



April 4, 2006

## Recommendations for Improving Proposition 36

### 1. Access to Opiate Agonist Treatment:

**The Problem:** Approximately 10% of Prop 36 arrestees use heroin, but only 10% of them are referred for MMT. In part this is an ideological barrier in some courts, in part ideological in some counties.

**The Improvement:** Access to methadone should be offered and clients can be free to refuse, but we need regulatory prose that (a) makes it available to all opiate addicts, either as a detox (its only useful for treatment initiation, it is no good as a definitive intervention) or full maintenance, (b) require counties to develop access plans for methadone or buprenorphine.

### 2. Dual-Diagnosis Patients:

**The Problem:** UCLA data has shown that 53% of SACPA clients have been arrested for methamphetamine abuse and that methamphetamine has reached epidemic proportions in California. Stimulants in general, and methamphetamine in particular, are well-known to induce longstanding (often permanent) brain conditions of paranoia, hallucinations, and/or depression. These require prompt and continuing access to psychiatric evaluation and prescriptions of antipsychotic and antidepressant medications.

**The Improvement:** Funding anomalies need to be ironed out by DMH and DADP to make psychiatric assessments and prescription medication both *available* and *reimbursable*. Some Prop 63 funds need to be allocated as a supplement to Prop 36 funds to help care for the dual-diagnosis disorders in general and the persistently psychotic individuals in particular.

### 3. Case Outreach

**The Problem:** 30% of Prop 36 arrestees never make a treatment visit and a substantial proportion of those who do drop out early. Retention thru completion of a treatment course has emerged as a gold standard of comparison for efficacy.

**The Improvement:** Each county needs to hire outreach workers (BA level) to find no-show and drop-outs. These employees should specialize in outreach and treatment initiation. DADP should insist that each county plan designate a pro-rated amount of funding to pay for these positions. Results of outreach should be tabulated.

### 4. Case Management:

**The Problem:** UCLA's April 2006 Report on the fiscal outcomes has found significant cost benefits for enrollees and even higher benefits for program completers, but it has also identified a subgroup of high utilizers who are highly recidivistic and highly expensive for both criminal justice and treatment services. This is similar to a problem well known in community mental health and in the parole systems—that a few individuals cost a vastly disproportionate amount of time and effort.

**The Improvement:** High utilizers should be identified using data analysis methods and should be assigned to case management workers, who will have authority for outreach, intervention, and decisions about failure of a treatment episode. Repeat failures to progress in treatment should ideally lead to a higher level of supervised care in the Drug Court system.

CSAM does *not* support the addition of “flash incarceration” as a means of ensuring “accountability” until Prop 36 episodes have been used up. CSAM conceptualizes Prop 36 as the Emergency Room entrance and Drug Courts as the Intensive Care Unit. We support stratification of services rather than competition between them for “best” clients.

## 5. Parole Self-Pay:

**The Problem:** The Parole system is receiving Prop 36 funds even though they have a higher funding base than Prop 36 for what they do. And, they may receive more in the coming budget/s. With the rate of inflation the true dollar value of Prop 36 (\$120M) has dropped by about 15% over 5 years.

**The Improvement:** Arguably, Prop 36 was designed to keep people out of jail, not to offer the best treatment for those who are leaving prison on parole. The CDC has deep pockets and a powerful lobby. Parole should pay for post-incarceration treatment out of criminal justice/CDC funds; probation should continue to be supported by Prop 36 monies. Such a change would require buy-in from the original proponents.

## 6. Urine Toxicology Testing:

**The Problem:** Drug testing was deliberately kept out of Prop 36 in order to prevent criminal justice from declaring testing a form of treatment dollars. However, both the CJS and the treatment system need to do randomized testing as a matter of routine.

**The Improvement:** Although we appreciate the initial motive, continuing to block this use of Prop 36 dollars simply looks naive. We are probably better off to declare funded testing a necessary "improvement." However, this will cost money, currently captured from other funding sources.

## 7. Increased Funding:

**The Problem:** Prop 36 has been funded \$120M per year for the past five years. This means that the funding has already decayed about 15% just from inflation.

**The Improvement:** \$138M might cover inflation, but better estimates of true cost run from \$180M to \$209M per year.

## 8. Improved Central Data Set:

**The Problem:** Data analysis has been weak from the beginning for a variety of reasons, including the fact that DADP's core data is limited and the 57 counties vary in what else they capture. This has led to the necessity of UCLA's outcomes research group having to do focus groups and individual interviews to capture missing data elements. (A core dataset was originally recommended in CSAM's White Paper on recommendations for implementation).

**The Improvement:** UCLA needs to help design a core dataset that will be used by all counties and all jurisdictions. It should not be overly comprehensive and should not be a typical overly burdensome research database. It should provide data points for the key markers of recidivism, compliance, testing data, employment, and completion. DADP should use Prop 36 money to hire a dedicated Prop 36 data analyst on a full-time basis.