. These characteristics were examined: race/ethnicity, age, sex, and primary drug problem.

There were no significant differences in placement of high-severity clients in relation to age, sex, or primary drug (data not shown).

Placement of high-severity clients by race/ethnicity

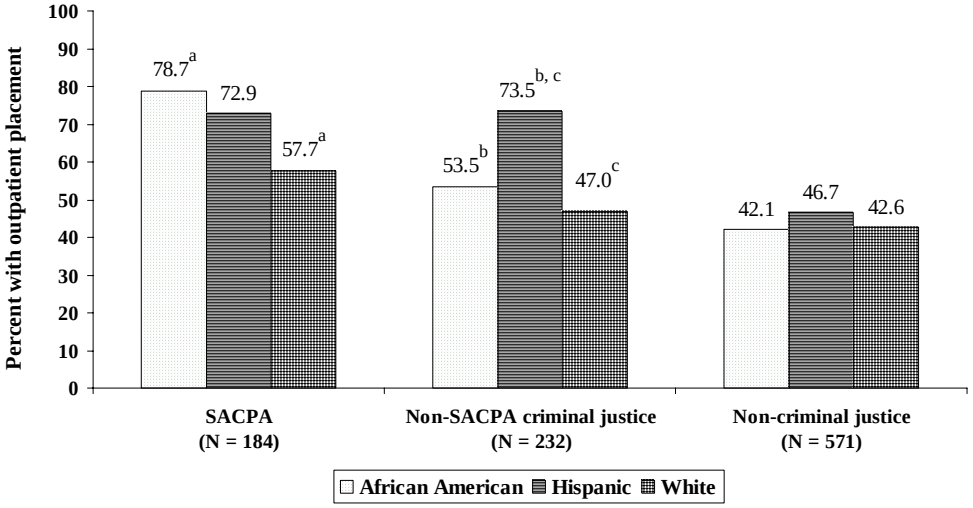
As shown in Figure 6.4, 78.7% of African American clients, 72.9% of Hispanic clients, and 57.7% of White clients received outpatient placement in SACPA. The outpatient placement rate for Hispanics was not significantly higher than that for Whites or significantly lower than that for African Americans. The rate for African Americans was, however, significantly higher than that for Whites. Thus, while differences between Hispanics and others in SACPA were not large enough to indicate a strong probability of similar differences in the

13-county CalTOP client population, it is probable that outpatient placement was more common for high-severity SACPA African American clients in CalTOP.

Also shown in Figure 6.4 is placement of high-severity clients referred to treatment by sources other than SACPA. Placement in outpatient treatment occurred at a similar rate for African Americans and Whites in the non-SACPA criminal justice group and was virtually the same for African Americans and Whites in the non-criminal justice group. (The outpatient placement rate was higher for Hispanics in the non-SACPA criminal justice group. No such difference was apparent in the non-criminal justice group. Because SACPA was the focus of this comparison, placement patterns in the two non-SACPA groups are not discussed further.)

It is possible that client characteristics other than race/ethnicity might account for the differences seen among SACPA clients in Figure 6.4. UCLA adjusted for age, sex, marital status, level of formal education, employment status, primary drug, psychiatric severity, alcohol severity, lifetime treatment experience, and recent involvement in crime. Findings for race/ethnicity did not change. Finally, UCLA performed additional analyses to explore the possibility that findings might be driven by placement procedures specific to particular counties. Findings did not change.

Figure 6.4
Outpatient Treatment Placement of High-Severity Clients by Race/Ethnicity (CalTOP), 7/1/01 - 6/30/02 (N = 987)



Same superscript indicates statistically significant difference: [a]p<.05, [b]p<.02, [c]p<.01.

If no other client characteristics or county of residence explained the higher rate of outpatient placement for high-severity African Americans in the CalTOP sample, how can this finding be explained? First, placement might, in part, reflect client preference. Studies of treatment seeking and satisfaction with treatment suggest that some African American drug users are uncomfortable with residential treatment and prefer outpatient (e.g., Longshore et al., 1992; Tucker, 1985). Second, assessment staff and others making the placement decisions may lack sufficient awareness of cultural factors affecting client presentation of drug-related

problems and service needs. As a result, client problems and needs may be under-estimated, and clients may be under-treated. Third, there may be some degree of racial bias, purposeful or inadvertent, in SACPA placements. While each of these factors may come into play, they are unlikely to be important in this instance—for one particular reason. Outpatient placement was not more likely for high-severity African Americans in either of the other two client groups, namely those referred to treatment by criminal justice sources other than SACPA and those referred by non-criminal justice sources. If placement reflected client self-selection, any disinclination among African Americans to enter residential treatment should be apparent across the board. Moreover, it seems unlikely that bias or lack of cultural awareness would affect placement of African American SACPA clients across 13 counties without similarly affecting placement of other African American clients in the same counties.

Alternatively, race/ethnic patterns in placement may be due to the geographic dispersion of residential programs supplying treatment for SACPA clients. Distance from the client's home to available program sites is often a factor in treatment placement because it affects the client's ability and willingness to attend. If African Americans, on average, live farther away from residential programs that serve SACPA clients, an outpatient placement may be judged appropriate for some whose drug problem is severe, as treatment need is weighed against the convenience of treatment location. In other words, residential capacity may be lower, relative to need, in predominantly African American communities. Moreover, in some counties, clients are sent directly to a treatment provider for assessment. Clients may then be placed in an outpatient or residential program operated by that provider. If African American SACPA clients are sent to providers with less residential capacity relative to need, those clients may be placed in outpatient despite needing residential. These factors might well interact with those affecting placement for SACPA clients overall. That is, when prompt placement is a priority and resources for residential treatment are limited, unevenness in the geographic dispersion of residential programs across a county could be having a disproportionate impact on African American clients.

Conclusion

Most treatment clients in the second year of SACPA, as in the first, were placed in outpatient drug-free treatment. However, many clients had drug problems severe enough to suggest a need for residential treatment. To examine treatment placement, UCLA employed a sample of clients entering treatment in 13 counties during the first year of SACPA. Comparing SACPA and non-SACPA clients with high-severity drug problems, UCLA found that placement in outpatient rather than residential treatment was more common for SACPA clients. Within SACPA, outpatient placement of high-severity clients was more common for African Americans. These findings indicate a need to assess the adequacy of treatment resources available to support appropriate placement of SACPA clients, especially those who are African American.

In a climate of fiscal belt-tightening, development of more day-treatment capacity, as an alternative to residential, might enable counties to provide a treatment experience more intensive than outpatient to a greater proportion of their high-severity clients. Further, residential slots could be redistributed more evenly within counties through treatment contracting procedures without necessarily creating new residential programs or increasing the total resources devoted to residential treatment. Changes in local procedure, so that clients are assessed before being sent to the treatment site, may help to avoid narrowing the

range of treatment options available to a client. (Both SACPA and non-SACPA clients may be assessed at treatment sites. This procedure is not unique to SACPA.) Finally, development of pre-treatment services, such as short-term motivational intervention or self-help support groups for drug users awaiting treatment, might reduce the pressure to send high-severity SACPA clients to outpatient treatment instead of having them wait until a residential slot is open.

It should be acknowledged that availability of residential treatment for SACPA clients depends on county-specific factors such as overall treatment capacity, funds available from SACPA and other sources, and the volume of SACPA clients to be handled. Appraisal of the reasons for placement and the range of solutions available depend in part on considerations like these.

Chapter 7: Treatment Completion and Duration

Treatment completion among SACPA offenders thus far is typical of drug users referred to treatment by criminal justice. About one-third (34.4%) of offenders who entered treatment in SACPA's first year completed treatment. Overall, about one-quarter (23.8%) of offenders who agreed to participate in SACPA in its first year completed treatment (based on a 69.2% treatment entry rate among all SACPA offenders in the first year and a 34.4% completion rate among those who entered treatment).

Treatment completion rates were lower, and treatment duration shorter, for African Americans, Hispanics, and Native Americans than for Whites and Asians/Pacific Islanders. These findings signal the importance of understanding the possible disproportionate impact of limited treatment capacity, assessment procedures, and treatment protocols across racial/ethnic groups.

Treatment completion was lower, and duration shorter, for heroin users than for users of other drugs. Few heroin users in SACPA were placed in methadone detoxification or maintenance. Their performance in SACPA would likely improve if methadone treatment were available to those who wish to receive it.

Treatment duration and completion rates were lower among parolees than among probationers in SACPA.

Methamphetamine users were similar to the overall SACPA population in treatment completion and duration. Concern has been raised regarding the treatment system's ability to meet the clinical challenges (e.g., poor engagement in treatment, severe paranoia, severe and protracted dysphoria, and high relapse rates) presented by methamphetamine users. Findings suggest that treatment providers in SACPA have handled these challenges effectively.

Asian/Pacific Islander clients in SACPA were mostly Filipino and South Asian (Cambodian, Laotian, and Vietnamese). Treatment duration and completion were as good for these clients as for others despite possible cultural barriers to treatment.

Clients with no prior experience in treatment may find it particularly difficult to conform to unfamiliar requirements such as open acknowledgement of their drug problem and self-disclosure in groups. Despite the potential difficulties, first-time clients did as well in treatment as repeat clients.

Research on drug treatment effectiveness has shown that treatment completion and time in treatment are associated with favorable post-treatment outcomes such as abstinence from drug use, reductions in drug-related problems, and improved psychosocial functioning (Anglin & Hser, 1990; DeLeon, 1991; Hubbard et al., 1989, 1997; Simpson, 1979; Simpson et al., 1997; TOPPS II Interstate Cooperative Study Group, 2003). Thus, the performance of SACPA offenders on these two indicators of treatment performance—completion of

treatment and time in treatment—serves as a useful indicator of the likelihood of post-treatment success. The analysis of treatment performance does not tell the whole story, however. SACPA clients must not only attend treatment but also comply with other requirements set by the court and probation/parole. Their obligations in SACPA are not fully met even if they do complete treatment, and failure to complete it may have adverse consequences even for noncompleters who attended treatment for a sustained period.

Chapter 7 reports rates of treatment completion among offenders who participated in SACPA in its first year. Also reported are background characteristics of clients who completed treatment. These characteristics include, for example, race/ethnicity, sex, and primary drug. In addition, the chapter includes findings on treatment duration, i.e., the dose of treatment received by SACPA's first-year clients, regardless of whether they completed treatment or how well they fared. Like the findings in treatment completion, findings on duration are examined in relation to client background characteristics. The focus is restricted to SACPA's first year because data are not yet available to determine how SACPA's second-year population will fare after entering treatment. The data source for these analyses was the California Alcohol and Drug Data System (CADDS).

To provide a context for findings on treatment completion and duration, Chapter 7 begins with a review of key issues in the analysis.

Analytic issues

To understand treatment completion and duration, it is necessary to deal with some interpretive and data problems. For example, what completion rates are typical for persons who enter drug treatment? Typical completion rates provide a standard of comparison against which to judge the performance of SACPA's treatment clients. Also, how should missing data be handled? In CADDS, as in other large administrative databases, discharge records cannot be found for some clients who entered treatment many months ago. Have they remained in treatment for an unusually long time, or was their discharge simply not recorded?

Typical treatment completion rates

For a standard of comparison against which to judge SACPA completion rates, this chapter summarizes findings on treatment completion from other large-scale studies of drug treatment and drug courts. In addition, completion rates for SACPA clients are compared to those for non-SACPA criminal justice clients and non-criminal justice clients[1] who received treatment during the same timeframe.

[1] The CADDS record for each incoming client indicates the referral source as either SACPA (court/probation or parole), non-SACPA court/criminal justice, or non-criminal justice. CADDS also indicates the client's legal status. Most clients (77%) sent from non-SACPA court/criminal justice were on probation or parole or were incarcerated. Among the remaining 23% were clients participating in a diversion program and others with no legal status on record. Thus, while a portion of the non-SACPA court/criminal justice population may actually not have been in the criminal justice system, the overall population can be characterized as non-SACPA criminal justice. Non-criminal justice clients were those referred by health care provider, employee assistance program, self, or other sources but not by criminal justice.

Non-SACPA completion rates were adjusted to ensure that the comparison to SACPA was not confounded by differences in client background characteristics. For example, the proportion of heroin users was higher among non-criminal justice clients than among SACPA clients (see Chapter 3), and heroin users had lower rates of treatment completion than users of other drugs (see below). By adjusting (weighting) the composition of each client group, UCLA removed the effect of such differences on completion rates. In analyses of completion rates in relation to client background characteristics such as age and sex, a similar adjustment was made to ensure that each comparison was not confounded by client characteristics other than the one being examined. Finally, for SACPA clients, the relationship between background characteristics and completion was examined in a multivariate model (not shown) to ensure that bivariate findings reported here were reliable.

Treatment completion: primary and alternative indicators

In CADDS, a client's status at discharge is noted by the treatment provider on the client's discharge record. There are four possible statuses at discharge: completed treatment, did not complete treatment but made satisfactory progress, did not complete treatment and did not make satisfactory progress, and transferred to another treatment provider. The most rigorous criterion for success is completion of treatment. That is the primary indicator employed here in the analysis of treatment completion and the analysis of characteristics of clients who completed treatment.

UCLA employed two alternative measures reflecting the view that treatment can be beneficial even for clients who do not complete it. These measures are called "satisfactory progress" and "standard dose of treatment."

Clients who do not complete treatment may have been doing well nevertheless. In many cases, clients leaving treatment early have found a job that requires them to be at work during treatment hours, have moved to a location farther away from the treatment provider, have taken on competing responsibilities such as child care, or have lost their means of transportation. The purpose of the "satisfactory progress" criterion is to enable providers to enter a discharge status that reflects the opinion that a client was doing well.

Some clients who do not have either "completed treatment" or "satisfactory progress" on their discharge record may still have participated in treatment long enough to have benefited from it. The threshold for an effective dose of treatment depends on many factors, and it is impossible to stipulate a minimum effective dose applicable to any client. However, using information on treatment duration for SACPA clients who completed treatment, it is possible to calculate the standard dose of treatment received by the typical successful client. This "standard dose" criterion is the median time in treatment[2] for first-year SACPA clients who had a discharge status of "completed treatment." Because medians differed widely by treatment type and county (see below), separate standards were applied, depending on the type of treatment provided to the client (e.g., outpatient drug-free or long-term residential) and on the client's home county. These median treatment times represent the dose regarded by the client's home county as sufficient for the typical SACPA client participating in each type of treatment. This is the measure called "standard dose of treatment."

[2] Median time in treatment was the "middle case" in the distribution from lowest to highest number of days in treatment.

SACPA requires completion of treatment. Thus, while clients who made satisfactory progress or received a standard dose may have benefited from treatment, they were out of compliance with the treatment requirement and were subject to disqualification from SACPA by the court.

Definition of the treatment episode

SACPA provides for up to 365 days of treatment. (An additional six months of aftercare attendance may also be required.) Thus, offenders who entered SACPA as late as June 30, 2002 (the end of the first year) had 365 days in which to complete their SACPA treatment episode, and the discharge record for most of them should have appeared in CADDS on or before June 30, 2003. However, this was not always the case. During the course of their treatment episode, some clients were transferred from one provider to another. If the transfer entailed an interruption in treatment, a client's treatment episode, counting all segments of it, might have extended beyond one calendar year. Similarly, clients who dropped out of treatment may have been allowed to re-enter treatment at a later date. They too may have had a treatment episode of two or more segments spanning more than a calendar year.

UCLA defined the treatment episode as follows. First, clients who entered treatment between July 1, 2001 and June 30, 2002 were counted as first-year SACPA clients if their initial intake record showed a referral from SACPA probation or parole. Most SACPA clients had only one treatment segment during that timeframe. Those with two or more segments were regarded as transfers if the later segment began not more than two days after the earlier segment ended and even if the intake record for the later segment(s) did not indicate referral from SACPA. This procedure maximized the likelihood that the client was still a SACPA participant when the later segment began. It is unlikely that a person could leave treatment, be dropped from SACPA, and begin treatment again as a non-SACPA client within such a short window of time. Moreover, most transfers (65%) occurred within this two-day window. (In a supplemental analysis, the transfer window was extended to 30 days. Findings did not change.) Second, to measure time in treatment, UCLA counted the number of calendar days from intake to discharge for each segment of the client's treatment episode. Third, to allow for clients whose time in treatment may have extended past 365 calendar days (and to allow for lag in data entry as well), UCLA scanned CADDS for discharges appearing as late as October 31, 2003—16 months past the end of the first SACPA year.

Time in treatment was typically far shorter than 365 days among offenders who completed their SACPA treatment. Hence, an analysis allowing 16 months for a discharge to appear in CADDS missed few clients, whether they completed treatment or dropped out prematurely. What about clients not shown in CADDS to have completed treatment or to have dropped out? The last discharge on record for 11% of SACPA's first-year clients indicates a transfer to another provider. It can only be assumed that they remained in treatment for a time far longer than usual, although the transfer recorded for some of them may be in error. An additional 13% of SACPA's first-year clients had no discharge on record as of October 31, 2003. Historically, a discharge never appears in CADDS for about 4% of clients—presumably a result of data entry error or simple oversight.

Primary analyses reported in this chapter included SACPA's first-year clients who, by October 31, 2003, had a discharge record indicating one of three statuses: completed

treatment, did not complete treatment but made satisfactory progress, or did not complete treatment and did not make satisfactory progress. The number of such clients was 18,695. Excluded were clients with a transfer at last discharge and clients with no discharge. In supplemental analyses, UCLA included such clients by adopting empirically-based assumptions regarding their fate. For example, using non-SACPA clients who entered treatment before July 1, 2001, UCLA determined status at discharge for those still in treatment beyond 16 months to learn what happened to clients with an unusually long lag between intake and discharge. It was assumed that the distribution of discharge statuses for SACPA clients still in treatment 16 months past intake will eventually resemble the distribution observed for other such clients. These supplemental analyses produced findings similar to those based on primary analyses and are not reported here.

Treatment completion

Typical treatment completion rates

As with treatment of many chronic diseases (e.g., diabetes and hypertension) and psychological disorders, effectiveness of drug treatment is compromised if patients are not willing or able to adhere to the treatment protocol (McLellan et al.,1996). Many drug treatment clients drop out prematurely and later relapse to drug use (Hubbard et al., 1989; Simpson, 1979, 1997).

In national studies of drug treatment effectiveness, completion rates have ranged from 35% to 60% (Substance Abuse and Mental Health Services Administration, 2002; TOPPS II Interstate Cooperative Study Group, 2003). Treatment completion rates have been reported in two large-scale California studies. The completion rate was 32% in CALDATA, fielded in the early 1990's (Gerstein et al., 1994). More recently, the CalTOP study (Hser et al., 2003) found that 41% of clients with a discharge on record (excluding clients whose discharge indicated a transfer for additional treatment) had completed treatment.

Drug court completion rates have ranged widely, from 36% to 73%, as shown in Belenko's (2001) review of drug court studies (see also Rempel et al., 2003). In California, completion rates between 36% and 48% have been reported (Belenko, 2001; California Department of Alcohol and Drug Programs, 2002). Drug court completion rates are instructive but do not provide a direct standard of comparison to SACPA because drug courts typically require frequent appearances before the judge and participation in lengthy and intensive treatment and because drug court clients are often screened on criteria such as prior criminal record and motivation for treatment. The comparison between drug courts and SACPA should be made with these differences in mind.

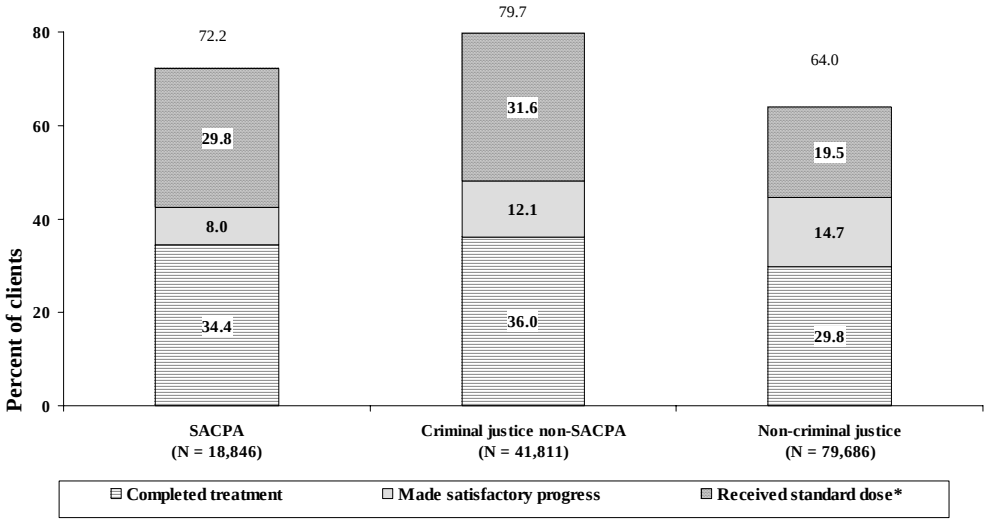
SACPA treatment completion rate

As shown in Figure 7.1, 34.4% of SACPA's first-year clients completed treatment. This completion rate is slightly lower than the adjusted rate for non-SACPA criminal justice clients (36.0%) and higher than the adjusted rate for non-criminal justice clients (29.8%).[3]

[3] Non-SACPA findings were adjusted to ensure that the comparison was not confounded by differences in client background characteristics. For example, the proportion of heroin users was higher among non-criminal justice clients than among SACPA clients (see Chapter 3), and heroin users had lower rates of treatment

Also shown in Figure 7.1 are clients who did not complete treatment but were making satisfactory progress. Among SACPA clients 8.0% met criteria for satisfactory progress. The adjusted rates for non-SACPA criminal justice clients (12.1%) and non-criminal justice clients (14.7%) were higher.

Figure 7.1
Discharge Status by Referral Source
(CADDS), 7/1/01 - 6/30/02



* Treatment duration at least equal to the median treatment duration for SACPA clients who successfully completed treatment in the same county and modality.

Note: Non-SACPA completion rates were adjusted to account for differences in client background characteristics.

Finally, Figure 7.1 shows how many clients received a standard dose of treatment, i.e., remained in treatment at least as long as the median treatment time among SACPA treatment completers (in the relevant type of treatment in the client's home county) but did not have treatment completion or satisfactory progress on their discharge records. About three in every ten SACPA clients (29.8%) met the criterion for standard dose of treatment. The figure for non-SACPA criminal justice clients and non-criminal justice clients were 31.6% and 19.5% respectively. The comparison between SACPA and non-SACPA clients is complicated by the fact that median treatment time for those who completed treatment was shorter for non-SACPA clients than for SACPA clients (shown below); thus, typical treatment protocol was more demanding in SACPA. However, the comparison does indicate how many non-SACPA clients met the same "standard dose" criterion applied to SACPA clients.

Overall, 72.2% of SACPA clients either completed treatment, made satisfactory progress, or remained in treatment as long as SACPA clients who did complete treatment successfully. Criminal justice non-SACPA clients and non-criminal justice clients had rates of 79.7% and 64.0% on this overall indicator of treatment performance.

Client characteristics and treatment completion

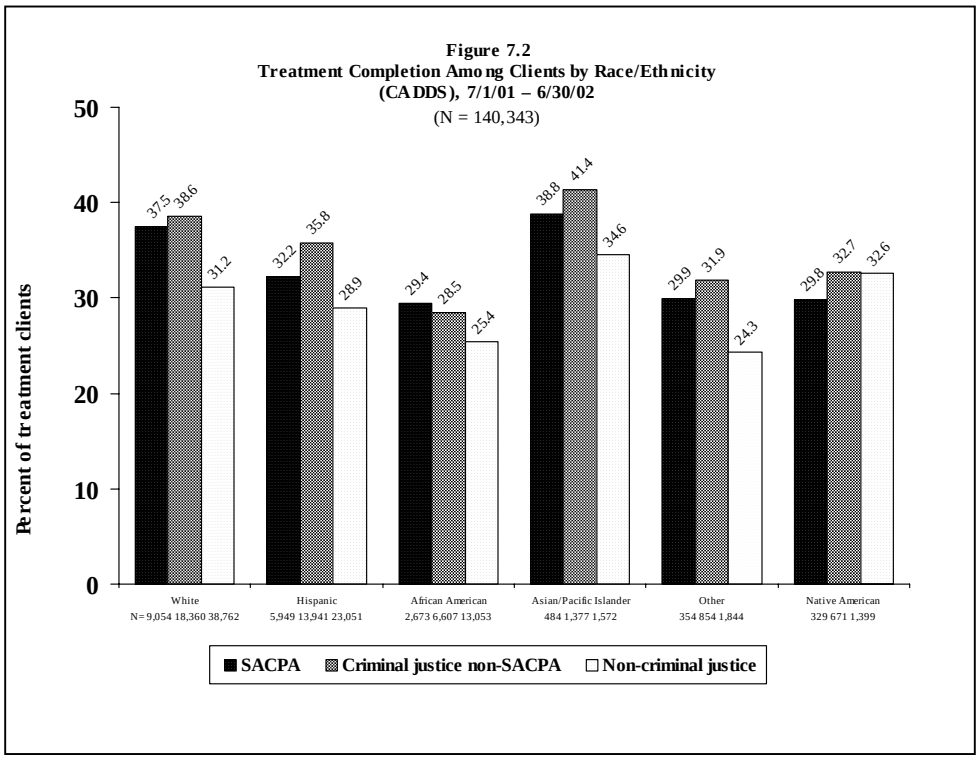
---

completion than users of other drugs (see below). By adjusting (weighting) the composition of each client group, UCLA removed the effect of such differences on completion rates.

To analyze characteristics of clients who completed treatment, UCLA employed the most rigorous criterion for success, namely a discharge record showing "completed treatment." UCLA conducted an analysis to see whether SACPA client characteristics associated with treatment completion when taken one at a time were uniquely associated with completion when tested as a set (see Appendix D). Findings reported here were confirmed in that analysis. In addition, UCLA adjusted the non-SACPA completion rates to ensure that comparisons reported here were not confounded by differences in client background characteristics other than the one being examined.

As shown in Figure 7.2, 37.5% of Whites and 38.8% of Asians/Pacific Islanders had the highest rates of treatment completion in SACPA. African Americans (29.4%), Hispanics (32.2%), and Native Americans (29.8%) had somewhat lower rates.

Compared to SACPA clients, non-SACPA criminal justice clients completed treatment at a slightly higher rate and non-criminal justice clients at a slightly lower rate. The race/ethnic differences in SACPA were paralleled outside SACPA: higher completion rates for Whites and Asians/Pacific Islanders and lower rates for African Americans, Hispanics, and Native



Americans.

Treatment completion rates for men and women are shown in Figure 7.3. Each group had roughly the same completion rate in SACPA (35.6% of women; 34.0% of men) and in the two non-SACPA groups.

A positive association between age and treatment completion is apparent in Figure 7.4. The rate for SACPA clients in the youngest age bracket (18-25 years old) was 28.0%. Rates climbed steadily to a maximum of 42.7% in the oldest age bracket (46 years and older). This same stair-step pattern is apparent for the two non-SACPA groups as well. Problems arising

from drug use have accumulated for older drug users, who may accordingly be more likely to see the value of completing treatment.

Figure 7.5 shows completion rates by primary drug. Findings are most relevant for the four drugs commonly used by SACPA clients. Heroin users in SACPA had the lowest completion rate (28.3%); methamphetamine users, the highest (35.2%). This was also true in the non-SACPA groups.

The association between years of drug use and treatment completion among SACPA clients (see Figure 7.6) mirrors that between age and treatment completion. The rate for SACPA clients with the fewest years of use (no more than five) was 32.2%. Clients with at least 21 years of use had the highest rate (37.2%). The two non-SACPA groups showed the same pattern.

Figure 7.7 shows treatment completion rates by frequency of drug use in the month prior to intake. Rates varied only slightly for clients reporting at least one occasion of use. Those who reported no use at all in the past month (38.7%) were somewhat more likely to complete treatment, perhaps because they were less likely to experience craving/withdrawal symptoms while in treatment or because prior-month abstinence, whether voluntary or imposed by circumstance (e.g., being in jail), was indicative of greater motivation to stop using or lower access to drugs.

Treatment completion rates were very similar for SACPA clients with (34.1%) and without (34.8%) prior experience in treatment. This was true in the non-SACPA groups as well. See Figure 7.8.

As shown in Figure 7.9, SACPA clients on probation had a somewhat higher completion rate (35.0%) than clients on parole (28.6%). The figure does not include non-SACPA groups because CADDS data on non-SACPA referral source do not distinguish probation and parole and because the distinction is not applicable to non-criminal justice referrals.

Figure 7.3
Treatment Completion Among Clients by Sex
(CADDS), 7/1/01 – 6/30/02
(N = 140,343)

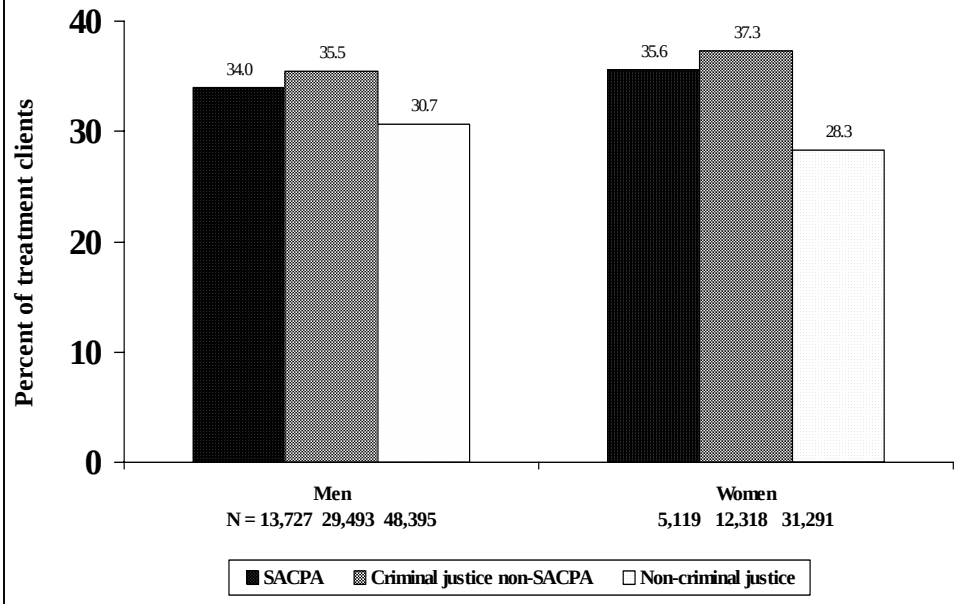


Figure 7.4
Treatment Completion Among Clients by Age
(CADDS), 7/1/01 – 6/30/02
(N = 140,343)

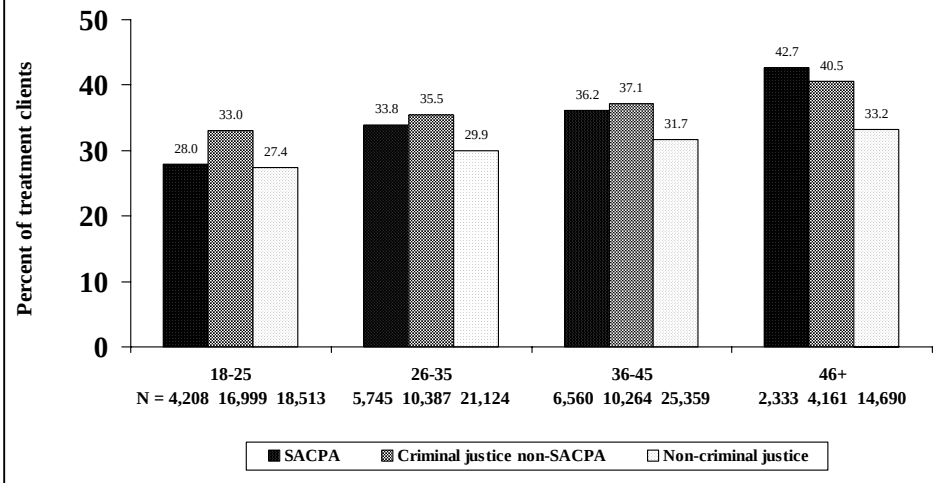


Figure 7.5
Treatment Completion Among Clients by Primary Drug
(CADDS), 7/1/01 – 6/30/02
(N = 140,343)

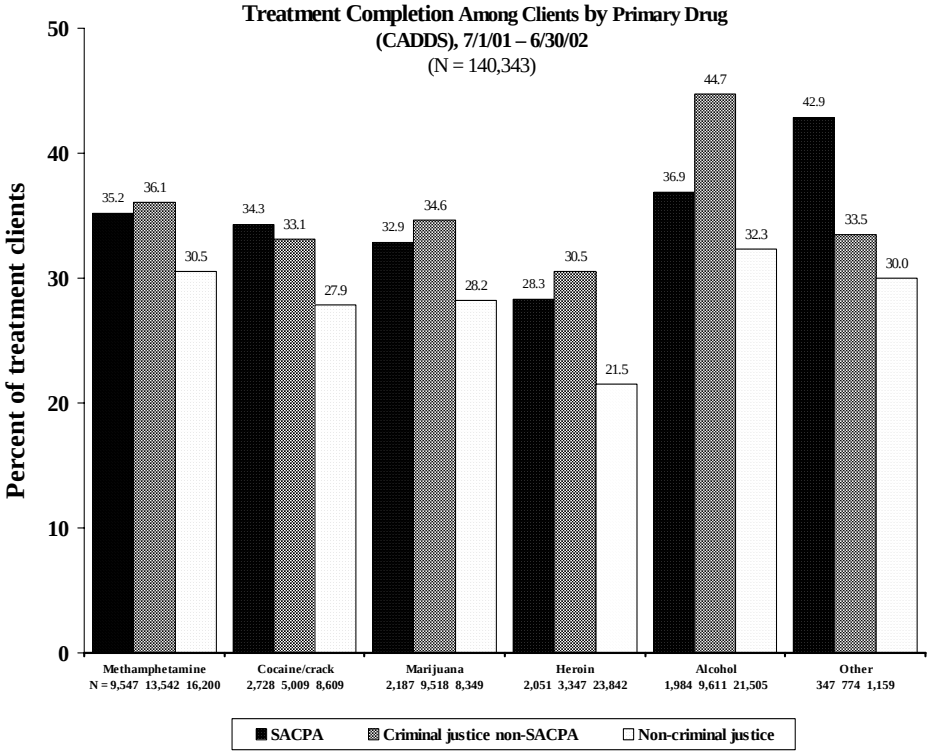


Figure 7.6
Treatment Completion Among Clients by Years of Drug Use
(CADDS), 7/1/01 – 6/30/02
(N = 140,343)

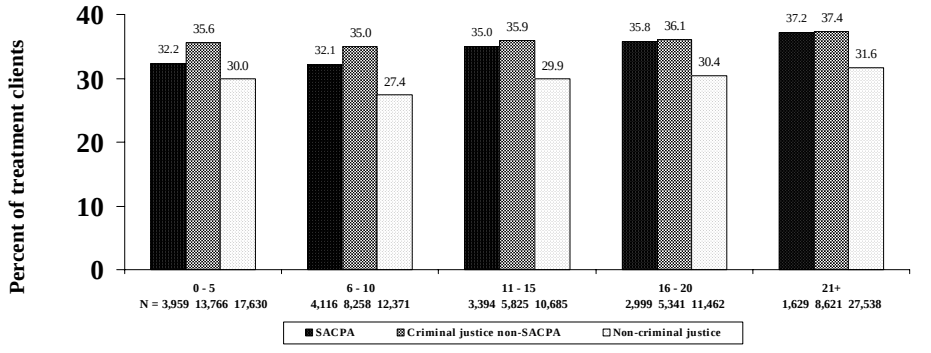


Figure 7.7
Treatment Completion Among Clients
by Frequency of Primary Drug Use in Past 30 days (CADDS), 7/1/01 – 6/30/02
(N = 140,343)

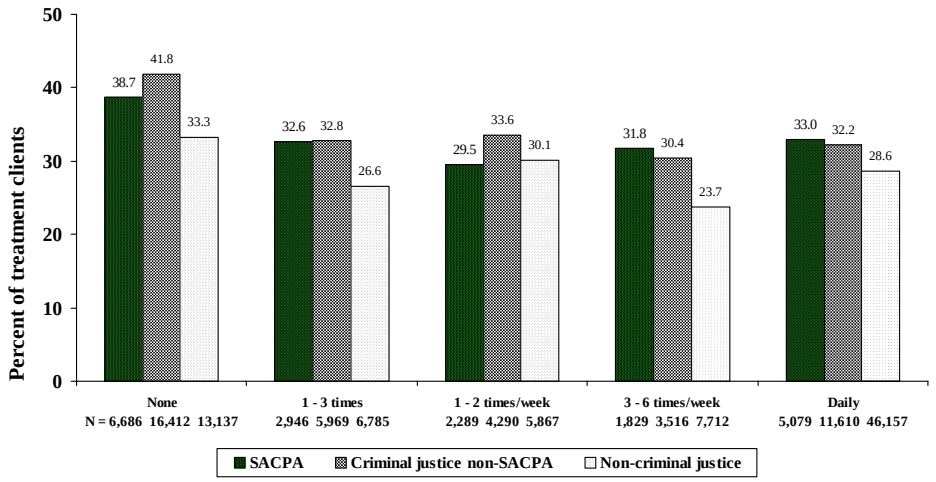
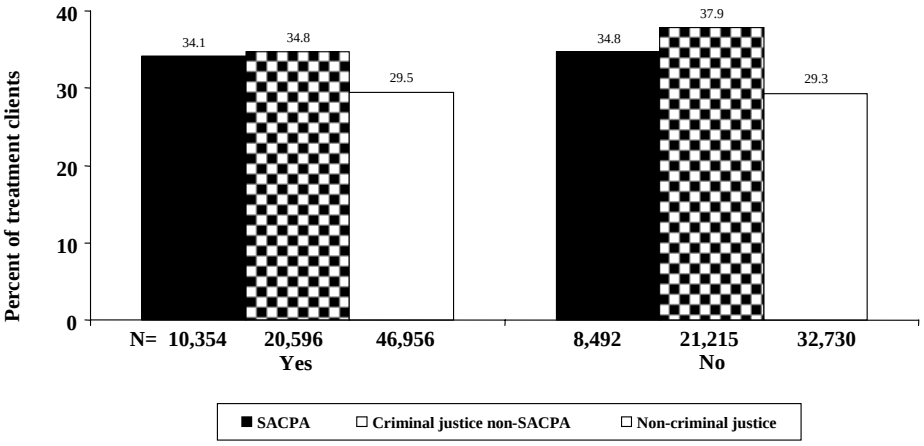
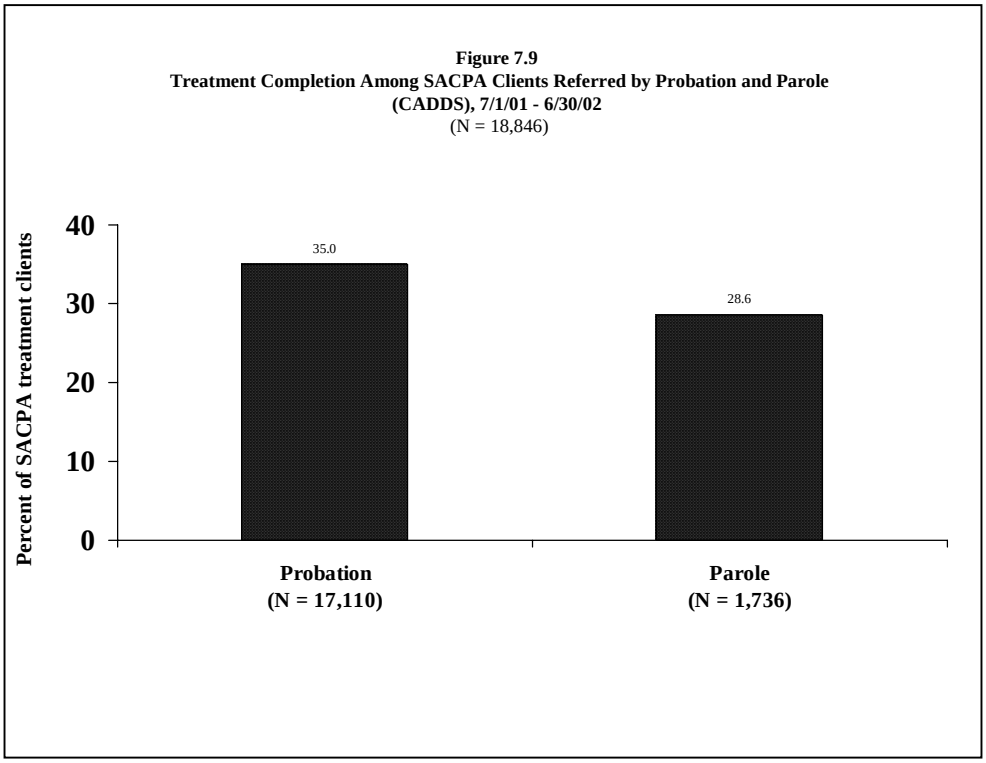


Figure 7.8
Treatment Completion Among Clients by Prior Treatment Experience
(CADDS), 7/1/01 - 6/30/02
(N = 140,343)





Treatment duration among clients who completed treatment

To arrive at findings on "standard dose of treatment," reported above, UCLA used information on median treatment duration for clients who completed outpatient drug-free and long-term residential treatment in each county. (These were the two types of treatment in which almost all clients were placed.) This chapter now refocuses on treatment duration itself. Among clients who completed treatment, how much treatment was required, and how much variability was there across counties in the required duration of treatment?

Classification of clients as outpatient or residential depended on their initial placement. Most SACPA clients who completed treatment did so in the program where they were initially placed. For clients whose treatment episode included two or more segments, either in the same type of treatment or in different types, the calculation of treatment duration covered their total time in treatment from first intake to last discharge.

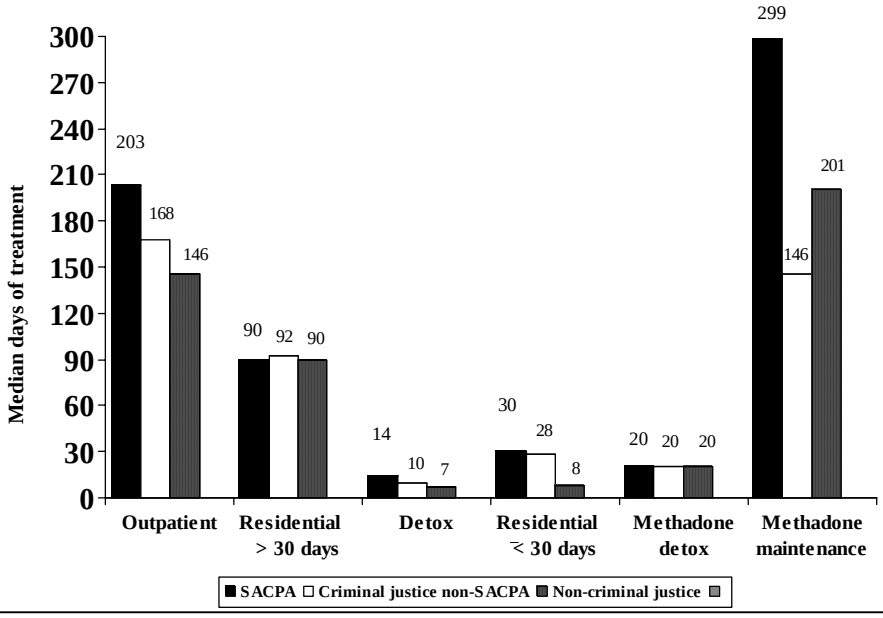
Across the state, median time to treatment completion was 203 days for SACPA clients in outpatient drug-free treatment and 90 days for those in long-term residential treatment. See Figure 7.10.[4]

Among clients referred from criminal justice sources other than SACPA, median duration for completers was 168 days in outpatient drug-free and 92 days in long-term residential. Non-criminal justice clients who completed treatment typically spent 146 days in outpatient or 90

[4] Means were slightly higher (229 days for outpatient drug-free and 129 days for residential) because of a few outliers with unusually long stays in treatment. In this analysis, the median number of days in treatment was the more meaningful indicator of treatment duration for the typical client.

days in residential. In short, SACPA outpatient clients spent more time in treatment than non-SACPA outpatient clients.

Figure 7.10
Median Length of Stay in Treatment Among SACPA Treatment Completers by Modality
(CADDS), 7/1/01 - 6/30/02
(N = 48,101)

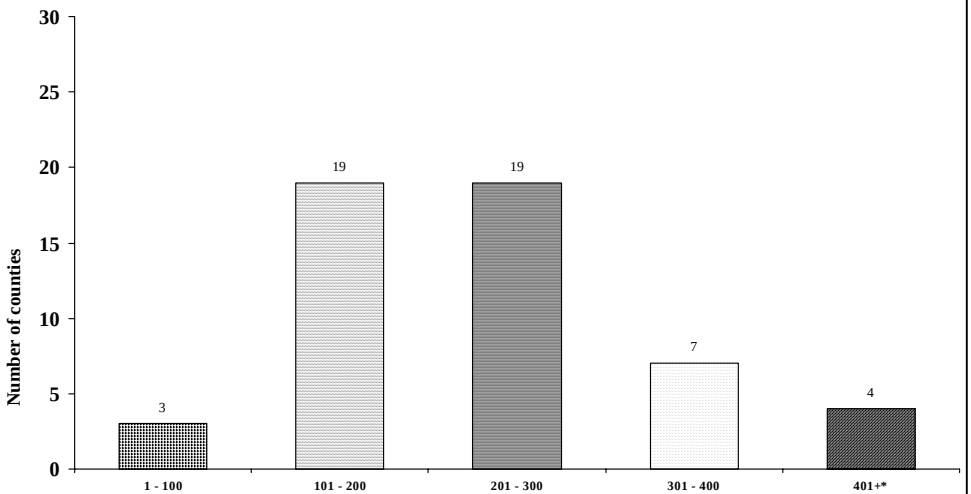


Counties varied widely on the number of days required for successful completion of treatment by SACPA clients. Figure 7.11 shows the distribution of counties for outpatient drug-free treatment. While 11 counties required over 300 days, 22 counties required no more than 200 days, and three counties required no more than 100 days.[5]

Figure 7.12 shows the distribution of counties for long-term residential treatment. Most counties required no more than 200 days. However, seven counties required over 200 days.[6]

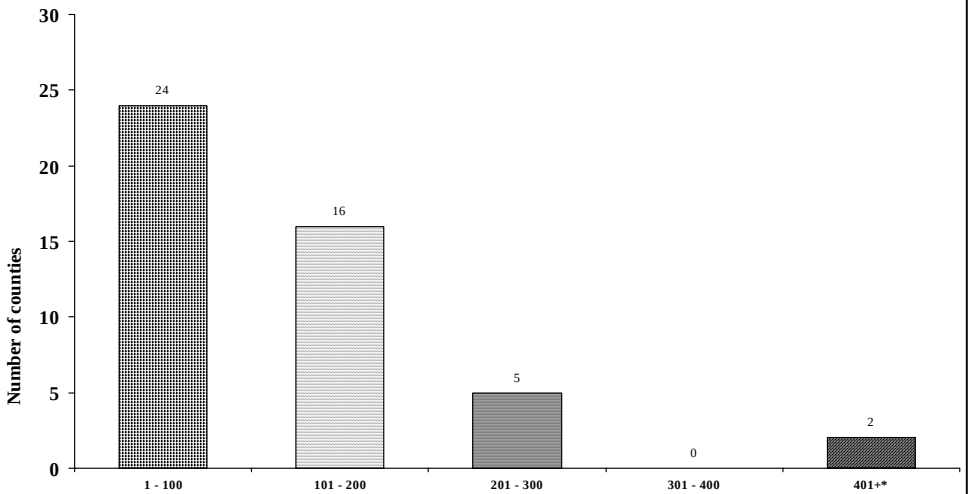
[5] Six counties are missing because the number of clients who completed outpatient treatment was too low to support a reliable estimate of treatment duration.
[6] Eleven counties are missing because the number of clients who completed outpatient treatment was too low to support a reliable estimate of treatment duration.

Figure 7.11
County Variation in Median Length of Stay Among SACPA Outpatient Treatment Completers
(CADDS), 7/1/01 – 6/30/02
(N = 52)



*** Maximum number of days in 16 months after treatment entry.**

Figure 7.12
County Variation in Median Length of Stay Among SACPA Residential Treatment Completers
(CADDS), 7/1/01 – 6/30/02
(N = 47)



*** Maximum number of days in 16 months after treatment entry.**

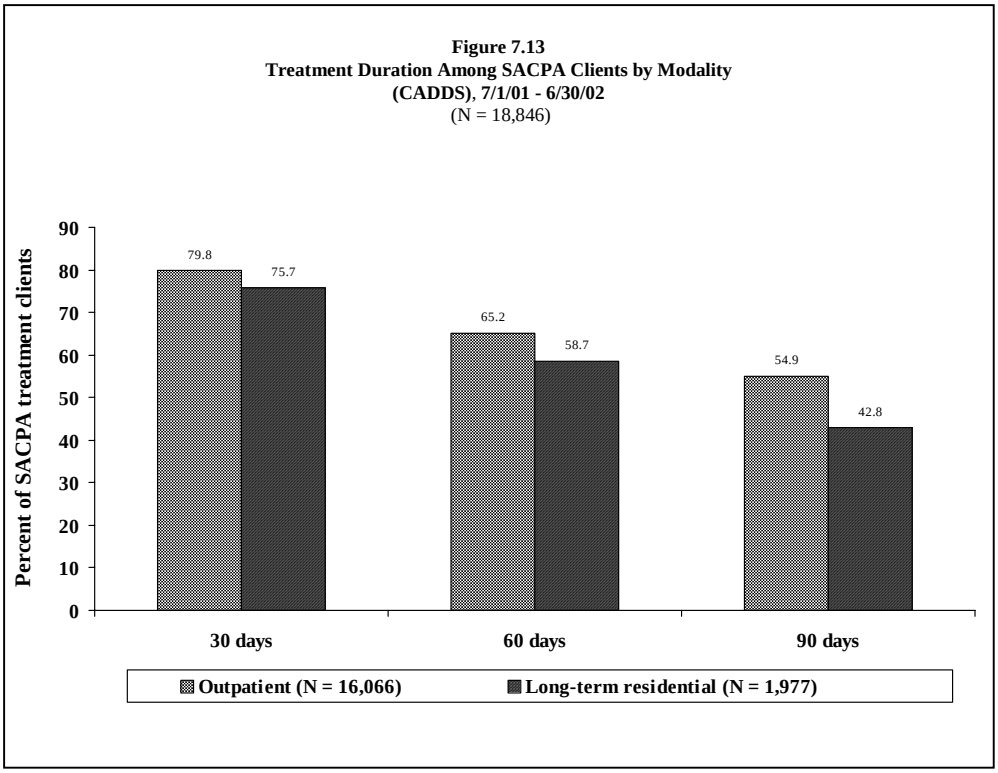
Treatment duration among all clients

The last topic in this chapter is treatment duration, i.e., the dose of treatment received by SACPA clients, regardless of whether they completed treatment, made satisfactory progress, or stayed in treatment at least as long as the median time in treatment for SACPA completers. A period of at least 90 days is widely cited as the minimum threshold for beneficial treatment (Hubbard et al., 1997; Simpson et al., 1997, 1999, 2002; TOPPS II Interstate Cooperative Study Group, 2003). The typical first-year SACPA client who completed residential treatment reached this threshold, and the typical outpatient client in SACPA exceeded it (see above). The 90-day threshold remains a useful benchmark for evaluating exposure to treatment among SACPA clients, regardless of how much longer they may have stayed, whether they completed treatment, or how well they fared. This analysis reports the percent of first-year SACPA clients who remained in outpatient drug-free or long-term residential treatment for at least 90 days and who had a discharge record. To cover clients who did not receive at least 90 days of treatment, the analysis was expanded to show the percent spending at least 30 days and at least 60 days in each treatment type.

For clarity of presentation, detailed information on treatment duration among non-SACPA clients is omitted from the figures. Instead, the comparison of SACPA and non-SACPA clients is noted briefly in the text. Appendix E contains figures showing treatment duration for non-SACPA criminal justice clients and non-criminal justice clients.

Most SACPA clients (79.8%) who entered outpatient drug-free programs were there for at least 30 days. See Figure 7.13. Among long-term residential clients, 75.7% received at least 30 days of treatment. The 60-day rates were 65.2% in outpatient drug-free and 58.7% in long-term residential. Finally, a majority of SACPA outpatient drug-free clients (54.9%) received at least 90 days of treatment, as did 42.8% of long-term residential clients.

Figure 7.13
Treatment Duration Among SACPA Clients by Modality (CADDS), 7/1/01 - 6/30/02
(N = 18,846)



Duration was very similar among non-SACPA criminal justice clients in both modalities at all three time-points. The percent of clients who reached each benchmark in each modality was generally lower for non-criminal justice clients than for SACPA clients.

Client characteristics and treatment duration

UCLA examined treatment duration in relation to these background characteristics of SACPA clients: race/ethnicity, sex, age, primary drug, years of drug use, recent frequency of drug use, and referral source (probation or parole). Clients in outpatient and long-term residential treatment were combined.

Figure 7.14 shows treatment duration by race/ethnicity of SACPA clients. Differences were small at the 30- and 60-day intervals. The percent of SACPA clients who reached 90 days was somewhat lower among African Americans, Hispanics, and Native Americans. In comparison, 90-day rates among non-SACPA criminal justice and non-criminal justice clients were very similar across race/ethnic groups.

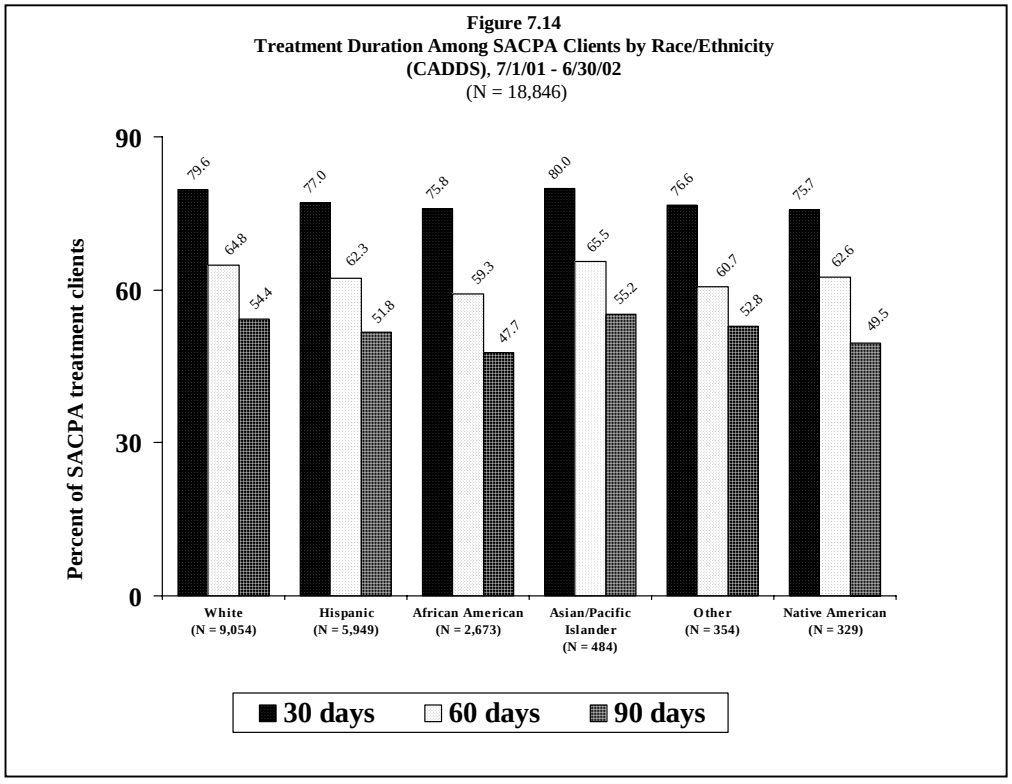
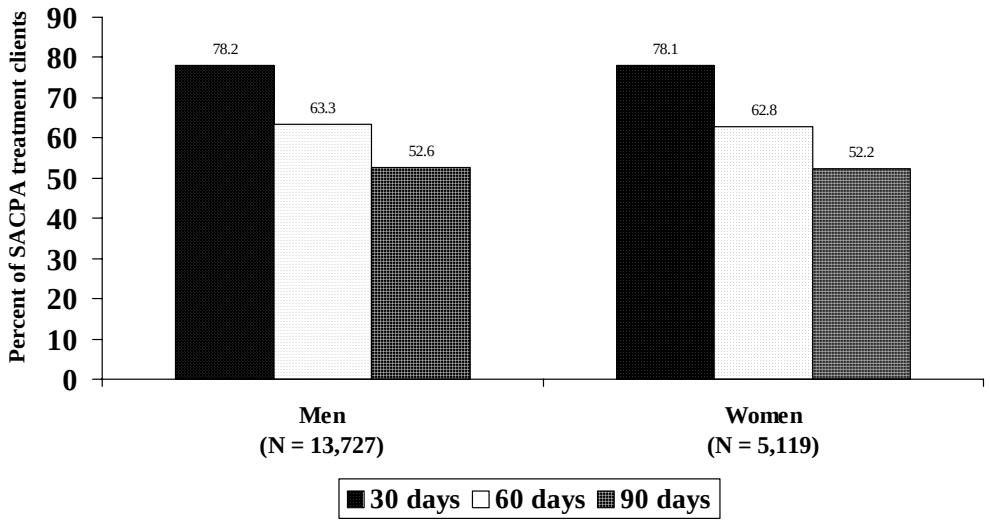


Figure 7.15 shows treatment duration for SACPA clients by sex. Men and women in SACPA had similar patterns of duration at 30, 60, and 90 days. The same was true among non-SACPA criminal justice clients, but non-criminal justice women were more likely than non-criminal justice men to be in treatment at each interval.

Figure 7.15
Treatment Duration Among SACPA Clients by Sex
(CADDS), 7/1/01 - 6/30/02
(N = 18,846)



Treatment duration by age is shown in Figure 7.16. At all three intervals, duration rates were slightly higher among older SACPA clients. In contrast, age was unrelated to treatment duration among non-SACPA criminal justice clients, and younger clients had higher rates than older clients in the non-criminal justice group.

Treatment duration by primary drug is shown in Figure 7.17. Users of methamphetamine, cocaine/crack, and marijuana had similar duration patterns at 30, 60, and 90 days. Heroin users were somewhat less likely to reach 60 and 90 days. The pattern was similar for non-SACPA criminal justice clients and non-criminal justice clients.

Figure 7.18 shows treatment duration by years of use. SACPA clients with over 20 years of drug use were slightly more likely to be in treatment at each interval. The opposite pattern was apparent among non-SACPA criminal justice and non-criminal justice clients. Those with over 20 years of drug use were slightly less likely to be in treatment at each interval.

Figure 7.16
Treatment Duration Among SACPA Clients by Age
(CADDS), 7/1/01 – 6/30/02
(N = 18,846)

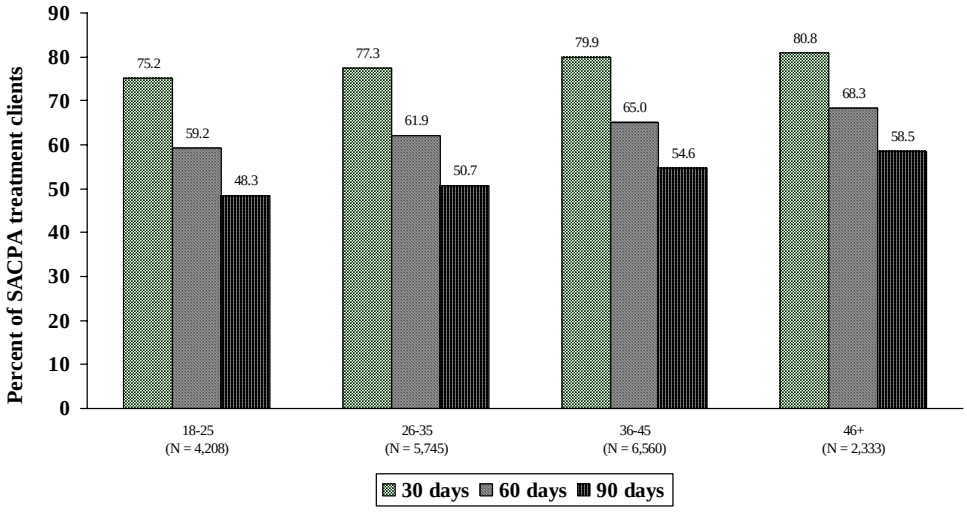
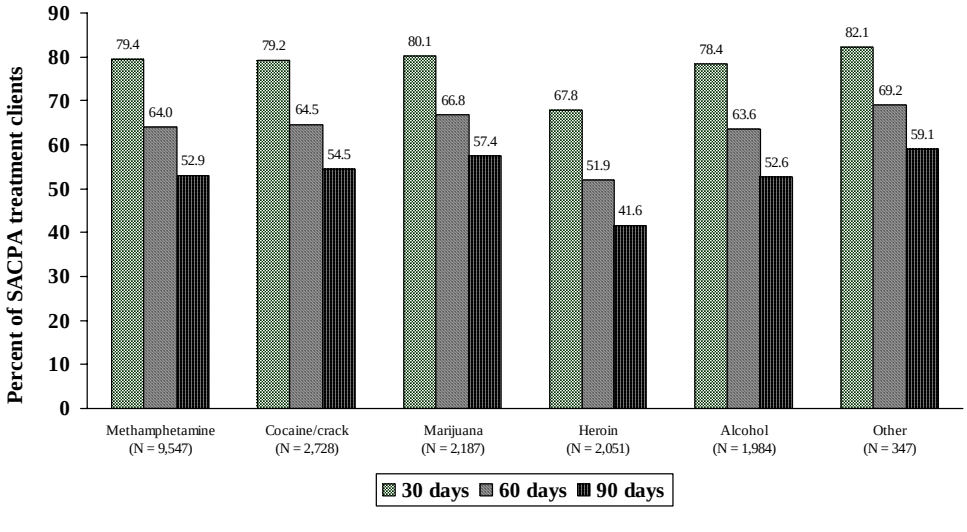


Figure 7.17
Treatment Duration Among SACPA Clients by Primary Drug
(CADDS), 7/1/01 – 6/30/02
(N = 18,846)



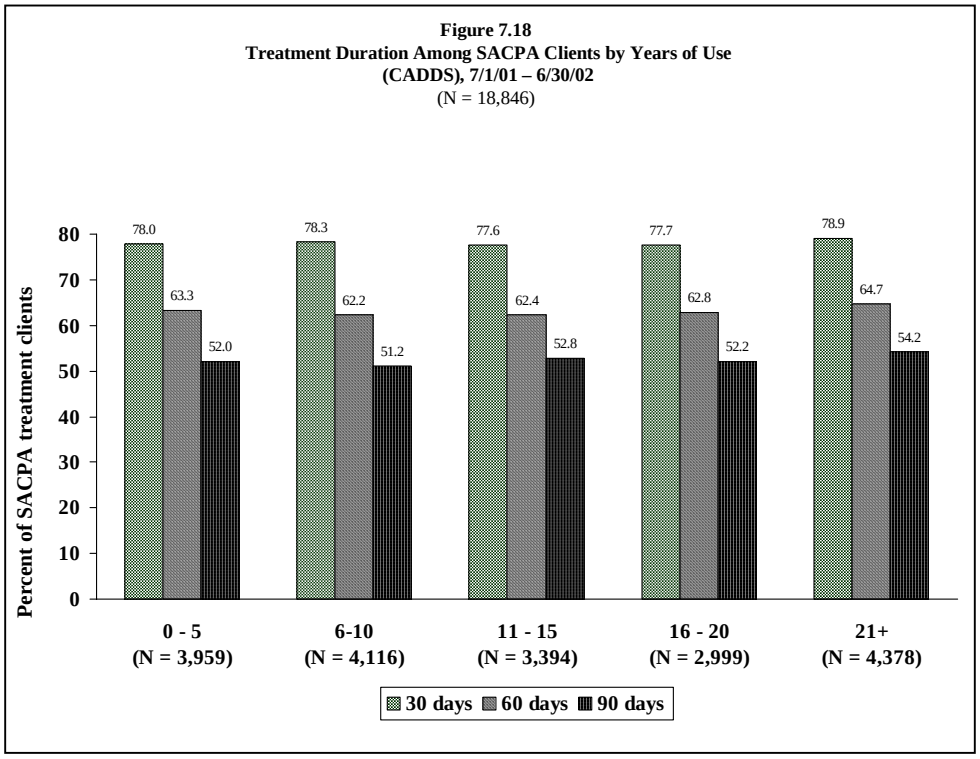


Figure 7.19 shows treatment duration by frequency of use in the 30 days before treatment entry. The percent of SACPA clients in treatment at each interval declined as frequency rose. Clients who had been using drugs daily were least likely to be in treatment at all three intervals. This pattern may reflect the difficulty of drug abstinence, once one's drug use has become an everyday habit. The same pattern was apparent among non-SACPA criminal justice and non-criminal justice clients.

Figure 7.20 shows treatment duration for SACPA clients with and without treatment experience. The percent in treatment at each interval was about the same in both groups. This pattern was repeated among non-SACPA criminal justice clients. Non-criminal justice clients had somewhat lower percents at each interval.

Figure 7.21 shows duration patterns separately for SACPA clients on probation and on parole. Parolees were less likely to be in treatment at each interval. Appendix D does not include a comparison to non-SACPA groups because CADDS data on non-SACPA referral source do not distinguish probation and parole and because the distinction is not applicable to non-criminal justice referrals.

Figure 7.19
Treatment Duration Among SACPA Clients by Frequency of Primary Drug Use in Past 30 Days (CADDS), 7/1/01 - 6/30/02
(N = 18,846)

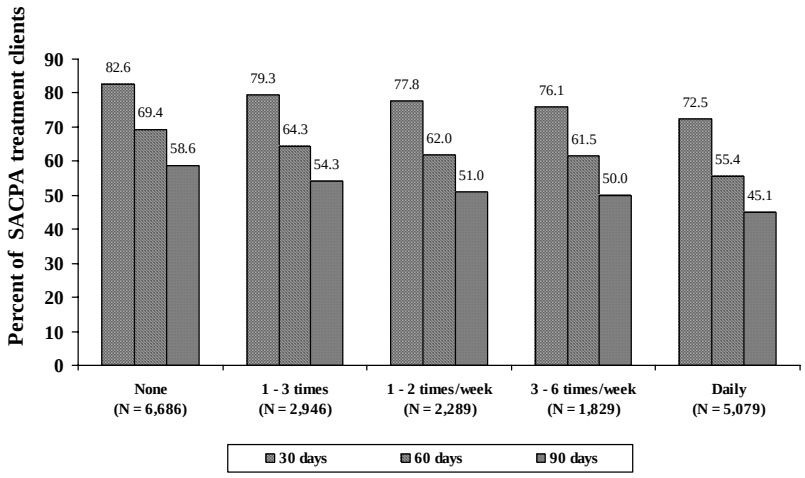


Figure 7.20
Treatment Duration Among SACPA Clients by Prior Treatment Experience (CADDS), 7/1/01 - 6/30/02
(N = 18,846)

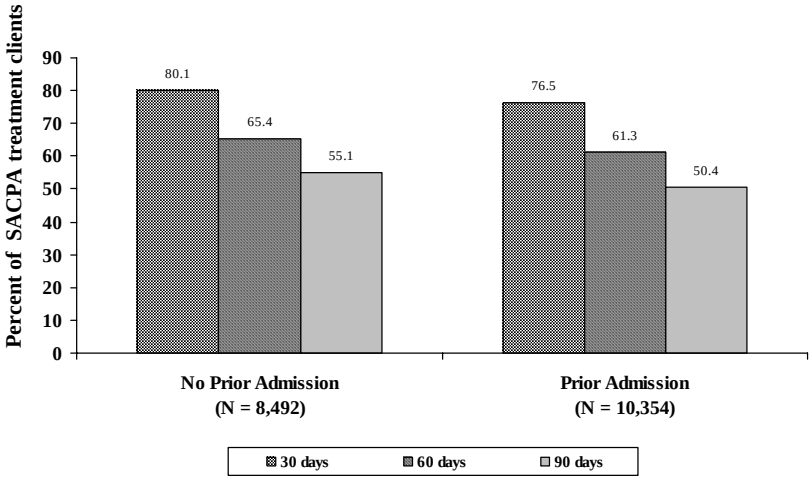
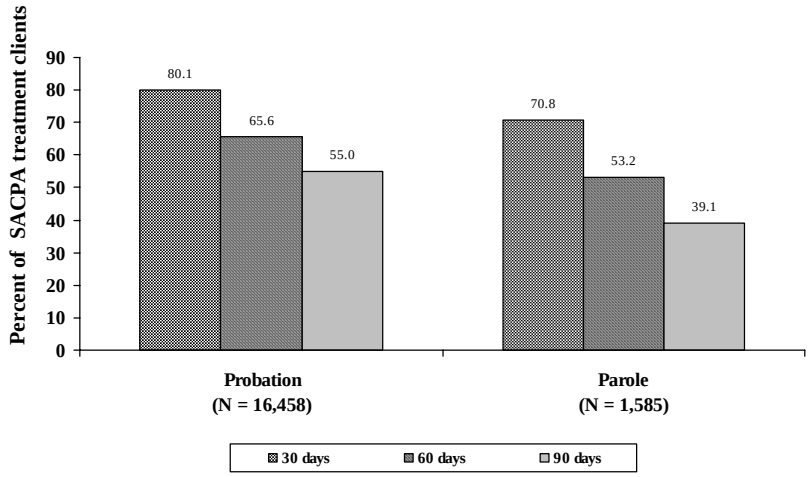


Figure 7.21
Treatment Duration Among SACPA Clients by Referral Source
(CADDS), 7/1/01 - 6/30/02
(N = 18,846)



Conclusion

SACPA clients appeared to be faring about as well as others receiving treatment in the same timeframe. One-third (34.4%) of offenders who entered treatment in SACPA's first year completed treatment. Overall, about one-quarter (23.8%) of offenders who agreed to participate in SACPA in its first year completed treatment (based on a 69.2% treatment entry rate among all SACPA offenders in the first year and a 34.4% completion rate among those who entered treatment). These findings are typical of drug users referred to treatment by criminal justice (Marlowe, 2002).

A total of 72.2% of SACPA clients completed treatment, were making satisfactory progress when discharged, or remained in treatment at least as long as the median time to completion for the relevant type of treatment in the client's home county. Satisfactory progress and sustained participation in treatment are good signs, but SACPA requires completion of treatment. Clients who complete treatment may fail to comply with additional requirements, and clients who fail to complete treatment may or may not commit new crimes.

In SACPA, treatment completion rates were lower, and 90-day treatment duration less common, for African Americans, Hispanics, and Native Americans than for Whites and Asian/Pacific Islanders. Race/ethnic differences in completion *were also seen in the other two client groups*, namely non-SACPA criminal justice and non-criminal justice. Race/ethnic differences in placement of high-severity clients (Chapter 6) and treatment duration *were not seen in the other two client groups.* This suggests that SACPA may be able to address race/ethnic disparities at the "front end" (placement and early retention) more readily than disparities at the "back end" (completion). Disparities in completion may reflect

broad societal conditions difficult to change. Nevertheless, disparities in treatment completion are cause for concern as well and should be addressed, even if they are not more pronounced in SACPA than elsewhere.

How can race/ethnic disparities be addressed? Chapter 6 discussed the importance of treatment capacity—not just the number of treatment slots available for high-severity clients but also the mix of slots across modalities and the geographic dispersion of capacity. Opportunities to add residential capacity may be limited, especially in the current fiscal climate. But redistribution of existing residential slots and development of day treatment capacity may enable SACPA to refer African American, Hispanic, and Native American clients to treatment more congruent with clinical need. These strategies may have more impact on initial placement and duration than on completion, but eventual success in treatment is more likely if clients stay in treatment long enough to benefit from it.

It may also be important to explore opportunities to improve cultural competence in assessment and treatment of SACPA clients. Cultural competence reflects an "awareness of cultural differences and the development of skills to work in multicultural situations" (Betancourt et al., 2003; Campbell et al., 2002, page 110) and is believed to have a positive impact on health service utilization, sustained participation, satisfaction with services, and outcomes (Campbell et al., 2002; Paniagua, 1994; Resnikow and Braithwaite, 2001; Smedley et al., 2003). Alternatives for promoting cultural competence include race/ethnic matching between staff and clients, offering clients the opportunity to choose a counselor of the same race/ethnicity, offering single-race group counseling sessions or self-help support groups, hiring personnel who are bilingual, and training staff in cross-cultural awareness and skills. While placement and retention appear to be particular concerns in SACPA, it is reasonable to expect improvement of cultural competence in assessment and treatment to affect treatment completion as well and to have favorable "spillover effects" on non-SACPA clients at assessment and treatment.

Completion rates were higher among clients who were older, those who had been using drugs for a longer time, and those reporting no drug use in the month prior to treatment intake. Rates were similar for male and female clients and for clients with and without prior treatment experience. In every comparison, the pattern found among SACPA clients was also found among non-SACPA clients.

Treatment completion was lower, and duration shorter, for heroin users than for users of other drugs. In the national Drug Abuse Treatment Outcome Study, heroin users did not benefit from outpatient drug-free and residential treatment as much as users of other drugs (Hser et al., 1998; Hubbard et al., 1997; see also Hubbard et al., 1989; Katz et al., 2004). Success in treatment may be particularly difficult for people with heroin addiction histories extending over many years. Few heroin users in SACPA were placed in methadone detoxification or maintenance. Their performance in SACPA would likely improve if opportunities to participate in methadone treatment were more widely available to clients who wish to receive it (Desmond & Maddux, 1996).

Parolee completion and duration findings pertain to SACPA's first year, when the Board of Prison Terms had jurisdiction over the disposition of violations by SACPA parolees. The Parole and Community Services Division now holds that jurisdiction; completion and duration patterns may change as a result. Nevertheless, lower completion rates and shorter

duration of treatment among parolees in SACPA's first year suggest a need to devote resources for more intensive treatment, supervision, drug-use monitoring, and other methods by which to improve parolee performance.

Methamphetamine users were similar to the overall SACPA population in treatment completion and duration. Concern has been raised regarding the treatment system's ability to meet the clinical challenges (e.g., poor engagement in treatment, severe paranoia, severe and protracted dysphoria, and high relapse rates) presented by methamphetamine users (Rawson, 2002). Findings suggest that treatment providers in SACPA have effectively handled the challenges presented by methamphetamine users.

Asian/Pacific Islander clients in SACPA were mostly Filipino and South Asian (Cambodian, Laotian, and Vietnamese). Treatment duration and completion were as good for these clients as for others despite possible cultural barriers to treatment.

Clients with no prior experience in treatment may find it particularly difficult to conform to unfamiliar requirements such as open acknowledgement of their drug problem and self-disclosure in groups. Despite the potential difficulties, first-time clients did as well in treatment as repeat clients.

Chapter 8: Implementation

Quality of SACPA implementation, as perceived by county representatives, was very good in SACPA's first and second years.

This chapter focuses on overall quality of SACPA implementation as perceived by county stakeholders. Findings are compared across SACPA's first and second years.

It is important to provide a context for SACPA implementation. Criminal justice innovations can be quite difficult to implement because they typically require new definitions of the relationships among stakeholders. Moreover, the boundaries separating public agencies are "fuzzy" (Sutton, 1994). Their interests often overlap, and the scope and limits of their authority are often indefinite and guided by arrangements and decision-rules that are informal and subject to change (Wolf, 2002). Finally, system resources are often fragmented and stretched thin. Clients referred to drug treatment by criminal justice need an appropriate level of community supervision and may also need vocational, educational, mental health, and other services. Public agencies serving these functions may find it very difficult to handle a large volume of criminal justice clients and may have little pre-existing capability for regular communication and information-sharing. Criminal justice innovations have often foundered as a result (Musheno et al., 1989; Nolan, 2002). Problems encountered and solutions adopted in SACPA must be evaluated in that context.

Each section of the stakeholder survey (see Appendix B) asked respondents to provide their overall judgment of SACPA implementation. Scores range from 1 (poor) to 5 (very good). UCLA created two types of summary scores. The first was an average of the judgments reported by sectors for the county. Sectors were the lead agency, alcohol and drug program administration, court administration, district attorney's office, public defender's office, and probation department. The second type of summary score was an average of the judgments reported across the state by respondents for each sector. These two scores provided, first, a look at the variation in perceived implementation across counties; and, second, a look at variation in perceived implementation across sectors.

County implementation

The statewide average (combining all sectors from all counties) was 4.13, indicating that respondents overall were reporting "very good" implementation. Figure 8.1 shows the variation in county scores. Half of the counties reported "very good" implementation, and almost all reported "very good" or "good" implementation. The statewide average in SACPA's first year was virtually the same (4.08).

Sector implementation

Figure 8.2 shows implementation scores by sector. County alcohol and drug program administrators expressed the most favorable views of SACPA implementation (mean = 4.48). The views of court administrators (mean = 4.31), lead agency representatives (mean =

Figure 8.1
County Scores for SACPA Implementation
(Stakeholder Survey)
(46 Counties Reporting)

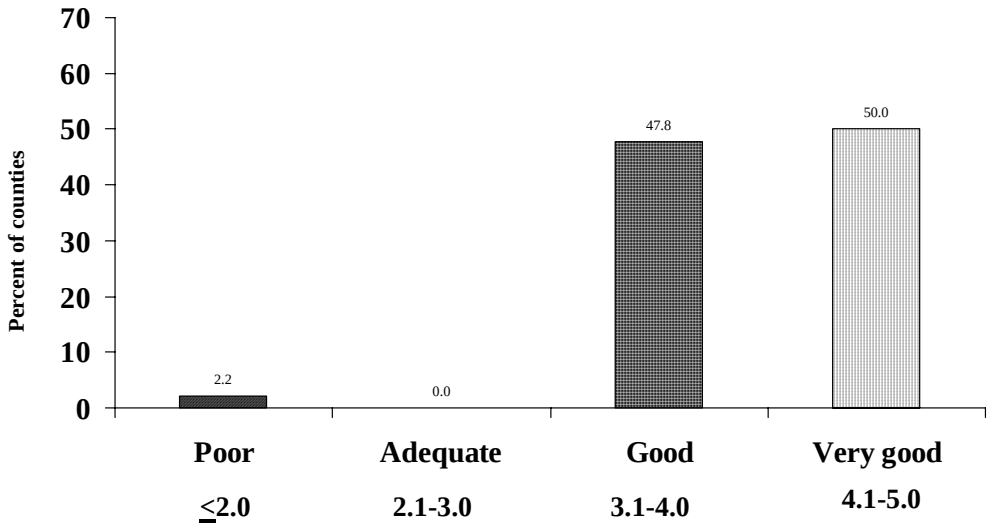
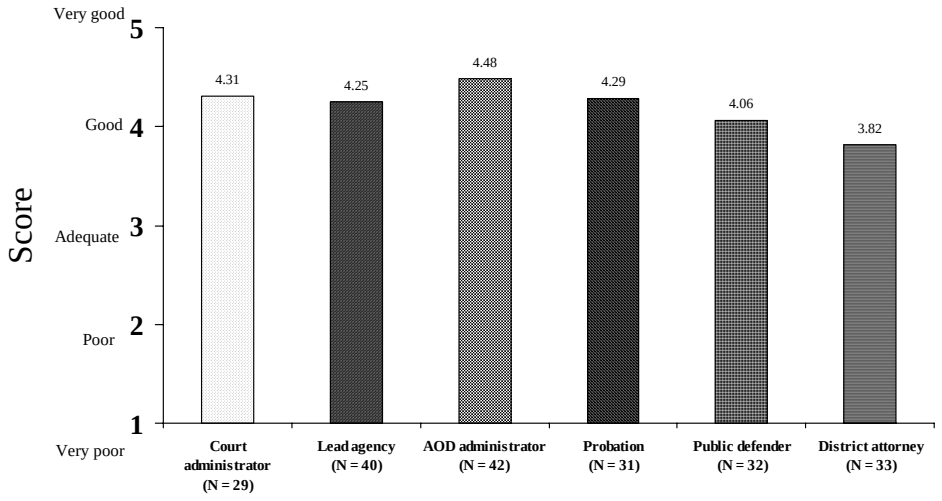


Figure 8.2
Sector Score for SACPA Implementation
(Stakeholder Survey)



4.25), probation representatives (mean = 4.29), and public defenders (mean = 4.06) were also favorable. Scores above 4.0 correspond to a rating of "very good." District attorneys (mean = 3.82) were somewhat less favorable.

Sector ratings in SACPA's first year were similar to these. Two patterns are noteworthy. First, the rating by district attorneys was somewhat lower than ratings by other sectors in both SACPA years. This may reflect persistent concerns about SACPA on the part of district attorneys. Their rating was nevertheless "good" in both years. Second, ratings by alcohol and drug program administrators, probation representatives, and public defenders were somewhat higher in SACPA's second year than in its first. These sectors seem to have adopted views more in line with court administrators and lead agencies.

Conclusion

Variation across years and sectors in perceived quality of SACPA implementation was minor. Ratings across both years and all sectors suggest a "very good" consensus regarding SACPA implementation.

Chapter 9: Evaluation Progress and Planning

The evaluation is guided by 11 research questions.

All counties are asked to complete an annual stakeholder survey.

Ten "focus counties" are participating in additional evaluation activities.

Future evaluation reports will include a more in-depth analysis of the possible cost-savings associated with SACPA; criminal recidivism, drug abstinence, and other outcomes for SACPA clients; crime trends spanning years before and after SACPA began; and overall lessons learned.

The evaluation will continue to report on implementation, especially emerging innovations in offender processing and supervision, treatment, and other service delivery.

This final chapter covers procedural matters in the evaluation. Potential topics for the evaluation have been prioritized, resulting in the set of research questions specified here. Also described are products to be delivered in 2004, procedures followed in the annual stakeholder survey, progress made by UCLA in collaboration with the evaluation's ten focus counties, and the status of UCLA's acquisition of state administrative databases needed for future analysis.

Research questions

The evaluation's research questions were developed by UCLA in collaboration with the Department of Alcohol and Drug Programs (ADP), the Statewide Advisory Group and Evaluation Advisory Group (both convened by ADP), and other stakeholder groups. Questions cover four domains: cost-offset, client outcomes, implementation, and lessons learned.

UCLA subdivided each research question into subquestions that represent more specifically the scope of the evaluation and serve as an organizing framework for detailed planning (e.g., identification of data sources and analytic techniques).

UCLA also estimated the percent of evaluation resources required for completion of work on the research questions in each domain. The purpose of these estimates is to convey the approximate "level of effort" to be expended. They are shown in parentheses in the heading for each domain.

Cost-offset (40% level of effort)

UCLA will use administrative data maintained by state agencies and will collect unit-cost information from treatment, criminal justice, and other sources in order to measure costs and cost savings and to evaluate the adequacy of funds appropriated.

Research question 1: Does SACPA lead to cost savings?

Subquestions 1.1 to 1.7 cover components of costs and cost savings. The difference in cost for SACPA offenders and comparison offenders will be calculated for each component and combined across all components to determine whether SACPA leads to net cost savings. Subquestion 1.8 pertains to possible averted costs of prison and jail construction, and those costs will be calculated separately.

Subquestion 1.1: Drug treatment costs and cost savings. What are the drug treatment costs for SACPA offenders versus comparison offenders?

Subquestion 1.2: Services costs and cost savings. What are the health and social service costs for SACPA offenders versus comparison offenders?

Subquestion 1.3: Case processing costs and cost savings. What are the law enforcement, prosecution, defense, and court costs for SACPA offenders versus comparison offenders?

Subquestion 1.4: Probation costs and cost savings. What are the probation supervision costs for SACPA offenders versus comparison offenders?

Subquestion 1.5: Parole costs and cost savings. What are the parole supervision costs for SACPA offenders versus comparison offenders?

Subquestion 1.6: New crimes costs and cost savings. What are the costs of new crimes (recidivism) by SACPA offenders versus comparison offenders?

Subquestion 1.7. Incarceration costs and cost savings. What are the costs of jail and prison incarceration for SACPA offenders versus comparison offenders?

Subquestion 1.8. Construction. Does SACPA lead to a cost saving from prison and jail construction delayed or averted?

Research question 2: Does the enacted SACPA allocation cover the cost of treatment, other services, case processing, and supervision of SACPA offenders?

Subquestion 2.1: SACPA allocation. What percent of the cost of treatment, other services, case processing, probation supervision, and parole supervision (measured in subquestions 1.1 to 1.5) is covered by the SACPA allocation?

Outcomes (35% level of effort)

UCLA will estimate SACPA's effects on crime, drug use by offenders, and the well-being of offenders and their families during the offenders' participation in SACPA and for one year to two and one-half years after. Sources will include state administrative databases, covering all 58 counties, and a survey of approximately 2,000 offenders who participate in SACPA in some counties. Outcomes will be compared between these offender groups: (1) SACPA-eligible offenders versus matched offenders from a pre-SACPA period; (2) SACPA-eligible offenders who complete an assessment versus those who do not complete an assessment; (3) SACPA-assessed offenders who enter treatment versus those who do not enter treatment; and (4) offenders who enter and complete SACPA treatment versus those who enter but do not complete it.

Research question 3: What is SACPA's effect on crime?

Subquestion 3.1: Officially recorded crime. How many arrests for property crimes, violent crimes, and drug crimes (SACPA-eligible or ineligible) are on record for SACPA offenders versus comparison offenders?

Subquestion 3.2: Revocations. How many probation and parole revocations are on record for SACPA offenders versus comparison offenders?

Subquestion 3.3: Self-reported crime. How many property crimes, violent crimes, and SACPA-ineligible drug crimes are reported by SACPA offenders versus comparison offenders?

Subquestion 3.4: Crime trends. How did crime rates change after commencement of SACPA?

Research question 4: What is SACPA's effect on offender drug use?

Subquestion 4.1: No drug use. What is the rate of drug abstinence for SACPA offenders versus comparison offenders?

Subquestion 4.2: Reduced drug use. What change in drug problem severity occurs for SACPA offenders versus comparison offenders?

Research question 5: What is SACPA's effect on offender employment?

Subquestion 5.1: Employment. What is the employment rate for SACPA offenders versus comparison offenders?

Research question 6: What is SACPA's effect on offender health and family well-being?

Subquestion 6.1: Reduced medical problems. What change in medical problem severity occurs for SACPA offenders versus comparison offenders?

Subquestion 6.2: Reduced mental health problems. What change in mental health problem severity occurs for SACPA offenders versus comparison offenders?

Subquestion 6.3: Family. What changes in family well-being occur for SACPA offenders versus comparison offenders?

Implementation (15% level of effort)

To describe how offenders move through SACPA and to document innovation in criminal justice and treatment procedures, UCLA is using "pipeline" models; an annual survey of county representatives in all 58 counties; in-depth discussion with representatives in ten focus counties; and observation at meetings, conferences, and other events.

Research question 7: How many SACPA-eligible offenders enter and complete treatment?

Subquestion 7.1: Treatment entry. What percent of SACPA-eligible offenders enter treatment, and what are their characteristics?

Subquestion 7.2: Treatment completion. What percent of SACPA-eligible offenders complete treatment, and what are their characteristics?

Research question 8: What procedures are used for assessment, placement, and supervision of SACPA offenders?

Subquestion 8.1: Assessment. What assessment instruments and procedures are used to identify service needs and risk levels of SACPA offenders?

Subquestion 8.2: Placement. What treatment placement instruments and procedures are used to determine the types of treatment to which SACPA offenders are referred?

Research question 9: How do sectors of the criminal justice and treatment systems respond to SACPA?

Subquestion 9.1: Law enforcement. Do arrest or charging practices change during SACPA?

Subquestion 9.2: Offender management. What procedures (such as dedicated court calendars, mental health courts, case management, SACPA-specific urine test protocols, or placement in services for co-occurring disorder or other characteristics) are used in managing SACPA offenders?

Subquestion 9.3: Treatment provision. What procedures are used (such as expanding treatment capacity and treatment matching) in the provision of drug abuse treatment to SACPA offenders?

Research question 10: What problems occur in implementing SACPA, and how are those problems addressed?

Subquestion 10.1: Counties. What implementation problems occur at the county level, and how are they addressed?

Subquestion 10.2: State. What implementation problems occur at the state level, and how are they addressed?

Lessons learned (10% level of effort)

To arrive at implications for policy and practice, UCLA will use its annual survey of county representatives in all 58 counties; in-depth discussion groups in ten focus counties; and observation at meetings, conferences, and other events.

Research question 11: What implementation strategies are associated with SACPA outcomes?

Subquestion 11.1: Counties. What implementation strategies are associated with SACPA outcomes at the county level?

Subquestion 11.2: Offenders. What implementation strategies are associated with SACPA outcomes for particular types of offenders?

Upcoming products

Next year is a crucial period for the evaluation, as it will be possible to conduct an in-depth analysis of SACPA costs (research questions 1-s2) and to document a range of client outcomes (research questions 3-6). Annual reports for 2004 through 2006 will cover those questions, update findings on SACPA implementation (research questions 7-9), and identify lessons learned (research questions 10 and 11).

A supplemental report in 2004 will map aggregate crime trends in the state before and after 2001, the year in which SACPA began (subquestion 3.4).

Stakeholder survey

Approximately 400 respondents in all 58 counties are asked to complete the annual stakeholder survey by mail. The survey along with a cover letter is mailed to the designated primary SACPA contact for each county in August. Follow-up phone calls are made to ensure that the survey is received and to answer any questions about it. To improve the response rate, UCLA has prioritized questions so that counties with limited time and resources may focus on completing portions of the survey regarded as most crucial to the evaluation.

The survey recipient is asked to bring in knowledgeable stakeholders in the county to help complete the survey. To facilitate this procedure, UCLA has divided the survey into six detachable sections corresponding to county agencies involved in SACPA: the lead agency, county alcohol and drug administration, court administration, district attorney, public defender, and probation. See Appendix B.

Questions focus on SACPA planning and implementation, operations, and needs of each county; perceived strengths and weaknesses of SACPA in each county; offender management strategies and other responses by the criminal justice and treatment systems; and suggestions for improving SACPA implementation.

The 2002 survey was returned by 51 counties, which represent 88% of California's 58 counties. The 2003 survey was returned by 49 counties (84%). Response rates for individual questions vary, depending on whether stakeholders have the time and information needed to answer them.

Focus counties

UCLA has worked with ten "focus counties" to create mechanisms for tracking offenders as they move from SACPA eligibility through assessment, treatment, supervision, and completion. Tracking involves accessing raw data sources on offenders and recruiting samples of offenders for the outcome survey.

Selection of focus counties

All California counties that expressed interest in being a focus county were considered for inclusion. During late 2001, UCLA joined with ADP in conducting site visits, collating information on possible focus counties, and reviewing that information. From the pool of interested counties, UCLA identified ten (Alameda, Kern, Los Angeles, Mendocino, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Shasta, and Ventura) that, in combination, best met these criteria:

(1) mix of urban and rural counties;
(2) broad geographic coverage of the state;
(3) capabilities for collecting SACPA-relevant data; and
(4) diversity of implementation strategies.

The scope and terms of collaboration with focus counties have been tailored to each county and designed to serve both the evaluation's needs and county-specific purposes. County collaboration is needed in procedural matters, such as facilitating contact with SACPA offenders and accessing automated data. Collaboration is also needed in conducting and interpreting data analysis and arranging focus groups.

These topics were covered in discussions with potential focus counties:

(1) informing SACPA offenders about the evaluation and possible later contact;
(2) analyzing automated records;
(3) accessing, abstracting, and analyzing paper records;
(4) participation of agency representatives and other stakeholders in focus groups;
(5) factors limiting the county's ability to collaborate (it might be possible to overcome some of those factors);
(6) county monitoring and evaluation needs and how the collaboration can assist in meeting those needs;
(7) resources or other incentives needed to make collaboration possible; and
(8) how to ensure that the evaluation team is in place to conduct as much of the work as possible (to minimize extra burden on county staff).

UCLA developed a set of data elements to be used in tracking. These data elements represent information regarded as most crucial for evaluation purposes and are needed at the offender level. Only with offender-level data will it be possible to link and analyze offender information from multiple sources and distinguish events and outcomes for different types of offenders. Data elements fall into five categories: case processing, conviction, probation/parole supervision, treatment, and outcomes (see Table 9.1).

Elements expected to be available in automated statewide databases are marked with an asterisk in Table 9.1. Elements available only through primary data collection (offender surveys) are marked with a double asterisk. The elements in bold italics are those likely to be found only in raw data sources (court records, probation/parole files, treatment program records, or other county sources). Focus counties have agreed to compile the data and make them accessible to UCLA. Precise definitions of the data elements appear in Table 9.2.

Table 9.1 Data Elements Required for Tracking Eligible Offenders
CASE PROCESSING
CII number
arraignment date
name: first, middle, last
Address
Phone
DOB
Gender
social security number (entire or last four digits only)
race/ethnicity
primary drug
charge(s) by code number
charge(s): misdemeanor or felony
new case
was on probation
was on parole
has no, one, or two "strikes"
if case went to trial, number of trial days
completed SACPA
completion date
case dismissed
dismissal date
date of conviction
found SACPA-eligible ***if no, why (prior record or additional current charges)***
found eligible only after additional charge(s) dismissed/deferred ***if yes, specify charges***
accepted SACPA
appeared for treatment assessment/placement
treatment placement (level, tier)
PROBATION/PAROLE SUPERVISION
for each violation (by code) ***violation was counted as first, second, or third SACPA violation*** ***reinstated or disqualified*** ***if reinstated, whether placement was changed (no or specify new treatment)*** ***if disqualified, was offender danger to others, unavailable, refused treatment*** ***days supervised***
TREATMENT
entered treatment*
treatment type*
treatment duration*
completed treatment*
OUTCOMES (FOLLOW-UP PERIODS VARY)
completed probation/parole*
arrested on new charge (drug, property, violent)*
convicted on new charge (drug, property, violent)*
incarcerated in state prison*

* Available in existing databases

Table 9.1 Data Elements Required for Tracking Eligible Offenders, Cont'd.
prison days sentenced*
prison days served*
incarcerated in city/county jail
jail days sentenced
jail days served
committed new offenses (drug, property, violent; arrested or not)**
number of crimes or crime days (drug, property, violent; arrested or not)**
employment*
days worked*,**
welfare received*
days on welfare*,**
any drug use (self-reported or based on urine test records) by drug type*,**
frequency of use by drug type*,**

** To be obtained by primary data collection
Available only if counties provide access (***bold italics***)

Table 9.2 Detailed Definition of Data Elements to be Provided by Focus Counties	
Variable	**Definition**
CII number	Criminal Identification and Information number used by the Department of Justice
Arraignment date	Date offender was arraigned
Name	First, middle, last name
Address	Current mailing or residence address (the more addresses, the better)
Phone	Current phone number
DOB	Date of birth
Gender	Male/female
Social security number	Entire or last four digits only
Race/ethnicity	Race/ethnicity in most detailed form available (may be split into race as well as Hispanic/non-Hispanic ethnicity if available)
Primary drug	Primary drug at treatment admission
Charge code	Charges by code (e.g., penal code, health & safety code), e.g., possession of a controlled substance might be indicated as H&S 11053. If charges are not available by code, a text description (e.g. "possession of a controlled substance") would be next best
Charge level	For each charge, misdemeanor, felony, or probation/parole violation
Probation/parole/neither	At the time of arrest, offender was already on probation, on parole, or neither
Has no, one, or two strikes	How many strikes the offender had at the time of arrest as defined in P.C. 667.5(c) or 1192.7(c)
Date of conviction	Date the offender was convicted of the SACPA offense
If not eligible, why	Ineligible for SACPA due to prior record or additional current charges
Charges dismissed for eligibility	Yes/no
Charges dismissed specified	If charges were dismissed/deferred for the sake of eligibility, specify charges dismissed/deferred
Accepted SACPA	Offender chose to enter SACPA at the time of conviction
Appeared for assessment	Offender appeared for assessment
Appeared for treatment	Offender appeared for treatment
Treatment placement	Level / tier of treatment
Case dismissed	Court set aside the drug charge as a result of SACPA participation
Dismissal date	Date of above
Completed	Court determined that the offender completed SACPA requirements as defined by PC 1210(c)
Completion date	Date of above

Table 9.2 Detailed Definition of Data Elements to be Provided by Focus Counties, Cont'd.	
Variables below are for each SACPA violation as described in P.C. 1210.1(e). There could be more than one occurrence of each of these variables per offender.	
Type of violation	If violation is a new offense, please indicate code (e.g., penal code #) of the offense that constituted the violation. If the violation is not a new offense, please indicate what it was (e.g., a violation of a drug-related condition of probation (as defined in PC 1210.1(f) or parole (PC 3063.1(d))
Violation count	Violation was counted as first, second, or third violation
Reinstated or revoked	Offender was reinstated following the violation, or eligibility was revoked as a result of it
If reinstated, was the treatment placement changed	No change, moved to level 1, moved to level 2, etc.
If revoked why	Offender was (1) a danger to others, (2) unavailable, or (3) refused treatment
Incarcerated in city/county jail	After being placed on probation for the SACPA offense, offender was sentenced to a jail term upon conviction for any subsequent offense or for a probation violation
Jail days sentenced	Number of days the offender was sentenced as a result of a SACPA violation
Jail days served	Number of days the offender actually served in jail as a result of the subsequent conviction or probation violation

Data access

UCLA has identified the administrative databases required to answer the evaluation's research questions. Obtaining access to these databases can be a lengthy and involved negotiation with agencies that maintain them. UCLA has proceeded as rapidly as possible to reach agreements for data sharing.

UCLA has formalized access to the Statewide Reporting Information System, the California Alcohol and Drug Data System, and the Drug and Alcohol Treatment Access Report, each of which is maintained by the California Department of Alcohol and Drug Programs (ADP). Data from the California Treatment Outcome Project and the Los Angeles County Evaluation System have been accessed with permission of project leaders at ADP, UCLA, and the Los Angeles County Alcohol and Drug Program Administration. The California Department of Justice has granted permission to access its databases and has forwarded data for offenders arrested on drug-related charges during SACPA's first and second years and a pre-SACPA era from 1991 to mid 2001. The Board of Prison Terms, Department of Corrections, and Department of Motor Vehicles also granted access to their databases and forwarded extractions of data. UCLA has an interagency agreement with the Department of Mental Health, which will begin data sharing in early 2004.

UCLA remains engaged in data-sharing discussions with the Office of Statewide Health Planning and Development, the Department of Health Services, the Employment Development Department, and the Department of Social Services. Access to these databases for the SACPA evaluation will depend on cooperation from those agencies.

Glossary

Addiction Severity Index (ASI) – A standardized assessment designed to gather data on treatment client status in seven domains: drug use, alcohol use, employment, family and social relationships, legal status, psychiatric status, and medical status.

Board of Prison Terms (BPT) – The agency that protects and preserves public safety through the exercise of its statutory authorities and policies, while ensuring due process to all criminal offenders who come under the Board's jurisdiction. The Board is responsible for the adjudication of parole violations referred by the Parole and Community Services Division of the California Department of Corrections. This agency developed the initial procedure for referring and monitoring parolees during SACPA's first year.

Cost-offset – The difference between costs incurred by the taxpayer as a result of SACPA and costs that would have been incurred by the taxpayer in the absence of SACPA.

Drug court – Courts that handle drug-using offenders in an approach emphasizing treatment and close supervision; direct contact between judge and offender; and collaboration between judge, prosecutor, defense attorney, and treatment provider.

Drug court procedure – Processing SACPA offenders through a court having all or some features of a drug court.

Flash incarceration – Short-term jail stay for noncompliance with the terms of program participation or release to the community.

Median – The "middle case" in the distribution from lowest to highest.

Multivariate regression – Prediction of a dependent variable on the basis of two or more independent variables.

Parole and Community Services Division (P&CSD) of the California Department of Corrections – The agency providing field supervision of California parolees.

Appendices

Appendix A. SACPA-eligible Offenses
Appendix B. 2003 SACPA Stakeholder Survey
Appendix C. Pipeline Analysis
Appendix D. Multivariate Analysis of Treatment Completion
Appendix E. Treatment Duration Among Non-SACPA Clients

Appendix A. SACPA-eligible Offenses

UCLA consulted a variety of knowledgeable sources to compile an inclusive list of offenses for which a person might be deemed eligible for SACPA. Sources included specifications in the SACPA legislation, analyses by the California Public Defenders Association (2001) and the California District Attorneys Association (2001), criminal justice experts on ADP's Statewide Advisory Group and Evaluation Advisory Group, and the Parole and Community Services Division of the California Department of Corrections. Offenses for which a person might be deemed eligible for SACPA are shown below.

Health and safety code

H&S 11170 (Prescribe, administer, or furnish a controlled substance)
H&S 11550 (Under the influence of controlled substance)
H&S 11350 (Possession of controlled substance)
H&S 11352 (Transportation for personal use)
H&S 11357 (Possession of cannabis)
H&S 11358 (Marijuana planted, cultivated, harvested, dried, or processed for personal use)
H&S 11360 (Transportation for personal use)
H&S 11363 (Plants, cultivates, harvests, dries, or processes peyote)
H&S 11364 (Paraphernalia)
H&S 11365 (Unlawful to visit or be in a room where controlled substances are being used)
H&S 11368 (Drug was secured by a fictitious prescription and is for personal use)
H&S 11377 (Possession Schedule III-V)
H&S 11379 (Transportation for personal use)
H&S 11590 (Failure to register)

Business and professions code

B&P 4140 (Possession of a syringe)
B&P 4060 (Possession of controlled substance)

Vehicle code

V.C. 23152 (DUI)[1]
V.C. 23153 (DUI) [2]
V.C. 23222 (b) (Open container in vehicle)

Penal code

P.C. 647 (f) (Public intoxication [drug])

[1] Dugan, B. (2001). Grey Area Issues for the Judicial Officers' Consideration.
[2] Ibid.

Conditions of parole

012 (Failure to participate in anti-narcotic testing)
019 (Violation of special conditions of parole if they are related to drugs)
024 (Failure to follow instructions from P&CSD where instructions are related to drug use)
025 (Failure to inform P&CSD of arrest if for a SACPA eligible violation only)
707 (Possession of heroin)
709 (Use of heroin)
717 (Possession of cocaine)
719 (Use of cocaine)
727 (Possession of marijuana)
729 (Use of marijuana)
737 (Possession of PCP)
739 (Use of PCP)
747 (Possession of any other illicit controlled substance)
749 (Use of any other illicit controlled substance)
750 (Possession of drug paraphernalia [related to drug use])
776 (Illicit possession of amphetamine/methamphetamine)
778 (Illicit use of amphetamine/methamphetamine)
779 (Loitering in an area of drug-related activity)
780 (Under the influence of a controlled substance)
793 (Other violations of law relating to drug use)
947 (Failure to register per H&S 11590)

Offenses regarded as ineligible by California District Attorneys Association (2001)

P.C. 191.5 (Gross vehicular manslaughter)
P.C. 191.5 (c) (3) (Vehicular manslaughter without gross negligence)
P.C. 4573-4573.9 (Bringing, sending, possessing drugs or drug paraphernalia in jail/prison)

Appendix B. 2003 SACPA Stakeholder Survey

LEAD AGENCY SECTION

These questions ask about SACPA implementation in your county during July 1, 2002 through June 30, 2003. We realize that you may not be able to answer some questions calling for precise numerical information, but please provide that information if you have it or make your best estimate. If other stakeholders have the information for your county, please confer with them regarding any of these questions.

Date: _____/_____/03

Who completed this survey? Please attach business card of person(s) involved.

Name: _____ Job title: _____

Department or agency: _____ Mailing address: _____

Phone: _____ Fax: _____

Email: _____

Are you the person who completed this survey last year?	*Yes* ☐	*No* ☐	*Don't remember* ☐

These questions ask about the "flow" of offenders into SACPA. If you have records indicating the actual number for each question, please provide that number in Q1, Q4, and Q9. For the other questions in this section, please estimate number or percent. Please count offenders entering the county's criminal justice system on a new charge (including parolees) and those already on probation. Do not count parolees referred to SACPA by a parole agent.

1. Between July 1, 2002 and June 30, 2003, how many offenders in your county were convicted of a SACPA eligible offense and were not ineligible because of a concurrent or prior offense. This is a count of eligible offenders, whether they opted to participate in SACPA or not. Do not count offenders from "out of county."	_____
2. Of the number in Q1, how many were originally charged with a SACPA-ineligible offense and became eligible for SACPA when they pled down?	_____
3. Of the number in Q1, how many became eligible for SACPA only because other charges were dismissed or not filed?	_____
4. Between July 1, 2002 and June 30, 2003, how many offenders in your county opted for SACPA (whether they completed their assessment or not, and whether they actually entered treatment or not)?	_____
5. Of the number in Q4, how many were "SACPA repeaters" (they had opted for SACPA upon conviction for a prior offense occurring on or after July 1, 2001)?	_____
6. Of the number in Q4, how many were sent out of county for assessment and/or treatment?	_____
7. Of the number in Q4, how many were held in custody while awaiting disposition of their charge(s)?	_____
8. Of the number in Q4, how many were held in custody while awaiting SACPA screening/assessment?	_____
9. Between July 1, 2002 and June 30, 2003, how many offenders in your county completed the SACPA screening/assessment and were referred to treatment?	_____
10. Of the number in Q9, how many were held in custody while waiting for a treatment slot?	

	_____
11. Of the number in Q9, how many were required to attend a self-help support group while waiting for a treatment slot?	_____

12. In Q1, were you counting offenders eligible for SACPA when charged or only those who opted for SACPA when sentenced? If other, please specify in Q42.	When charged	☐
	When sentenced	☐
	Other: Specify in Q42.	☐

13a. In your county, how many offenders were assessed before sentencing? (If zero, please enter zero.)	_____
13b. If your answer to Q13a is not zero, how many offenders in Q13a opted out of SACPA at sentencing?	_____

14. How many persons assessed and/or treated in your county were convicted of a SACPA-eligible offense in another county?	_____

15. How many persons charged with a SACPA-eligible offense opted for routine sentencing instead of SACPA?	_____
16. How many persons charged with a SACPA-eligible offense opted for deferred entry of judgment or other diversion instead of SACPA?	_____
17. How many persons charged with a SACPA-eligible offense opted for drug court instead of SACPA?	_____

18. At sentencing, were SACPA offenders told they must report for screening/assessment within a specific number of days?	*Yes* ☐	*No* ☐
19. If yes, how many days? If less than one day, enter 0. If instructions were not the same for all offenders or not the same throughout the year, please explain at Q42.	_____ Days	

20. Were SACPA assessments conducted at the courthouse where the offender was sentenced (or within walking distance)?	*Yes* ☐	*No* ☐
21. Were SACPA assessments conducted at the treatment site?	*Yes* ☐	*No* ☐
22. Were SACPA assessments scheduled by appointment, were walk-ins allowed, or both?	*Appointment* ☐	
	Walk-ins ☐	
	Both ☐	
23. In some counties, the assessment process—including intake, screening, assessment, and treatment placement—is completed in a single visit. In other counties, the process normally takes more than one visit. How many visits are normally required to complete the assessment process in your county?	_____ *# of visits*	

24. Approximately what percent of SACPA offenders (the number in Q4) were transported at county expense from the court to screening/assessment?	_____ *%*
25. What percent of SACPA offenders (the number in Q4) were transported at county expense from screening/assessment to treatment?	_____ *%*

26. What percent of SACPA offenders received services from a case manager?	_____ %

27. Between July 1, 2002 and June 30, 2003, how many SACPA offenders entered the treatment program to which they were referred?	_____
28. Of the number in Q27, how many were later referred to and entered a different treatment level (higher or lower)?	_____
29. Of the number in Q27, how many enrolled in an aftercare program to which SACPA referred them?	_____

30. In the period between July 1, 2002 and June 30, 2003, what inter-agency communication methods were used to implement SACPA in your county?	**Yes**	**No**
Face-to-face meetings	☐	☐
Workshops for training or technical assistance	☐	☐
Formal agreement (such as MOU or contract)	☐	☐
Informal agreement	☐	☐
Case conferencing	☐	☐
Co-located staff for the assessment process	☐	☐
Co-located services ("one-stop shopping")	☐	☐
Other (If other, please specify in Q42.)	☐	☐

These questions will help us interpret your county's SRIS data on referrals, assessments, and treatment placements during July 1, 2002 to June 30, 2003.

31. Do the numbers in SRIS represent unique offenders (counted only once even if they were referred, assessed or placed more than once) or do they represent events (each referral, assessment, and placement is counted)? If other, please specify in Q42.	*Unique offenders*	☐
	Events	☐
	Other: Specify in Q42.	☐

32. Do referrals, assessments, and placements in SRIS include parolees sent to SACPA by the court or/and by the parole agent?	*Sent by court*	*Sent by parole agent*
	Yes	No
Referrals	☐	☐
Assessments	☐	☐
Placements	☐	☐

33. Is your count of placements in SRIS based on the number of offenders who actually entered treatment or the number assigned to treatment (whether they entered or not)?	Actually entered	☐
	Assigned	☐

	Other: Specify in Q42	☐

34. Did your country's SRIS reporting procedures change in any way from July 2001-June 2002 to July 2002-June 2003? If yes, please explain in Q42.	*Yes* ☐ Explain in Q42.	*No* ☐

These questions ask about favorable or unfavorable effects that you believe SACPA may have had in your county.

35. Between July 1, 2002 and June 30, 2003, which of these coordination problems, if any, affected SACPA implementation in your county?

	Not a problem	*Minor problem*	*Serious problem*	*Very serious problem*
Lack of consensus regarding the role of probation/parole	1	2	3	4
Lack of consensus regarding the role of treatment	1	2	3	4
Inadequate participation by one or more agencies	1	2	3	4
Inadequate communication among agencies	1	2	3	4
Inadequate coordination of decision-making	1	2	3	4
Difficulty in linking/referring to services	1	2	3	4
Inadequate information system	1	2	3	4
Other (If other problems affected SACPA, specify in Q42.)	1	2	3	4

36. Between July 1, 2002 and June 30, 2003, what effect, in your opinion, did SACPA have in your county regarding:

	Very favorable effect	*Favorable effect*	*No effect*	*Unfavorable effect*	*Very unfavorable effect*
Inter-agency consensus on treatment/supervision of offenders	1	2	3	4	5
Inter-agency communication	1	2	3	4	5
Service linkages	1	2	3	4	5
Information availability	1	2	3	4	5
Drug use in the general population	1	2	3	4	5
Drug-related crime	1	2	3	4	5
Non drug-related crime	1	2	3	4	5
Jail bed availability	1	2	3	4	5

37. Between July 1, 2002 and June 30, 2003, did county leaders (elected officials or administrators) formally consider any options regarding jail capacity?	*Yes* ☐	*No* ☐

38. If yes, what was decided? Please check all that apply.

No decision reached	☐	Decided to lease beds outside the county	☐
Decided to build a new jail	☐	Released inmates early to relieve overcrowding	☐
Decided to renovate or reconfigure an existing jail in order to get more beds	☐	Decided something else (Specify in Q42)	☐
Closed all or part of a jail	☐		

39. Please provide your overall judgment of SACPA implementation in your county.

Very good	*Good*	*Adequate*	*Poor*	*Very poor*
1	2	3	4	5

40. Has any change occurred in SACPA in your county for fiscal reasons? If yes, please explain in Q42.	*Yes* ☐	*No* ☐
41. Has any change occurred in SACPA in your county for reasons other than fiscal? If yes, please explain in Q42.	*Yes* ☐	*No* ☐

42. In the space below, please record any additional comments on SACPA implementation in your county and explain any "other" boxes you checked above. Thank you.

COUNTY ALCOHOL AND DRUG ADMINISTRATION SECTION

These questions ask about SACPA implementation in your county during July 1, 2002 through June 30, 2003. We realize that you may not be able to answer some questions calling for precise numerical information, but please provide that information if you have it or make your best estimate.

Date: _____/_____/03

Who completed this survey? Please attach business card of person(s) involved.

Name: _____ Job title: _____

Department or agency: _____ Mailing address: _____

Phone: _____ Fax: _____

Email: _____

Are you the person who completed this survey last year?	*Yes* ☐	*No* ☐	*Don't remember* ☐

1. Between July 1, 2001 and June 30, 2002, how many outpatient treatment programs (no medication prescribed) handled SACPA clients in your county?

County-run _____ County-contracted _____ VA _____ Private _____

2. How many outpatient treatment programs (methadone or other medication prescribed) handled SACPA clients?

County-run _____ County-contracted _____ VA _____ Private _____

3. How many intensive outpatient or day treatment programs handled SACPA clients?

County-run _____ County-contracted _____ VA _____ Private _____

4. How many residential treatment programs handled SACPA clients? Include residential detox (with or without medication prescribed) as well as residential treatment/recovery (with or without medication prescribed).

County-run _____ County-contracted _____ VA _____ Private _____

5. How many drug education or other "early intervention" programs handled SACPA clients? ☐

6. Please provide your overall judgment of SACPA implementation in your county .

Very good	*Good*	*Adequate*	*Poor*	*Very poor*
1	2	3	4	5

7. Has any change occurred in SACPA in your county <u>for fiscal reasons</u>? If yes, please explain in Q9. *Yes* ☐ *No* ☐

8. Has any change occurred in SACPA in your county <u>for reasons other than fiscal?</u> *Yes* ☐ *No* ☐
If yes, please explain in Q9.

9. In the space below, please record any additional comments on SACPA implementation in your county and explain any "other" boxes you checked above. Thank you.

COURT ADMINISTRATOR SECTION

These questions ask about SACPA implementation in your county during July 1, 2002 through June 30, 2003.

Date: _____/_____/03

Who completed this survey? Please attach business card of person(s) involved.

Name: _____ Job title: _____

Department or agency: _____ Mailing address: _____

Phone: _____ Fax: _____

Email: _____

Are you the person who completed this survey last year?	*Yes* ☐	*No* ☐	*Don't remember* ☐

1. Between July 1, 2002 and June 30, 2003, what court procedures were used to handle SACPA cases?	**Yes**	**No**
Dedicated or centralized court for <u>all</u> SACPA offenders	☐	☐
Dedicated or centralized court for <u>some</u> SACPA offenders but not all	☐	☐
Expedited case processing	☐	☐
Case conferences	☐	☐
Probation assessment hearings	☐	☐
Status hearings	☐	☐
Drug testing requirements set specifically for SACPA offenders	☐	☐

These questions are about "drug court" defined as follows: court calendar dedicated to drug offenders; dialog between judge and offender; close supervision by judge or case manager; and a collaborative courtroom process involving judge, prosecutor, defense attorney, and treatment provider. Between July 1, 2002 and June 30, 2003…

	Yes	*No*
2. Were <u>all SACPA offenders</u> handled in a drug court?	☐	☐
3. Were <u>some but not all SACPA offenders</u> handled in a drug court?	☐	☐

4. On the list of offenses below, please check any offense for which offenders would <u>not be eligible for SACPA</u> in your county.	**Not eligible**
H&S 11170 (Prescribing, administering, or furnishing controlled substance for self)	☐
H&S 11550 (Under the influence of controlled substance)	☐
H&S 11350 (Possession of controlled substance)	☐
H&S 11352 (Transportation for personal use)	☐
H&S 11357 (Possession of cannabis)	☐
H&S 11358 (Planting, cultivating, harvesting, drying, or processing marijuana for personal use)	☐
H&S 11360 (Transportation for personal use)	☐
H&S 11363 (Planting, cultivating, harvesting, drying, or processing peyote)	☐
H&S 11364 (Paraphernalia)	☐

H&S 11365 (Being in room where controlled substances are being used)	☐
H&S 11368 (Securing drug by fictitious prescription for personal use)	☐
H&S 11377 (Possession Schedule III-V)	☐
H&S 11379 (Transportation for personal use)	☐
H&S 11590 (Failure to register)	☐
V.C. 23222 (b) (Open container in vehicle)	☐
P.C. 647 (f) (Public intoxication)	☐
B&P 4140 (Possession of syringe)	☐
B&P 4149 (Paraphernalia)	☐
B&P 4060 (Possession controlled substance)	☐
V.C. 23152 (DUI)	☐
V.C. 23153 (DUI)	☐

5. Please record any other offenses (if not listed in Q4) for which offenders would be <u>eligible for SACPA</u> in your county.

6. Which of these coordination problems, if any, occurred in your county?

	Yes	*No*
Lack of agreement regarding offenses that are SACPA eligible	☐	☐
Lack of agreement regarding SACPA charging practices	☐	☐
Lack of agreement regarding SACPA plea negotiation	☐	☐
Lack of agreement regarding how to handle probation violations	☐	☐
Lack of agreement regarding how to define "unavailable for" (or not amenable to) treatment	☐	☐

7. Please provide your overall judgment of SACPA implementation in your county.

Very good	*Good*	*Adequate*	*Poor*	*Very poor*
1	2	3	4	5

8. Has any change occurred in SACPA in your county <u>for fiscal reasons</u>? If yes, please explain in Q10.	*Yes* ☐	*No* ☐
9. Has any change occurred in SACPA in your county <u>for reasons other than fiscal?</u> If yes, please explain in Q10.	*Yes* ☐	*No* ☐

10. In the space below, please record any additional comments on SACPA implementation in your county and explain any "other" boxes you checked above. Thank you.

DISTRICT ATTORNEY SECTION

These questions ask about SACPA implementation in your county during July 1, 2002 through June 30, 2003.

Date: _____/_____/03

Who completed this survey? Please attach business card of person(s) involved.

Name: _____ Job title: _____

Department or agency: _____ Mailing address: _____

Phone: _____ Fax: _____

Email: _____

Are you the person who completed this survey last year?	*Yes* ☐	*No* ☐	*Don't remember* ☐

1. Between July 1, 2002 and June 30, 2003, what SACPA-specific policies were in effect?

	Yes	**No**
Standard set of charges on which offenders were eligible for SACPA	☐	☐
Charging practices designed for SACPA (If yes, please attach or specify in Q5)	☐	☐
Case processing designed for SACPA (If yes, please attach or specify in Q5)	☐	☐
Plea negotiation guidelines designed for SACPA (If yes, please attach or specify in Q5)	☐	☐
Plea agreements under which SACPA-eligible defendants could decline SACPA	☐	☐
Other (If other, please specify in Q5)	☐	☐

2. Please provide your overall judgment of SACPA implementation in your county.

Very good	*Good*	*Adequate*	*Poor*	*Very poor*
1	2	3	4	5

3. Has any change occurred in SACPA in your county <u>for fiscal reasons</u>? If yes, please explain in Q5.	*Yes* ☐	*No* ☐
4. Has any change occurred in SACPA in your county <u>for reasons other than fiscal reasons?</u> If yes, please explain in Q5.	*Yes* ☐	*No* ☐

5. In the space below, please record any additional comments on SACPA implementation in your county and explain any "other" boxes you checked above. Thank you.

PUBLIC DEFENDER SECTION

These questions ask about SACPA implementation in your county during July 1, 2002 through June 30, 2003. We realize that you may not be able to answer some questions calling for precise numerical information, but please provide that information if you have it or make your best estimate.

Date: _____/_____/03

Who completed this survey? Please attach business card of person(s) involved.

Name: _____ Job title: _____

Department or agency: _____ Mailing address: _____

Phone: _____ Fax: _____

Email: _____

Are you the person who completed this survey last year?	*Yes* ☐	*No* ☐	*Don't remember* ☐

1. Please estimate the percent of SACPA offenders represented by a public defender (or court-appointed attorney) and the percent represented by a private attorney.	
Percent represented by public defender (or court-appointed attorney)	_____ %
Percent represented by private attorney	_____ %

2. Apart from those who have a private attorney, are SACPA offenders assigned to public defenders (or court-appointed attorneys) who specialize in SACPA?	*Yes* ☐	*No* ☐

3. Has any change occurred in SACPA in your county for fiscal reasons? If yes, please explain in Q6.	*Yes* ☐	*No* ☐
4. Has any change occurred in SACPA in your county for reasons other than fiscal? If yes, please explain in Q6.	*Yes* ☐	*No* ☐

5. Please provide your overall judgment of SACPA implementation in your county.					
	Very good	*Good*	*Adequate*	*Poor*	*Very poor*
	1	2	3	4	5

6. In the space below, please record any additional comments on SACPA implementation in your county and explain any "other" boxes you checked above. Thank you.

COUNTY PROBATION DEPARTMENT SECTION

These questions ask about SACPA implementation in your county during July 1, 2002 through June 30, 2003. We realize that you may not be able to answer some questions calling for precise numerical information, but please provide that information if you have it or make your best estimate.

Date: _____/_____/03

Who completed this survey? Please attach business card of person(s) involved.

Name: _____ Job title: _____

Department or agency: _____ Mailing address: _____

Phone: _____ Fax: _____

Email: _____

Are you the person who completed this survey last year?	*Yes* ☐	*No* ☐	*Don't remember* ☐

These questions ask about the status of SACPA offenders in your county. If you have records indicating the actual number for each question, please provide that number in Q1, Q7, and Q11. For the other questions in this section, please estimate the number or the percent.	
1. Between July 1, 2002 and June 30, 2003, how many SACPA offenders were on probation in your county? Please include SACPA offenders placed on probation during that time period and those already on probation before July 2002.	_____
2. Of the number in Q1, how many were in SACPA on a felony conviction, and how many were in SACPA on a misdemeanor conviction?	Felony _____ Misd. _____
3. Of the number in Q1, how many had no new drug violations recorded while in SACPA?	_____
4. Of the number in Q1, how many had one new drug violation recorded while in SACPA?	_____
5. Of the number in Q1, how many had two new drug violations recorded while in SACPA?	_____
6. Of the number in Q1, how many had three new drug violations recorded while in SACPA?	_____
7. Of the number in Q1, how many were revoked from probation?	_____
8. Of the number in Q7, how many were revoked because they had three drug violations?	_____
9. Of the number in Q7, how many were revoked for non-drug violations?	_____
10. Of the number in Q7, how many were sent to jail or prison?	_____
11. How many SACPA offenders completed probation on or before June 30, 2003?	_____
12. Of the number in Q11, how many had their convictions expunged (or dismissed) on or before June 30, 2003?	_____

13. Please describe SACPA reporting in your county between July 1, 2002 and June 30, 2003.

	Always or almost always	**Usually**	*Sometimes*	*Never or almost never*
Treatment plans reported by treatment provider within 30 days	1	2	3	4
Positive/missed drug tests reported by treatment provider within 2 weeks after test date	1	2	3	4
Other noncompliance reported by treatment provider within 2 weeks after noncompliance occurred	1	2	3	4
Quarterly progress reports sent by treatment provider within 2 weeks after the end of the quarter	1	2	3	4
Successful completion reported by treatment provider within 2 weeks	1	2	3	4
Drop-outs reported by treatment provider within 2 weeks	1	2	3	4

14. Between July 1, 2002 and June 30, 2003, what SACPA-specific policies were in effect?

	Yes	**No**
Risk assessment/classification procedures designed for SACPA probationers	☐	☐
Supervision protocols designed for SACPA probationers	☐	☐
Drug testing requirements designed for SACPA probationers	☐	☐
Service referral/linkage procedures designed for SACPA probationers	☐	☐
Other (If other, please specify in Q18.)	☐	☐

15. Please provide your overall judgment of SACPA implementation in your county.

Very good	*Good*	*Adequate*	*Poor*	*Very poor*
1	2	3	4	5

16. Has any change occurred in SACPA in your county <u>for fiscal reasons</u>? If yes, please explain in Q18. *Yes* ☐ *No* ☐

17. Has any change occurred in SACPA in your county <u>for reasons other than fiscal?</u> *Yes* ☐ *No* ☐
If yes, please explain in Q18.

18. In the space below, please record any additional comments on SACPA implementation in your county and explain any "other" boxes you checked above. Thank you.

Appendix C. Pipeline Analysis

Offenders who choose SACPA are referred to assessment and treatment. Assessment entails a systematic review of the severity of the offender's drug use and other problems, a decision regarding appropriate placement in a drug treatment program, identification of other service needs, and a determination of the appropriate level of community supervision. Upon completion of assessment, offenders must report promptly to the assigned treatment program. Thus, referral is the first step in the SACPA pipeline. Completion of assessment is the second step, and treatment entry is the third.

Information to describe the pipeline was compiled from three sources: the SACPA Reporting Information System (SRIS) maintained by ADP, the county stakeholder survey conducted by UCLA, and the California Alcohol and Drug Data System (CADDS). The first two of these sources were created specifically for SACPA monitoring and evaluation. The third, CADDS, predates SACPA, having been maintained by ADP since July 1991.

Each data source had unique value in this analysis but was also subject to limitations. To overcome these limitations, the pipeline analysis employed a mix of data taken directly from these sources along with estimates validated across multiple sources when possible. Appendix C enumerates the known limitations of data sources and explains the estimation procedure.

Data limitations

SRIS data were missing or unreliable for a small number of counties in SACPA's second year. Three strategies were utilized to deal with the data problems.

1. For counties missing SRIS referral, assessment, and placement data for SACPA's second year, UCLA substituted numbers provided by counties on the second year's stakeholder survey.
2. For counties missing SRIS and stakeholder survey data, UCLA adjusted SRIS data from SACPA's first year by the percent of change from the first to the second year in the total SACPA client population in CADDS.
3. If SRIS placement data were present but failed a logic check (CADDS client count was much higher than the total shown in SRIS, or SRIS showed more offenders placed than assessed), UCLA substituted numbers from the stakeholder survey.

Estimation procedure

The stakeholder survey asked counties to specify the number of offenders found in court to be eligible for SACPA in its second year. Twenty one counties responded to that question, and the total number of eligible offenders in those counties was 28,232. To arrive at a statewide estimate, UCLA assumed that the 21-county proportion of the statewide total is equal to the 21-county proportion of the statewide population of SACPA offenders in treatment. According to CADDS, offenders from these 21 counties comprised 52% of the

statewide SACPA treatment population during the second year. Hence, the estimated statewide number of offenders found in court to be SACPA-eligible is 54,140.[1]

Counties are asked to report in SRIS the number of offenders who accepted SACPA, i.e., how many eligible offenders chose to participate in SACPA and were referred for assessment? For all 58 counties combined, that total was 51,845 in SACPA's second year. However, some counties may have reported the number of referrals; others, the number of offenders referred. UCLA's stakeholder survey asked counties which number they had reported to SRIS. Of the 42 respondents, 12 (29%) said that they were reporting referrals, while 30 (71%) reported offenders. In counties reporting referrals, any offender who recycled through SACPA (i.e., had two or more separate episodes) during the year would have been counted twice. Hence the raw total in SRIS would be too high as a count of offenders. (The same problem affects interpretation of SRIS data on assessment and treatment placement; see below.) To estimate the number of offenders referred to SACPA, UCLA reduced the statewide SRIS total of referrals by 11% in counties known to be reporting the number of referrals. This percent is based on an analysis of CADDS data showing how many SACPA offenders recycled through treatment during the year. Furthermore, some counties reported more placements than assessment or more assessments than referrals. It was assumed that these counties were reporting events rather than unique clients, and the same adjustment was made. Finally, for counties not reporting whether the numbers represented referrals or offenders, UCLA assumed that 29% of the reported numbers were referrals. Numbers were adjusted downward accordingly. Numbers from counties known to be reporting offenders were not adjusted. After summing the numbers for all counties, UCLA estimated a statewide total of 50,335 offenders referred to SACPA. This estimate includes offenders referred by the court and by parole agents.[2]

Counties are asked to report in SRIS the number of offenders who completed a SACPA assessment. For all 58 counties combined, that total was 44,219. However, again some counties may have been reporting the number of assessments completed; others, the number of offenders assessed. Any offender who recycled through SACPA during the year would have been counted at least twice in the number of assessments. The raw total in SRIS may therefore be too high. Therefore, to estimate the number of offenders assessed, UCLA reduced the statewide SRIS total by 11% in counties reporting the number of assessments. This percent is based on an analysis of CADDS data showing how many SACPA offenders recycled through treatment during the year. For counties not reporting whether the SRIS numbers represented offenders or assessments, UCLA assumed that 29% of the reported numbers were assessments and adjusted downward accordingly. Numbers from counties known to be reporting offenders were not adjusted. The total across all counties was 42,972, including probationers and parolees.

Finally, counties are asked to report in SRIS the number of SACPA offenders placed in treatment. For all 58 counties combined, that total was 38,438. Some counties may have been reporting the number of offenders placed, but others may have been reporting the

[1] 28,232 / .521466 = 54,140.

[2] The SRIS manual defines "referrals" as probationers and parolees sent from the court, probation department, or parole authority.

number of placements. Any offender who recycled through SACPA during the year would have been counted at least twice in the number of placements. In addition, any offender who received treatment at two or more programs during the same SACPA episode may have been counted two or more times in the number of placements. The raw total in SRIS may be too high for these reasons. To estimate the number of offenders placed, UCLA reduced the statewide SRIS total of placements by 24% in counties reporting placements. This reduction accounted for both recycling and multiple treatment placements and was based on the ratio of SACPA admissions to unique SACPA clients shown in CADDS. For counties not reporting whether the numbers represented placements or offenders, UCLA assumed that 29% of the reported numbers represented placements. UCLA adjusted downward accordingly. Numbers from counties known to be reporting offenders were not adjusted. The total across all counties was 35,947, including probationers and parolees.

Appendix D. Multivariate Analysis of Treatment Completion

Chapter 7 included findings on treatment completion among offenders who participated in SACPA in its first year and identified client characteristics associated with treatment completion. This appendix presents findings from a multivariate analysis in which all client characteristics tested in Chapter 7 were employed simultaneously as predictors of completion. The purpose of this analysis was twofold: (1) to determine whether characteristics associated with completion when taken one at a time were uniquely associated with completion when tested as a set; and (2) to clarify the magnitude of differences in completion rates by converting the percentage differences shown in the figures in Chapter 7 to the relative likelihood of treatment completion in each client group.

As in Chapter 7, the most rigorous criterion for success—namely a CADDS discharge record showing "completed treatment"—was employed in the multivariate analysis. These client characteristics, also on record in CADDS, were tested as predictors of completion: race/ethnicity, sex, age, primary drug, years of drug use, frequency of recent drug use, prior treatment experience (any versus none), and referral source (probation or parole). The analytic technique was multivariate logistic regression. The adjusted odds ratio (O.R.) for each characteristic indicates the client's relative likelihood of completion, given that characteristic. Tests of the statistical significance of odds ratios are also provided for readers who wish to see them. However, the analysis was based on the population of SACPA's first-year treatment clients whose CADDS record contained all data needed for this analysis, and the number of such clients was very large (N = 18,617). An odds ratio that is statistically significant might therefore be quite small. The magnitude of the odds ratio is more meaningful.

The analysis confirmed that characteristics individually associated with completion in Chapter 7 were also uniquely associated with completion when tested as a set. Findings also showed that differences cited in Chapter 7, when expressed as odds ratios, appear large enough to warrant attention by policymakers and service providers. Findings are shown in Table D.1.

The adjusted odds ratios for treatment completion were lower for African Americans (O.R. = 0.60), Hispanics (O.R. = 0.85), and Native Americans (O.R. = 0.70) than for Whites (treated as the reference category, O.R. = 1.00) and Asian/Pacific Islanders (O.R. = 1.10). Thus, after adjustment for other characteristics, African Americans were 40% less likely to complete treatment, Hispanics 15% less likely, and Native Americans 30% less likely.

The completion rate was higher among older clients (O.R. = 1.15) and not related to years of drug use (O.R. = 0.99) in the multivariate model. Age and years of use were very highly correlated (r = 0.61), and there was a positive relationship between years of use and treatment completion in a regression analysis excluding age (not shown). Thus the finding in Chapter 7—that completion rates were higher among clients with a longer history of drug use—is correct.

Table D.1. Multivariate Analysis of Treatment Completion Among First-Year SACPA Clients (N = 18,617)	
Variable	Adjusted odds ratios
Sex	
Women	1.00
Men	0.95
Age (continuous)	1.15***
Primary drug	
Marijuana	1.00
Heroin/opiates	0.69***
Methamphetamine	0.88*
Cocaine	0.99
Alcohol	1.34*
Other	1.08
Race/ethnicity	
White	1.00
Hispanic	0.85***
African American	0.60***
Asian	1.10
Native American	0.70**
Other	0.72**
Years used primary drug (continuous)	0.98**
Prior treatment admissions (continuous)	1.00
Referral source	
Parole	1.00
Probation	1.30***
Frequency of primary drug use	
No use	1.00
1-3 times in past month	0.76***
1-2 times in past week	0.66***
3-6 times in past week	0.75***
Daily	0.83***
*p≤ .05; **p≤ .005, ***p≤ .001	

Clients reporting marijuana as their primary drug were treated as the reference category (O.R. = 1.00) in the analysis of primary drug. The adjusted odds ratios for treatment completion were lowest for heroin users (O.R. = 0.69). The odds of completing treatment were about the same for methamphetamine, cocaine, and marijuana users. The table shows a somewhat lower completion rate for methamphetamine users compared to marijuana users, even though bivariate findings in Chapter 7 showed similar completion rates in these two groups. Methamphetamine use was strongly correlated with race/ethnicity (Whites were more likely, and African Americans less likely, to be methamphetamine users). Race/ethnic differences in treatment completion were strong and consistent in both the bivariate and the

multivariate analysis, while the difference between methamphetamine users and marijuana users was small and inconsistent. For this reason, it seems appropriate to rely on the bivariate findings suggesting no difference in completion rates between methamphetamine users and marijuana users.

Clients reporting no use of their primary drug in the past 30 days were treated as the reference category (O.R. = 1.00) in the analysis of frequency of recent use. All clients reporting recent use were less likely to complete treatment (O.R. = 0.66 to 0.83). Differences across categories of drug use frequency are minor. The most meaningful difference is between clients reporting no use and those reporting any use—as highlighted in Chapter 7.

With an adjustment for other characteristics, the analysis confirmed the relevance of referral source. Clients on probation (O.R. = 1.30) were more likely to complete treatment than clients on parole (O.R. = 1.00).

Finally, completion rates were similar for male and female clients and for clients with and without prior treatment experience. These similarities were cited in Chapter 7.

Appendix E. Treatment Duration Among Non-SACPA Clients

Figure E.1
Treatment Duration Among Criminal Justice Non-SACPA Clients by Modality (CADDS), 7/1/01 - 6/30/02
(N = 41,811)

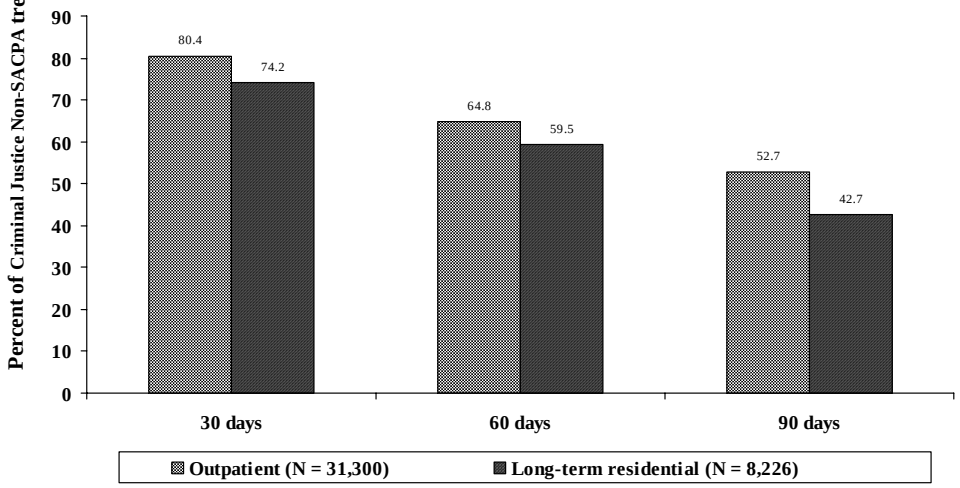


Figure E.2
Treatment Duration Among Criminal Justice Non-SACPA Clients by Race/Ethnicity (CADDS), 7/1/01 - 6/30/02
(N = 41,811)

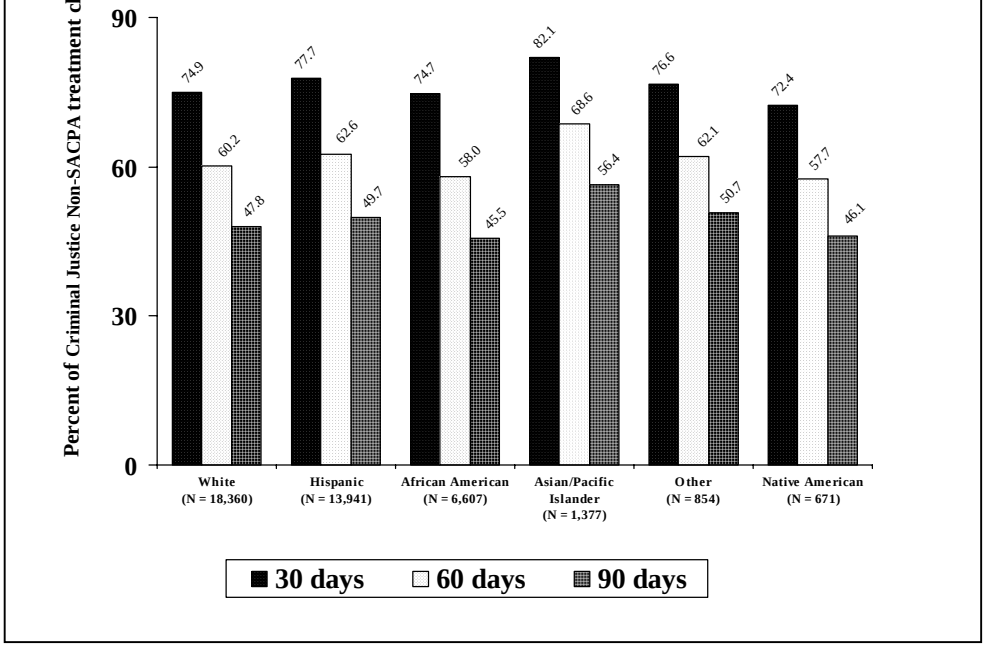


Figure E.3
Treatment Duration Among Criminal Justice Non-SACPA Clients by Sex
(CADDS), 7/1/01 - 6/30/02
(N = 41,811)

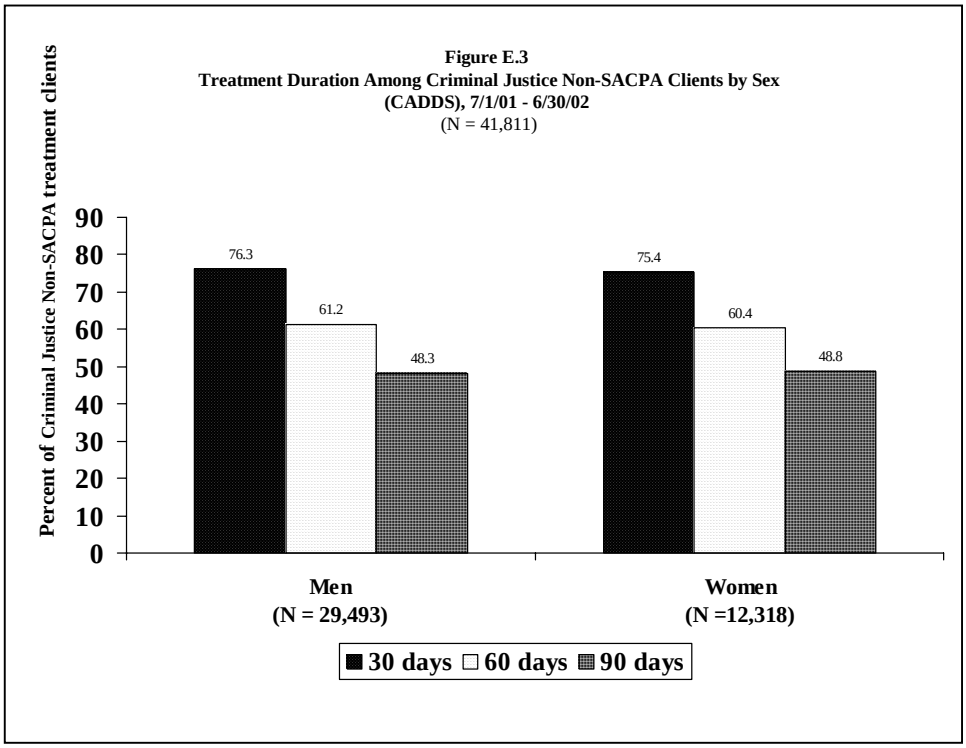


Figure E.4
Treatment Duration Among Criminal Justice Non-SACPA Clients by Age
(CADDS), 7/1/01 - 6/30/02
(N = 41,811)

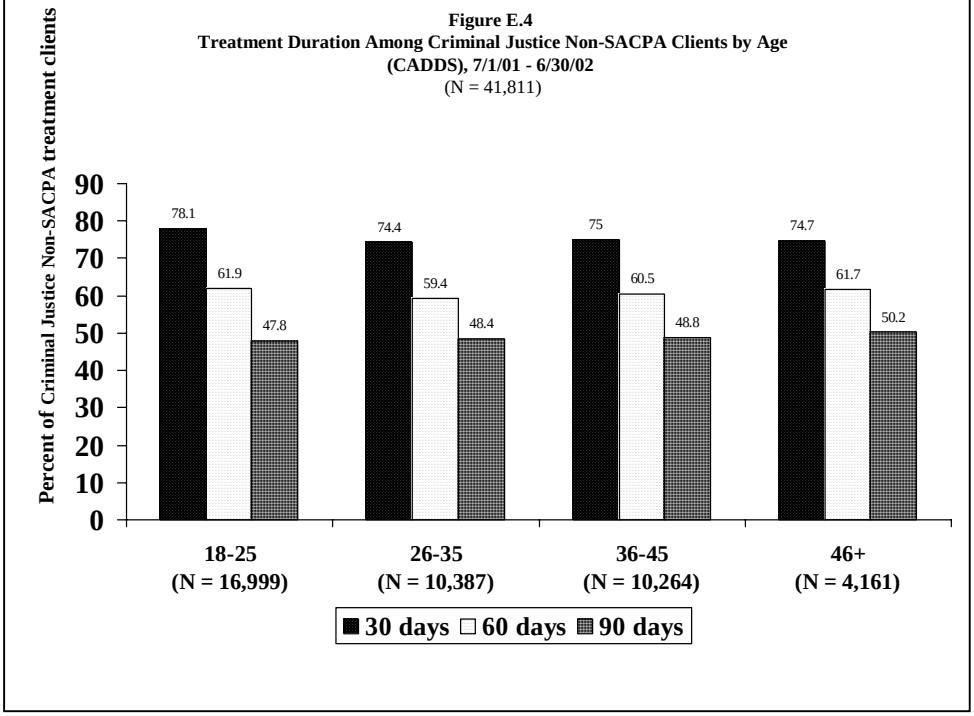


Figure E.5
Treatment Duration Among Criminal Justice Non-SACPA Clients by Primary Drug
(CADDS), 7/1/01 - 6/30/02
(N = 41,811)

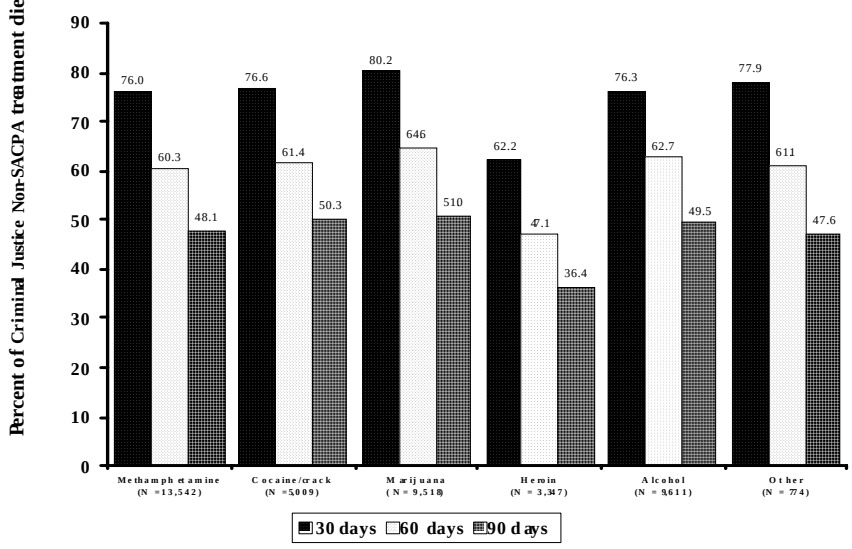


Figure E.6
Treatment Duration Among Criminal Justice Non-SACPA Clients by Years of Use
(CADDS), 7/1/01 – 6/30/02
(N = 41,811)

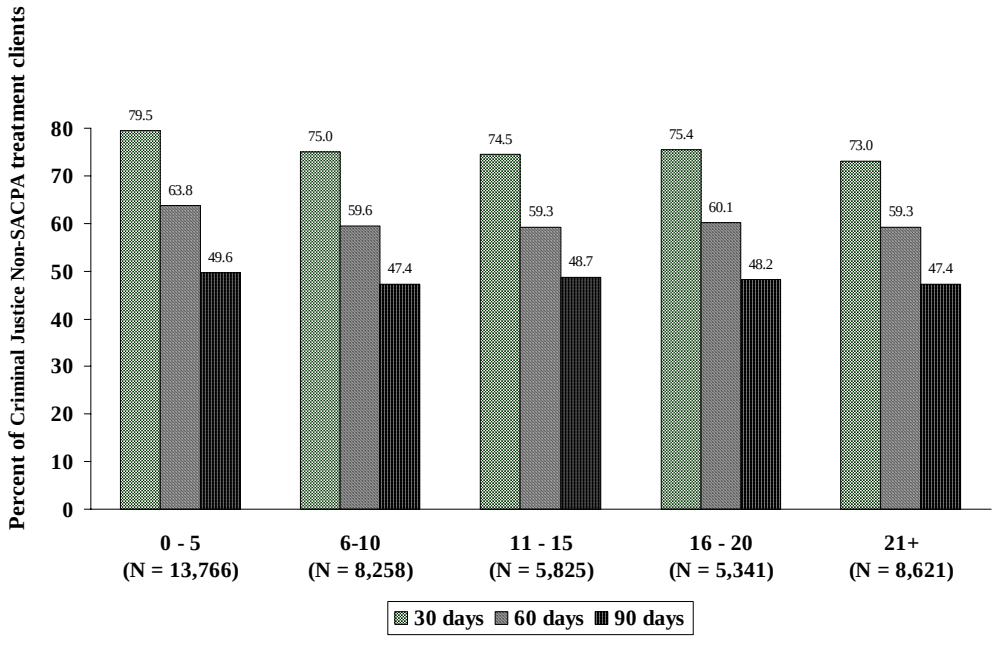


Figure E.7
Treatment Duration Among Criminal Justice Non-SACPA Clients by Frequency of Primary Drug Use in Past 30 Days
(CADDS), 7/1/01 - 6/30/02
(N = 41,811)

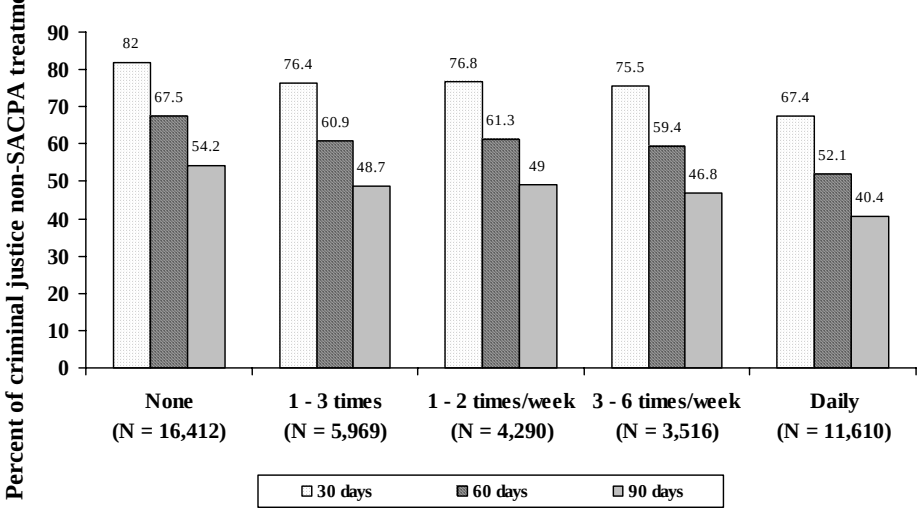


Figure E.8
Treatment Duration Among Criminal Justice Non-SACPA Clients by Prior Treatment Experience
(CADDS), 7/1/01 - 6/30/02
(N = 41,811)

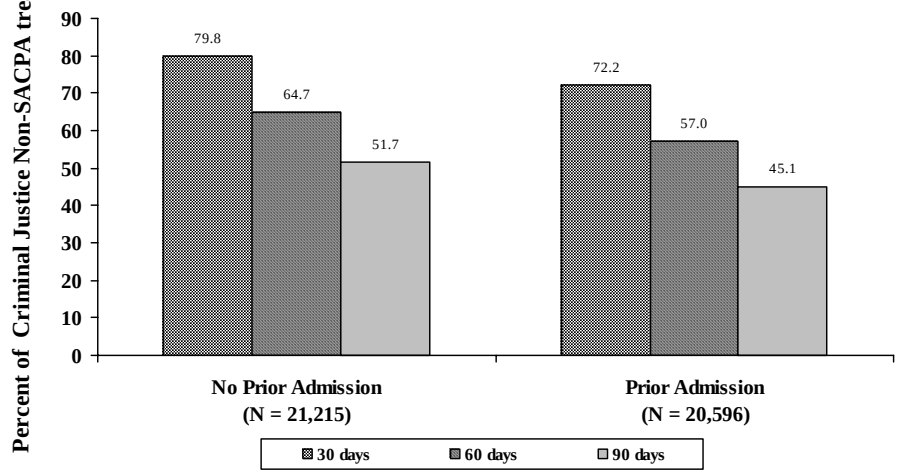


Figure E.9
Treatment Duration Among Non-Criminal Justice Clients by Modality
(CADDS), 7/1/01 - 6/30/02
(N = 79,686)

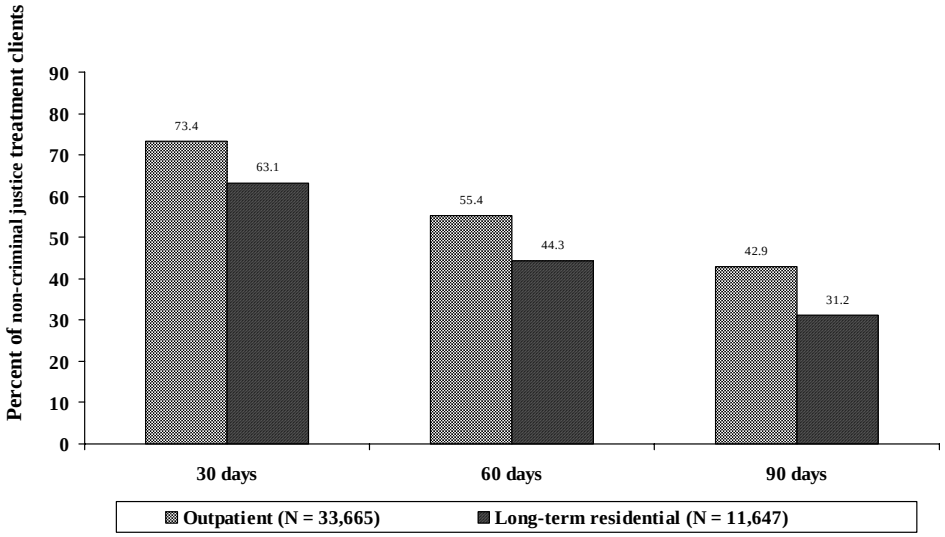


Figure E.10
Treatment Duration Among Non-Criminal Justice Clients by Race/Ethnicity
(CADDS), 7/1/01 - 6/30/02
(N = 79,686)

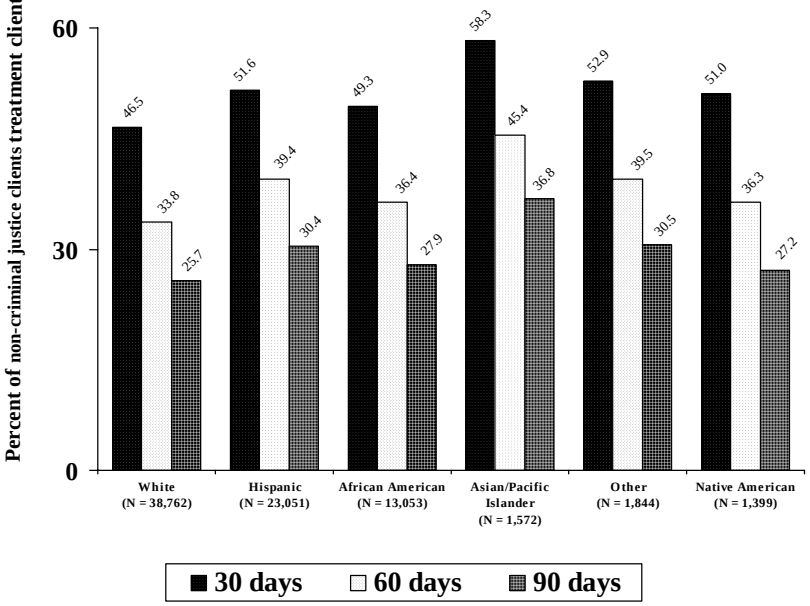


Figure E.11
Treatment Duration Among Non-Criminal Justice Clients by Sex
(CADDS), 7/1/01 - 6/30/02
(N = 79,686)

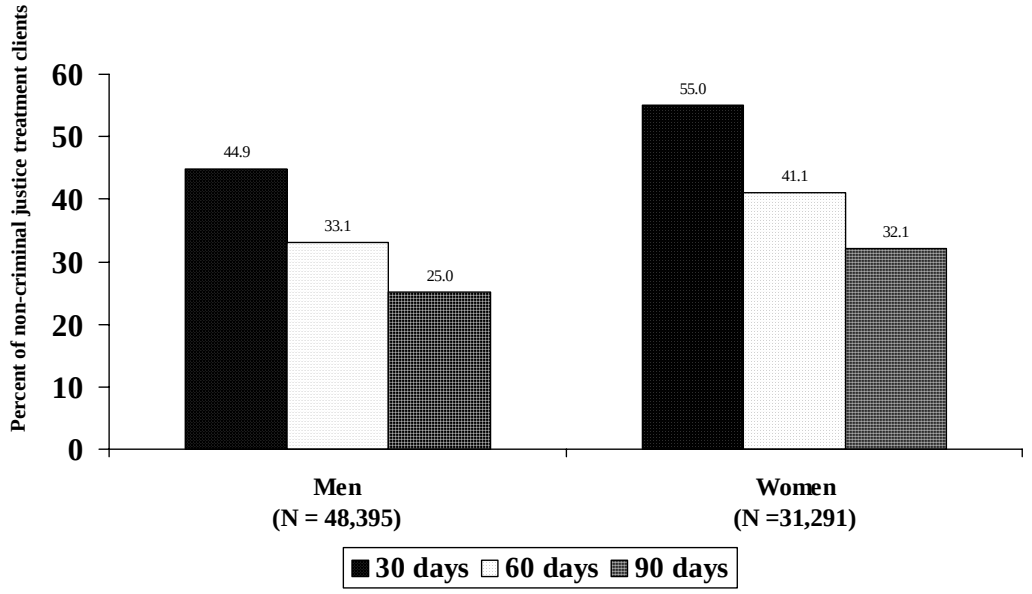


Figure E.12
Treatment Duration Among Criminal Justice Non-SACPA Clients by Age
(CADDS), 7/1/01 - 6/30/02
(N = 79,686)

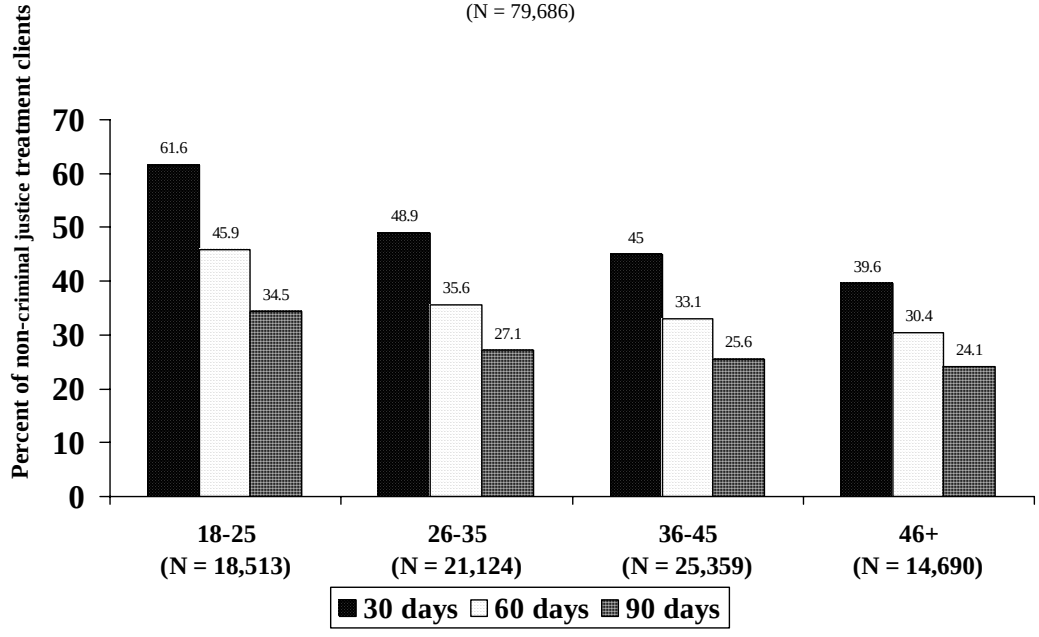


Figure E.13
Treatment Duration Among Non-Criminal Justice Clients by Primary Drug (CADDS), 7/1/01 - 6/30/02
(N = 79,686)

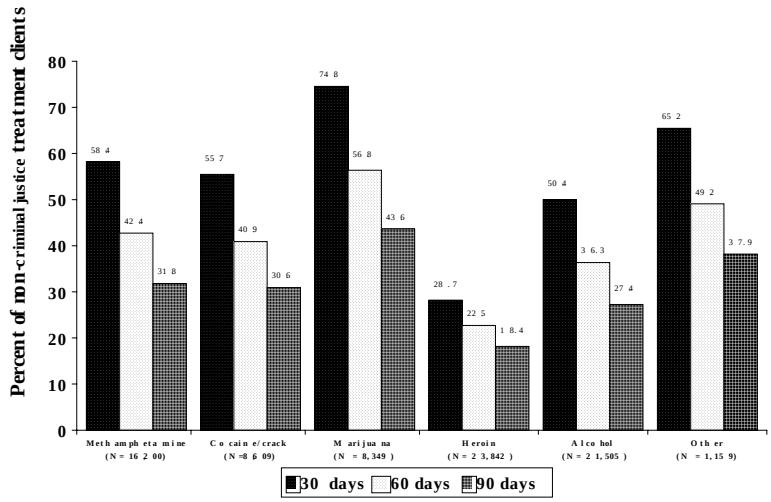


Figure E.14
Treatment Duration Among Non-Criminal Justice Clients by Years of Use (CADDS), 7/1/01 – 6/30/02
(N = 79,686)

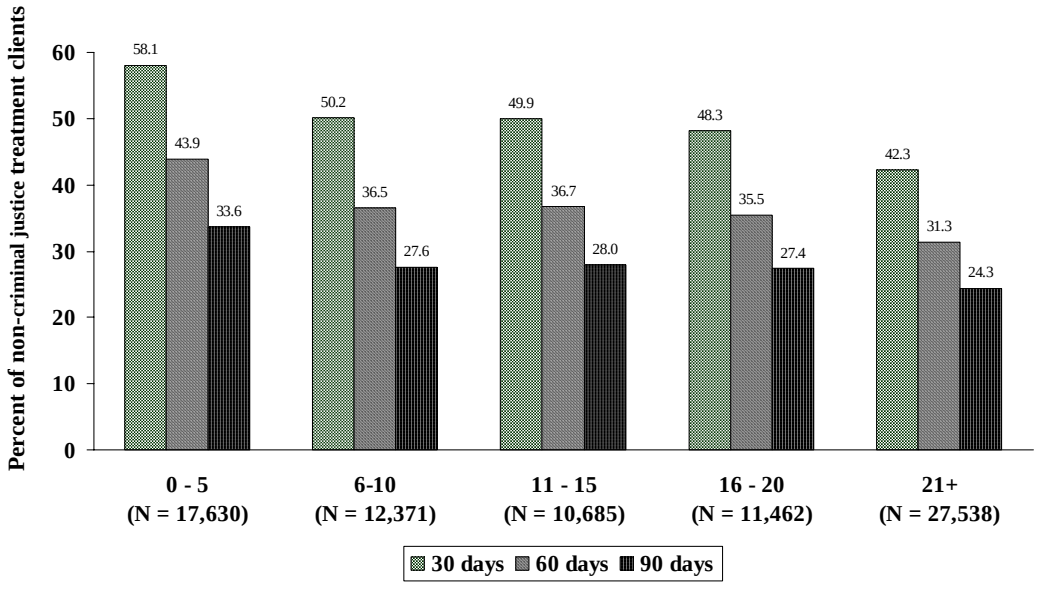


Figure E.15
Treatment Duration Among Non-Criminal Justice Clients by Frequency of Primary Drug Use in Past 30 Days
(CADDS), 7/1/01 - 6/30/02
(N = 79,686)

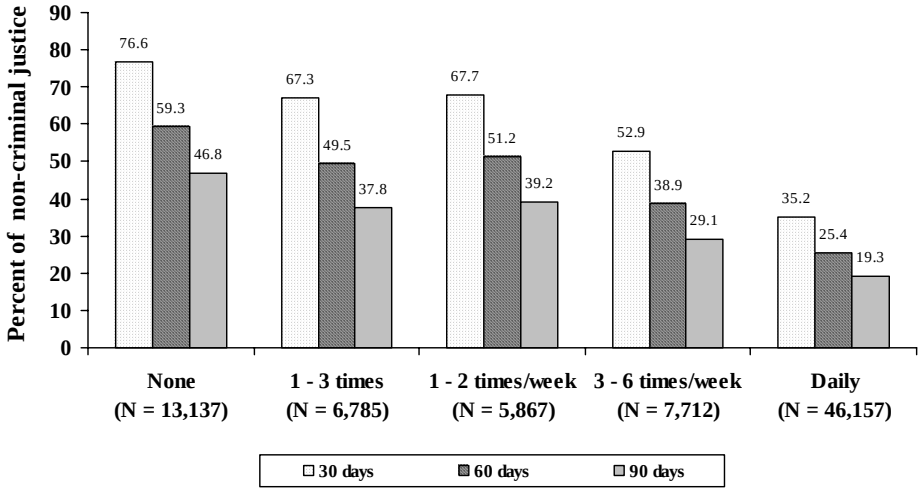
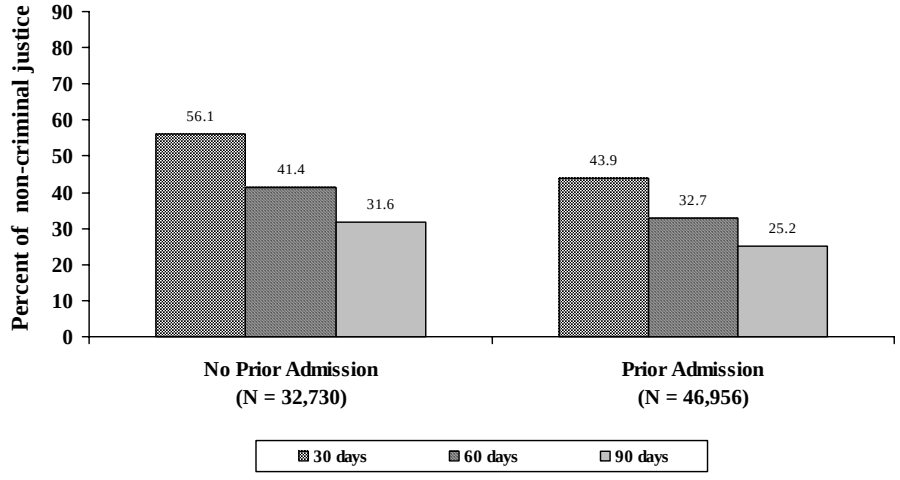


Figure E.16
Treatment Duration Among Non-Criminal Justice Clients by Prior Treatment Experience
(CADDS), 7/1/01 - 6/30/02
(N = 79,686)



References

American Methadone Treatment Association, Inc. *Fact sheet: Why methadone treatment works*. American Association for the Treatment of Opioid Dependence. Retrieved March 31, 2004, from www.aatod.org/factsheet1_print.htm.

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

Anglin, M.D., Prendergast, M.L., Farabee, D., & Cartier, J. (2002). *Final report on the substance abuse program at the California substance abuse treatment facility and state prison at Corcoran: A report to the California legislature*. Sacramento, CA: The California Department of Corrections.

Belenko, S. (2001). *Research on drug courts: a critical review*. New York: The National Center on Addiction and Substance Abuse at Columbia University. Retrieved on April 4, 2004, from http://www.drugpolicy.org/docUploads/2001drugcourts.pdf.

Betancourt, J.R., Green, A.R., Carrillo, J.E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, 118, 293-118.

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

Bonczar, T.P. (1995). Characteristics of adults on probation, 1995 (NCJ 164267). *Bureau of Justice Statistics Special Report.* Washington DC: U.S. Department of Justice. Retrieved on May 27, 2004, from http://www.ojp.usdoj.gov/bjs/abstract/cap95.htm.

California Department of Alcohol and Drug Programs & the Judicial Council of California, Administrative Office of the Courts (2002). *Drug court partnership act of 1998, chapter 1007, statutes 1998, technical report.* Sacramento, CA: Drug Court Partnership. Retrieved on April 9, 2004, from http://www.courtinfo.ca.gov/reference/documents/dc_partnership.pdf.

California Department of Corrections (2004). *Rate of felon parolees returned to California prisons*. Sacramento, CA. Retrieved on May 27, 2004, from http://www.corr.ca.gov/OffenderInfoServices/Reports/Annual/PVRET2/PVRET2d2003.pdf

California Department of Justice (2002). *Crime in California 2002*. Sacramento, CA: Criminal Justice Statistics Center, Bureau of Criminal Information and Analysis. Retrieved on April 9, 2004, from http://caag.state.ca.us/cjsc/publications/candd/cd02/preface.pdf.

California District Attorneys Association. (2001). *Implementing Proposition 36.* Retrieved on April 9, 2004, from http://www.cdaa.org/prop_36.pdf.

California Public Defenders Association. (2001). *Analysis of Proposition 36*. California Public Defenders Association.

Campbell, C.I. & Alexander, J.A. (2002). Culturally competent treatment practices and ancillary service use in outpatient substance abuse treatment. *Journal of Substance Abuse Treatment*, 22, 109-119.

Chaiken, J.M., & Chaiken, M.R. (1982). *Varieties of criminal behavior*. Santa Monica, CA: The RAND Corporation.

De Leon G. (1991). Retention in drug-free therapeutic communities. Pickens R.W., Leukefeld C.G., & Schuster C.R. (Eds.), *Improving drug abuse treatment. NIDA research monograph 106* (DHHS Publication No. ADM 91-1754). Rockville, MD: National Institute on Drug Abuse. Retrieved on April 9, 2004, from http://www.nida.nih.gov/pdf/monographs/download106.html.

Desmond, D.P. & Maddux, J.F. (1995). Compulsory supervision and methadone maintenance. *Journal of Substance Abuse Treatment*, 13 (1), 79-83.

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

Ettner, S.L., Huang, D., Evans, E., Ash, D. R., Hardy, M., Jourabchi, M., & Hser, Y.-I. (2003). Cost-offset in the California Treatment Outcome Project (CalTOP): Does substance abuse treatment "pay for itself?" Manuscript under review.

Fain, T., & Turner, S. (1999). *Evaluation of the Bay Area Services Network*, Presentation to the California Department of Corrections. Santa Monica, CA: RAND Corporation.

Gerstein, D., Dean, R., Johnson, M., Foote, N., Suter, K., Jack, G., et al. (1994). *Evaluating Recovery Services: The California drug and alcohol treatment assessment (CALDATA) methodology report*. Sacramento, CA: California Department of Alcohol and Drug Programs.

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

Gray, M.K., Fields, M., & Maxwell, S.R. (2001). Examining probation violations: Who, what, and when. *Crime & Delinquency*, 47 (4), 537-557.

Hirschi, T. & Gottfredson, M. (1983). Age and the explanation of crime. *American Journal of Sociology*, 89, 552-84.

Hser, Y.I., Evans, E., Teruya, C., Hardy, M., Ettner, S., Urada, D., et al. (2003). *The California Treatment Outcome Project (CalTOP) final report*. Los Angeles, CA: UCLA Integrated Substance Abuse Programs. Retrieved on April 9, 2004, from http://www.uclaisap.org/caltop/index.htm.

Hser, Y.I., Grella, C., Chou, C.P., & Anglin, M.D. (1998). Relationships between drug treatment careers and outcomes. *Evaluation Review*, 22 (4), 496-519.

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

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

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

Hughes, T.A., Wilson, D.J., & Beck, A.J. (2001). Trends in state parole, 1990-2000 (NCJ 184735). *Bureau of Justice Statistics Special Report*. Washington DC: U.S. Department of Justice. Retrieved on May 27, 2004, from http://www.ojp.usdoj.gov/bjs/abstract/tsp00.htm.

Katz, E.C., Brown, B.S., Schwartz, R.P., Weintraub, E., Barksdale, W., & Robinson, R. (2004). Role induction: A method for enhancing early induction in outpatient drug-free treatment. *Journal of Consulting and Clinical Psychology*, 72 (2), 227-234.

Kirby, K.C., Marlowe, D.B., Lamb, R.J., & Platt, J.J. (1997). Behavioral treatments of cocaine addiction: Assessing patient needs and improving treatment entry and outcome. *Journal of Drug Issues*, 27 (2), 417-429.

Longshore, D., Hsieh, S., Anglin, M.D., & Annon, T.A. (1992). Ethnic patterns in drug abuse treatment utilization. *The Journal of Mental Health Administration*, 19 (3), 268-277.

Longshore, D., Turner, S., & Fain, T. (2004). Effects of case management on parolee misconduct: The Bay Area Services Network. *Criminal Justice and Behavior*, 34: 333-350.

Marlowe, D. B. (2002). Effective strategies for intervening with drug abusing offenders. *Villanova Law Review*, 47 (4).

Mathias, R. (1997). NIH panel calls for expanded methadone treatment for heroin addiction. *NIDA Notes*, 12 (6). Retrieved on March 31, 2004, from www.drugabuse.gov/NIDA_Notes/NNVol12N6/NIHPanel.html.

Mayzer, R., Gray, M.K., & Maxwell, S.R. (2004). Probation absconders: A unique risk group? *Journal of Criminal Justice*, 32, 137-150.

McLellan, A. T., Kushner, H., Metzger, D., Peters, R., Smith, I., Grissom, G., et al. (1992). The fifth edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment*, 9, 199-213.

McLellan, A. T., Luborsky, L., Woody, G. E., & O'Brien, C. P. (1980). An improved diagnostic evaluation instrument for substance abuse patients: The Addiction Severity Index. *Journal of Nervous and Mental Disease*, 168, 26-33.

McLellan AT, Woody GE, Metzger D. (1996). Evaluating the effectiveness of addiction treatments: reasonable expectations, appropriate comparisons. *Milbank Quarterly*, 74, 51-85.

Musheno, M.C., Palumbo, D.J., Maynard-Moody, S., & Levine, J.P. (1989). Community corrections as an organizational innovation: What works and why. *Journal of Research in Crime and Delinquency*, 26, 136-167.

National Institute on Drug Abuse (1999). *Principles of drug addiction treatment* (NIH Publication No. 99-4180). Washington DC: National Institutes of Health. Retrieved on April 9, 2004, from http://www.nida.nih.gov/PODAT/PODATindex.html.

National Institutes of Health Consensus Conference (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association*, 280 (22), 1936-1943. Retrieved on April 9, 2004, from http://odp.od.nih.gov/consensus/cons/108/108_intro.htm.

Nolan, J.L. (2002). *Drug courts in theory and in practice*. Hawthorne, New York: Walter de Gruyter, Inc.

Paniagua, F.A. (1994). *Assessing and treating culturally diverse clients: A practical guide*. Thousand Oaks, CA: Sage Publications.

Petersilia, J. & Turner, J. (1986). *Prison versus probation in California: Implications for crime and offender recidivism*. Santa Monica, CA: The RAND Corporation.

Prendergast, M., Hall, E., & Wexler, H. (2003). Multiple measures of outcomes in assessing a prison-based drug treatment program. *Journal of Offender Rehabilitation*, 37 (3-4), 65-94.

Rawson, R. A., Gonzales, R., & Brethen, P. (2002). Treatment of methamphetamine use disorders: an update. *Journal of Substance Abuse Treatment*, 23, 145-150.

Rempel, M. & Fox-Kralstein, D., Cissner, A., Cohen, R., Labriola, M., Farole, D., et al. (2003). *The New York State adult drug court evaluation: Policies, participants and impacts*. New York: New York State Unified Court System and the U.S. Bureau of Justice Assistance, Center for Court Innovation. Retrieved on April 9, 2004, from http://www.courtinnovation.org/pdf/drug_court_eval_exec_sum.pdf.

Resnicow, K. & Braithwaite, R.L. (2001). Cultural sensitivity in public health. Braithwaite, R.L. & Taylor, S.E. (Eds.), *Health issues in the black community*. San Francisco: Jossey-Bass Publishers.

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

Simpson, D., Joe, G.W., & Brown, B.S. (1997). Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, 11, 300-301.

Simpson, D., Joe, G.W., & Broome, K.M. (2002). A national 5-year follow-up of treatment outcomes for cocaine dependence. *Archives of General Psychiatry*, 59, 538-544.

Simpson, D., Joe, G.W., Fletcher, B.W., Hubbard, R.L., & Anglin, M.D. (1999). A national evaluation of treatment outcomes for cocaine dependence. *Archives of General Psychiatry*, 57, 507-514.

Smedley, B.D., Stith, A.Y., & Nelson, A.R. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: The National Academies Press.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2002). *Treatment Episode Data Set (TEDS): 1992-2000. National admissions to substance abuse treatment services* (Publication No. SMA 02-3727). Rockville, MD: Department of Health and Human Services. Retrieved on April 9, 2004, from http://wwwdasis.samhsa.gov/teds00/TEDS_2k_index.htm.

Sutton, J. H. (1994). Children in the therapeutic state: Lessons for the sociology of deviance and social control. In G. S. Bridges, & M.A. Myers. (Eds.). *Inequality, Crime, and Social Control*. San Francisco: Westview.

Tauber, J.T. & Huddleston, C.W. (1999). *DUI/drug courts: Defining a national strategy*. Alexandria, VA: National Drug Court Institute, U.S. Department of Justice. Retrieved on April 8, 2004, from http://www.ndci.org/dui.pdf.

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

Tucker, M.B. (1985). U.S. ethnic minorities and drug abuse: An assessment of the science and practice. *International Journal of the Addictions*, 20 (6&7), 1021-1047.

Wolf, E.M. (2002). Systematic constraints on the implementation of a northeastern drug court. James L. Nolan, Jr. (Ed.), *Drug Courts in Theory and in Practice*. Hawthorne, New York: Walter de Gruyter, Inc.

Wolfgang, M., Figlio, R., & Thorsten, S. (1972). *Delinquency in a birth cohort*. Chicago: University of Chicago Press.