TREATING DRUG-ABUSING OFFENDERS

Initial Findings From a Five-County Study on the Impact of California's Proposition 36 on the Treatment System and Patient Outcomes

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Five counties (Kern, Riverside, Sacramento, San Diego, San Francisco) that demonstrate both variations and similarities in their implementation of Proposition 36 (e.g., treatment approaches, urine testing) and patient mix have been selected to participate in a study assessing how California's Proposition 36 is affecting the drug treatment system and patient outcomes. Except for San Francisco, treatment admissions increased during the first year of Proposition 36 implementation over the prior year (27% in Kern, 21% in Riverside, 17% in Sacramento, and 16% in San Diego), mostly in outpatient drug-free programs. Compared to non-Proposition 36 patients, Proposition 36 patients were more likely to be men, first-time admissions, treated in outpatient drug-free programs, employed full-time, and users of methamphetamine or marijuana. They were less likely to be treated in residential programs or methadone maintenance programs and fewer reported heroin use or injection drug use. Guided by the multilevel open systems framework, the study examines key issues of Proposition 36 that influence treatment systems and outcomes and empirically identifies "best practice" approaches in treating drug-abusing offenders.

Keywords: *drug-abusing offenders; California Proposition 36; drug treatment system; criminal justice system; patient outcome*

In November 2000, California voters approved the Substance Abuse and Crime Prevention Act of 2000, also known as Proposition 36. This act allows (under certain conditions) adults convicted of nonviolent drug possession

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offenses to choose drug treatment in the community in lieu of incarceration. Offenders on probation or parole who commit nonviolent drug possession offenses or who violate drug-related conditions of probation or parole can also receive treatment. The impact of Proposition 36 on the criminal justice system and on the substance abuse treatment system will most likely have far-reaching and profound long-term implications for policy and practice at the national, state, and local levels. California has 58 counties, each implementing Proposition 36 under local control. Although the initiative mandates a statewide evaluation of its fiscal impact and effectiveness, it does not provide for an in-depth investigation of its effect on local drug treatment service delivery systems, the response of the systems, and treatment outcomes. However, such knowledge is critical to our understanding of issues surrounding the treatment of this large drug-using offender population and to the development and wide implementation of effective treatment strategies and policies.

This article describes a five-county study currently being conducted that has been designed to provide critical information on the effects of Proposition 36 on the treatment system and patient outcomes. The study takes advantage of treatment program and patient outcome data that were collected prior to the implementation of Proposition 36 to serve as a baseline or benchmark for comparisons with data to be collected by the present study. To provide the context within which Proposition 36 has been implemented, we first review the literature on the current knowledge of the relationship between drugs and crime, as well as the treatment of drug-abusing offenders in community-based treatment programs. We then discuss California's changing treatment service delivery system and present the conceptual framework that guides the study while highlighting the issues to be addressed. Finally, we describe the five participating counties and the initial findings about the impact of Proposition 36 approximately one year after the initiative was implemented.

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THE TREND TOWARD COMMUNITY-BASED TREATMENT FOR OFFENDERS

Criminal justice system and drug treatment policies typically are not determined directly by popular vote. In Arizona and California, however, public dissatisfaction with existing policies led advocates to propose and voters to approve state initiatives requiring mandatory treatment in lieu of incarceration for drug-abusing offenders. Similar efforts are under way in other states. Although unusual, this movement could be seen as the result of trends developing over the past 25 years.

The use of illicit drugs and alcohol has been at the center of pressing discussions over rising incarceration rates in California as well as across the United States. The National Institute of Justice's Arrestee Drug Abuse Monitoring (ADAM) program has shown that two out of three offenders in Los Angeles, Sacramento, San Diego, and San Jose counties show positive test results for at least one drug at arrest (National Institute of Justice 2000). California, with 33 state prisons, has more individuals under correctional supervision (i.e. prison and parole) than any other state. As of September 30, 2000, there were 162,533 inmates in California's prison system (California Department of Corrections [CDC] 2000a), representing a 118% increase since 1989. Of these, 28% were incarcerated for an offense involving drugs. Another 21% were incarcerated for a property offense, which in many cases was related to drug use (Lowe 1995). With respect to the parole population, as of September 30, 2000, there were 119,032 individuals on parole in California. Of these, 38% had been incarcerated for a drug offense, and 26% had been incarcerated for a property offense (CDC 2000a). Furthermore, according to the CDC (2000b), of the 67% of the individuals entering the state's prison system in 1999 as parole violators, 55.5% of them were returned to custody for a drug-related offense (i.e. either a new offense conviction or a parole violation). These large percentages of substance abuse-related convictions contributed to the high costs associated with incarceration and have increased the drain on public resources. The passage of Proposition 36 by California's voters clearly highlights the demand for treatment for drug-abusing offenders as a cost-saving and crime-abating alternative to incarceration.

Meanwhile, over the past 30 years, the need to provide effective treatment as a means of weakening or severing the connection between drug use and crime has been explicated in original research studies and comprehensive reviews (Anglin and Perrochet 1998; Ball et al. 1981; Chaiken 1986; Chaiken and Chaiken 1990; McBride and McCoy 1993; Speckart and Anglin 1985, 1986; Tonry and Wilson 1990). Drug users, especially heavy users, commit a disproportionate amount of crime (Chaiken and Chaiken 1982; Johnson et al.

1985); however, many drug-abusing offenders have not received treatment. ADAM results for Los Angeles County in 1997 indicated that less than 15% of arrestees reported receiving prior treatment for drug or alcohol abuse (National Institute of Justice 1998). By contrast, according to a Bureau of Justice Statistics (BJS) report (1999, Table 8) concerning inmates of state prisons in the United States, 41% of the state prisoners with histories of alcohol or drug use reported previous participation in drug or alcohol treatment, with 18% having participated in treatment while on probation or parole. Further complicating the picture, the percentage of inmates participating in treatment while in state prisons dropped from about 24.5% in 1991 to about 9.7% in 1997 (BJS, 1999), although other data suggest that treatment availability for offenders has been increasing in recent years (Camp and Camp 1998).

Substance abuse treatment has consistently demonstrated its effectiveness through declines in the substance abuse and criminal activity of drug offenders (Anglin and Perrochet 1998; Chaiken and Chaiken 1990; Fagan 1990; Farabee, Joshi, and Anglin 2001; McBride and McCoy 1993; Parker and Auerhahn 1998; Peyton and Gossweiler 2001; Speckart and Anglin 1985, 1986; White and Gorman 2000). During the past few decades, the criminal justice system has been searching for cost-effective means of increasing the provision of treatment to this large population. Several programs have been implemented in an attempt to reduce recidivism rates. For example, for nearly 30 years, the nationwide Treatment Alternatives to Street Crime (TASC) programs have established and facilitated the coordination between the criminal justice and drug treatment systems at the local level to offer drug-using offenders the opportunity to enter community-based treatment in lieu of, or as a supplement to, criminal justice sanctions and procedures (Anglin, Longshore, and Turner 1999; Wellisch, Prendergast, and Anglin 1993). The passage of Arizona's Drug Medicalization, Prevention and Control Act of 1996 (Proposition 200) provides court-supervised community-based drug treatment and education programs for nonviolent persons who are convicted of personal possession or use of drugs. Over the past decade, the California legislature has funded a substantial increase in the number of prison-based treatment programs based on the therapeutic community model. In 1990, there was one such program, which had 200 beds; now there are 33 programs, with a total of about 8,000 beds. In addition, graduates of the prison-based programs are eligible for up to 6 months of community treatment while on parole.

Concomitantly, the national drug court movement, which began in 1989 in Florida, has expanded to more than 483 adult drug courts in all 50 states (operating or in development), with an additional 257 in the planning stages (Belenko 2001). The total estimated number of individuals who have been

enrolled in adult drug court programs is 226,000, and the estimated number of graduates as of June 2001 was 74,000. Currently in California, there are approximately 120 drug courts in operation. Drug courts provide a mechanism for providing offenders access to community-based treatment while minimizing the use of incarceration, thereby integrating treatment with criminal justice supervision (Peyton and Gossweiler 2001).

The passage of California's Proposition 36 by 61% of California voters underscores the trend toward community-based, court-monitored treatment for drug-involved offenders as a less punitive, potentially more efficacious, and cost-effective means of weakening the connection between drugs and crime. Policymakers, criminal justice system personnel, and the public at large will be turning their attention toward California, which has the largest prison system and one of the most expansive drug treatment systems in the nation. Lessons learned from the implementation and outcomes of Proposition 36 will undoubtedly play a crucial role in terms of whether support for the legislation will be continued and whether other states will be prompted to enact similar laws and programs. Given the large number of offenders being diverted to treatment and the substantial funding dedicated to the program ($60 million for the 2000-01 fiscal year and $120 million each year until the 2005-06 fiscal year), Proposition 36 promises to have an immediate, significant, and far-ranging impact on both the criminal justice and drug treatment delivery systems.

THE NEED FOR ASSESSING THE IMPACT OF PROPOSITION 36 ON DRUG TREATMENT SERVICE DELIVERY IN CALIFORNIA

Proposition 36 represents a major experiment that may affect the quantity and quality of drug treatment, with tremendous implications for various groups of stakeholders across the state and, indirectly, across the country. According to a RAND report analyzing the key issues and questions surrounding Proposition 36, some important potential impacts are changes in the client mix, treatment capacity, quality of treatment, and affordability of treatment (Riley et al. 2000). California has one of the largest drug treatment systems in the nation, with more than 900 community-based programs serving approximately 250,000 patients annually (Hser et al. 1998). In a recent survey (Hser et al. 1998) that examined 463 drug treatment programs in California (60 residential, 192 outpatient drug free, 118 day treatment, and 93 methadone maintenance), the most common primary drugs used by these patients were alcohol, cocaine/crack, amphetamines (including methamphetamine), and heroin. Many patients were under some form of legal

supervision—from 19.8% of patients in methadone maintenance to 48.4% in outpatient drug-free programs. The majority of those patients were on probation, although many patients were on parole or under court-ordered diversion to treatment.

Because of the drug treatment system's growing complexity and interconnectedness with other systems such as the criminal justice system, we need to gain a more in-depth understanding of how that system operates and responds to both internal and external demands such as the implementation of new legislation and collaborations. California began implementing Proposition 36 on July 1, 2001, and so far very little is known about how it has affected an already overtaxed treatment service delivery system. A better understanding of the changes taking place at the county and provider levels and of the variability among counties and the providers within the counties would inform the planning and decision-making process of the various stakeholder groups (e.g., criminal justice personnel, county administrators, individual treatment providers, and public policy makers) within the state as well as in other states that are considering similar initiatives.

Furthermore, although prior drug policies and programs have affected treatment delivery across the country, little is known about their consequences. For example, Arizona's Proposition 200 is similar in some aspects to California's Proposition 36, but relatively little information has been published to inform California's implementation, particularly in terms of its impact on the treatment system. Similarly, despite the evaluation studies conducted on TASC (e.g., Anglin, Longshore, and Turner 1999) and on drug courts (e.g., Feinblatt, Berman, and Fox 2000; U.S. Department of Justice 1998; Prendergast and Maugh 1995), the effects of these innovations on counties and treatment providers are not documented. Notably, the present study will glean lessons from the study of the impact of Proposition 36 on the treatment delivery system, providing heretofore unavailable information useful to treatment planners and providers.

A MULTILEVEL "OPEN SYSTEMS" FRAMEWORK

The treatment service delivery system, which comprises counties and treatment providers, can be conceptualized as a multilevel "open system," a framework useful in examining how organizations respond to a changing external environment. The open systems perspective, derived from biology, builds on the principle that organizations, like organisms, are open to environmental influences, rather than being isolated from them, or "closed," as in a mechanical system (Katz and Kahn 1966; von Bertalanffy 1956, 1968).

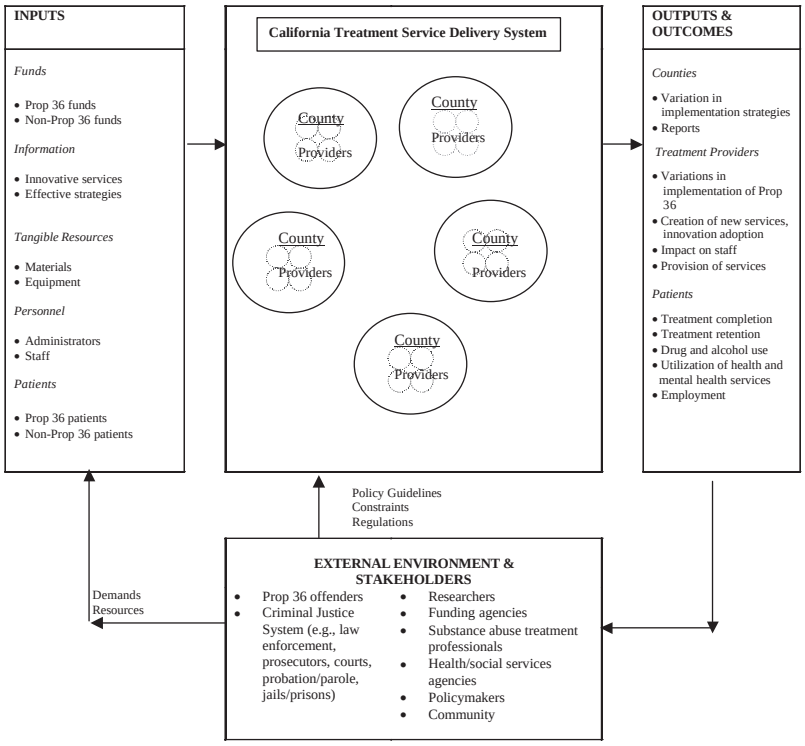

Figure 1: Multilevel "Open Systems" Framework

This conceptual framework is shown schematically in Figure 1. As an open system, the treatment service system continually strives to strategically adapt to changes within its external environment.

The drug treatment system draws on the environment for inputs such as funding, patients, and information. These inputs are "transformed" through the treatment process. The treatment service delivery system creates outputs such as outcome data for patients in recovery and treatment that affect, or are used by, the larger environment. The environment, however, is not simply passive in this exchange. Changes and stresses in parts of the environment occurring outside the treatment service delivery system (such as the passage of Proposition 36 in California) may create demands and constraints that affect the system's internal processes. Similarly, the outputs from the treatment system may have significant effects on the environment causing it to react in ways that again affect the system (feedback loops).

There are several important characteristics of open systems. One of them is that they follow the principle of equifinality, whereby there are multiple ways of reaching the same goals or end states (Katz and Kahn 1966). Thus it is important to examine the variations across counties and across providers within each county. Another characteristic of an open system is homeostasis, which refers to the organization's ability to regulate itself based on information from the environment (Morgan 1986). For example, the treatment system's ability to adapt to external changes such as Proposition 36 can determine whether it can successfully accommodate Proposition 36 offenders. Finally, the treatment system can be conceptualized as comprising subsystems (Scott 1992). The various counties and providers are interrelated subsystems enabling the system to function. It is important to examine the multilevel relationships between these counties and their providers and other social service systems outside the treatment system, such as the criminal justice system. Although these units can vary in terms of their inputs, internal processes, and outputs, each contributes toward the goal of providing treatment services for substance-abusing patients.

We use the open systems framework to conceptually organize the components of the study and highlight the dynamic nature of the phenomena being examined, namely, the implementation of Proposition 36 in five diverse counties in California. Using this framework as a guide, we focus our investigation on changes in the treatment system, including environmental context (e.g., economic, social, political), organizational characteristics of the participating counties and providers serving Proposition 36 offenders (e.g., treatment capacity, staffing, services, patient base, structure, culture), the organizational change process within each of these units, and the systemic changes that occur as a result of the implementation of Proposition 36. Because collaboration between the treatment service delivery system and other key stakeholder groups (e.g., community entities) is needed to fulfill the requirements of the initiative, we investigate these dynamic relationships and processes, especially focusing on the criminal justice system. We also examine the related patient, treatment provider, and county outcomes (e.g., treatment completion and retention, provision of new treatment services).

A FIVE-COUNTY STUDY TO ASSESS TREATMENT SYSTEM IMPACT

Implementation of Proposition 36 began on July 1, 2001, in 58 California counties, each having been granted local control of their programs. Hence, much diversity can be seen across counties. We are currently conducting a nonexperimental 5-year study in five diverse counties to assess the impact of

Proposition 36 on the drug treatment delivery system in California and evaluate the effectiveness of services delivered to the Proposition 36 patients within the context of the countywide system of treatment service delivery. Both quantitative and qualitative methods will be used. The study is guided by a Steering Committee of individuals from key stakeholder groups (e.g., administrators from the participant counties) and includes data collection through personal interviews, focus groups, surveys, client assessment, and administrative data records. The development of our instruments for administrator interviews, program surveys, focus group discussion, and client assessments is guided by the issues and factors identified by our multilevel open system framework previously discussed. We describe characteristics of the five chosen counties and report the initial findings from this study below.

STUDY COUNTIES

The project formed a partnership with five diverse California counties. We decided that random sampling of counties is neither practical nor applicable as each of the 58 counties has distinctive Proposition 36 implementation policies and procedures as well as patient mixes. Instead, to efficiently use research resources to maximize the usefulness of the findings from the cross-county comparisons, the counties were selected according to factors that have been hypothesized to influence the impact of Proposition 36 on the drug abuse treatment system. We first narrowed the counties down to the 13 counties that are participating in the California Treatment Outcome Project (CalTOP),[1] as they had already provided baseline data (one year prior to Proposition 36 implementation) on program type, services, cost, and patient outcomes, with which the present study's results can be compared to assess changes. The second criterion applied in the county selection process was whether there were sufficient Proposition 36 cases (e.g., more than 100 in the first year of implementation) to allow for the measurement of significant system impact. The third criterion used was the variation across the selected counties in Proposition 36 implementation strategies or policies (e.g., treatment approach, drug testing policy, handling of patients with co-occurring mental disorders)[2] that may have important implications for the county's drug treatment system and patient outcomes. Together, the five chosen counties, Kern, Riverside, Sacramento, San Diego, and San Francisco, represent variation in terms of being urban or rural, geographic location in the state (north, central, south), size of the county population (e.g., large, small), and implementation strategies (e.g., requiring urine testing or not). This diversity will not only allow us to investigate variations of substantive interest but will

also increase the generalizability of the study results. Because all selected counties have participated in CalTOP, they have experience contributing to research efforts, including data collection. Table 1 presents general characteristics of the five participating counties.

Kern County is located in California's great Central Valley and is the gateway to Southern California, the San Joaquin Valley, and California's High Desert. It is California's third-largest county in land area, at 8,141 square miles, but is among the least densely populated, with 662,000 residents. Census 2000 data indicate a demographic distribution as follows: 50% white, 38% Hispanic, 6% African American, 3% Asian, 2% Native American, and 1% other; 49% of the residents are female. Less than a majority of voters (47%) in this county voted in favor of Proposition 36.

Riverside County is a semi-urban area covering more than 7,200 square miles of river valleys, low deserts, mountains, foothills, and plains in the southeastern region of the state. The county has more than 1.5 million residents. Census 2000 data indicate a demographic distribution as follows: 51% white, 36% Hispanic, 6% African American, 4% Asian, 1% Native American, and 2% other; 50% of the residents are female. A total of 56% of the residents voted for Proposition 36.

Sacramento County encompasses 966 square miles in California's Central Valley. Nearly half of the county's 1.2 million residents live in unincorporated areas, a situation unique among California's urban counties. Census 2000 data indicate a demographic distribution as follows: 58% white, 16% Hispanic, 10% African American, 11% Asian, 1% Native American, and 4% other; 51% of the residents are female. A total of 56% of the residents voted for the initiative.

San Diego County is an urban area stretching along California's border with Mexico and is home to more than 2.8 million people. Census 2000 data indicate a demographic distribution as follows: 55% white, 27% Hispanic, 6% African American, 9% Asian, 1% Native American, and 2% other; 50% of the residents are female. A total of 56% of the residents voted for the proposition.

San Francisco County is a large urban county located in northwestern California. More than 777,000 people live in this area, and Census 2000 data indicate a demographic distribution as follows: 44% white, 14% Hispanic, 8% African American, 31% Asian, 4% Native American, and 2% other; 49%

TABLE 1: County Characteristics

	Kern	*Riverside*	*Sacramento*	*San Diego*	*San Francisco*
Geographic location in California	Central	Southern	Northern	Southern	Northwestern
Geographic size (in square miles)	8,141	7,207	966	4,225	47
Population size in 2000 census[a]	662	1,545	1,223	2,813	777
Demographics (%)					
Female	49	50	51	50	49
White	50	51	58	55	44
African American	6	6	10	6	8
Latino/Hispanic	38	36	16	27	14
Asian/Pacific Islander	3	4	11	9	31
Native American	2	1	1	1	<1
Other	1	2	4	2	2
Vote for Proposition 36 (%)	47	56	56	56	76

a. In 1,000.

of the residents are female. A much higher percentage of voters (76%) in San Francisco County voted for the initiative, compared to the other four counties in the study and to the state overall (61%).

FINDINGS DURING THE FIRST YEAR OF PROPOSITION 36 IMPLEMENTATION

The following are our initial findings on the California Proposition 36 implementation from these five counties, including their implementation strategies, patient populations served during the year before and after July 1, 2001, when Proposition 36 was implemented, and Proposition 36 patients compared to non-Proposition 36 patients treated during the first year of implementation. Three important research questions in this initial stage of the study are addressed: (a) How do counties vary in their implementation of Proposition 36? (b) Did the patient mix in the county treatment population change during the first year of Proposition 36 implementation? (c) How do Proposition 36 patients differ from non-Proposition 36 patients? Information on implementation was obtained from surveys, personal communications, and county reports. Patient characteristics were based on data collected in the

California Alcohol and Drug Data System (CADDS), which contains admission and discharge records of all patients admitted to alcohol and drug programs that receive public funding or to private methadone programs licensed by the state. We conducted chi-square tests[3] assessing changes in rates, and set a stringent criterion of $p < .001$ for the significance level due to large sample sizes and multiple comparisons.

IMPLEMENTATION

The initiative requires each of the 58 California counties to designate a lead agency to receive and manage the allocated funds for Proposition 36, as well as to be responsible for its implementation. In all five counties participating in this study, the lead agency is the county's alcohol and other drug (AOD) administrative agency, but counties vary in the structural location of this agency. In Kern and Riverside counties, the AOD agency is part of the Department of Mental Health, in Sacramento and San Diego, it is under the Department of Health and Human Services, and in San Francisco, it is under the Department of Public Health (see Table 2).

Treatment approaches. Treatment approaches for Proposition 36 patients also vary across counties. Most counties describe their treatment approaches in terms of levels of treatment, but each county defines levels of treatment differently and San Diego County has decided not to classify treatment by levels of intensity (see Table 2). Generally speaking, treatment approaches appear to be characterized by modality and duration. San Diego has a separate category for individuals with co-occurring mental disorder. Noticeably, Kern does not include methadone maintenance programs for Proposition 36 patients, and San Diego does not fund nor contract for methadone (detoxification and maintenance) programs for Proposition 36 patients (or any patient), although these programs are available in the county. All five counties use the Addiction Severity Index (ASI) (McLellan et al. 1992) for patient assessment, and most (Kern, Riverside, Sacramento, San Francisco) use the American Society of Addiction Medicine (ASAM) to determine the level of treatment in which the patient will be placed. Some counties (Sacramento, San Francisco) work with a limited number of treatment programs to provide services for their Proposition 36 patients, whereas others (Kern, Riverside, San Diego) have a more distributed system. Only programs that have been certified or licensed by the California Department of Alcohol and Drug Programs are eligible to treat Proposition 36 patients. Examination of counties' treatment options (e.g., methadone programs, dual diagnosis programs) will

TABLE 2: County Implementation of Proposition 36

	Kern	*Riverside*	*Sacramento*	*San Diego*	*San Francisco*
Lead agency	Mental Health Department Substance Abuse System of Care	Department of Mental Health	Department of Health and Human Services Alcohol and Drug Services Division	Health and Human Services Agency, Alcohol and Drug Services	Department of Public Health
Treatment approaches	Level I—education (6 months) Level II—pretreatment (3 months) Level III—outpatient drug-free (ODF) treatment (8 months: 6 months *plus* 2 months aftercare) Level IV—intensive ODF (10 months: 6 months treatment *plus* 4 months aftercare) Level IV(a)—ancillary housing (3 months) Level V—detox/residential (3 to 5 days detox) (up to 45 days residential)	Level I—outpatient education (4 months) Level II—outpatient treatment (4 months) Level III—intensive (up to 6 months) Detox (3 to 7 days) Residential (1 to 3 months) Day treatment (4 months) Methadone detox/ Methadone maintenance (up to 1 year) *Plus* 3 to 6 months aftercare	Level I—outpatient (3 months *plus* 3 months aftercare) Level II—outpatient (6 months *plus* 3 to 6 months aftercare) Level II(a)—Methadone (21 days detox and Methadone maintenance) Level III (3 to 6 months) Day treatment Residential (30 to 90 days) Detox (7 to 14 days)	Nonresidential (3 to 12 months *plus* 3 months aftercare) Residential (3 to 12 months *plus* 6 months aftercare) Detox (5 to 14 days *plus* transfer) Dual diagnosis Nonresidential (up to 12 months *plus* 6 months aftercare)	Education Outpatient (3 to 6 months *plus* aftercare) Day treatment (3 to 6 months *plus* aftercare) Residential (3 to 6 months *plus* aftercare) Methadone maintenance (3 to 6 months *plus* aftercare)

(continued)

TABLE 2 (continued)

	Kern	*Riverside*	*Sacramento*	*San Diego*	*San Francisco*
Drug testing					
Treatment	On suspicion	On suspicion	Random	Random	No
Probation	Random	Random	Random	Limited on court days	No
Dual diagnosis (DD)	Screens for mental health (MH) problems and refers out for MH services if needed	Uses a mobile DD intensive case management team Provides MH stabilization services prior to long-term (Level III) treatment	Screens for MH problems and refers out for MH services if needed	DD treatment provided for up to 12 months (nonresidential) and up to 6 months of aftercare MH treatment for Veterans through VA	Specialized pretreatment groups for DD during assessment referral process

provide opportunities for direct contrast of their impact on outcomes for specific patient populations (e.g., heroin users, patients with mental disorder).

Urine testing. Although the initiative specifies that no Proposition 36 funds can be used for urine testing of Proposition 36 patients, additional state funds have been made available for counties to conduct such tests. Both probation officers and drug treatment staff may conduct the testing, and counties appear to vary considerably in their testing policies, including whether and how urine tests are conducted. San Francisco does not require urine testing, whereas Sacramento does random testing by both treatment and probation staff, and the other counties rely more heavily on treatment providers to conduct urine testing. Some counties (Riverside and San Diego) emphasize the use of urinalysis results to inform therapeutic decisions. Data sharing procedures between the treatment system and the criminal justice system, particularly in terms of patient assessment and urine testing results vary across counties, with Kern and Sacramento having an automated database shared between the treatment and criminal justice systems within each county.

Serving the dually diagnosed. During the first year of Proposition 36's implementation, one of the leading concerns expressed by administrators and treatment providers within each of the five counties has been how to identify individuals who have co-occurring mental and substance use disorders and how to accommodate them within the treatment options available through Proposition 36. These individuals (referred to as "dually diagnosed") are purportedly more prevalent among Proposition 36 participants, have more severe drug use and other psychosocial problems, and have poorer rates of treatment entry and retention and worse posttreatment outcomes, compared with non–dually diagnosed Proposition 36 participants. All five counties stated that they screened for mental health problems as part of the Proposition 36 assessment process, although the tools used differed. Three counties developed their own mental health screening instruments (Kern, Sacramento, San Diego), two counties reported that they used the ASI psychological severity score (San Francisco, San Diego), and one county used the ASAM (Riverside). County administrators also expressed concerns about the resources needed to appropriately treat individuals with co-occurring disorders, given their generally higher levels of severity and lower levels of functioning. Clients who lack health insurance or other means to pay for the costs of prescription medication may be particularly disabled, thus affecting their ability to participate in treatment and the overall outcomes of their treatment participation.

To begin addressing the needs of dually diagnosed patients, one county (Riverside) expanded an existing mobile intensive case management program for dually diagnosed patients in order to accommodate Proposition 36 patients; another county (San Diego) forged a new partnership with the Department of Veterans Affairs (VA) to provide treatment for Proposition 36 patients who are veterans, which enabled them to receive mental health services through the VA. Specialized stabilization services, pretreatment groups, and nonresidential treatment, and aftercare for dually diagnosed patients were also mentioned among the interventions provided to this population. San Diego has additionally developed a network of nonresidential, dual-diagnosis treatment programs specifically designed to meet the needs of this hard-to-serve population. Yet, despite these interventions, administrators were still concerned that the multiple and complex treatment needs of this population posed a challenge to their Proposition 36 programs, and that this population could disproportionately contribute negative outcomes to the overall evaluation of Proposition 36's effectiveness if they are not properly identified and assessed, and if their treatment needs are not appropriately addressed.

Other implementation issues. Additional implementation issues commonly identified by counties include the need for more intensive treatment for patients with more severe substance abuse or mental disabilities, housing for the homeless, and the fiscal uncertainty as a result of the current state budget crisis (Steering Committee Meeting 2003). Furthermore, all county administrators emphasized the importance of documenting the current implementation strategies and program operations, as the processes involved in operationalizing Proposition 36 is dynamic with the issues and resolutions evolving and changing over time.

PATIENT CHARACTERISTICS

We compared patient populations before and after Proposition 36 implementation to get an indication of the impact of this initiative on counties' drug treatment systems. We also contrasted Proposition 36 patients with non-Proposition 36 patients in each county to assess the differences between the two groups within each county.

County patient populations. Table 3 presents information on the treatment population in each county during the year before and after July 1, 2001, when the initiative took effect.

TABLE 3: Treatment Populations During the Year Before and the Year After the Implementation of Proposition 36 in July 2001

	Kern		*Riverside*		*Sacramento*		*San Diego*		*San Francisco*	
	Pre	*1st Year*	*Pre*	*1st Year*	*Pre*	*1st Year*	*Pre*	*1st Year*	*Pre*	*1st Year*
Treatment admissions	4,620	5,861	7,475	9,044	5,116	5,987	18,643	21,651	19,345	16,018
Modality (%)										
Residential	1.4	2.5**	32.3	29.1**	34.9	30.4**	41.4	37.6**	23.8	25.7**
Day treatment	0.1	0.4	1.9	5.2**	9.3	9.0	15.8	18.2**	2.1	3.2**
Outpatient drug free	75.6	82.6**	46.2	52.4**	35.2	45.1**	22.9	30.3**	32.9	38.6**
Methadone detox	20.4	14.5**	11.6	6.7**	9.5	6.0**	15.0	9.4**	34.6	26.0**
Methadone maintenance	2.5	0.0**	8.0	6.6**	11.1	9.5	4.9	4.5	6.7	6.5
First-time admissions (%)	44.1	45.7	45.8	49.9**	34.4	37.4	29.0	30.4	31.2	39.0**
Women (%)	46.0	37.6**	44.6	41.6**	53.9	54.5	35.1	33.7	33.5	35.3**
Ethnicity (%)										
White	54.0	51.2	53.3	52.1	53.7	54.4**	52.7	52.7	41.5	38.3**
African American	8.6	8.7	8.2	8.1	21.1	22.7	12.8	13.6	36.3	38.3**
Latino/Hispanic	29.9	34.7**	34.3	35.8	17.8	16.0	27.3	27.0	15.4	15.9
Asian/Pacific Islander	0.8	1.1	1.0	0.9	4.3	3.3	4.1	3.5	3.0	3.6
Native American	6.4	4.2**	2.1	1.8	1.6	2.2	1.8	1.6	1.5	1.5
Other	0.3	0.2	1.2	1.3	1.5	1.3	1.4	1.5	2.2	2.5
Age										
12 to 17 years of age	9.5	8.1	6.8	4.3**	5.2	3.2**	14.1	13.6	1.9	2.6**
18 to 25 years of age	22.6	24.6	18.1	19.9	13.0	12.8	16.2	16.8	10.1	11.3**
26 to 35 years of age	27.9	27.7	29.8	31.0	30.8	31.9	26.1	25.8	24.7	24.2
36 to 45 years of age	28.4	28.2	33.2	33.3	34.7	35.5	29.8	29.3	36.4	34.9
46 and older	11.6	11.4	12.2	11.6	16.3	16.8	13.8	14.5	27.0	27.0
Mean age	32.3	32.2	33.7	33.9	35.7	36.0	32.7	32.9	38.8	38.5

(continued)

TABLE 3 (continued)

	Kern		*Riverside*		*Sacramento*		*San Diego*		*San Francisco*	
	Pre	*1st Year*	*Pre*	*1st Year*	*Pre*	*1st Year*	*Pre*	*1st Year*	*Pre*	*1st Year*
Other patient attributes										
Homeless	11.1	11.4	17.5	17.2	20.9	20.1	4.4	5.1	39.2	40.9
Full-time employment	14.5	13.6	16.3	16.0	13.5	13.3	19.1	18.9	16.5	11.2**
Welfare to work	6.5	3.2**	4.2	2.9**	11.8	10.9	1.3	1.0	0.7	0.5
Drug use in the past month (%)										
Heroin	24.9	17.1**	25.2	18.8**	28.3	20.7**	25.6	20.0**	51.9	44.2**
Cocaine/crack	6.7	5.0**	7.4	6.0**	12.5	12.6	9.1	7.6**	34.7	35.0
Methamphetamine	26.9	30.6**	29.4	41.3**	20.6	26.1**	16.9	21.9**	5.9	7.2**
Marijuana	22.3	17.5**	16.1	18.4**	14.2	17.0**	14.5	15.6**	7.2	10.0**
Alcohol	26.0	18.7**	30.0	28.7	28.9	30.7	24.8	21.5**	26.9	31.3**
Injected drugs	28.3	21.5**	26.2	21.1**	27.9	22.5**	24.4	20.3**	45.2	39.3**
Legal status										
Probation	27.0	46.7**	27.4	36.4**	29.5	39.5**	30.3	39.4**	11.6	12.5
Parole	9.3	10.3	13.4	12.5	9.2	9.3	9.3	9.7	5.6	5.3
Diversion for any court	12.3	4.6**	2.0	4.2**	2.0	2.1	8.8	9.8**	5.1	6.0**
Incarcerated	6.3	5.4	1.3	1.3	1.5	1.7	0.6	1.6**	4.1	4.7
No criminal justice system involvement	45.1	33.0**	56.0	45.6**	57.9	47.3**	50.9	39.4**	73.6	71.6**

**Chi-square test on rates between patients during the year before and the year after Proposition 36 with $p < .001$.

Except for San Francisco County, total treatment admissions during the first year after Proposition 36 implementation in each county increased from the year before, with increases of 27% in Kern, 21% in Riverside, 17% in Sacramento, and 16% in San Diego. Admissions in San Francisco, however, decreased by 17%. The proportion of admissions to outpatient drug-free programs increased over the 2 years in all five counties. In contrast, both the numbers and percentages of admissions in methadone detoxification programs decreased appreciably in all five counties. The percentage of admissions in methadone maintenance also decreased in Kern and Riverside, and the proportion of admissions to residential programs decreased in Riverside, Sacramento, and San Diego counties.

There were slight increases in first-time admissions in all five counties, although the increase was significant only in Riverside and San Francisco counties. The proportion of women admissions decreased in Kern and Riverside and increased in San Francisco, whereas there were no significant changes in Sacramento and San Diego. The proportion of Latino/Hispanic patients increased by 5% in Kern. Age distributions appeared stable across the 2 years. San Francisco observed a 5% decrease in patients with full-time employment, and Kern and Riverside had a 2% to 3% decrease in patients who were in welfare-to-work programs. In terms of drug use in the previous month before treatment admission, the proportions of patients reporting heroin use decreased significantly in all five counties (at least by 5%), as did injection drug use. In contrast, methamphetamine use increased in all counties, as did marijuana use, although to a lesser extent (the exception is Kern, which showed a decrease in the proportion of patients reporting marijuana use). Proportions of patients on probation increased appreciably in four counties (20% in Kern, 9% in Riverside, 10% in Sacramento, 9% in San Diego); in San Francisco, the increase was minimal (1%).

Proposition 36 patient populations. We further broke down the first-year admissions to compare Proposition 36 patients with non-Proposition 36 patients (see Table 4). Proposition 36 patients accounted for 28% of the total patient population in Kern County, 16% in Riverside, 20% in Sacramento, 16% in San Diego, and 1% in San Francisco. Any change in patient mix in San Francisco County is not likely attributable to the implementation of the initiative as the number of Proposition 36 patients in the first year was relatively small. Across all five counties, almost 20% more Proposition 36 patients were treated in outpatient drug-free programs than non-Proposition 36 patients, whereas the modality distributions for the non-Proposition 36 patients were similar to those during the year before Proposition 36 implementation. Similarly, across these counties, significantly lower percentages

TABLE 4: Comparisons Between Proposition 36 Patients and Non-Proposition 36 Patients

	Kern		*Riverside*		*Sacramento*		*San Diego*		*San Francisco*	
	Prop. 36	*Non-Prop. 36*	*Prop. 36*	*Non-Prop. 36*	*Prop. 36*	*Non-Prop. 36*	*Prop. 36*	*Non-Prop. 36*	*Prop. 36*	*Non-Prop. 36*
Prop. 36 admitted to treatment	1,645	4,216	1,461	7,583	1,206	4,781	3,499	18,152	171	15,847
Modality (%)										
Residential	2.2	2.7	22.1	30.4**	19.0	33.3**	20.7	40.9**	25.7	25.7
Day treatment	0.4	0.4	9.0	4.4**	1.4	10.9**	22.9	17.3**	16.4	3.0**
Outpatient drug free	97.4	76.8**	66.9	49.6**	73.1	38.0**	56.4	25.3**	52.6	38.5**
Methadone detox	0.0	20.1**	0.4	8.0**	0.8	7.3**	0.0	11.2**	0.0	26.3**
Methadone maintenance	0.0	0.0	1.6	7.6**	5.6	10.5**	0.0	5.4**	5.3	6.5
First-time admissions (%)	50.3	45.6**	64.1	48.2**	49.2	34.8**	34.8	29.7**	57.9	38.9
Women (%)	26.9	41.7**	26.5	44.6**	35.7	59.2**	27.3	34.9**	24.0	35.4
Ethnicity (%)										
White	47.8	52.5	52.1	52.1	58.7	53.4**	45.8	54.1**	19.9	38.5**
African American	10.8	7.8**	8.9	7.9	22.3	22.8	19.0	12.6**	53.2	38.1**
Latino/Hispanic	36.4	34.1	36.0	35.8	13.6	16.6	27.8	26.9	15.2	15.9
Asian/Pacific Islander	1.7	0.9	0.7	0.9	2.7	3.4	4.0	3.4	8.8	3.5**
Native American	3.1	4.6	1.5	1.9	2.0	2.3	1.6	1.6	0.6	1.5
Other	0.2	0.1	0.7	1.4	0.7	1.5	1.8	1.4	2.3	2.5
Age										
18 to 25 years of age	26.3	24.0	21.3	19.6	10.9	13.3	15.4	17.1	12.9	11.3
26 to 35 years of age	30.3	26.7	29.3	31.3	29.5	32.4	31.6	24.7**	22.8	24.2
36 to 45 years of age	32.8	26.4**	38.7	32.3**	41.9	33.8**	37.9	27.7**	39.2	34.8
46 and older	10.2	11.8	10.6	11.8	16.2	16.8	15.1	14.4	25.2	27.0

Other patient attributes										
Homeless	4.7	14.1**	9.3	18.9**	10.8	22.4**	5.1	5.1	22.8	41.1**
Employed full-time	18.8	11.5**	22.2	14.8**	18.2	12.1**	23.9	18.0**	14.6	11.2
Welfare to work	2.0	3.7**	1.4	3.1**	2.0	13.2**	0.3	1.1**	0.6	0.5
Drug use in the past month (%)										
Heroin	4.4	22.1**	10.4	20.4**	11.2	23.1**	9.5	22.0**	22.8	44.5**
Cocaine/crack	7.4	4.1**	5.9	6.0	10.8	13.1	10.0	7.1**	35.1	35.0
Methamphetamine	41.3	26.5**	60.0	37.8**	38.6	23.0**	37.9	18.9**	13.5	7.1
Marijuana	20.2	16.4**	22.7	17.5**	23.4	15.3**	17.6	15.4	21.1	9.9**
Alcohol	20.6	18.0	21.4	30.1**	23.6	32.5**	17.6	22.2**	27.5	31.4
Injected drugs	10.3	25.8**	14.5	22.4**	19.9	23.1	12.9	21.7**	21.1	39.5**
Legal status										
Probation	80.4	33.6**	65.2	30.9**	84.4	28.1**	90.6	29.5**	55.6	12.0**
Parole	12.0	9.6	13.6	12.2	13.1	8.3**	5.4	10.5**	28.1	5.0**
Diversion for any court	3.0	5.2**	13.5	2.4**	1.3	2.4	3.9	11.0**	9.9	5.9
Incarcerated	0.06	7.5**	0.0	1.5**	0.08	2.1**	0.0	1.9**	0.0	4.7

**Chi-square test on rates between Proposition 36 patients and non-Proposition 36 patients with $p < .001$.

of Proposition 36 patients were treated in methadone (detoxification and maintenance) programs than were non-Proposition patients; no Proposition 36 patients were reported from methadone programs in Kern and San Diego counties.

The percentages of first-time admissions were much higher, whereas female admissions much lower among Proposition 36 patients than among non-Proposition 36 patients. Ethnic distributions appeared similar between the Proposition 36 and non-Proposition 36 patients in these counties, except in San Diego and San Francisco, where a higher percentage of African Americans and a lower percentage of Whites were among the Proposition 36 patients than were among non-Proposition 36 patients. Compared to non-Proposition 36 patients, higher percentages of Proposition 36 patients were in the age category of 36 to 45 years old. The percentages of homeless and welfare-to-work patients were lower, and patients with full-time employment higher, among Proposition 36 patients than among non-Proposition 36 patients.

In terms of drug-use patterns, rates of heroin use and any drug use by injection were significantly lower among Proposition 36 patients than among non-Proposition 36 patients, although use rates of both methamphetamine and marijuana were consistently higher among Proposition 36 patients across all five counties. Again, as expected, greater percentages of Proposition 36 patients compared to non-Proposition 36 patients were on probation or parole at treatment admission.

SUMMARY AND FUTURE PLANS

The initial findings from the five counties participating in the study of Proposition 36's impact on the drug treatment system have been encouraging both in progress made in Proposition 36 implementation and in meeting some of the study's initial objectives. Partly due to study selection criteria, the five counties indeed demonstrate tremendous diversity with respect to treatment approaches, urine testing policy, and patient mix. However, there are also similarities across the counties. Common issues identified by counties in the first year of Proposition 36 implementation include identifying and treating dually diagnosed patients, providing services for patients having greater than expected needs for intensive treatment, and meeting the housing needs of the homeless. Counties also shared their uncertainties of continued state funding due to the state's projection of a large deficit in the next fiscal year.

Although it is premature at this early stage of the study to draw conclusions about the significant system impacts of Proposition 36, a few trends and

common implementation issues have already emerged based on the initial findings. These would be important to follow over the 5 years of the study, as they have policy implications. For example, treatment admissions have increased in four of the five counties (the exception being San Francisco) since the implementation of Proposition 36. These increases may be due to natural growth in the treatment population, but perhaps are more plausibly attributed to Proposition 36 in counties such as Kern, Sacramento, and San Diego, and to a lesser extent in Riverside, as the increases in admissions were close to or less than the number of Proposition 36 patients. Capacity increases appear primarily in outpatient drug-free programs. Patients reporting heroin use decreased across all counties, and there was a corresponding decrease in the percentages treated in methadone detoxification and maintenance programs. Although it is unclear why there was lower use of heroin among Proposition 36 patients than non-Proposition 36 patients, this finding is consistent across the five counties and with the changes observed in these counties' overall patient mix. The differences between Proposition 36 and non-Proposition 36 patients appear to reflect the differences generally observed between the criminally involved and those not criminally involved (e.g., more men among the Proposition 36 patients and those criminally involved). Proposition 36 appears to effectively bring in more offenders for their first drug treatment.

To follow the preliminary emerging trends, examine common implementation issues described by the counties, and address the other major issues identified earlier within the multilevel open system framework, our next steps are to collect more in-depth data at the county, program, and patient levels by conducting interviews with key stakeholders in these counties, surveying treatment programs that serve Proposition 36 offenders, and collecting patient assessment data. Over the 5 years of the study, these, along with other patterns revealed by the data collected across the counties, will be examined with respect to client outcomes and policy implications.

Research aimed at improving the delivery of services to drug-abusing offenders is vitally important and urgently needed by policymakers and providers to inform decision making. To take advantage of the extraordinary opportunity offered by the implementation of Proposition 36 to examine the impact of such a far-reaching policy change and the maturation of the research/practice/stakeholder agency cooperative efforts in California, we have taken the initial steps of selecting five counties of diverse characteristics and documenting the proposition's first year of implementation in these counties. We are committed to helping shape the design and delivery of treatment according to "best practice" approaches based on empirical evidence. By improving our understanding of the impact of new drug policies on the

treatment service delivery system and how the system responds, significant gains for patients, stakeholder organizations, and funding agencies can result and ultimately increase the effectiveness of service delivery and improve patient outcomes. Importantly, if timely feedback is provided to the state, counties, and providers, they could use the information to identify areas needing technical assistance or to inform future actions. In the process of assessing the impact of Proposition 36, we will gain a more in-depth understanding of California's treatment service delivery system and its linkages with the criminal justice system in particular, yielding important information on methods to achieve beneficial change in the provision of treatment services to substance-abusing offenders. Finally, the refinement of our knowledge of the factors that hinder or facilitate the implementation of new drug policies will lead to improving the effectiveness of drug abuse treatment delivery for substance-abusing offenders.

NOTES

1. The California Treatment Outcome Project (CalTOP) is a multicounty treatment outcome evaluation effort. The goal of CalTOP is to develop and pilot-test an outcome-monitoring system that provides a standardized patient assessment and measures service needs, records service utilization, assesses treatment outcomes, and determines cost offsets in other health and social service systems. The CalTOP study began collecting data in April 2000 by 44 CalTOP providers in 13 counties. The county and program selection criteria included demographics and patient flow, automation readiness, familiarity with assessment tools, geographic location, and commitment to CalTOP. The project collects data on patients, programs, and services in the participating programs (Hser et al. 2002).

2. A brief survey was conducted among all CalTOP counties to assess their current implementation policies with respect to treatment approaches, urine testing, dual diagnosis, and drug court experience. All 13 counties responded to the survey.

3. Because for each county we included all the patients (i.e., entire census rather than a sample), statistical inference is not formally needed. We provide *p* values for readers who find them useful nevertheless.

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