REPORT

THE ADATSA PROGRAM: CLIENTS, SERVICES AND TREATMENT OUTCOMES

A Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act

Washington State
Department of
Social and Health Services
Planning, Research &
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EXECUTIVE SUMMARY

STUDY BACKGROUND

ADATSA Legislation

In 1987, the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) established a treatment and shelter program for Washington State's indigent and chemically dependent adults. This act was most recently amended in 1989, virtually eliminating the shelter program, but reaffirming the treatment program. ADATSA eligibility requires that all clients accepted for treatment are indigent, unemployable, and incapacitated due to their chemical dependency.

Program Purpose

ADATSA-eligible adults are provided a maximum of six months of treatment and financial support in any two-year period. Financial support is contingent upon participation in treatment. The immediate aim of treatment is abstinence from alcohol and other drugs. The long-term goal is to foster self-sufficiency by arresting the progression of the illness through the provision of supportive services. The program helps clients build personal coping skills, increase social support, and acquire re-employment skills.

Treatment Components

ADATSA eligible clients are matched with appropriate treatment programs, arranged in an array of available treatment paths, most of which involve primary care, re-integration, and aftercare components. The tracks differ in total duration of treatment, in emphasis, in length of the various treatment components, and whether or not a residential setting is used for the primary care and reintegration components. While participating in the outpatient treatment phase, clients are provided a living stipend for housing, in addition to food stamps and medical coupons which all clients receive.

The Purpose of the Study

This study was sponsored by the Division of Alcohol and Substance Abuse (DASA) in order to gain an understanding of ADATSA clients and the overall functioning of the ADATSA system. The study describes the clients, evaluates the appropriateness of treatment placements, and identifies the major obstacles in implementing the program from the point of view of managers and directors of treatment agencies and assessment centers.

Using client employment, publice assistance, and re-entry into DASA-funded services as measures of the impact of treatment, the study assessed the outcomes of chemical dependency treatment. The study also examined the effect on employment of three pilot programs which have been providing extra vocational services to ADATSA clients. Finally, a number of former shelter clients were tracked in an effort to determine their current circumstances, including their subsequent use of other publicly funded services.

STUDY METHODS

Overall Study Design and Components

This study does not have an experimental design; it is retrospective.

Clients: Client information was obtained from a sample of 1118 case records of clients actually assessed in the fall of 1989 in 23 out of 37 assessment centers across the state.

Directors: Interviews were conducted with a 50% sample of directors of assessment centers, a 50% sample of directors of ADATSA funded inpatient agencies and a 39% sample of managers of outpatient treatment agencies.

Peer Panel Review: A representative group of fifteen ADATSA clinical professionals were assembled as a Peer Panel Review Board to re-assess and make treatment recommendations for a sample of sixty clients.

Outcomes: Employment, public assistance, and re-entry data were obtained from state agency records and matched with client data. These outcomes mainly cover a six-month period after completion of treatment or drop-out.

Vocational Pilot Programs: Client information was obtained directly from three vocational pilot programs and matched with employment state agency records.

Shelter Clients: Finally, a sample of former shelter clients from a previous ORDA study were tracked for 18 months on available state agency electronic files.

STUDY FINDINGS

Who are ADATSA eligible clients?

Indigent by eligibility requirement, ADATSA clients have little or no social support.

They are late-stage chemically-dependent adults with an average history of 15 years of chemical abuse, starting at age 16. Many live alone or are homeless (41%); only 16% are married. Most have a family history of substance abuse.

The majority have been involved with the criminal justice system. One of five assessments is prompted by court action. One of four clients is on probation or parole.

The average client is white, male and in his early thirties. However, there are significant proportions of women (35%) and of minorities (31%).

One of five ADATSA clients also has other physical and mental/emotional problems.

Do clients receive appropriate placement?

This question involved three main concerns:

1) clinicians' agreement on most appropriate treatment paths for certain types of clients;
2) actual placement corresponding to such agreement; and
3) adequacy in terms of length of treatment and types of services among treatment paths available in the ADATSA system.

Clinicians' agreement

A fifteen-member Peer Panel agreed on the main criteria used for placing clients into five major treatment paths and reached a high degree of consensus in placing a sample of sixty clients. They reviewed these client cases first individually, then in teams of three, and then, for twenty cases, as a whole group.

Major Treatment Path Definitions:

OUTPATIENT PATH - Clients are placed in outpatient treatment for both primary care and aftercare (total time not to exceed 90 days).

30/90 PATH - Clients are initially placed in an up to 30-day intensive inpatient treatment program for primary care to be followed directly by outpatient treatment (not to exceed 90 days Outpatient treatment time).

30/60/90 PATH - Clients are initially placed in a 30-day intensive inpatient treatment program for primary care followed by a 60-day recovery house, and aftercare outpatient treatment (not to exceed 90 days Outpatient treatment).

LONG-TERM RESIDENTIAL PATH - This path consists of an extended-stay drug residential (not to exceed 180 days) or extended-care recovery house (not to exceed 90 days). It may be followed by recovery house care and/or outpatient care, if not all 180 days are used in the residential treatment.

MICA PATH - This treatment path is for clients who are assessed as probably both Mentally Impaired and Chemically Addicted. It begins with a 28-day treatment and diagnostic program. This program is often extended by 90 days to a total of 120 days of MICA treatment. It may also be followed by recovery house and/or outpatient treatment, with a mental health component, until the total 180 days have been used up.

Actual placements

The panel reviewed actual placements and found that placements in the three most intensive paths (MICA, Long Term, and 30/60/90) agreed well with their recommendations. There was much less agreement between panelists' recommendations and actual placements in the 30/90 and outpatient paths. This seems to be related to the lack of available residential beds; some clients are placed in less intensive paths inappropriately, according to the panel, because of lack of beds.

Estimates of proportion of clients affected

Estimates were made after checking for the generalizability of the Peer Panel Review findings to the larger ADATSA client sample.

1) Overall, 49% of all clients were estimated to be placed in a treatment path which was not the most appropriate one.
2) 88% of the difference between actual and most appropriate placement is due to panelists recommendations of more intensive/residential treatment paths.
3) The paths estimated to be most recommended and with the least placements are the following:

•MICA path: 13% recommended, 4% placed

•Long Term path: 32% recommended, 16% placed

•30/60/90 path: 26% recommended, 17% placed.

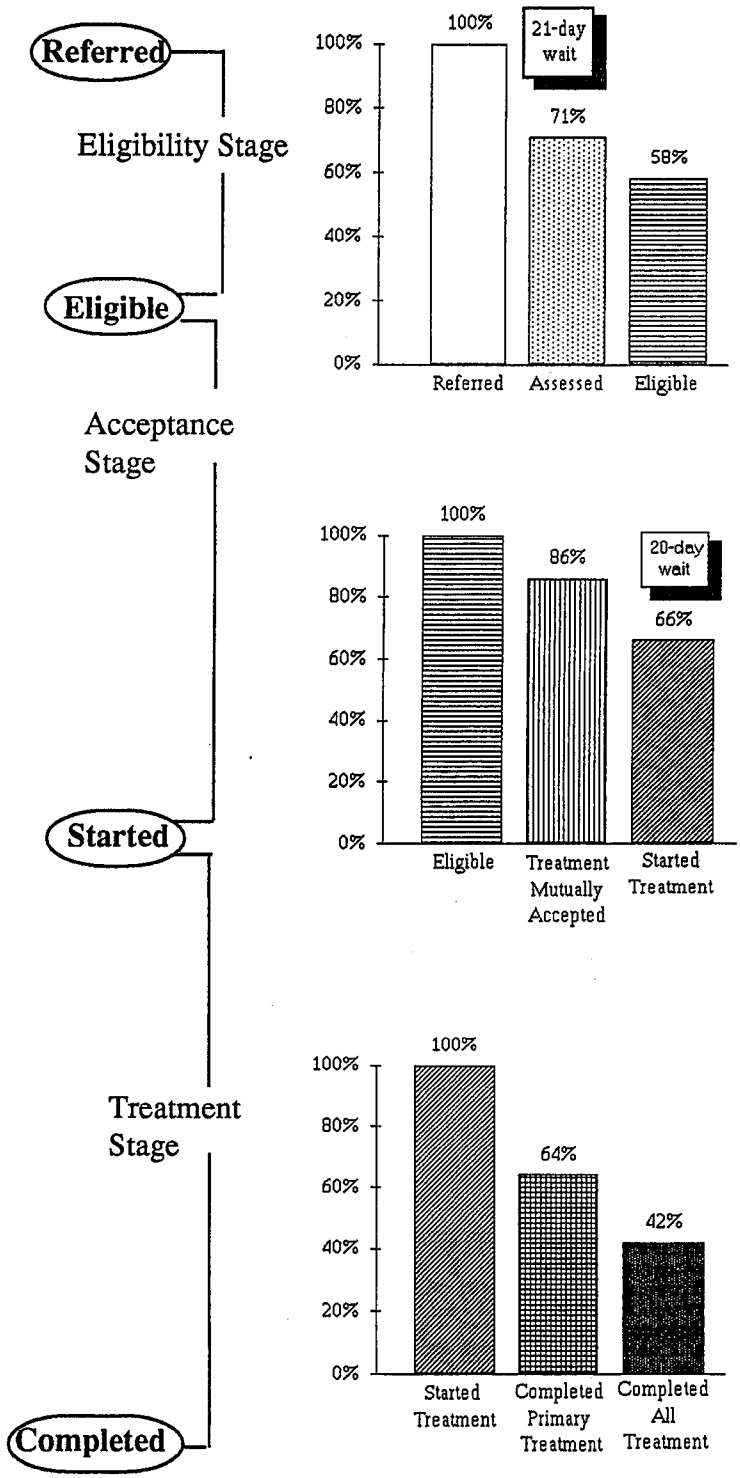
While they account for only 37% of actual placements, the above paths together involve 71% of recommended placements .

Adequacy of treatment length and services

The ideal minimum treatment length for all ADATSA clients recommended by the panel is longer than the six months allowed under the law. The recommended aftercare outpatient component is twice as long. The panel identified three kinds of services as lacking:

1) psychological/physical (medical) services during primary care,
2) housing during reintegration, and
3) more available adequate vocational services during outpatient care.

Chart 1
Wait Times and Retention Rates for ADATSA Clients



Do we lose too many clients due to waiting times before assessment and before the start of treatment?

58% of referred clients became eligible for ADATSA treatment. 66% of eligible clients started treatment. Overall, only two-fifths (38 percent) of all clients referred for assessment actually began treatment. A small proportion of the 'losses were due to clients found not eligible or not amenable to treatment. A much larger proportion, half of all dropouts in all the ADATSA program steps, were 'lost' during two waiting periods. These were clients who did not show up for assessment and clients who did not start treatment. At the time of this study, the average wait for assessment was 21 days, for treatment, 20 days (see Chart 1).

The length of wait time for treatment is highly correlated with the proportion of clients not showing up for treatment. This holds true for clients in almost all treatment paths.

Is the ADATSA program functioning at capacity?

A review of the number of clients assessed and the number of beds contracted showed that:

1) In the fall of 1989, the ADATSA system was placing in residential programs 46% more clients than it could treat. This generated long wait times, and consequently, a high proportion of clients who did not show up for treatment .
2) Capacity could not be increased by more efficient use of bed space.
3) More appropriate treatment by exclusive placement of all clients in residential programs would require funding of 21% to 43% more beds to serve the same number of clients.

Assessment Centers

The major concern of assessment center directors about placement of ADATSA clients into treatment is the lack of bed space. This problem causes:

1) longer wait times and attrition before treatment.
2) counselors spending extra time locating empty beds for clients (estimated at 1.5 to 3 hours per client) and
3) restricted possibilities for placing clients in appropriate treatment (the clients most impacted being MICA clients and those requiring long term or recovery house beds).

Treatment Agencies

Interviews with managers of residential programs indicated that their major concern is low vendor rates. They are reluctant to contract for more beds because they need some proportion of private paying clients to balance the budget. Recovery Houses are in the worst financial condition because there are few, if any, private paying clients to fill the funding gap.

The major concern of outpatient agency managers is the lack of transitional housing between residential and outpatient treatment.

What proportion of the clients complete treatment?

Among clients starting treatment, two-thirds complete the primary phase, and more than four out of ten finish all treatment phases (lasting usually three to six months)(see Chart 1). Comparative data from other similar programs serving indigent clients in other states suggest these retention rates are equal to or better than the average (National Survey of Select Treatment and Prevention Issues, DASA: April, 1991).

Who completes treatment?

With few exceptions, completion rates are similar for clients of different backgrounds.

The following few factors have independent effects on the likelihood of completion:

- one prior treatment experience increases the likelihood of completion;
- clients using only alcohol complete treatment more often;
- older clients (50 or more) have higher completion rates;
- clients with physical or mental problems are less likely to start treatment, but complete at the same rate as others once they are in treatment.

Are all types of clients equally served, even considering the drop-out rates during wait periods and subsequently during treatment?

The profiles of persons being assessed for eligibility, of those accepting treatment, and of those who complete all treatment are very similar in almost all regards. The few exceptions to this generalization have been mentioned.

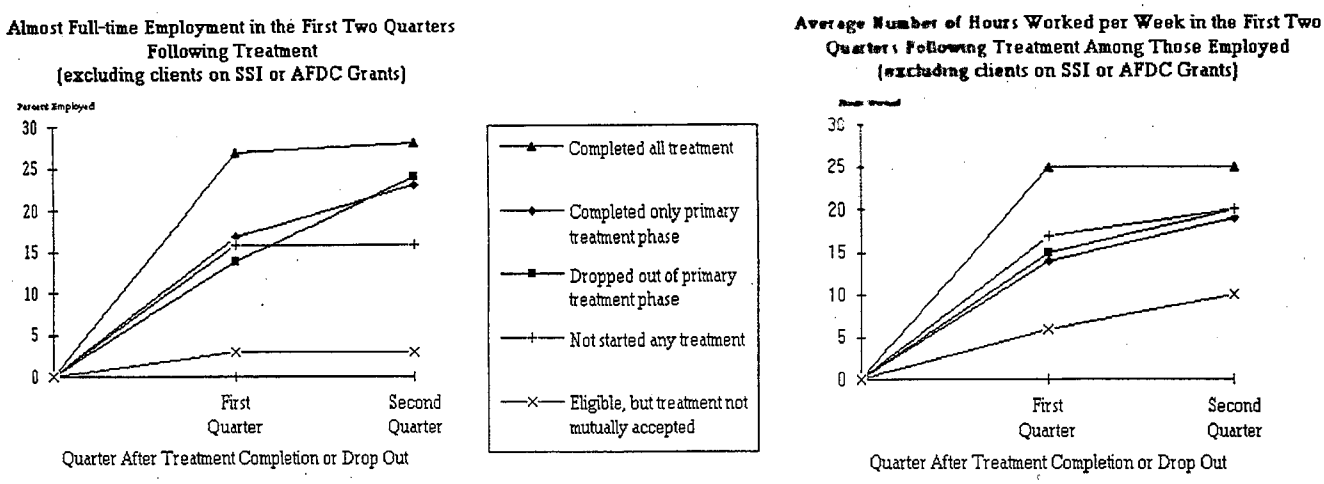
One corollary to the above generalization is that 'involuntary' clients (i.e. persons referred to ADATSA by the justice system) do as well as 'voluntary' (self referred) ones in accepting and completing treatment.

What are treatment outcomes?

Employment: Clients who finish treatment have higher employment rates in the first six months. Their employment rates are higher than those of clients who drop out of treatment, those who never started treatment and those who were eligible, but treatment was not mutually accepted (see Chart 2).

Most importantly, this is true beyond the expected effects of selectivity on characteristics usually related to employment. Treatment completion has an independent effect on rates of employment even after accounting for the effects of education level, prior work experience, age, ethnicity, and gender.

Chart 2



Use of Public Assistance: The proportion of clients on General Assistance-Unemployable (GAU) after completing treatment is smaller than that before treatment. Use of Supplemental Security Income (SSI) grants and use of Aid to Families with Dependent Children (AFDC) grants remained the same as before treatment. These programs cover clients incapacitated for physical or family related reasons other than chemical dependency ones.

Detoxification re-entry: Evidence from a sample of previous users of detoxification services allowed a tentative study of resumption of substance abuse by measuring the incidence of detoxification services after treatment. Clients completing at least the primary phase of treatment have significantly lower relapse rates.

Re-entry into DASA-funded service programs: Among clients completing all ADATSA treatment, 25% re-enter some form of DASA-funded program within a 12-month period, but mainly for continued outpatient support.

Do clients who received extra vocational services work more?

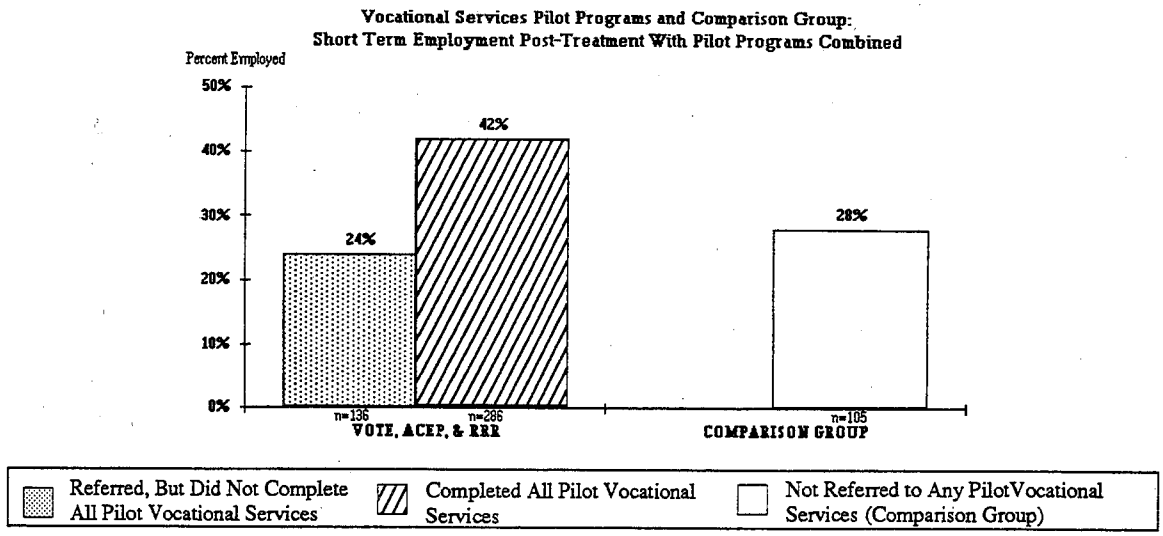
Some ADATSA clients received extra vocational services from three pilot programs: Rapid Rehabilitation Resolution (RRR), ADATSA Cooperative Employment Program (ACEP), and Vocational Opportunity Training/ Education Program (VOTE).

Clients completing any of these pilot programs have higher rates of short term employment (6 months) than a comparable sample of ADATSA clients who completed chemical dependency treatment but did not receive these extra services. Those working half time or more were considered substantially employed (see Chart 3). Clients completing the VOTE program at Pierce College and, to a lesser extent, the ACEP program in King County have higher rates of long term employment (6 to 15 months).

The effects of these extra vocational services on the likelihood of employment are independent of those background characteristics which are usually related to employment: education level, prior job experience, age, and ethnicity.

Most interesting is the fact that these extra vocational services increased the rate of employment for clients who were poorly educated and had no significant prior work experience. These are the clients for whom simply completing chemical dependency treatment had little or no effect on increasing their chances of employment.

Chart 3



Note: Short term employment is measured as working half-time or more in one of the first two quarters (6 months) after treatment and vocational services.

Comparison group did not receive any pilot vocational services but completed at least primary chemical dependency treatment

What happened to former shelter clients?

This study tracked a sample of former shelter clients for eighteen months starting July 1st, 1989 when eligibility to the shelter program became highly restricted.

Thirty-six percent of this sample of former shelter clients was on some form of public assistance grant at the end of this eighteen month-period. These grants were mainly part of disability related (SSI) and general assistance (GAU) programs. Only 4% were on grants from ADATSA. Less than 0.5% were still on shelter grants.

A few, 20%, were employed, but they were earning very little: an average of about $50 per month. About 4% were found serving sentences in state prison and about 2% died.

The circumstances of the remaining 38% still remain unknown.

What are the major implications of this study?

The ADATSA program is working under difficult constraints due to under-funding and due to a legislatively imposed six months limit to treatment.

Problems and Constraints

A number of problems exist in the ADATSA System:

1) A lack of capacity to serve clients eligible for treatment with consequent long wait periods and considerable placement in less appropriate treatment paths;
2) Insufficient auxiliary services such as medical and dental care;
3) Unavailable safe and sober housing, particularly in the reintegration phase of treatment; and
4) According to the results of the peer review, most clients ideally need longer treatment, particularly a longer aftercare phase than currently available.

Because the system is operating at more than capacity, the attempts to shorten waiting periods without increasing capacity cannot succeed. Within overall capacity constraints, attempts to solve one problem may result in other problems not being addressed.

Despite these problems, the ADATSA program shows many favorable results in terms of treatment completion rates, and outcomes measured six months after clients leave treatment.

Performance and Opportunities

1) Treatment completion rates compare favorably with rates in other states.
2) On the whole, the ADATSA program does not favor or impede treatment completion by any particular group of clients.
3) Tentative findings on detoxification relapse rates suggest that treatment completion is associated with more and longer abstinence.
4) Tentative findings on re-entry into DASA-funded services in the first 12 months indicate that clients re-enter mainly for continued outpatient support.
5) Clients completing treatment are more likely to be employed in the immediate post-treatment period, and
6) Extra vocational services, designed for ADATSA clients, improve the probability of employment.

One implication of these findings is that if more appropriate vocational services are funded, more ADATSA clients will become employed post-treatment.

This study found that it is difficult to predict the likelihood of treatment completion on the basis of client characteristics measured. Furthermore, few background characteristics were found to affect the likelihood of employment post-treatment other than completing treatment and obtaining extra vocational services. The implication is that attempts to resolve capacity problems by restricting access to those more likely to succeed on the basis of characteristics studied in this report are not justifiable.

General Concern and Further Research

When one views the treatment of addiction as a process including multiple treatment episodes, a general concern emerges. The lack of support services during and after treatment (particularly transitional housing, appropriate vocational services and continued aftercare) may increase the number of treatment intervention these clients need to reach long term abstinence or at least a reduction in substance abuse.

Follow-up studies of clients across more than one treatment episode are necessary to indicate rates of more permanent treatment success.

Furthermore, it is also necessary to conduct a cost benefit study of the system which includes not only the savings attributable to long-term abstinence but also the interim cost savings included when clients stop using public assistance and/or become employed even temporarily in between treatment episodes.[1]

[1] DASA has already funded such a follow-up and cost-savings study covering 18 months after finishing treatment. This report will be available December 1992.

INTRODUCTION

1

In 1987, the Washington State Legislature passed the Alcohol and Drug Addiction Treatment and Support Act (ADATSA), creating a treatment and shelter program for Washington State's indigent and chemically dependent adults. The act was most recently amended in 1989 virtually removing the shelter option for those who refused treatment or were considered not amenable to treatment. Non-shelter clients are currently eligible for a maximum of six months of treatment and financial support in a two-year period, contingent upon participation in treatment (see Appendix 1).

The immediate aim of treatment is abstinence from drugs and alcohol. The long-term goal is to increase the self-sufficiency of clients by arresting the progression of the illness and by providing support services. This involves building personal coping skills, increasing social support, and acquiring employment skills. Employment skills, in particular, were emphasized in the legislation.

To achieve these goals, clients are placed in a continuum of appropriate treatment programs. These are arranged in different treatment paths, each involving primary care, reintegration, and aftercare components. The paths differ in emphasis, the total length of treatment, the length of the various treatment components, and whether a residential setting is used for the primary and reintegration phases. While participating in the outpatient phase, clients are provided a living stipend for housing, in addition to food stamps, and medical coupons which all clients receive.

The typical ADATSA client is a Caucasian male, age 32, indigent, unemployable, with a fifteen-year history of alcohol or drug use.

THE PURPOSES OF THE STUDY

This study describes the clients and the overall functioning of the ADATSA system, evaluates the appropriateness of placement provided, and summarizes the major problems reported by managers and directors of treatment agencies and assessment centers.

Given the legislative emphasis on client employment as a measure of success of treatment, the study assesses employment outcomes, public assistance, and detoxification relapse for clients. Further, it examines the employment outcomes for clients in three pilot programs which provide extra vocational services to ADATSA clients.

Finally, because of concern about restrictions in eligibility for the shelter program, a number of former shelter clients were tracked to determine their current circumstances, especially their use of other public assistance programs.

METHODOLOGY

A number of methods were used in this study, including interviews with assessment center and treatment agency directors, review of client files, professional review of client placement, and analysis of treatment outcomes.

ORGANIZATION OF THE REPORT

Each chapter of the report addresses a specific question as outlined below:

Chapter 2: Assessment Centers as Hubs

How do assessment centers work?

The role of the ADATSA assessment centers in the selection, assessment and placement of clients into treatment programs is described in Chapter 2. The barriers assessment centers face in placing clients into appropriate treatment and their repercussions are discussed. Further, the relationships and communication between assessment centers and other parts of the system are described.

Chapter 3: Treatment Agencies and Program Utilization

How do treatment agencies serve ADATSA clients?

Chapter 3 describes the different treatment paths available to ADATSA clients and their distribution in inpatient (residential) and outpatient settings. It also discusses the major problems treatment agencies face in delivering the expected services, as well as bed utilization rates by treatment program and path.

Chapter 4: Client Profiles

Who is the typical ADATSA client?

In Chapter 4, ADATSA clients are described in terms of background characteristics, drug use, mental and physical problems, and involvement with the criminal justice system.

Chapter 5: Results of a Peer Panel Review

Does the ADATSA system prescribe appropriate treatment?

A panel of professionals compared actual placements with their recommendations for placement of ADATSA clients and reached consensus on the criteria used to recommend specific treatment paths. The experts then recommended minimum duration for each treatment phase and essential additional services. These comparisons and panel recommendations are presented in Chapter 5.

Chapter 6: Treatment Placement

How are clients actually placed in the various treatment paths?

Chapter 6 compares research findings on actual client placements to the professional recommendations reported in the previous chapter and discusses the distribution of clients among treatment paths.

Chapter 7: Wait Times, No Shows, and Completion Rates

What happens when ADATSA clients meet barriers to treatment?

The main barriers to treatment are two waiting periods: one before clinical assessment and the other before entry into treatment. In Chapter 7, retention rates are discussed at each step and overall. The correlation between wait times and retention rates is analyzed. Completion rates are discussed for each treatment path, and a multivariate analysis is performed to identify factors affecting the likelihood of starting and completing treatment.

Chapter 8: Client Outcomes: Employment and Public Assistance

Are ADATSA clients employed after treatment or do they remain on public assistance?

In Chapter 8, post-treatment employment, use of public assistance, and detoxification re-entry are analyzed by treatment path and by whether the client completed treatment.

Chapter 9: Employment Outcomes After Supplemental Vocational Services: Clients of Three Pilot Programs

Does extra vocational training improve the probability that an ADATSA client will be employed?

The employment of ADATSA clients who participated in three pilot programs, Rapid Rehabilitation Resolution, ADATSA Cooperative Employment Program, and Vocational Opportunity Training/Education Program is compared to the employment of other ADATSA clients in Chapter 9.

Chapter10: Shelter Clients: What Became of Them?

What happened to former shelter clients after the program was virtually eliminated?

Chapter 10 follows former ADATSA shelter clients to determine if they switched to other public assistance programs, worked enough to support themselves, were jailed, or died after the shelter program was no longer available to them.

Chapter 11: Conclusion

What are the implications of the study results?

A brief summary of findings is presented on the performance of the ADATSA program and on its constraints. Some major implications are discussed for both the opportunities and problems analysed. Finally the consequent need for further research is presented.

ASSESSMENT CENTERS AS HUBS

2

The ADATSA act designated assessment centers as the gateway to chemical dependency treatment for the indigent. Since chemically dependent people are often amenable to treatment only for a short period at a time, assessment centers try to make ADATSA services easily available during those times. This chapter addresses the role of the assessment centers in selecting, assessing and placing clients into treatment programs and providing treatment services in appropriate time frames. It also addresses the barriers assessment centers face in placing clients as reported by agency directors.

METHODS

Two-hour to three-hour interviews were conducted with directors and staff at 18 of the 36 assessment centers in Washington State (see Appendix for sampling methods). Staff and directors of ADATSA assessment centers were interviewed about client referrals; utilization of beds/slots; program operation; relationships with Community Service Offices (CSOs), courts, and treatment agencies; and client employment issues.

Assessment center staff described how the centers function and identified problems faced in serving ADATSA-eligible clients. Directors interviewed had the same chance of responding to various questions in a two-hour interview. The Directors were asked the same questions on the following topics: Structure of the center; relationships with CSOs; courts and treatment agencies; certification; and MICA clients. A summary question was asked on the four most important issues or areas for improvement of the functioning of the ADATSA system.

HOW THE ADATSA SYSTEM WORKS

The ADATSA client by eligibility is an adult alcoholic or drug addict, who is indigent and unemployable by reason of his/her drug condition.

Referral Sources

Referrals to ADATSA Treatment are made by Community Services Offices (CSO's). The client comes to a CSO to determine financial eligibility for chemical dependency treatment. Then the client is referred to the ADATSA assessment center to determine:

1. If the client is clinically addicted, and
2. If the client meets the incapacity criteria to be eligible for ADATSA service.

Often people convicted of driving while intoxicated (DWI) and other alcohol/drug-related offenses seek ADATSA services through this process.

FINANCIAL ELIGIBILITY - THE COMMUNITY SERVICES OFFICE

To qualify for ADATSA treatment, a client must first be determined financially eligible by a financial services specialist at a CSO[1] (see Figure 2A). The client must be indigent and unemployed. Financially eligible individuals are referred to the assessment center for a clinical evaluation.

CLINICAL ELIGIBILITY - THE ASSESSMENT CENTERS

An ADATSA assessment center counselor assesses the client's history, current level of alcohol/drug use, and functioning. To be clinically eligible for ADATSA, a client must be chemically dependent, incapacitated by that dependence, and unemployable because of it. When a client is determined to be clinically eligible, the counselor drafts a treatment plan. If the client agrees to treatment (ADATSA financial support is contingent upon treatment), the counselor begins the placement process.

Priority Populations

While all indigent, chemically dependent clients are eligible for ADATSA services, five groups of people are given priority in placement, because the state has a special interest in preventing damage to newborns, child abuse and neglect, and the spread of AIDS. These special groups are:

1) pregnant women,
2) women who have given birth in the last two months (post-partum),
3) parents with small children,
4) intravenous drug users, and
5) clients referred by Children's Protective Services.

Wait Times and Pre-treatment Arrangements for Clients

The average wait time between assessment and placement into treatment is over three weeks. To ensure that clients do not lose interest in treatment, assessment centers have taken the responsibility of keeping contact with the client until a treatment bed or slot is available. This is done in a variety of ways:

1) **On an informal basis**- Keeping track of clients becomes a part of case management.

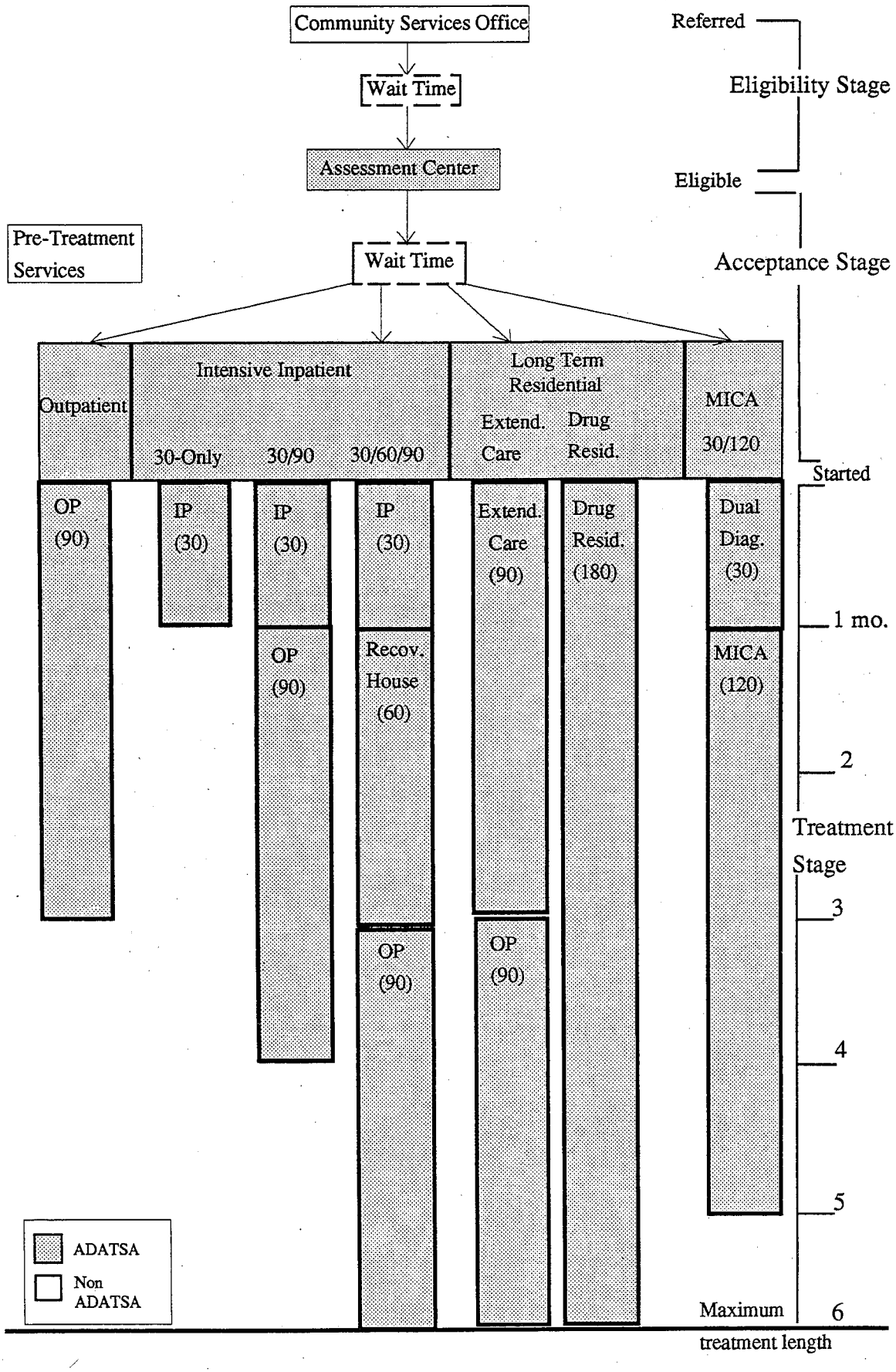
2) **By providing waiting clients with outpatient services**- This occurs most often when the assessment center is also an outpatient facility, and uses non-ADATSA funds for this purpose.

3) **By providing pre-bed services**- Such services are provided by some assessment centers, but are neither paid for by, nor are a part of ADATSA treatment. These services may increase the likelihood of a client starting treatment and facilitate treatment completion in several ways. Counselors can identify and respond to medical and dental problems, which may interfere with treatment. Further, pre-bed programs make it easier to locate a client when a bed becomes available, which is important for this transient population. Pre-bed programs also help the client

[1]There are 67 CSOs in Washington, at least one in every county. The CSO is the access point for all public assistance programs, including ADATSA, Aid to Families with Dependent Children (AFDC), General Assistance-Unemployable (GAU), and refugee and medical assistance programs.

Figure 2A

Eligibility, Acceptance, and Treatment Phases for ADATSA Clients, and Treatment Paths Funded



develop a support system which can be re-activated when the client returns from residential treatment. They also educate clients, introducing them to the 12 Step program and other treatment concepts. Clients are encouraged to join Alcoholics/Narcotics Anonymous and to get a sponsor.

TREATMENT PATHS

There are three phases of treatment: primary, reintegration, and aftercare. In primary care, addiction is addressed and clients are provided with the information and other tools needed to recover. In the reintegration phase, clients are helped to transition from a structured treatment setting to independent living. In aftercare, clients are provided continued support to maintain sobriety in an unstructured setting.

Unless an exception to policy is granted, the maximum amount of treatment is 180 days, although shorter programs are common. The maximum amount for the outpatient treatment track is 90 days within the allowable180 days. Depending on the needs of the client, he/she can be placed into one of several treatment paths.

The standard treatment paths as prescribed by assessment counselors for ADATSA-eligible individuals are described below.

The 30/60/90 path- consists of up to 30 days inpatient (IP) followed by 60 days in a recovery house and 90 days of outpatient (OP) treatment. The 30/60/90 path is most frequently recommended, but clients may receive an abbreviated version such as 30/90.

In this path, the reintegration phase is provided in a recovery house. The recovery house provides a support system and alcohol/drug free housing, as well as serving as a transition between inpatient and outpatient programs.

The 30/90 path- consisting of up to 30 days IP treatment followed directly by 90 days OP treatment, this path is rarely the first choice of treatment counselors. Although a few individuals are better suited to this abbreviated treatment, it is often used because of a lack of recovery house beds.

The 30-Only path- consists of only thirty days of inpatient service. This is not a complete treatment plan since it includes only a primary phase. After inpatient treatment, clients may obtain outpatient services from a funding source other than ADATSA due to their preferences or due to necessity. Some clients re-entering treatment may have only a limited time of eligibility left for ADATSA treatment (six months in any two year-period). Pregnant and parenting individuals as well as SSI recipients often are slotted here.

The Long Term Residential path- Clients using hard drugs (cocaine, heroin, amphetamines) and clients who have a long history of treatment failure may be placed in a long term residential path such as a 90 to 180 day residential program. These treatment paths may be either **Drug Residential** or **Extended Care** facilities. In both types of treatment, reintegration is provided at the inpatient facility.

The Mentally Impaired Chemically Addicted (MICA) path- Clients who are both mentally ill and chemically dependent need more than chemical dependency

treatment alone. Only one facility, located in western Washington, is contracted to provide specially-defined MICA services through ADATSA, making this the most difficult treatment path to arrange.[2]

MICA clients may also go to Oregon to receive MICA treatment if the client qualifies under a different public assistance program. In this case, treatment is not paid for with ADATSA funds.

Outpatient treatment as the primary or follow-up treatment path- If the client is not amenable to inpatient treatment, has a supportive family or culture, and/or is judged to be able to maintain sobriety on an outpatient basis, he/she may receive outpatient services as primary treatment. This means, however, that he/she can receive only 90 days of ADATSA-funded treatment.

Most treatment paths include an outpatient component. Besides providing chemical dependency treatment, the outpatient treatment agency must help the ADATSA client find employment.

In many cases, outpatient treatment (beyond the first 90 days) is necessary. The outpatient treatment agency may continue to serve the client outside ADATSA through county contract with state and federal funds. Many agencies continue to treat clients in this manner on a sliding scale once they are employed. Both these situations are post-ADATSA.

The Protective Payee system is designed to support the client during the 90 days of outpatient treatment. A monthly stipend is paid to the outpatient treatment agency for the client, which uses the money for the client's bills, rent, etc. This money is withheld for the subsequent month or returned to the state if the client does not attend outpatient treatment in the current month.[3] The purpose of these funds is to assist the individual in meeting their basic needs while in early recovery. In addition to the stipend, the client also receives food stamps and medical coupons.

THE DELIVERY OF ASSESSMENT SERVICES

Respondents were asked about the most important problems assessment centers face in the delivery of assessment services. Three major problems were frequently cited:

1. Lack of treatment beds for placing clients,
2. Low vendor rates, which impedes expansion of services, and
3. Paperwork and communication obstacles.

LACK OF BEDS

Lack of ADATSA-funded inpatient and recovery house beds was the most frequently mentioned concern of assessment center staff who were interviewed (see Table 2.1). Sixty percent reported that the number of beds is inadequate to serve both the general ADATSA population and certain special groups, such as those without housing and the mentally

[2] Other programs accept clients with mental impairment and mental health problems, however, they may not be able to always provide mental health services and cannot charge for these extra services. Such services inlclude the extra 28 days of evaluation allowed for MICA clients

[3] See Charles Morgan, et al, February, 1990, Intensive Protective Payee for Chemically Dependent Indigents: An Evaluatio n of the ADATSA Intensive Protective Payee Pilot Project, Office of Research and Data Analysis DSHS, Olympia, Washington.

impaired. There are four major consequences of this bed shortage:

1) Increased Wait Times- The limited supply of ADATSA-funded beds results in longer wait times for treatment. As wait times increase, fewer clients start treatment (see Chapter 7). During this wait, most assessment centers try to keep in contact with the client and maintain motivation, but these services are not covered by ADATSA funds.

2) Assessment center staff spend more time locating beds- Over half of the people interviewed felt that too much time is spent contacting treatment centers to locate empty beds. Counselors spend an estimated 1.5 to 3 hours calling treatment agencies for each client served. This affects small centers disproportionately as their small ADATSA caseload makes it difficult to build informal relationships with treatment agencies.

3) Lack of access to most appropriate treatment- Lack of residential beds impacts all sub-groups of the ADATSA population. The 30/60/90 path is the most commonly recommended treatment, but there is an acute shortage of recovery house beds for both men and women. Two optional treatment paths, the 30/90 and the 30-Only, have developed partially because of this shortage.

MICA clients are affected more than others by the lack of beds. One of 8 eligible clients qualify for MICA status.[4] MICA clients wait an exceptionally long time for inpatient treatment, often as long as 4 months.

Three recommendations were made for improving services to MICA clients: increase the number of MICA beds, provide a MICA treatment agency east of the mountains, and provide a way to incorporate a mental health component in some OP and IP treatment programs.

4) Lack of transitional housing, especially Recovery House beds-The lack of transitional housing, especially recovery house beds, was described as a serious problem by five of 18 respondents. Four of these 5 were directors of medium-sized assessment centers. The respondents see recovery house treatment as transitional housing, and housing seems to be a particular problem in towns large enough to have a significant need for low-income housing but too small to have attracted much funding to develop such housing. Smaller assessment centers seem able to place the occasional ADATSA client needing housing in a temporary home or shelter.

EXPANSION OF SERVICES

The vendor rates for ADATSA inpatient beds and outpatient slots were the second major problem according to assessment centers (Table 2.1). Directors mentioned a need for both greater accessibility to ADATSA-funded treatment and more auxiliary services.

Assessment center directors would perfer ADATSA eligibility requirements be re-worked to accommodate clients with no prior legal involvement, clients with no history of treatment failure, and those already in treatment when they apply for ADATSA funding. They also expressed needs for longer treatment time and more

[4] Estimates ranged from 1% to 41%; the median response was 12.5% as observed in this study.

Table 2.1
Responses from Assessment Center Directors on the Four Most Important Issues for Improvement that the State and the ADATSA Community Should Work On

Response Categories/Issues		Large n=11	Medium n=5	Small n=2	Total n=18
A.	**ADDITIONAL BEDS/SLOTS**				
1.	More ADATSA beds are needed	7	3	2	12
2.	More transitional housing	1	4		5
3.	More MICA beds	3			3
4.	More OP slots	2			2
5.	More recovery house beds	1	1		2
B.	**ADDITIONAL FUNDING**				
1.	Higher vendor rate - IP and OP facilities	6	2		8
2.	Make longer treatment time available	1	2		3
3.	More funding for assessment centers	2	1		3
4.	Reduce wait times	2			2
5.	Increase funding for vocational rehabilitation	1	1		2
6.	Access to treatment for people in jail		2		2
7.	Larger initial GAU checks		1		1
8.	Increase number of ADATSA treatment agencies	1			1
9.	Fund transportation to treatment		1		1
10.	Fund pre-treatment medical needs		1		1
11.	Fund urinalysis		1		1
12.	Fund psychological exams		1		1
C.	**PROGRAMMATIC REQUESTS**				
1.	Easier paperwork	1	2	1	4
2.	Stabilize funding for agencies	2	1		3
3.	Easier exception to policy procedures	1			1
4.	Better communications with CSO		1		1
5.	Have central bed registry			1	1
6.	An ADATSA newsletter		1		1

funding for assessment centers.

ADATSA clients receive state-funded medical coverage, which provides a very narrow scope of services and excludes, for example, dental care. The directors felt this gap should be covered by ADATSA.

PAPERWORK, COMMUNICATION, AND FUNDING STABILITY

Paperwork, communication, and funding stability were mentioned as the most important programmatic problems.

SUMMARY

Assessment center directors said a lack of treatment beds significantly hampers the treatment of chemically dependent, indigent Washington State residents. MICA, Drug Residential, Extended Care and Recovery House beds are in especially short supply. Though covered by state Medicaid funds, some clients have difficulty getting dental, medical, and mental health care.

TREATMENT AGENCIES AND PROGRAM UTILIZATION

3

At the time of this study there were 99 programs contracted to treat ADATSA clients, in 90 treatment agencies. ADATSA-funded programs constitute less than one-third of all Washington State programs which have the necessary accreditation to serve ADATSA clients.

ADATSA contracted agencies can be divided into two groups:

1) Residential treatment programs - including Intensive Inpatient, Recovery House, Extended Care and Drug Residential. Each of these treatment programs has a specific length and focus in treatment. Each has a contract directly with the state (DASA).

2) Outpatient treatment programs - these programs are funded through county contracts at a fee-for-service rate and have a monthly limit of reimbursable sessions per client.

This chapter includes three separate topics:

- A description of the ADATSA treatment programs and service capacity of each;
- The results of a survey of treatment directors or program managers regarding their perceptions of needed improvements in these services; and
- The findings regarding the demand for services and the capacity for providing them.

SURVEY METHODS

Information was gathered by interviewing directors and staff of half the residential treatment agencies (19 of 39 agencies) and one-third of the outpatient agencies (20 of 60 agencies) across Washington state. Outpatient agencies were stratified by size and inpatient agencies by type of program (see Appendix 3 for more information).

All treatment agency managers interviewed had the same chance of responding to a common set of questions in a two-hour interview. Questions were asked about the functioning of treatment agencies, programs and services, costs, staffing, and the ADATSA client treatment process. In addition, managers were then asked the same summary questions as assessment center directors on the four most important issues or areas for improvement and any issue overlooked.

TREATMENT PROGRAMS

The assessment center counselor designs a treatment path composed of one or more treatment programs for each ADATSA client based on that client's needs. The client therefore is placed into any one or more treatments discussed below, while on ADATSA.

PRIMARY TREATMENT: INTENSIVE INPATIENT PROGRAMS

Intensive inpatient programs focus on the treatment of the disease of addiction and are the first step of many treatment paths. The needs of most ADATSA clients can best be met in structured residential facilities for at least a brief period of time.

At the time of this study there were 15 intensive inpatient programs which contract with the state to treat ADATSA clients. Treatment usually lasts 21 or 28 days. During the 1989-1991 biennium there were 263 intensive inpatient beds contracted for ADATSA treatment (see Table 3.1).

PRIMARY TREATMENT: DRUG RESIDENTIAL PROGRAMS

Drug Residential programs differ from intensive inpatient in that they are designed for clients who need more than 30 days of intensive inpatient treatment, but are not thought to be mentally impaired. These programs are used most often for 'hard' drug (heroin, cocaine, and amphetamines) users. Clients can stay up to 180 consecutive days, the maximum allowed for an ADATSA client, and therefore do not receive subsequent ADATSA outpatient treatment, as they have used all ADATSA eligibility.

Table 3.1
Occupancy Rate by Type of Program
Fall of 1989

Type of Treatment Program	# of Agencies	# Beds/Slots Contracted	Maximum Length of Stay	Nov. 1989* % of Beds/Slots Occupied
RESIDENTIAL				
Intensive Inpatient	15	263	30	92%
Drug Residential	6	95	180	106%
Extended Care	2	191	90	96%
Dual Diagnosis + MICA Extended Care	1	16 16	30 90	100% 100%
Recovery House	15	197	60	93%
Total	39	778	--	95%
OUTPATIENT				
**Largest Counties	25	666	90	82%
Other Counties	35	245	90	75%
Total	60	911	--	80%

* Data source: Requested report provided by Gary Reynolds, Region 6 Administrator for Division of Alcohol and Substance Abuse; Clients in Bed/Slots as of November 14, 1989.

** Five counties in order of largest number of contracted slots: (King 354, Pierce 130, Spokane 73, Snohomish 60, Yakima 49)

There are six Drug Residential facilities with ADATSA contracts, accounting for 95 beds. Five of these facilities are in the western part of the state.

There are only one-third as many contracted drug residential beds as there are intensive inpatient beds (see Table 3.1). Considering the maximum length of stay, one intensive inpatient bed can accommodate as many as twelve clients a year. On the other hand, with a maximum length of stay of 180 days, a drug residential bed accommodates two clients a year.

PRIMARY TREATMENT: EXTENDED CARE PROGRAMS

Extended Care programs are used most often for alcoholic clients who have not previously responded to the shorter treatment programs because they are more debilitated and respond to therapy more slowly. Washington has two Extended Care facilities, one in Seattle and one in Spokane, with 191 ADATSA beds. There are 73% as many contracted extended care beds as intensive inpatient beds. Clients can stay up to 90 days. Therefore, one extended care bed can accommodate four clients a year.

MICA TREATMENT FACILITIES

Only one facility, located in Seattle, is contracted to provide specialized MICA services. A client who is provisionally diagnosed as having mental problems enters the facility as a differential diagnosis client, with questionable mental status. Following 28 days of detoxification and treatment, the client is reassessed. His/her specialized treatment as a MICA client is often extended, for an additional 90 days. There are 16 MICA beds, about 1 MICA treatment bed for every 17 Intensive Inpatient beds. One MICA bed can accomodate three clients a year.

TRANSITION TREATMENT: RECOVERY HOUSES

Following intensive inpatient treatment, many clients need some kind of support for transitioning into the less structured outpatient treatment phase. Recovery (or halfway) houses are all designed to provide this kind of reintegration.

Recovery House treatment is used most frequently by clients who do not have a safe or stable living situation supportive of the recovery process. It builds on recovery concepts acquired during intensive inpatient treatment, but also focuses on the acquisition of living and job skills necessary for independent living.

There are 15 ADATSA-contracted Recovery Houses in the state, with a total of 197 beds. ADATSA funds up to 60 days of Recovery House treatment per admission. This allows for six clients a year per bed. Since the recovery house stay is twice the intensive inpatient stay, the availability of recovery house beds is about one-third of intensive inpatient beds.

OUTPATIENT PROGRAMS

DASA contracts with each county to provide ADATSA outpatient treatment services for a total of 911 slots. Sixty programs have county sub-contracts to treat ADATSA clients. ADATSA caseloads range from fifty clients at the largest to

only one client at the smallest facility. Outpatient facilities may provide "intensive" and/or "regular" aftercare outpatient services. Regardless, the total time available per client cannot exceed 90 days, thus allowing for four clients per slot a year.

Regular outpatient programs are designed to provide continuing support for the client in the recovery process after completion of the primary, usually inpatient, treatment. Regular outpatient programs usually provide open group sessions with additional one on one counseling as needed.

The intensive outpatient program is designed to provide primary care (like most intensive residential programs), concentrating on treatment issues rather than on re-entry skills. They are usually closed sessions of no more than 15 people.

ADATSA outpatient providers are required to also teach living and job skills to these clients. Large facilities may contract with private agencies for job-training seminars. Smaller facilities in urban areas may refer clients to Vocational Rehabilitation services, GED programs, or other job service programs. Small agencies have the most difficulty complying with this requirement because they have too few ADATSA clients to justify separate groups. As such, ADATSA clients are integrated into groups with other non-ADATSA outpatient clients.

SURVEY RESULTS ON TREATMENT DELIVERY

Each treatment program described above plays a different role in an ADATSA client's treatment and has its own difficulties fulfilling that role. The most notable differences in treatment agency responses about these differences were found between residential programs and outpatient ones (see Table 3.2).

RESIDENTIAL PROGRAMS

Inpatient program directors said the greatest concern of residential facilities is funding, specifically the vendor rate. Asked about this rate, of the nineteen inpatient programs interviewed, only four said that the per diem rate was adequate for ADATSA clients. They estimated that two private paying clients are necessary to cover the cost of an ADATSA client. Though their facilities had empty beds, they could not afford to accept more ADATSA clients to fill these beds.

The other major concerns of residential programs were respectively: better communication (with CSOs and the state), easier paperwork, improvement in the data entry system, and reimbursements for medical/dental care.

Table 3.2
Responses from Treatment Center Directors on the Four Most Important Issues for Improvement on which the State and ADATSA Community Should Focus

	Residential Programs			
	Long Term* n=6	Recovery House n=6	Intensive Inpatient n=7	Total n=19
A. ADDITIONAL BEDS				
1. More transitional housing	1	1		2
2. More recovery house beds are needed	1		1	2
3. More drug residential	2			2
Total	4	1	1	6
B. ADDITIONAL FUNDING				
1. Higher vendor rate IP and OP facilities	3	3	5	11
2. Make longer treatment time available	2		1	3
3. Realistic reimbursements for medical exams, psych exams, dental work	1	2	1	4
4. Improve de-tox system	1			1
5. Increase funding for voc-rehab				
Total	7	5	7	19
C. PROGRAMMATIC REQUESTS				
1. Better communication CSO-AC-TA	-	1	3	4
2. Easier paperwork - simpler system	2	1	1	4
3. Improved data entry system	1	1	2	4
4. Take special group beds from other sources than general bed pool	1	1	1	3
5. Stabilize funding			1	1
6. One ADATSA coordinator/county		1	1	2
Total	4	5	9	18

Table 3.2 (continued)

	Outpatient Programs			
	Large Outpatient n=5	Medium Outpatient n=7	Small Outpatient n=8	Total n=20
A. ADDITIONAL BEDS				
1. More transitional housing	2	4	1	7
2. More recovery house beds are needed	1	1		2
3. More intensive inpatient	1		3	4
4. More outpatient slots	1		1	2
Total	5	5	5	15
B. ADDITIONAL FUNDING				
1. Higher vendor rate IP and OP facilities	1	3	1	5
2. Make longer treatment time available		1	3	4
3. Realistic reimbursements for medical exams, psych exams, dental work		1		1
4. Improve de-tox system			1	1
5. Increase funding for voc-rehab		1	1	2
Total	1	6	6	13
C. PROGRAMMATIC REQUESTS				
1. Better communication CSO-AC-TA	1			1
2. Easier paperwork - simpler system			1	1
3. Take special group beds from other sources than general bed pool			1	1
4. IOP decisions should be made by assessment center	1			1
5. Stabilize funding		1		1
6. Living stipends should arrive on time	1			1
7. Should be longer than 24 months to access ADATSA		1		1
8. Protective payee system needs improvement		1		1
9. Want list of job referral centers			1	1
10. DSHS should track ADATSA clients			1	1
Total	3	3	4	10

OUTPATIENT PROGRAMS

The most frequent problems mentioned by outpatient programs were the need for more transitional housing, higher vendor rate, longer treatment time, and more intensive inpatient treatment prior to outpatient placement. The major concern for transitional housing among outpatient programs stems from their role in transitioning clients into independent living in the community. The lack of inexpensive living situations in neighborhoods supportive of recovering clients hinders this effort.

BED AVAILABILITY

Staff of both assessment centers and treatment agencies believe more beds are needed. To measure the size of the need, occupancy rates for current beds were examined, percentages of clients exceeding the supply of beds were computed, and bed availability estimates were made.

OCCUPANCY RATES

Table 3.1 shows residential programs were operating at close to 100% capacity, whereas outpatient programs were operating at less than capacity during the fall of 1989[1]. Few, if any, extra beds can be obtained by more efficient utilization of current bed allocations.

PERCENT OF CLIENTS PLACED WHICH EXCEEDS NUMBER OF BEDS AVAILABLE

Table 3.3 shows the number of beds available during the four-month study period in each residential treatment path, with and without drop outs. The number of clients waiting for placement in each bed, and the number of available beds are used to compute percentages of clients exceeding the supply of beds. Even given the fact that counselors may place the client in less-than-ideal treatment because of lack of beds, these percentages of excess clients for all residential paths and for the Drug Residential path in particular are very high.

Treatment agencies overbook clients assuming a certain percentage will not show-up. This is necessary for the agencies to use beds to capacity given long wait times and consequent high proportion of no-shows. If the overbooking percentage exceeds the percentage of no-shows, agencies still accept clients for treatment in extra beds, but wait times and no-shows will increase. In other words, wait times and no-shows are the main mechanisms which eventually balance demand with relatively fixed supply.

From August to November, 1989, the system was placing in residential programs about 46% more clients than it could treat. No-shows, as a percentage of clients treated were only 31%, so wait-times were expected to increase. This demand grew even more: more assessments were performed in early 1990 (Figure A3C in Appendix), resulting in longer wait lists and wait times (Figure A3D in Appendix).

The other mechanism to balance demand and supply is the placement of clients in alternative treatment paths by assessment center counselors. The outpatient only path is usually the path most available for this purpose. This outpatient mechanism is discussed next.

[1] The fall of 1989 was a period in which capacity was being restored after funding cuts at the end of the previous biennium.

Table 3.3

Estimated Percent of Clients Placed Which Exceeds the Number of Beds Available: Comparison of Demand and Supply

(Average Monthly Data for August 1 - November 30, 1989)

	Bed Availability (Supply)		# of Clients Placed into Treatment (Demand)	% of Clients Placed Which Exceeds # of Beds Available* (% of Demand Exceeding Supply)
	Assuming No Drop-out (during treatment)	Adjusting for Drop-out (during treatment)		
Total # of Clients	381	454	665	46%
Actual Placement				
Intensive Inpatient Path	263	330	473	43%
Recovery House	98	135	184	36%
Long Term:				
Extended Care	69	85	96	13%
Drug Residential	16	24	65	171%
MICA	16	21	29	38%
Assuming Different Placement				
If All Intensive Inpatient Clients Placed into Treatment were also Placed into Recovery House (i.e. all 30/60/90 instead of 30/90 and 30 only)	98	135	473	250%

* Treatment agencies overbook clients assuming a certain percentage will not show-up. This is necessary for the agencies to use beds to capacity given long wait times and consequent high proportion of no-shows. If the overbooking percentage exceeds the percentage of no-shows, agencies still accept clients for treatment in extra beds, but wait times and no-shows will increase. In other words, wait times and no-shows are the main mechanisms which eventually balance demand with relatively fixed supply. The other mechanism to balance demand and supply is the placement of clients in alternative treatment paths by assessment center counselors. The outpatient only path is usually the path most available for this purpose.

Note: Clients can be placed into more than one program in certain treatment paths. Therefore, number of clients in each program do not add up to the total number of clients in treatment.

Table 3.4

Additional Beds Needed, Assuming All ADATSA Clients Treated Should Receive Treatment in a Residential Setting

(Estimates are based on the number of clients who actually showed up for treatment and based on ADATSA Residential bed availability by Treatment Path, monthly in two time periods.)

Bed Availability in Different Treatment Paths	Fall of 1989 (8/1/89 to 11/1/89)		First Year of Biennium (7/1/89 to 6/30/90)	
	# of Beds	% of Total Beds Available	# of Beds	% of Total Beds Available
Total Residential Beds Available	454	100%	454	100%
Number of Beds Needed to Accommodate All Clients in a Residential Setting	550	121%	648	143%
Additional Beds Needed to Accommodate All Clients in a Residential Setting*	96	21%	194	43%

* The number of additional beds needed is based on clients actually showing up for treatment in the time periods studied in spite of long wait times. This is a conservative estimate since it excludes clients who did not show-up for treatment even though accepted and placed into treatment. To accommodate all clients placed into treatment in a residential setting 261 additional beds would have been needed in the fall of 1989, an increase of 57%. The corresponding estimates for the first year of the biennium are 388 additional beds equivalent to an 85% increase in contracted beds.

Notes: Monthly bed availability is computed from number of contracted beds, adjusted for maximum length of treatment time, and for drop-out rates specific to each treatment path's primary program. (See Chapter 7.) Drop-outs are assumed to be distributed evenly across time.

30/60/90 clients are estimated by the number of recovery house beds still available after placement of clients into the recovery house only path.

Differential Diagnosis clients usually continue treatment in either MICA or regular extended care. The number of extended care beds is adjusted accordingly.

550 is the estimated average number of clients entering treatment August through November of 1989, excluding drop-outs due to wait times. Given the almost one month lag between assessment and treatment, the number treated in August was estimated from the number assessed in July. The same calculations were performed for the subsequent months. The same estimation procedures were used for the period of one year 7/1/89 to 6/30/90.

NEED FOR ADDITIONAL BEDS IF ALL CLIENTS TREATED WERE PLACED IN A RESIDENTIAL SETTING

Estimates were made for two time periods: the fall of 1989, when this study sample of clients were selected, and the first year of the biennium (7/1/89 to 6/30/90) (see Table 3.4).

During the fall of 1989, twenty-one percent more beds would have been needed to place all treated clients in a residential setting. During the period July, 1989 to June, 1990, the proportion of needed beds increased to 45% due to the higher number of clients entering treatment: about 650 per month versus 550 in the fall of 1989. This means that excess clients were placed exclusively in the outpatient treatment path, perhaps inappropriately, due to limitations in the number of available beds. The question of appropriateness of such placements will be discussed in Chapter 5.

The number of additional beds needed is even higher if we wish to consider not only all treated clients but also those accepted into treatment and dropping out due to wait times. In order to provide residential treatment for all persons who were accepted and placed into treatment in the fall of 1989, an additional 261 beds would have been necessary. This would have been an increase of 57% more beds. Similarly, 388 additional beds, or an 85% increase, would have been needed for the first year of the 1991/1993 biennium.

SUMMARY

Treatment agency staff agreed with assessment center staff about the shortage of ADATSA beds. Data on bed utilization and bed availability confirm this shortage. Residential agencies with extra capacity may refuse to increase ADATSA caseloads because they cannot recover their costs unless vendor rates are increased. Outpatient programs indicated the need for more transitional housing. This also confirms one of the major concerns of assessment center staff. Finally, some treatment agency staff mentioned communication problems among the components of the ADATSA system.

CLIENT PROFILES

4

Since its beginning in 1987, ADATSA has made treatment accessible to thousands of people living in Washington State. There is little information, however, about these clients' demographic and social characteristics, drug and legal involvement, and other factors which may affect treatment completion. This chapter describes the ADATSA client population at the assessment and eligibility stages of the program.

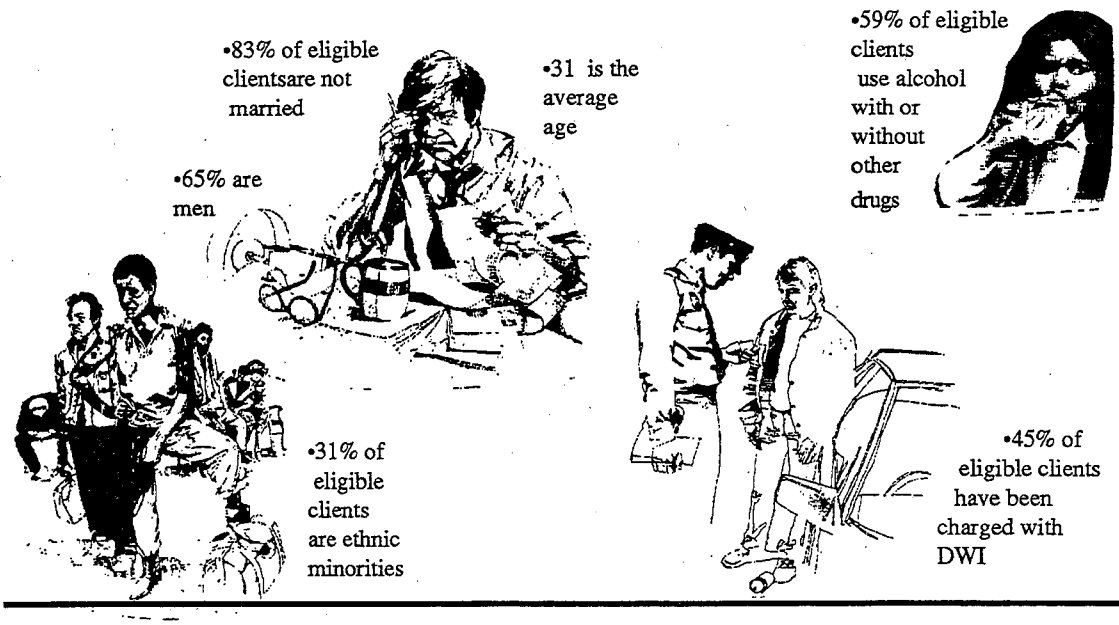
METHODS

A stratified sample of 23 assessment centers (62%) was selected randomly. From these centers, 1118 records of clients assessed between August and November, 1989 were reviewed (see Appendix 4 for sampling methods). These records contained information on client characteristics, eligibility, treatment placement and completion.

MAJOR FINDINGS

The typical client is an unmarried, white male in his early thirties, often homeless, living alone or with non-relatives, and often involved with the law. One out of every three clients is female, one out of every four is an ethnic minority. The average client (indigent and severely chemically dependent by eligibility requirements) has had a 15-year history of substance abuse starting at age 16, with one or more prior treatment episodes. A significant number of clients have physical, mental or emotional problems.

PROFILES



DEMOGRAPHIC AND SOCIAL CHARACTERISTICS OF ADATSA CLIENTS

Age - The average eligible client is relatively young: The median age of this population is 31.

Gender - Over one-third of the sample were women (35%) (Table 4.1). Among the eligible women, the proportion of those pregnant was slightly higher (12%) than among those assessed (9%).

Marital Status - 16% of the clients reported being married.

Education - Two-fifths of the clients had less than a high school education, an equal proportion had high school or GED. Only one-fifth had post-high school education.

Ethnicity - Two-thirds of the clients were white, 17% were black and 10% were Native American. Both the black and Native American proportions exceed their representation in the state's adult population; 2.8% and 1.4% respectively. This over-representation may be related to higher rates of poverty and chemical dependence among minority groups than among whites.

Table 4.1
Client Profiles at the Eligibility Stage*

BACKGROUND	ASSESSED APPLICANTS (n=1118)	ELIGIBLE* APPLICANTS (n=909)
MEDIAN AGE	32	31
ETHNICITY		
White	68%	69%
Black	18%	17%
Native American	9%	10%
Hispanic	3%	2%
Asian	1%	2%
SEX		
Men	65%	65%
Women	35%	35%
(Pregnant Among Women)	(9%)	(12%)
MARITAL STATUS		
Married	16%	16%
Not Married	83%	83%
EDUCATION		
Less Than High School	41%	42%
High School/GED	39%	38%
Post High School	19%	18%

* all eligible clients are indigent

*For this and other tables in this chapter, percentages don't add up to 100% because missing values or "don't know" answers are included in the computation.

DRUG HISTORY AND CRIMINAL JUSTICE INVOLVEMENT

Drug abuse and treatment history - About one-quarter of the clients used only alcohol; one-third used alcohol with other drugs; one-fifth used only cocaine; and the remaining one-fifth used heroin, marijuana, hashish, amphetamines, or other drugs. Hard drug users (cocaine, heroin and amphetamines) constitute 30% of all clients (Table 4.2).

Table 4.2
Substance Abuse History of Assessed and Eligible Clients

ABUSE HISTORY	ASSESSED APPLICANTS (n=1118)	ELIGIBLE APPLICANTS (n=909)
DRUG OF CHOICE		
Alcohol Only	24%	23%
Alcohol & Other Drugs	33%	36%
Cocaine	19%	20%
Heroin	8%	8%
Marijuana/Hashish	6%	7%
Amphetamines	2%	2%
Other Drugs	2%	2%
AGE AT FIRST USE (median)	16	16
# OF YEARS OF USE (median)	15	15
FAMILY HISTORY OF CHEMICAL DEPENDENCY		
Yes	83%	85%
No	14%	13%
PRIOR ADMISSION TO DETOX		
Yes	32%	34%
No	40%	37%
PRIOR TREATMENT		
None	32%	30%
One	29%	30%
Two	16%	17%
Three	9%	9%
Four+	12%	12%

Note: "Detox" refers to detoxification services usually lasting one to three days. "Prior Treatment" refers to client-reported treatment services received any time in their lifetime prior to current assessment. Funding of these services is unknown.

The median years of chemical use for this population was 15, and the median age at first use was 16.

Two-thirds of ADATSA-eligible clients had at least one prior episode of treatment, and 21% had three or more prior treatment episodes. One-third reported prior admission to detox and 85% reported a family history of chemical dependency, indicating a high level of multi-generational involvement with alcohol and drugs.

Criminal Justice Involvement - Table 4.3 shows information about the involvement of both assessed and eligible clients with the criminal justice system. Twenty-two percent of eligible clients were court-referred, whereas 27% were on parole or probation. Seventy-five percent of ADATSA clients have had a prior arrest or charge, and 45% have had a DWI.

MENTAL, PHYSICAL, AND SOCIAL PROBLEMS

ADATSA-eligible clients are indigent by definition. They also have been unemployed for at least 30 days before the assessment and are considered unemployable. Analysis of the sample revealed a number of other problems related to mental or emotional conditions, physical problems, and lack of life skills or social support (Table 4.4).

Mental/Emotional Problems - Twenty-two percent of eligible clients are reported to have mental or emotional problems. In addition, 16% reported a family history of mental problems.

Physical Problems - Nineteen percent of eligible clients had physical problems, including a need for medical and dental care.

Lack of social support - 41% percent of ADATSA clients lived alone or were homeless; 34% lived with relatives, and 16% were married. Over one-fifth (23%) lived in households with non-relatives.

Use of Other Public Assistance Programs - Half (51%) of all clients reported using one form of public assistance (excluding ADATSA). The majority of these were on General Assistance-Unemployable (GAU) (21%), and Aid to Families with Dependent Children (AFDC) (12%). Only 3% received Supplemental Security Income (SSI) and the rest (10%) reported receiving other forms of public assistance.

Table 4.3

Criminal Justice Involvement of Clients at the Asessment and Eligibility Stages.

LEGAL INVOLVEMENT	ASSESSED APPLICANTS (n=1118)	ELIGIBLE APPLICANTS (n=909)
ASSESSMENT COURT-ORDERED		
Yes	21%	22%
No	64%	62%
EVER ARRESTED OR CHARGED		
Yes	72%	75%
No	21%	19%
EVER CHARGED WITH DRIVING WHILE INTOXICATED		
Yes	42%	45%
No	47%	45%
ON PROBATION OR PAROLE		
Yes	26%	27%
No	64%	63%

Note: DWI and Ever Arrested data are based on the client's self report during the assessment interview.

Table 4.4
Additional Problems and Needs of Clients at the Eligibility Stage

PROBLEMS	ASSESSED APPLICANTS (n=1118)	ELIGIBLE APPLICANTS (n=909)
MENTAL/EMOTIONAL PROBLEMS		
Yes	22%	22%
No	75%	75%
FAMILY HISTORY OF MENTAL PROBLEMS		
Yes	16%	16%
No	75%	75%
PHYSICAL PROBLEMS		
Yes	21%	19%
No	77%	79%
LIVING ARRANGEMENTS		
Relatives	33%	34%
Unrelated-Household	23%	23%
Alone	24%	23%
Homeless Shelter	12%	12%
Homeless Streets	6%	6%
OTHER PUBLIC ASSISTANCE		
None	45%	49%
General Assistance (GAU)	27%	21%
AFDC Grant	11%	12%
SSI Grant	3%	3%
Other	10%	10%

Note: These problems are ascertained to exist by the assessment center counselor during the client's assessment for chemical dependency.
AFDC= Aid to Families with Dependent Children
SSI= Supplemental Security Income
Other public assistance includes Medicaid coverage and food stamps

PROFILE STABILITY BETWEEN ASSESSED AND ELIGIBLE CLIENTS

With one exception, the characteristics of assessed and eligible clients were found to be similar (chi-square tests showed no significant differences). The only significant difference between assessed and eligible clients was in GAU; fewer GAU clients were found eligible, suggesting that case workers sometimes cannot distinguish between chemical dependency-related problems and other mental/physical disabilities.

SUMMARY

To qualify for services, the ADATSA client has to be indigent and unemployable. This analysis found that eligible clients were, on average, white, male, and unmarried. However, there were large proportions of women and ethnic minorities.

The majority used alcohol alone or combined with other drugs, but a significant proportion (30%) used only hard drugs, the most common of which is cocaine. Clients were late-stage, chemically dependent users, with a drug use history of 15 years, starting at age 16.

The typical client had one or more prior treatment episodes and has a family history of substance abuse. The majority had been involved with the criminal justice system.

A significant proportion, one out of five, reported mental/emotional problems, or physical problems. Four out of ten lived alone or were homeless. Half used some form of public assistance prior to becoming eligible for ADATSA treatment.

IMPLICATIONS

1. The clients' long history of drug use, their coming from a chemically dependent family, and their having previous treatment failures, have implications for the most appropriate treatment length and its components.

2. The clients' living situation, marital status, and past legal involvement suggest the importance of housing, social support and community reintegration for clients after residential treatment.

3. The clients' indigence, low level of formal schooling, and previous support from public assistance have implications on the level of auxiliary services required to help clients get off welfare and into employment.

APPROPRIATE TREATMENT: RESULTS OF A PEER PANEL REVIEW

5

Chapter 2 reported assessment center directors' responses about problems counselors have placing clients in appropriate treatment. This chapter addresses the question of whether consensus exists on what is appropriate treatment.

METHODS

A peer panel of qualified professionals was convened to define the criteria used for placement, to evaluate the appropriateness of ADATSA placements, and to recommend program changes. The panelists were selected based on length and scope of experience, treatment modalities, regional representation, gender, ethnic diversity and variations in treatment philosophy (see Appendix 5).

After a brief review of a sample of cases, panelists were asked whether these four ADATSA-specified treatment paths were distinguishable, based on the available information for each client:

1. Outpatient (OP),
2. 30 days of Inpatient, 60 days of Recovery House and 90 days of Outpatient (30/60/90),
3. Long Term Residential (either Drug Residential or Extended Care) (LTR), and
4. Mentally Impaired/Chemically Addicted (MICA).

The panelists agreed that these four paths were distinguishable, but added that a variation of the 30/60/90 path was frequent and important. This is the 30 days of inpatient and 90 days of outpatient (30/90), which developed because of a lack of recovery house beds.

The five treatment paths were sampled equally. The cases reviewed were actual clients who had been assessed for an ADATSA placement, deemed eligible for treatment, had accepted treatment, and had been placed in one of the five treatment paths (Appendix 5, Table A5.1).

The 15 panelists made their treatment recommendations for the client cases without knowing the actual treatment recommendations. Ten of the 60 cases were common cases, reviewed by all five teams. Common cases were used to increase research confidence in the panelists' recommendations (inter-team reliability). Fifty of the 60 cases were team-specific cases, each case reviewed by only one 3-person team. Team-specific cases were used to increase the generalizability of these recommendations. Many different kinds of clients were reviewed by each team.

Recommendations for treatment placement were made within the constraints of the ADATSA system. Later, panelists were also asked to recommend ideal treatment scenarios, without considering current limitations.

MAJOR FINDINGS

1. There was a high degree of agreement among professionals on the most appropriate ADATSA treatment for specific clients.
2. The correspondence between actual placements of ADATSA clients and the recommendations made by the panelists was high for clients placed in more intensive/ residential paths. It was very low for clients placed in 30/90 and outpatient paths.
3. Professionals used consistent criteria to arrange appropriate treatment.
4. Ideal recommendations for the most appropriate duration of ADATSA-funded treatment were about twice as long as actual funded treatment time, but most often involved extra outpatient treatment; and
5. Specific additional client needs such as medical, dental, and psychological care, vocational training and affordable housing are not currently being met.

DEGREE OF AGREEMENT AMONG PANELISTS

Each panelist reviewed 20 cases (10 common and 10 team-specific), first making independent recommendations, then convening in groups of three to make team recommendations. Team recommendations were categorized as follows based on the amount of agreement in each group:

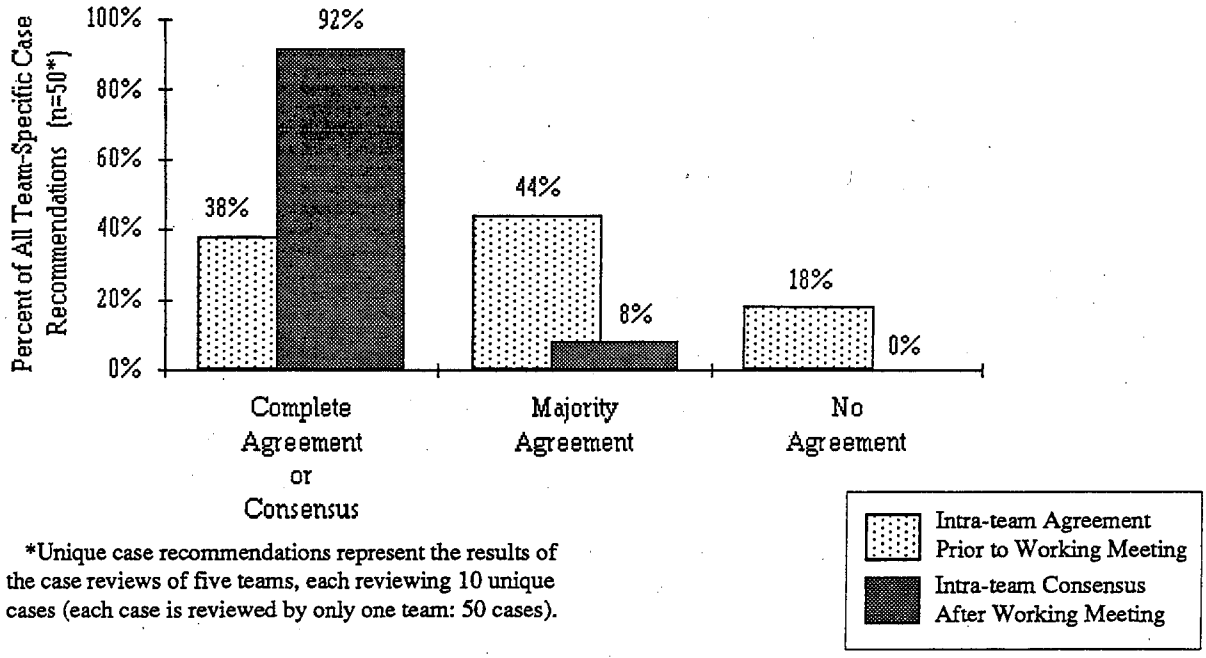
1. Complete Agreement or Consensus: all three team members agreed on the same mode of placement for a client.
2. Majority Agreement: two of the three team members agreed on a recommendation.
3. No Agreement: no two panelists agreed on the best recommendation.

There was considerable agreement on placements among team members making independent recommendations before the meeting (Figure 5A), but most of the agreement was at the majority level. Panelists reached majority agreement in 44% of the 50 team-specific cases and 54% of the 10 common cases. The panelists agreed completely in 28-38% of the cases and reached no agreement on 18% of both team-specific and common cases.

Agreement among panelists in each team was strengthened in the meetings where teams reached consensus in 92% of the 50 team-specific cases and 78% of the 10 common cases (Figure 5A). Missing information in client records caused most of the lack of agreement in the common cases (Appendix 5, Tables A5.2 and A5.3).

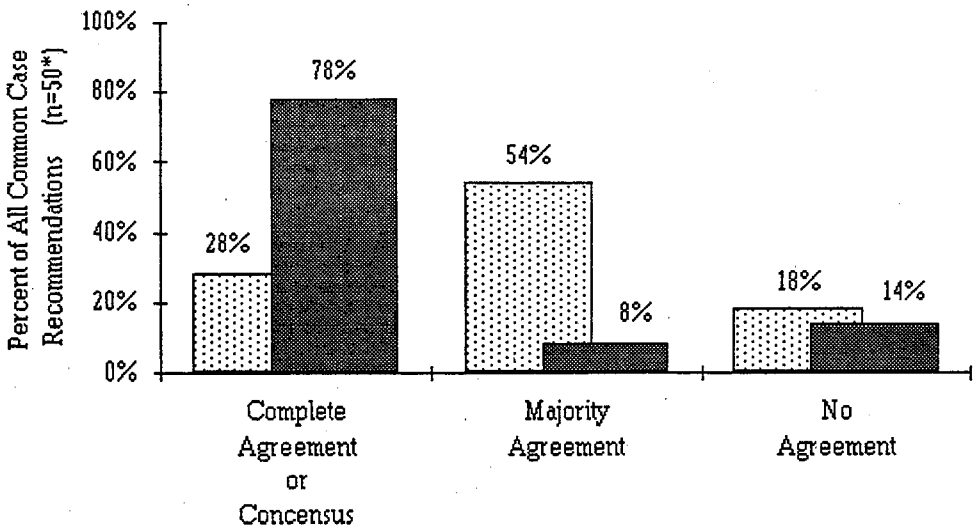
Figure 5A

Comparison of Agreement for 50 Team-Specific Cases



*Unique case recommendations represent the results of the case reviews of five teams, each reviewing 10 unique cases (each case is reviewed by only one team: 50 cases).

Comparison of Agreement for 10 Common Cases



*Common case recommendations represent the results of the case reviews of five teams on 10 commonly-shared cases (for a total of 50 recommendations: 5 teams).

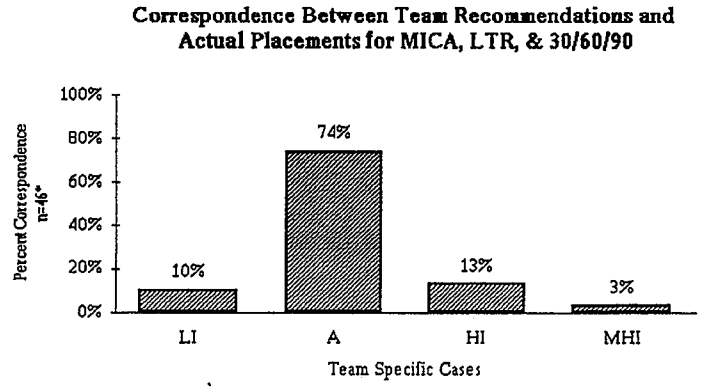
APPROPRIATENESS OF ACTUAL PLACEMENTS

The panelists' recommendations discussed above were for treatment within the existing ADATSA system and assumed needed beds were available in all modalities. Team recommendations were compared with the actual placements made by assessment center counselors. Observations drawn from this comparison are as follows:

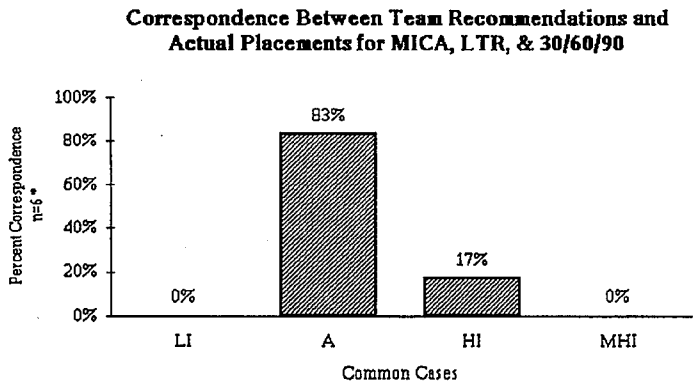
1. There was strong correspondence between recommended and actual placements in the three most intensive treatment paths. Clients who needed MICA, LTR or 30/60/90 were not difficult to identify and place (see Figure 5B). Despite lack of psychological test results and drug history information on assessment forms, most of these records had enough information to identify the need for the same type of treatment that was arranged for them (Appendix 5, Tables A5.4 and A5.5).

Differences between the recommended treatment and the actual placement not attributable to a lack of information were ascribed to the lack of recovery house beds and the resulting wait

Figure 5B

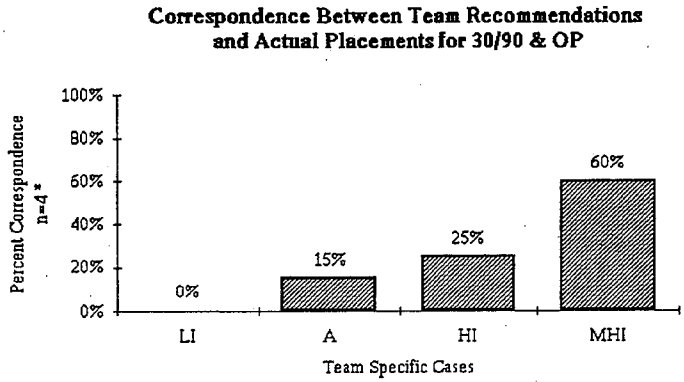


LI = Tx Recommendations for Lower Intensity
A = Agreement
HI = Tx Recommendations for Higher Intensity
MHI = Tx Recommendations for Much Higher Intensity

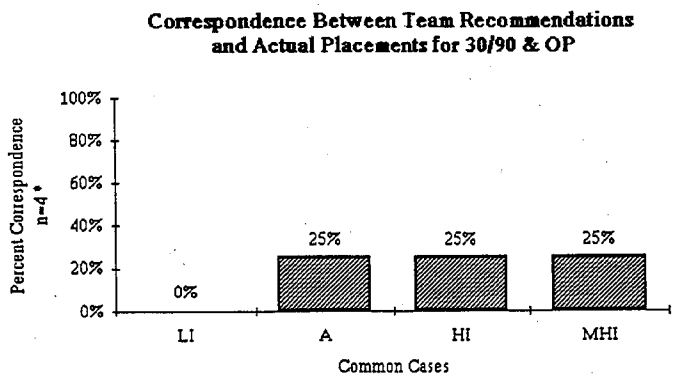


* Charts include majority and consensus cases only

Figure 5C



LI = Tx Recommendations for Lower Intensity
A = Agreement
HI = Tx Recommendations for Higher Intensity
MHI = Tx Recommendations for Much Higher Intensity



* Charts include majority and consensus cases only

times for this treatment path. Panelists preferred more intensive treatment in 17% of the common and 16% of the team-specific cases (see Figure 5B).

2. There was strong disagreement between the recommended and actual placement in the two less intensive treatment paths 30/90 and OP (see Figure 5C). Recommendations for these paths were in agreement with actual placements only 15% of the time for team-specific cases and 25% of the time for common cases. The panelists recommended the next closest treatment path (in terms of intensity) 40% and 50% of the time for team-specific and common cases respectively (see Appendix 5, Table A5.6 for a definition of the next closest treatment path).

3. Panelists preferred more intensive treatments. In the cases where there was a difference between the panelists' recommendation and the actual placement, panelists favored a more intensive treatment path for 85% of the common OP and 30/90 cases and 50% of the team-specific OP and 30/90 cases.

REASONS FOR DISAGREEMENT BETWEEN RECOMMENDED AND ACTUAL PLACEMENTS (30/90 AND OP)

Panelists indicated there was a lack of social or cultural information on the assessment forms. It is likely that for some of the cases recommended for other treatment paths, clients told their assessment counselors things that were not recorded or were not covered on the assessment form. Such missing information includes:

1. A description of a client's living situation including the current sobriety of family, roommates or significant others;

2. Available culturally-relevant resources allowing for the cultural needs of the client to be best met in the client's own community; and

3. A complete discussion of family ties including the ages of children, the type and extent of Children's Protective Service involvement and any long-term family plans such as reunification.

There was a notable proportion of women and blacks in the 30/90 path. The highest proportion of non-whites was in the OP path (see Appendix 6, Table A6.1). This supports the panelists' belief that cultural and family criteria are used by assessment center counselors to make placements into the 30/90 and OP treatment paths. Most panelists, however, believed that placement in lower-intensity paths may be inappropriate for this severely dependent population, regardless of family and cultural ties.

The lack of recovery house, MICA and LTR beds was another key point of the summary discussion. It was thought that some clients were placed in 30/60/90, 30/90 or OP treatment because of the extremely long wait times in more appropriate modalities.

Some communities have developed local systems that allow them to keep even MICA clients in the community appropriately. This is not common, but it may account for differences between panelists' recommendations and actual placements.

CRITERIA USED BY PANELISTS TO MAKE TREATMENT RECOMMENDATIONS

When panelists reviewed cases independently, they were asked to list the criteria used to make their recommendation. A master list of critical criteria was compiled and categorized from the individual responses of panelists. The list was ammended and approved by the group as comprehensive for this purpose.

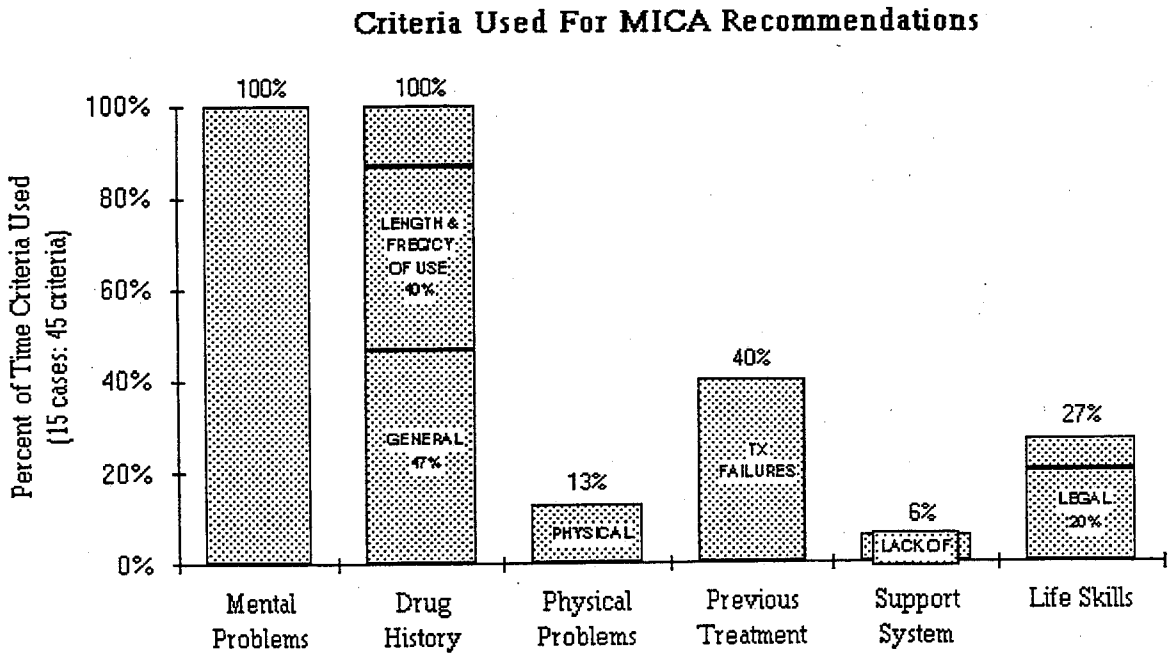
At the working meeting, panelists were asked to try to reach agreement among their own teams on the three most critical criteria for each case. As expected, elements of drug history, mental problems, life skills, support systems and previous treatment failures were all major factors in determining appropriate placement. The specific criteria, however, vary between treatment paths.

Criteria for Mentally Ill Chemically Addicted Recommendations

(Figure 5D)

1. Evidence of mental illness is the primary criterion[1] for this path.
2. Previous treatment failures and some physical problems also play a role in recommendations for MICA placement.

Figure 5D



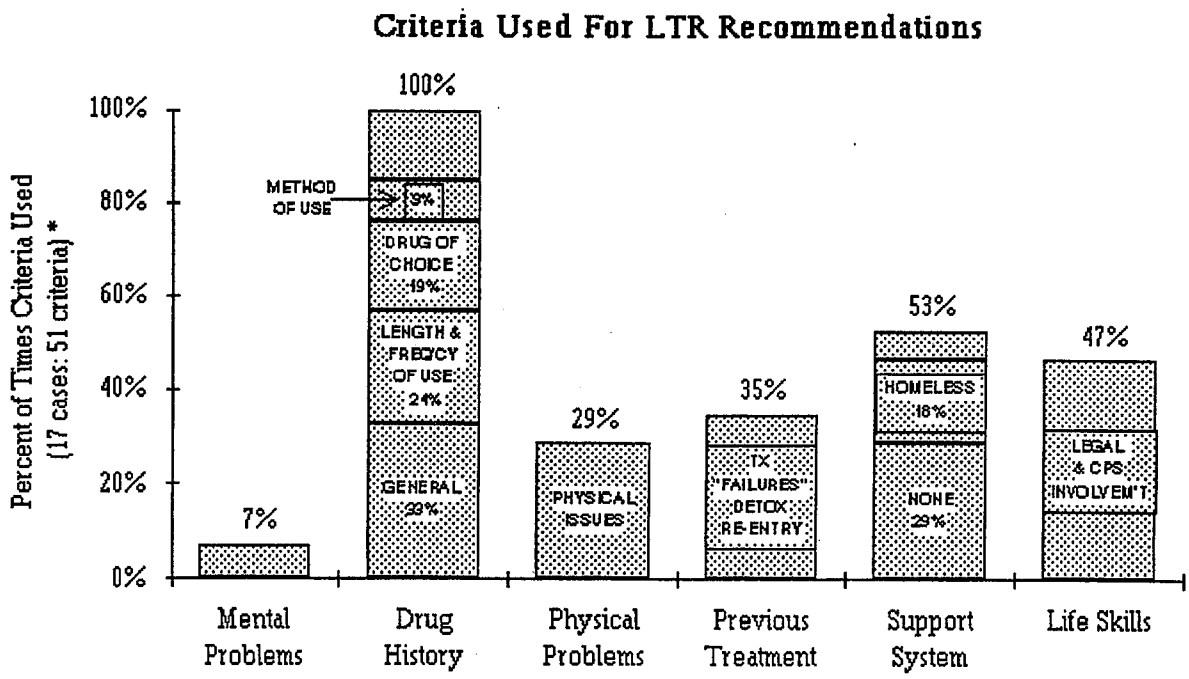
[1] Criteria used to determine mental problems include: history of mental illness, suicide attempts, current use of prescribed psychotropic drugs, counselor's observation and impression of client's current mental status, current psychological test results, and family history of mental illness.

Criteria for Long Term Residential (LTR) Recommendations

(Figure 5E)

1. Extreme addiction, in terms of frequent use of hard drug(s) intravenously or long term and heavy use of alcohol, was reported to be a significant concern when making a referral for LTR.
2. A lack of support systems and life skills were also cited.
3. Previous treatment failures for alcoholics are also a major consideration in LTR recommendations and detox recidivism was mentioned, uniquely for this group.
4. Physical problems, such as pancreatis, also were mentioned more often for LTR placement than in other groups. Physical problems related to alcohol often intensify the need for immediate and intensive residential treatment but can extend the time needed for chemical dependency treatment.

Figure 5E

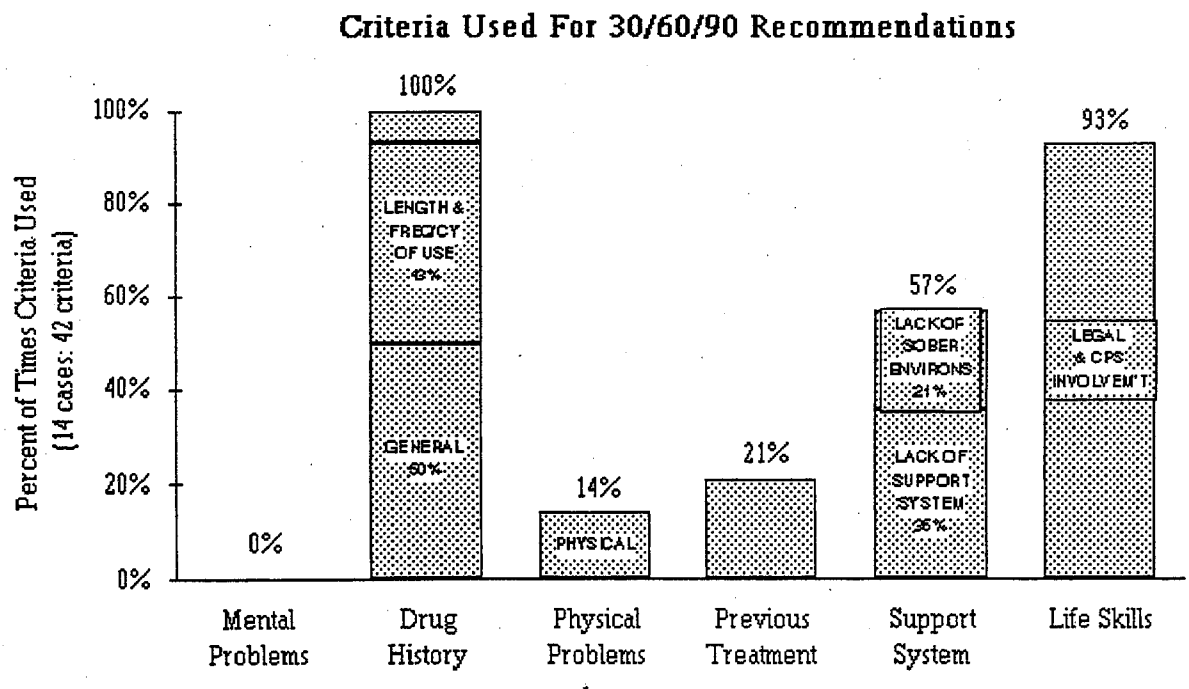


Criteria for 30/60/90 Recommendations

(Figure 5F)

1. Drug history was the primary criterion used to assess 30/60/90 cases. The panelists cited long drug history without intense hard drug use and alcohol-caused physical impairment for this treatment path.
2. Lack of life skills was mentioned almost as frequently as drug history when recommending the 30/60/90 treatment path. Legal history was particularly important to these recommendations.
3. Support systems also appeared to be an important consideration for 30/60/90 clients. The specific criterion most often cited was the lack of a sober household or neighborhood, which makes residential treatment especially important for these clients.

Figure 5F



Criteria for 30/90 and Outpatient Recommendations

1. Drug history responses focus on abstinence. Length of abstinence was important in the recommendations for both 30/90 and OP cases.
2. Motivation is listed as critical for an OP recommendation, but not for any other treatment path.
3. A positive support system is a critical consideration for 30/90 recommendations.

Only two of the cases reviewed were recommended for placement in the 30/90 and outpatient paths, so conclusions on these are very tentative.

ABILITY OF EXISTING TREATMENT PROGRAM TO MEET THE CLIENTS' NEEDS

The panelists were asked to take a step back from the ADATSA system to further evaluate the needs of the clients in two ways:

1. to record their team decisions on the most appropriate duration of treatment for each client; and
2. to try to reach agreement on the additional services most critical and difficult to arrange.

In order to do this, panelists had to agree first on more general definitions of types of treatment than those furnished by ADATSA program labels. It was agreed that all treatment paths, whether inpatient or outpatient, included three distinct phases:

Phase 1: Primary care, emphasizing clinical treatment fostering life change decisions.

Phase 2: Reintegration, emphasizing new life skills and situations, particularly housing, social relationships, and vocational skills.

Phase 3: Aftercare, emphasizing employment and community support networks, and continuing to address housing needs.

Most Appropriate Duration of Treatment

There was complete agreement among all panelists on the importance of re-assessing the client as he/she progresses through treatment. Panelists reached agreement on three different items:

1. ADATSA should fully fund or at least subsidize twice as much treatment time as is currently funded, but this should be mainly reintegration and aftercare treatment;
2. each client should complete at least six months additional aftercare treatment independent of ADATSA; and
3. the current duration of primary care is appropriate.

The teams agreed on total treatment times for all but 4 of 60 cases, and on minimum treatment durations of primary care and reintegration on all but five and six cases, respectively.

Reaching agreement on the total treatment time that would ideally be funded by ADATSA was apparently not as easy. Thirteen of 60 cases went without a team recommendation for this time frame.

The recommendations for treatment duration were grouped by the panelists' recommended ADATSA treatment path to compare the actual ADATSA paths to the most appropriate treatment. The modal responses (Appendix 5, Table A5.7) of total treatment length and the durations of each phase are discussed below and a comparison to the currently available treatment durations is shown in Figure 5G.

The recommendations for the duration of ADATSA-funded treatment were generally twice as long as current allowable treatment time. Panelists recognized the need to arrange alternate forms of support for long term treatment and many firmly believed that assuming financial responsibility for his/her own treatment is a critical step in the client's recovery process.

It was recommended that clients should continue treatment on their own beyond that which is funded by ADATSA. The recommended length of continued treatment differs for the various treatment paths but is usually six extra months.

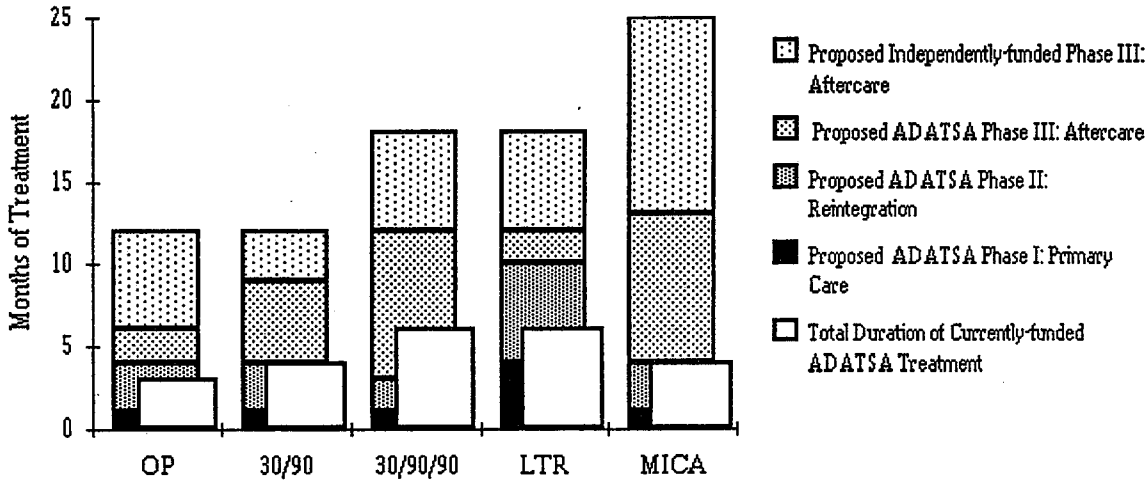
It was felt that ADATSA's primary treatment duration of approximately 30 days in a residential or an outpatient setting was sufficient in most cases. The only group of clients requiring more primary treatment than is already provided is the LTR group. The modal response favored a four month duration for primary treatment. Long term care providers may currently shorten their initial chemical dependency treatment to meet the ADATSA time line.

It was agreed that ADATSA support for reintegration and aftercare treatment should be extended. These services are generally offered on an outpatient basis. It was suggested that they need not always have full ADATSA funding but rather be paid for by clients on a sliding scale once they are employable.

It was argued that OP clients have a particular need for extended aftercare treatment as they are currently eligible for only 90 days of treatment but often require the full 180 days available to other ADATSA clients. The LTR group were also thought to have a need for particularly

Figure 5G

Most Appropriate Treatment Duration by Phase and Treatment Path Compared to Current ADATSA-Funded Duration



Critically Needed Services

The staging, or timing of additional services by treatment phase is important. Additional service needs recommended by the panel as critically needed do not differ markedly across treatment paths, so the following discussion is organized by treatment phase (Figure 5H).

Primary Treatment

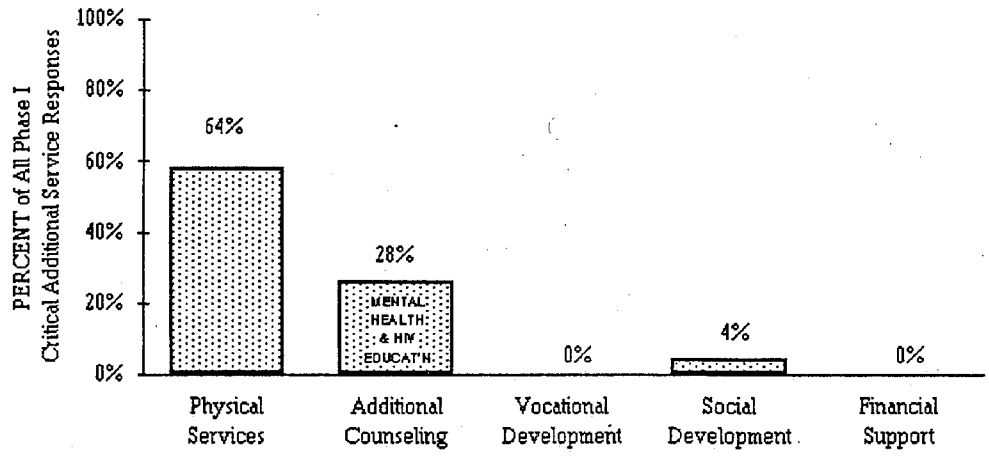
Physical services such as medical care was cited as the most critical additional services needed in primary treatment. They were also the most difficult to arrange. Appropriate and timely medical care is in short supply. Though the category received 64% of the possible responses made by individual teams, the summary meeting afterward clearly showed this to be a universal problem (Appendix 5, Table A5.8).

Additional counseling services were also reported as difficult to arrange in primary treatment. Panelists agreed that psychological care is effectively non-existent. Clients do not get appropriate psychological care unless an assessment counselor:

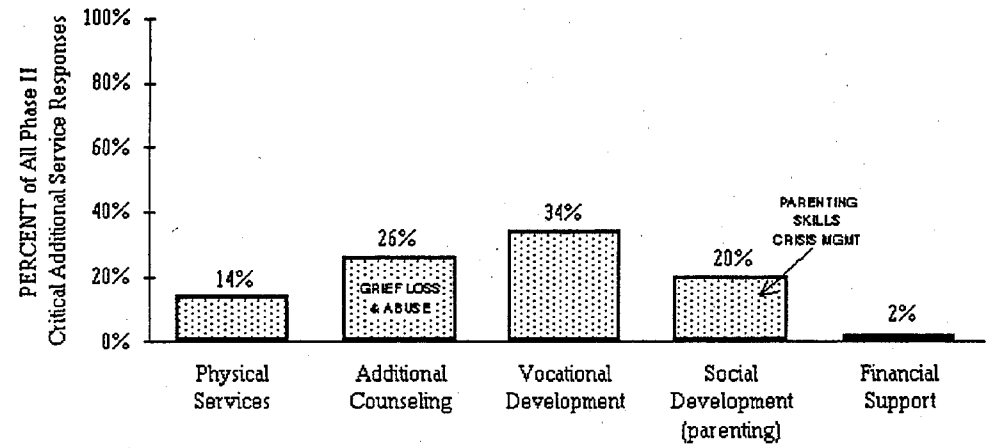
1. has an informal agreement with a psychiatric care provider;
2. has a client with an extreme or life-threatening need for immediate treatment that enables him to shortcut waiting list for the MICA program; or
3. arranges for the client to go to an Oregon facility, using another funding source.

Figure 5H

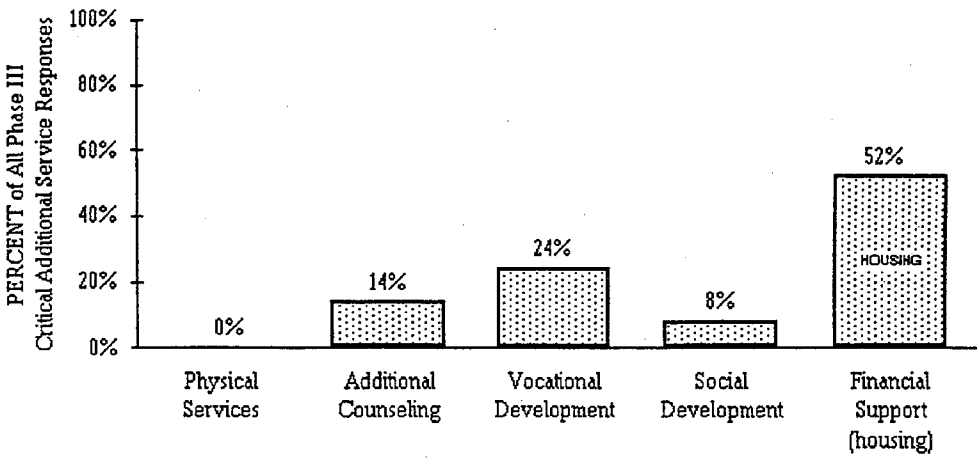
Additional Service Needs At Phase I of Treatment: Primary Care



Additional Service Needs At Phase II of Treatment: Reintegration



Additional Service Needs At Phase III Of Treatment: Aftercare



Reintegration Treatment

Vocational services should start in the reintegration phase. The availability of vocational support varied in different areas of the state. Panelists discussed the effectiveness of the pilot programs Rapid Rehabilitation Resolution (RRR) in Spokane, ADATSA Cooperative Employment Program (ACEP) in Seattle, and Vocational Opportunity Training/Education Program (VOTE) in Tacoma as steps in the right direction. Chapter 9 presents a discussion of these programs. Panelists agreed that the client should have access to such programs early enough in the treatment program to enable him to become employable and begin accepting financial responsibility for his own housing and treatment in the aftercare phase.

It was also agreed that additional counseling and social development services were also critical in the reintegration phase. This usually covers non-chemical dependency issues such as grief, loss, and child/spousal abuse. Social development services mentioned most often were parenting skills and crisis management, which may not be easy to provide or procure consistently.

Aftercare Treatment

The shortage of affordable, clean and sober housing is the primary difficulty faced by aftercare providers. As discussed in Chapters 2 and 3, housing pressures are not equal throughout the state, but housing problems emerged in the summary meeting as a limiting condition for all care providers. The provision of subsidized, sober housing was mentioned as a way to relieve the current pressures on recovery house and inpatient agencies, allowing 30/90 and OP to become a valid option for more clients.

Continued vocational development, additional counseling and social development services are often not available in the aftercare phase, though to a lesser degree. Sometimes, when services are available, they are not provided in a manner useful to or usable by recently recovered clients. For example, the Division of Vocational Rehabilitation requires the client be sober for a certain amount of time, which often has not occurred when the client is ready for vocational services.

The shortages of additional services discussed above are those felt throughout the state. Each individual county or community may have further needs of its own. The two most prominent areas of disagreement were:

1. Psychological evaluations are available to all assessment staff but panelists disagreed about the difficulty of arranging them in a timely fashion.

2. All panelists felt it was important to continue to assess the client and change treatment plans accordingly. Panelists, however, had different experiences with ADATSA's ability to meet the need for flexibility.

SUMMARY

The panel of professionals agreed on appropriate placements, criteria, treatment length and additional services. The agreement was moderate when decisions were made independently, but strong when panelists were brought together. This suggests that the identification of criteria for placement and intensive counselor training related to all treatment options may increase the appropriate placements.

The recommendations for MICA, LTR and 30/60/90 clients show a high level of agreement with the actual placement while the panel agreed only infrequently with a 30/90 or OP placement.

Criteria for placement were developed. The criteria are related to drug history, mental problems, physical problems, life skills, social support and previous treatment history.

The following were specific barriers to appropriate placement or treatment identified by the panel:

1. The shortage of all residential bed space, especially MICA, recovery house and long term residential, discourages appropriate treatment as wait times for various modalities prohibit their use if timely treatment is to occur.

2. Necessary information is often not recorded by the counselor. Other information that is used to make a placement is not included on the assessment forms. Results of psychological evaluations, detailed descriptions of living arrangements, special cultural needs and complete information on all family ties are examples of these types of information.

3. Treatment lengths are currently much shorter than those ideally needed, specifically for reintegration and aftercare treatment.

4. There is a lack of many additional services during all three treatment phases. Clients in primary care need medical, dental and mental health care. Clients in the reintegration phase need effective vocational rehabilitation that is accessible to and aimed at recovering clients. Clients in aftercare need affordable, clean and sober housing.

TREATMENT PLACEMENT

6

In this chapter some major implications of the findings of the Panel Review Board are examined and tested on the larger representative sample of ADATSA clients. The following topics are covered:

1) A summary of the forces and of the decision making processes affecting treatment placement within ADATSA bed constraints;
2) A check of the generalizability of these summary processes by analyzing a representative sample of 600 ADATSA clients placed into treatment in the Fall of 1989;
3) Estimates of proportions of clients in most appropriate treatment paths compared to their actual placement; and
4) An overall estimate of proportions of clients affected by differences between most appropriate and actual placement.

METHODS

Selected demographic characteristics, drug histories, criminal justice experiences and mental/physical problems from a sample of 600 clients who started ADATSA treatment were analyzed to determine differences by treatment path. Based on panelists' criteria for placement discussed in Chapter 5, specified differences are expected to exist. These differences were analyzed and are considered significant at the 0.05 level using multivariate analysis. Panelists' criteria for placement indicated that certain characteristics would be predominant among clients in certain paths. The multivariable technique allows a test of the independent significance of this predominance compared to other clients in each of the other paths.

Estimates for the distribution of clients in most appropriate treatment paths were derived by multiplying the matrix in Table 6.1 (appropriate by actual placement matrix) by the actual distribution of clients in Figure 6B.

The estimate of the proportion of clients who were not placed into an appropriate treatment path was calculated from the same matrix weighted by the actual distribution.

MAJOR FINDINGS

1) The analysis of predominant characteristics of clients in different paths shows overall support for the forces and decision making processes affecting treatment placement. While the severity of chemical dependency dictates clients should be placed in more intensive/residential paths, the lack of beds forces clients into less intensive more outpatient paths.
2) According to estimates based on the panelists' pattern of recommendations, 71% of all clients should be placed in more intensive/residential paths (MICA, Long Term, and 30/60/90) while only 37% were actually placed in these treatment paths. The treatment paths least recommended are the outpatient and 30/90 ones: only 4% of clients are recommended for each of these paths. However, 42% were placed in these paths: 28% in outpatient and 24% in the 30/90 path.
3) Overall, 49% of all clients were placed in a treatment path which was not the most appropriate one according to above estimates. The major explanation for this difference is the lack of beds in the more intensive/residential treatment paths.

MAJOR FORCES AFFECTING PLACEMENT AND THE DECISION MAKING PROCESS

OPPOSING FORCES AFFECTING PLACEMENT

Two major opposing forces seem to affect the assessment center counselor during the placement decision process:

1) a shortage of residential beds, especially in the four most intensive paths: MICA, Extended Care, Drug Residential, 30/60/90, and
2) the severity of the disease of chemical dependency of ADATSA clients, which implies that most appropriate placement is to these more intensive paths.

The professional panel (Chapter 5) recommended that 92% of reviewed cases enter the 30/60/90, Long Term,[2] or MICA treatment paths, while only 60% had been placed in these paths by assessment center counselors (Table 6.1). The largest deviation of the panel recommendations from actual placements were in outpatient and 30/90, where 2 of 10 and 1 of 10 respectively, were recommended to be placed in those paths.

Panel recommendations concerning most appropriate treatment were made assuming adequate bed availability, implying that the shortage of beds may be the major factor causing the discrepancy between actual placement and most appropriate placement.[3]

[2] Extended Care and Drug Residential paths were combined into a common Long Term path for purposes of the Peer Panel Review.

[3] At least two other reasons may be involved: 1) a lack of common criteria used by assessment counselors and 2) a lack of similar information available to panelists and counselors. The degree of agreement on criteria by the fifteen panelists and the correspondence between most appropriate and actual placement for the three most intensive paths tends to minimize, if not deny, the importance of these other two reasons.

Table 6.1

Recommendations of Most Appropriate Treatment Path Compared to Actual Placements

ACTUAL TREATMENT PATH PLACEMENTS OF CLIENTS BY ASSESSMENT CENTER COUNSELORS	PANEL RECOMMENDATIONS					
	OP	30/90	30/60/90	LTR	MICA	TOTAL FREQ.
OP	2	1	1	3	3	10
30/90	-	1	4	5	-	10
30/60/90	-	-	6	3	1	10
LTR	-	-	3	6	1	10
MICA	-	-	-	-	10	10
TOTAL FREQ.	2	2	14	17	15	50

DECISION-MAKING PROCESS AND MAIN CRITERIA USED

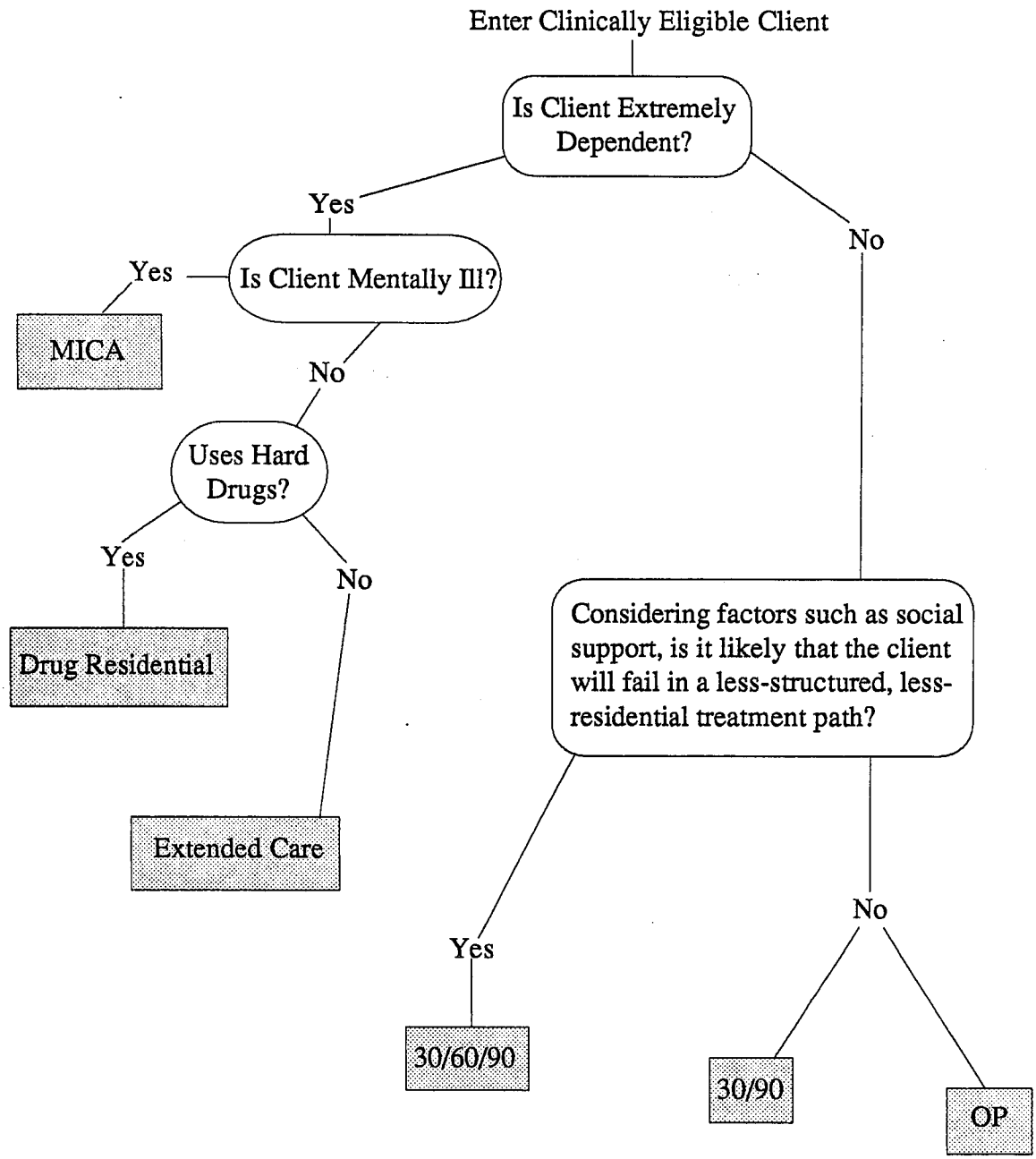
The following decision making process is based on the discussion by the panelists (Figure 6A).

1. Counselors first seek signs of extreme chemical dependency. Intensive residential paths are thought to be most appropriate for most ADATSA clients, but beds are few. So the most extremely dependent clients are selected for the few beds available.
2. Extremely dependent clients are placed in one of three paths: MICA (if signs of mental illness are apparent), Drug Residential (if hard drugs are used) and Extended Care (if alcohol is used).
3. Less dependent (but still severely dependent) clients are then sorted into the remaining paths.

The 30/60/90 path seems to be appropriate for the average ADATSA client, but recovery house beds are in short supply. Therefore, characteristics associated with treatment success (such as motivation, social support, and previous abstinence) are used to justify placement in the less intensive 30/90 path. The same logic applies to criteria for outpatient placement where the existence of a sober household or neighborhood becomes even more important.

Figure 6A

Client Placement Decision Tree



GENERALIZABILITY OF THE PANEL REVIEW CRITERIA FOR PLACEMENT OF CLIENTS INTO TREATMENT PATHS WITHIN CONSTRAINTS OF BED AVAILABILITY

Counselors are instructed to place clients in the most appropriate path. However, lack of beds means longer waits with a greater likelihood of client attrition (Chapter 7). To balance the risk of attrition, counselors sometimes place clients in less intensive paths, preferably the next less intense.

In summary, while the severity of the disease dictates clients be placed in more intensive paths, the lack of beds forces clients into less intensive paths.

EXPECTATIONS ABOUT CLIENT CHARACTERISTICS IN DIFFERENT TREATMENT PATHS

Given the pressures of these two forces, it is expected that:

1) Extended Care, Drug Residential, and MICA clients will have the highest percentages of extremely dependent clients, but the next less intensive paths will also have high proportions of extremely dependent clients.
2) MICA clients will have the highest percentage of mental illness but Extended Care and Drug Residential paths will have the next highest proportion of clients with mental illness problems.
3) 30/60/90 clients will lack support systems and motivation, while 30/90 and outpatient clients will be more likely to have support systems and evidence of motivation. These factors justify placing clients in less intense/residential treatment paths even though it may be more appropriate to place them in more intense ones.

RESULTS

Mental/emotional problems, evidence of very extreme dependence, and indirect evidence of motivation and support were tested for differences across paths. These characteristics varied across treatment paths and substantiated the expectation that the panelists' criteria are used for placement. However, the effects of bed shortages were clearly apparent in the high percentage of clients with the identified characteristics in the adjacent (in terms of intensity) path. Detailed tables and discussion of the findings are presented in the Appendix. The latter finding, based on a large sample of clients, is consistent with the differences between appropriate and actual placement found in the Peer Panel Review exercise.

THE PROPORTIONS OF CLIENTS PLACED IN EACH TREATMENT PATH

Almost 60% of the ADATSA clients are in treatment in one of three variations of the "30/60/90" treatment path. The first is the full 30/60/90 treatment path, which is recommended most frequently for the ADATSA population (Figure 6B). However, placement into the 30/60/90 path accounts for only 17% of ADATSA clients, mainly because of the shortage of recovery house beds.

The second variation is the 30/90 path. Twenty-four percent of the sample started treatment in the 30/90 variant. This is the modal path: the one with the highest proportion of clients.

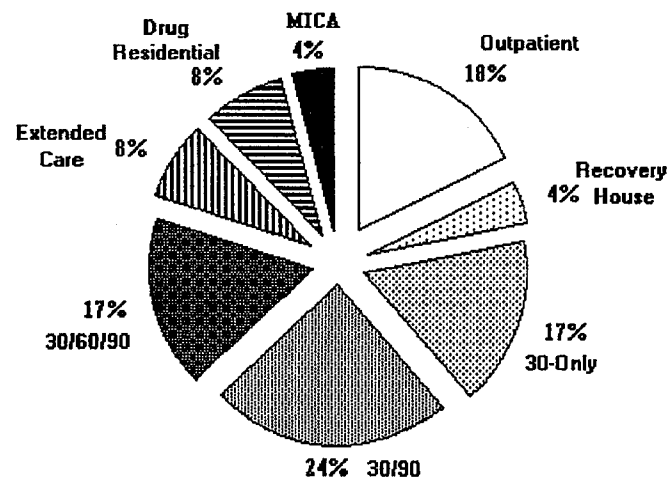
The third variant of the 30/60/90 path is the 30-only, accounting for 17% of the placements.

Clients placed only in Recovery Houses constitute 4% of all clients. The 30-only path and Recovery House paths probably evolved to fit the needs of clients who are primarily supported by other public funding and can arrange for alternative coverage of outpatient treatment. Women are a large proportion of these clients. Clients starting outpatient care as their primary care accounted for 18 percent of the total client placements.

MICA clients account for 4% of the clients, whereas Drug Residential and Extended Care each account for 8 percent of the clients. Thus, 20% of all clients are treated in one of these three long term/ residential paths. These paths, together with the 30/60/909 one can be considered the more intense/residential paths. 37% of all clients are treated in these paths: slightly more than one out of every three clients.

Figure 6B

Client Placement into Treatment Paths

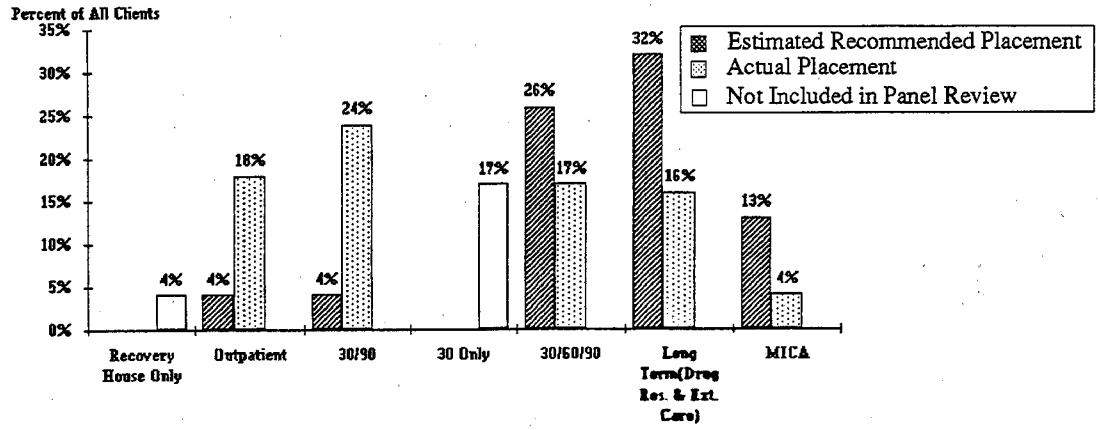


COMPARISON OF MOST APPROPRIATE PLACEMENT WITH ACTUAL PLACEMENT

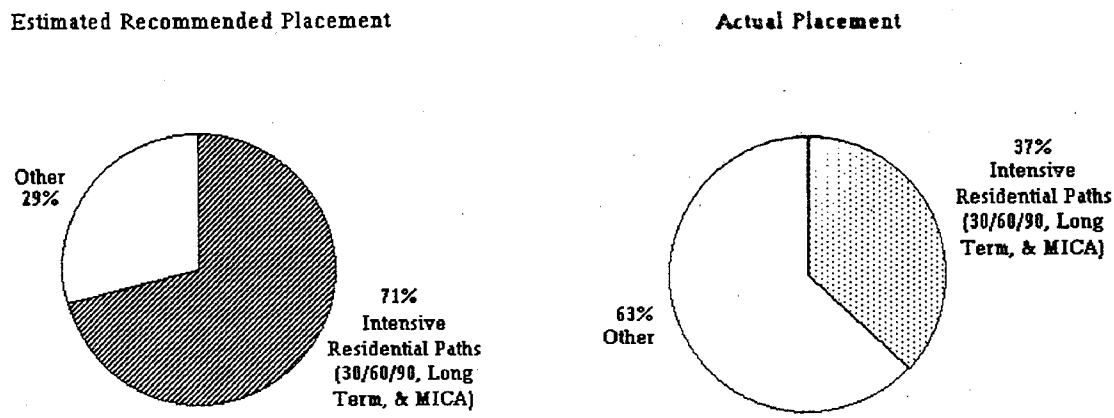
The table below depicts estimates of what the recommended placements would have been if the Panel Review professionals had reviewed all 600 cases in the representative sample of ADATSA clients. These more appropriate placements are contrasted to the actual placements.

Figure 6C
Estimated Recommendations of Most Appropriate Treatment Path Compared to Actual Placement Path (All Clients Starting Treatment: n=600)

By Specific Treatment Path



Estimated Recommended versus Actual Placements in More Intensive/Residential Paths Compared to Less Intensive/Residential Ones



Estimates were made of the distribution of recommended placements by multiplying the matrix in Table 6.1 by the actual placements in the total client sample. This was necessary since the Panel Review sample included an equal number of cases in each path as opposed to a representative number for each path as distributed in the population.

According to estimates based on the panelists pattern of recommendations, 71% of all clients should be placed in more intensive/residential paths while only 37% were actually placed in these treatment paths. In particular, examination of differences path by path show the following:

- **MICA path**: 13 % were estimated as likely to be recommended, 4% were actually placed:

- **Long Term paths**: 32% were estimated as likely to be recommended, 16% were actually placed; and

- **30/60/90 path**: 26% were estimated as likely to be recommended while 17% were actually placed.

The treatment paths estimated to be least recommended were the outpatient and 30/90: only 4% of clients for each of these paths. However, 42% were placed in these paths: 18% in outpatient and 24% in the 30/90 path.

Overall, 49% of all clients were placed in a treatment path which was estimated not the to be most appropriate one. The major explanation for this difference is the lack of beds in the more intensive/residential treatment paths. Recommended placements into a more intensive treatment path (30/60/90, Long Term or MICA) account for 88% of the estimated difference in placement. These figures were derived from appropriately weighing the results in Table 6.1 by the distribution of actual placements in the total ADATSA sample.

SUMMARY

The major forces and criteria affecting client placement were summarized. The presence of selected client characteristics in various treatment paths were found to be consistent with the operation of these forces and criteria. Having checked this consistency, estimates of most appropriate placements could be calculated and contrasted with actual placements. The findings highlight that the lack of beds prevents client placement into more appropriate intensive/residential treatment paths.

WAIT TIMES, NO SHOWS AND COMPLETION RATES

7

A significant investment of public funds begins when the potential ADATSA client is referred to the assessment center. The expected optimum return on this investment is client self-sufficiency resulting from treatment and job acquisition. Clients who drop out before or during treatment, however, have a reduced chance of benefitting from the program, and are more likely to having public funds spent on them.

This chapter identifies points at which clients are likely to be lost. It describes retention rates at each of these seven points; and then compares different treatment paths. The association between client wait time and drop out rate is analyzed. Client characteristics influencing the likelihood of completing treatment are identified. Their independent influence on treatment start and completion is tested statistically. Chi-square tests were performed to determine the level of significance of variables affecting treatment completion.

METHODS

Data extracted from the sample of assessment center records contained information on the number and characteristics of clients from assessment to treatment completion including dates of assessment, treatment start and completion. The total number of referred clients was determined from appointment lists (see Appendix 7). These data were collected for each of the seven points and variables thought to affect treatment start and completion were analyzed both in isolation and simultaneously (see Appendix for details of the multivariable analysis used.)

MAJOR FINDINGS

1. Two wait times result in significant client drop out. These are (1) between referral and clinical assessment, and (2) between acceptance and start of treatment. The longer the wait time, the higher the no-show rate.

2. Among clients starting treatment, two-thirds complete the primary phase, and more than four out of ten finish all treatment phases.

3. Having mental/emotional or physical problems decreases the chance of starting treatment.

4. Using alcohol only, having one prior treatment episode or being older (50+) increase the chance of completion.

RETENTION RATES AT VARIOUS STAGES

ELIGIBILITY STAGE

The CSO is the only point of entry to the ADATSA system and almost 30% of potential clients are lost between the CSO and the assessment center (Figure 7A). Among clients who show up and are assessed for chemical dependency, 19% are found not to meet ADATSA eligibility requirements. This translates to an overall 58% who are established as eligible persons among clients referred.

ACCEPTANCE STAGE

Of those who are found clinically eligible, 86% are accepted and accept a particular treatment plan (Figure 7A). However, in the following waiting period for treatment, 23% of the people who accept treatment do not show up for treatment. The result is that among eligible clients 66% start treatment.

TREATMENT STAGE

Of those who start treatment, 64% finish primary treatment and 42% finish all treatment. These retention rates are the same or higher than rates in similar populations in other states.[1]

ATTRITION FROM ASSESSMENT TO COMPLETION

Nearly half of all drop-outs occur during the two waiting periods:

1) between referral and assessment, and

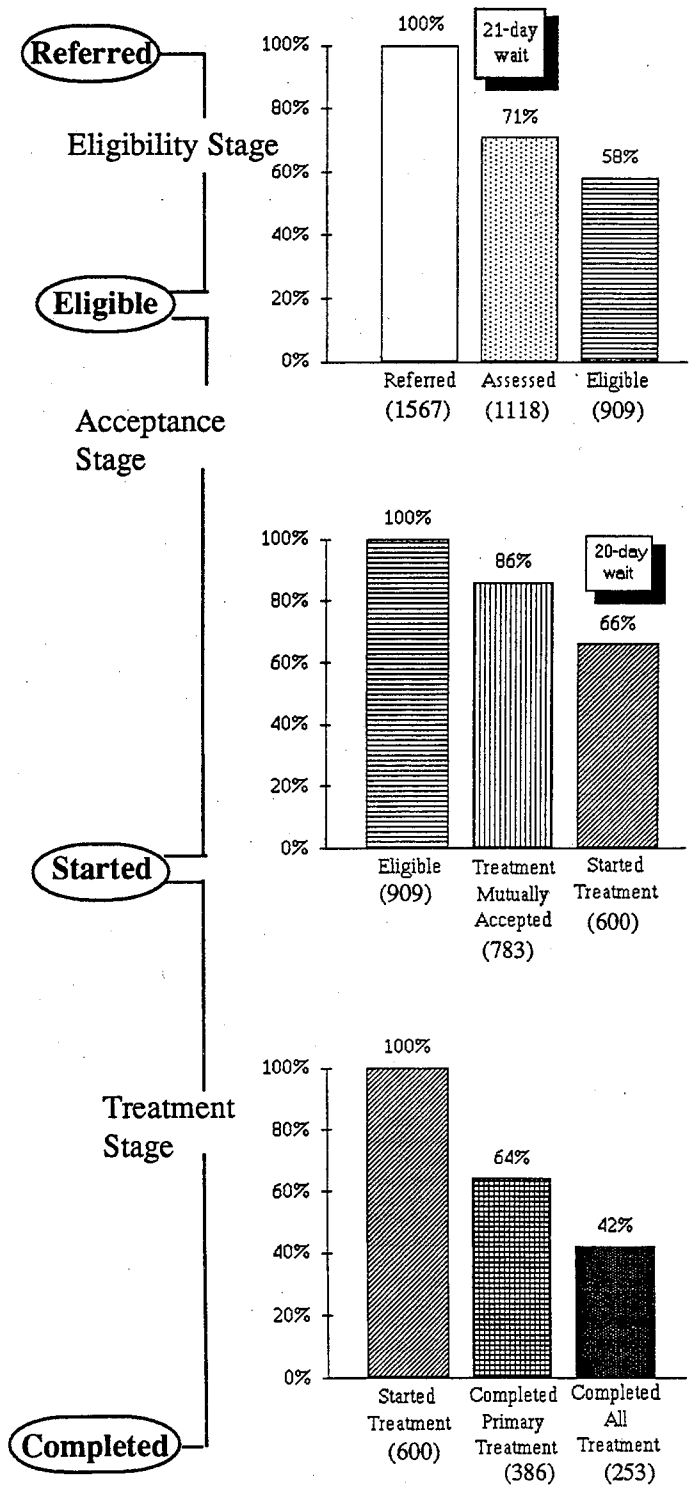
2) between acceptance and start of treatment.

THE EFFECT OF WAIT TIMES ON RETENTION AT TREATMENT START

During the period under study (August-November, 1989), the number of ADATSA clients surpassed the number of ADATSA-funded treatment slots. This discrepancy between demand and supply translated into long wait times for treatment and the wait times were significantly related to no-show rates. Due to data limitations, only the wait period between assessment and treatment was studied.

[1]Richard Catalano, et al, 1988, op cit

Figure 7A
Wait Times and Retention Rates for ADATSA Clients



The median wait for treatment was 20 days, while the mean wait time was 29 days (Table 7.1).

The scheduled wait time for clients who failed to start treatment was compared to the actual time waited for clients who started treatment. Clients who did not show up for treatment were scheduled to wait almost a week longer than clients who started treatment (Table 7.1). This is true in all treatment paths.

The association between the number of days waited and the proportion of no-shows is very strong, as indicated by a correlation coefficient of .81 (Table 7.2). At the median wait of 20 days, over 20% of clients do not show up for treatment. Table 7.2 shows the predicted no-show rate for various wait periods.

Table 7.1
Wait Time for Shows and No-shows*

Wait time	Shows	No-shows	Overall
Median	18 days	23 days	20 days
Mean	24 days	31 days	29 days
Number	(n=551)	(n=104)	(n=655)

* Between assessment and treatment start

Table 7.2
Association Between Wait-Time and No-shows

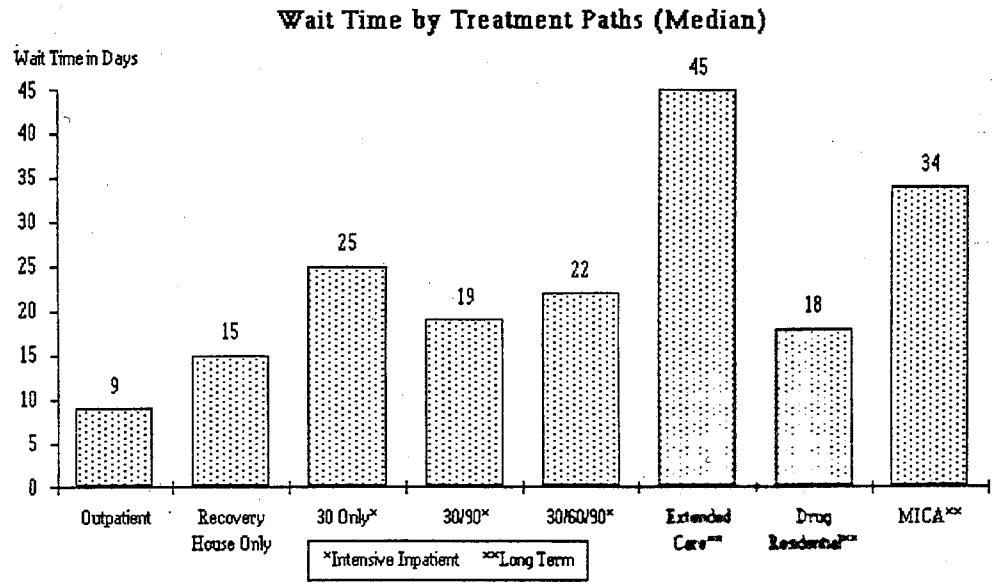
Given Wait-time (in days)	Estimated No-shows
7	13%
14	18%
20	22%
30	29%
60	50%
90	71%

Correlation Coefficient = .81
Regression Equation: (% No-shows) = (# days) .007 + .08

Wait Time by Treatment Path - The wait time for entry into treatment varied significantly across treatment paths; this is due at least partially to the unequal availability of beds in the paths (Figure 7B). The three intensive inpatient treatment paths show relatively long waiting times (ranging from 19 to 25 days). Even longer is the waiting time for MICA clients (over a month) and Extended Care clients (45 days). Regular outpatient treatment consists of open groups and there is only a minimal wait for this type of treatment.

When outpatient treatment is used as a primary treatment, groups are closed and limited in number: the average wait time for this outpatient path is 9 days.

Figure 7B

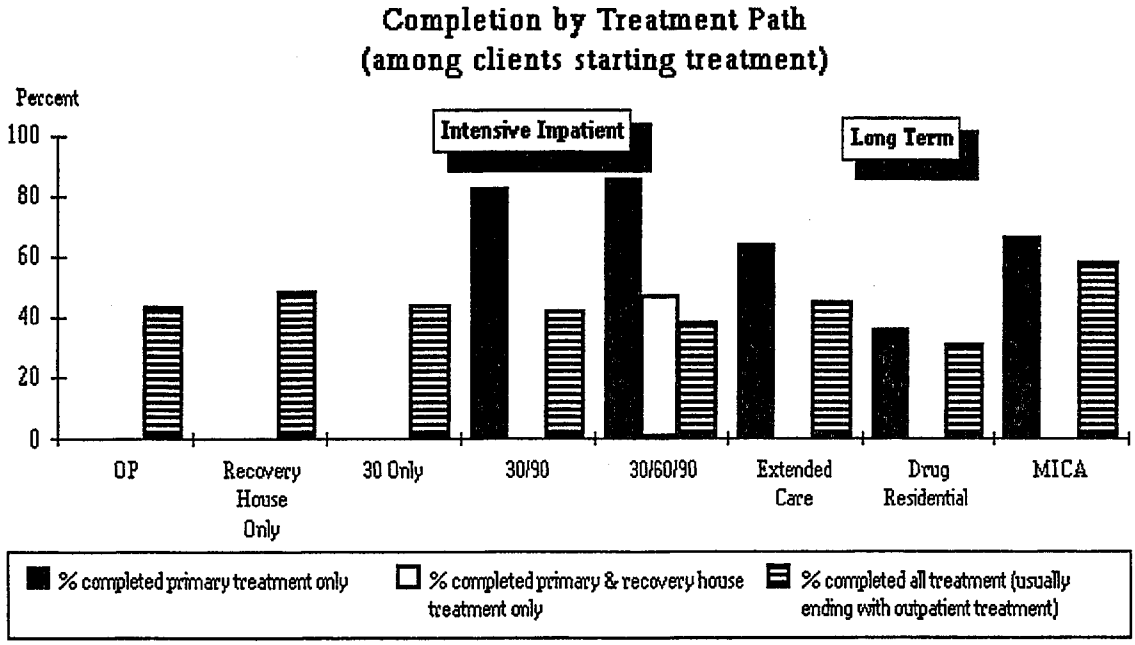


COMPLETION RATES BY TREATMENT PATH

Almost half of clients starting treatment completed all phases of treatment. There is little variation across treatment paths except that Long-Term Residential clients had a lower completion rate and MICA clients had a higher completion rate (Figure 7C).

Completion rates of the first intensive inpatient phase for clients in the 30/60/90 and 30/90 treatment paths are very high; completion rates of subsequent phase(s) for these clients are also above average.

Figure 7C



CLIENT CHARACTERISTICS AFFECTING STARTING AND COMPLETING TREATMENT

Client characteristics were examined one at a time to see if they affected treatment start or completion. Using logistic analysis, each client characteristic was tested separately for its statistical effect on either starting treatment or completing treatment once started. The overall effect of each characteristic on the combination of starting and completing treatment was also tested (Table 7.3).

Because some characteristics are correlated , it was necessary to use multivariate analysis to see which factors are significant, independent of the effects of others. For example, it is important to know whether alcoholics are more likely to complete treatment regardless of age or prior treatment experience. These factors may be correlated to the extent that younger clients, entering treatment for the first time, may use alcohol more than other drugs. If this is the case, the effect of alcohol use may not be significant when controlling for other factors. That is, alcoholics may tend to complete treatment because of being young first-timers, and not because of higher treatment success of alcoholics.

The simultaneous effects of all these characteristics were tested in a multivariate analysis. Three separate analyses were performed to identify:

Table 7.3
Percent of Clients Starting and/or Completing Treatment by Various Background Characteristics

(Separate Tests of Significance were Made for the Effect of Each Independent Variable on Each Dependent Variable.)

Client Characteristics as Independent Variables	As Dependent Variables		
	Start Treatment Among Eligible (n=909)	Complete Treatment Among Started (n=600)	Combined Start and Complete Among Eligible (n=909)
Age Categories			
18-19 (n=46)	54	48	26
20-29 (n=326)	71	38	27
30-39 (n=338)	67	42	27
40-49 (n=143)	56	38	22
50+ (n=56)	65	74*	47*
Ethnicity			
White (n=625)	66	40	27
Black (n=157)	65	43	28
Native American (n=88)	62	57	35
Asian (n=16)	64	47	30
Sex			
Male (n=591)	64	41	26
Women (n=318)	69*	44*	31
[Pregnant Women (n=37)]	[73*]	[29]	[21]
Education			
Post High School			
Yes (n=164)	68*	49*	33*
No (n=745)	66	41	27
Public Assistance			
None (n=487)	68	43	29
GAU (n=195)	56*	35	20
AFDC Grant (n=112)	72	47	34
SSI Grant (n=28)	48*	52	25
Medical Only (n=5)	--	--	--
Other (n=82)	71	39	28
Previous Employment			
Yes (n=46)	69*	51*	35*
No (n=863)	66	42	27

* Statistically significant at the .05 level, using logistic analysis. This technique permits testing the statistical significance of each value of an ordinally scaled independent variable on a dichotomous dependent variable.

Table 7.3 (cont.)

Client Characteristics as Independent Variables	As Dependent Variables		
	Start Treatment Among Eligible (n=909)	Complete Treatment Among Started (n=600)	Combined Start and Complete Among Eligible (n=909)
Alcohol Only			
Yes (n=176)	68*	54*	36*
No (n=733)	66	39	26
IV Drug User			
Yes (n=146)	63	29	19
No (n=763)	67*	44*	30*
Prior Admission to Detox			
Yes (n=297)	65	43	28
No (n=612)	67*	42	28
Prior Treatment			
None (n=283)	67	36	24
One (n=274)	71*	49*	34*
Two (n=153)	64	45*	29*
Three (n=85)	62	40	25*
Four+ (n=114)	58	36	22
On Probation or Parole			
Yes (n=246)	75*	43	32*
No (n=663)	63	42	26
Assessment Court-Ordered			
Yes (n=200)	75*	41	30*
No (n=709)	64	43	27
Ever Charged with Driving While Intoxicated			
Yes (n=407)	69*	44*	31*
No (n=502)	63	40	26
Living Arrangements			
With Family (n=309)	67	45	30
With Other (n=209)	69	40*	28
Alone (n=219)	61*	45	28
Homeless (n=153)	72*	36*	26
Mental/Emotional Problems			
Yes (n=202)	52	38	20
No (n=707)	70*	43*	30*
Physical Problems			
Yes (n=175)	53	38	20
No (n=734)	69*	43*	30*
Treatment Paths			
Outpatient (n=132)	84	43	35
Recovery House (n=29)	72*	48	34
30/60/90 (n=124)	85	38	32
30/90 (n=179)	89	42	37
30 (n=131)	70*	44	31
Extended Care (n=62)	76	45	35
Long Term Residential (n=60)	68*	32*	22*
MICA (n=27)	89	59*	53*
(Not accepted, not placed) (n=165)	--	--	--

* Statistically significant at the .05 level, using logistic analysis.

2. More likely completers among starters; and
3. Overall factors leading to both starting and completing.

The likelihood of starting depends on the likelihood of accepting treatment, and on enduring the wait period before treatment. The likelihood of completing is assumed to be related to performance during treatment.

RESULTS

Only two of fifteen factors significantly affect starting treatment (see Table 7.4):

1) Clients with mental/emotional problems are **less** likely to start treatment.

2) Clients with physical problems are **less** likely to start treatment.

Three characteristics significantly affect treatment completion rates (see Table 7.4):

1) Using alcohol only increases the probability of treatment completion.

2) Having one prior treatment increases the likelihood of treatment completion.

3) Being much older (50+) increases the likelihood of completing treatment.

The remainder of the client characteristics tested do not significantly affect completion rates.

Table 7.4

Multivariate Analysis of Factors Significantly or Non-Significantly Related to Starting or Completing Treatment

Client Factors as Independent Variables	As Dependent Variables		
	Start Treatment Among Eligible (n=909)	Complete Treatment Among Started (n=600)	Overall Start and Complete Among Eligible (n=909)
Age Categories 50+ (n=56)		Sig. +	Sig. +
Ethnicity			
Sex (Including Pregnant Women)			
Education			
Public Assistance			
Previous Employment			
Alcohol Only Yes (n=176)		Sig. +	Sig. +
I.V. Drug User			
Prior Admission to Detox			
Prior Treatment One (n=274)		Sig. +	Sig. +
On Probation or Parole			
Assessment Court-Ordered			
Ever Charged with Driving While Intoxicated			
Living Arrangements			
Mental/Emotional Problems Yes (n=202)	Sig. -		(Sig. <.10-)
Physical Problems Yes (n=175)	Sig. -		Sig. -
Treatment Paths (All)			

Sig. = Significant at the .05 level for specified independent variables controlling for the possible effect of all others using logistic regression.

"-" = Presence of this factor decreases the likelihood of starting or completing treat ment.

"+" = Presence of this factor increases the likelihood of starting or completing treatment.

SUMMARY

1. Thirty percent of clients drop out between the CSO and the ADATSA assessment center. Among clients accepting treatment, 23% do not show up for treatment. These high attrition rates occur during two waiting periods: one before assessment and one before treatment.

2. Wait time is highly correlated with no-show rates.

3. Treatment completion rates are high compared to national norms.

4. Few client characteristics affect the likelihood of starting or completing treatment.

5. In general, client profiles change little from eligibility to treatment completion. This suggests that most clients are not unduly favored or handicapped as they proceed through the various steps of the ADATSA treatment program.

CLIENT OUTCOMES: EMPLOYMENT AND PUBLIC ASSISTANCE

8

One of the long-term goals of ADATSA is to maximize client self-sufficiency and minimize client reliance on state support. This entails building personal coping skills, increasing social support and teaching employment skills. This chapter presents information about the clients' employment rates, use of General Assistance-Unemployable (GAU) and detox relapse rates for the first six months after treatment.[1]

Chemical dependency is a life-long disease that often requires more than one treatment episode. Between treatment attempts, clients may be temporarily employed and this success may help determine the client's ultimate outcome, as well as temporarily decreasing the cost of public assistance.[2]

METHODS

Employment and public assistance data were used in this analysis. These data were obtained by searching electronic files at two sources:

1. Office of Employment Security to determine clients employed, duration of employment, and hourly wages;

2. Office of Financial Management to determine clients' use of public assistance - GAU, AFDC, SSI.

People who were employed out of state and people who moved out of state cannot be tracked. In addition, some employers do not report hours and earnings to Employment Security, including those not legally obliged to do so (15%) and people who pay cash.[3] These employment data, therefore, probably underestimate the actual number of ADATSA clients working.

Pre-treatment employment and public assistance were measured for five quarters before treatment, starting the quarter before the assessment. Post-treatment employment and public assistance were measured for two quarters after treatment, starting the first month after treatment ended (see Appendix 8).

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[1] The current study presents data only for 6 months post-treatment. An 18-month follow-up study has been funded; results will be available in December, 1992.

[2] "Relapse in the Addictions: Rates, Determinants, and Promising Relapse Prevention Strategies," Catalano, Richard, et al, The Health Consequences of Smoking: Nicotine Addiction, Washington D.C., 1988.

"A Randomized Trial of Treatment Options for Alcohol-Abusing Workers," Walsh, Diana C., et al, The New England Journal of Medicine, September 12, 1991.

An analysis of possible cost savings for treated ADATSA clients has been funded. The report is due at the end of 1992.

[3] Informal employment may be particularly common in this population if employed part time in unskilled service or construction jobs in urban areas and in seasonal farm work in rural areas. For all these reasons, these data are not complete, but the amount and effect of missing information cannot be estimated.

Employment was measured in five different ways:

1. Percentage of clients with any employment during a calendar quarter.
2. Percentage of clients with at least half-time employment (50%+)[4]
3. Percentage of clients with full time employment (75% or more, an average of 30 hours or more per week in a quarter).
4. Average number of hours per week worked during a quarter by any employed persons.
5. Average hourly wage.

Analysis of public assistance was done by type of grant and focused on measuring trends in GAU for two reasons. First, ADATSA grants end when a client completes or drops out of treatment. Second, eligibility for AFDC and SSI grants is due to reasons other than chemical dependency. The main grant program affected by alcohol/drug dependency is the GAU program.[5]

The data were analyzed using multi-variate techniques and chi-square tests to determine the effect of variable on employment.

MAJOR FINDINGS

1. In the immediate post-treatment period, ADATSA clients who completed primary or all treatment are more likely to be employed than clients who did not start or dropped out of primary treatment.
2. ADATSA clients who completed primary or all treatment are less likely to be on public assistance than clients who did not start treatment or dropped out of primary treatment.
3. Of the clients who re-entered detoxification services, the proportion of those who completed treatment was smaller than those who did not.
4. Among clients completing all ADATSA treatment, 25% re-enter within a 12-month period, but mainly for continued outpatient support.

OVERALL EMPLOYMENT RESULTS

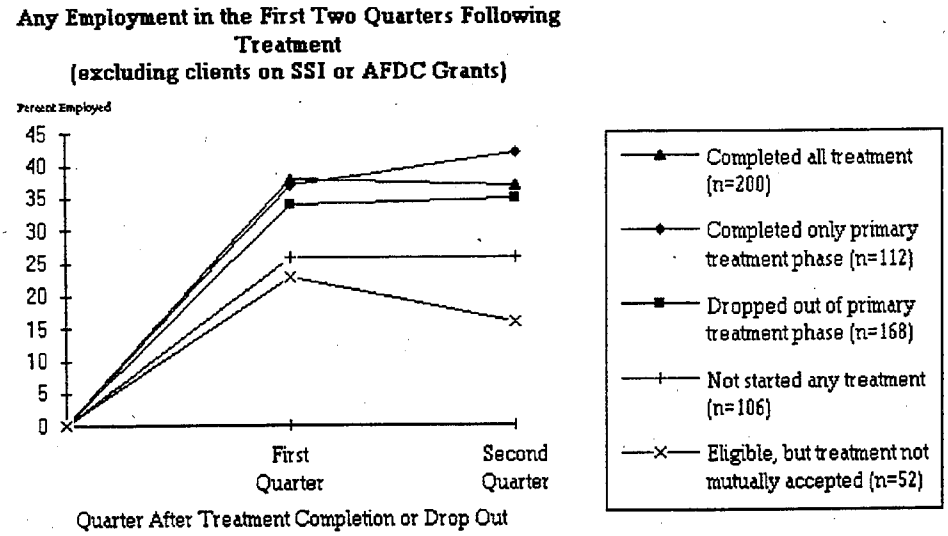
Rates of employment were compared for clients not accepted or accepting treatment, clients not starting treatment, clients dropping out at various steps, and clients finishing treatment.

[4] The percent of employment was computed on a quarterly basis. If a client worked full time for one month, he/she worked 33%.

[5] After treatment, no SSI recipients were employed. A good proportion of AFDC mothers were employed, most of them part time.

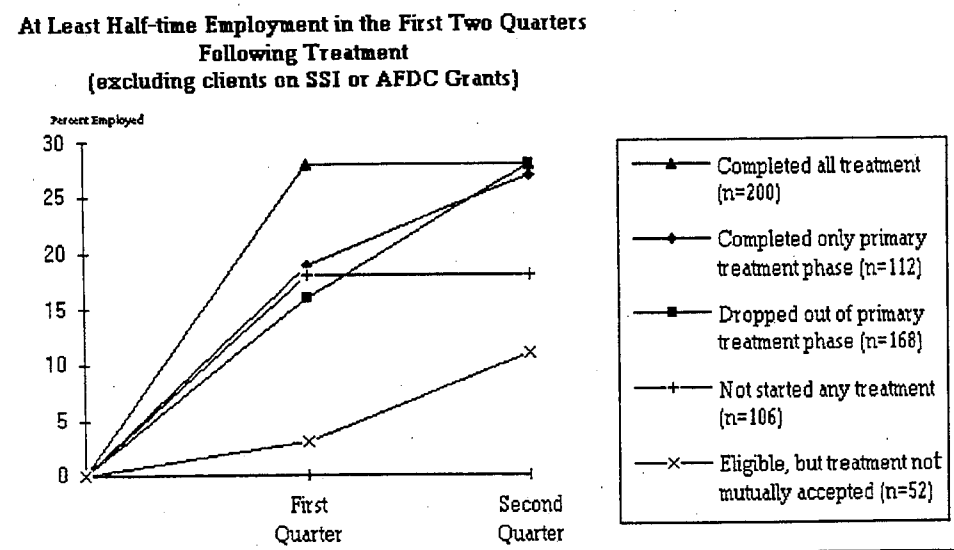
Any Employment- Clients completing at least some treatment were employed at a higher rate (35-45%) than clients who were eligible but did not accept or were not accepted for treatment (15 to 20%), or clients who did not start treatment (25%) (see Figure 8A).

Figure 8A



At Least Half-Time Employment (50%+)- A higher proportion of clients completing at least some treatment worked 50% or more by the second quarter than eligible clients who did not accept or were not accepted for treatment, or clients who did not start treatment (Figure 8B).

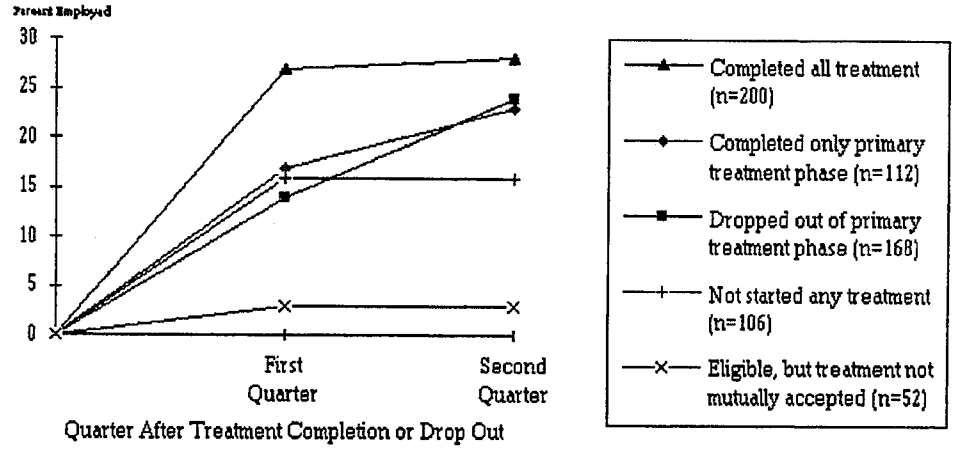
Figure 8B



Almost Full time Employment (75%)- When full-time employment is considered, the differences among groups increase. Those completing all treatment phases have a higher rate of full-time employment (25-30%) than other groups (20%). These in turn can be compared to the "eligible not accepted"group who have almost no full-time employment (less than 5%). More completers had full-time employment than non-completers (Figure 8C).

Figure 8C

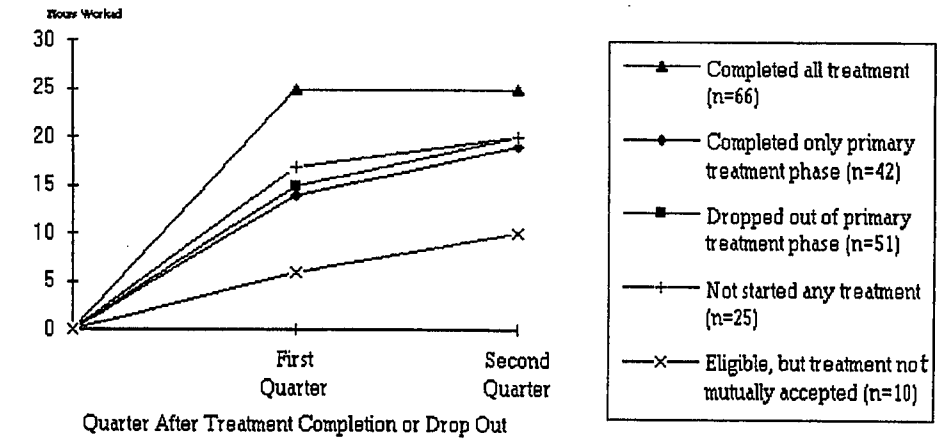
Almost Full-time Employment in the First Two Quarters Following Treatment (excluding clients on SSI or AFDC Grants)



Average number of hours employed (among employed)- This measure confirms the findings for those employed almost full time. Those who completed all treatment phases have the highest average number of hours worked—25 hours per week. This is greater than the 15 to 20 hours per week observed for those who did not complete treatment, and the 5 to 10 hours per week for eligible clients who did not enter treatment (Figure 8D). These findings are consistent for both quarters.

Figure 8D

Average Number of Hours Worked per Week in the First Two Quarters Following Treatment Among Those Employed (excluding clients on SSI or AFDC Grants)



Average hourly wages- The average hourly wage does not differ significantly for any group (Table 8.1).

Table 8.1
Mean Earnings
By Quarter After Treatment
(Dollars per hour)

	1st Qtr	2nd Qtr
Completed All Treatment	7.20 n=66	7.13 n=59
Completed Only Primary Tx	6.40 n=42	7.50 n=29
Dropped Out of Primary Tx	10.21 n=51	9.15 n=49
Did Not Start Any Treatment	6.63 n=25	6.86 n=18
Eligible, But Not Mutually Accepted	5.71 n=10	6.08 n=8

THE INDEPENDENT EFFECT OF TREATMENT COMPLETION ON EMPLOYMENT

Factors such as education, work experience, age, gender and ethnicity are often associated with employment. If these variables are also related to treatment completion, they could cause the apparent difference in employment between completers and non-completers. Because of this, employment was analyzed controlling for these background variables to measure the effect of treatment completion independent of the background variables.

Substantial (half-time or more) employment comes closest to capturing minimum levels of self-sufficiency, because half-time employment at minimum wage approximates the one-person state grant for public assistance. Because of this, at least half-time employment was the only variable studied at this stage.

Even after controlling for other factors, treatment completers are significantly more likely to be employed after treatment than those who did not complete and those who never entered treatment. Table 8.2 shows the results of the analysis. Of eight variables considered, only three were statistically significant: education, employment before treatment, and completion of treatment. High school graduates and those who had post-high school training were more likely to be employed after treatment. Those who were employed before treatment were more likely to be employed afterwards, as were those who completed treatment (Table 8.2).

Table 8.2

Results of Multivariate Analysis: Significance Levels for Variables Tested for Their Independent Effects on the Likelihood of Employment at Least Half-time After Treatment

(All ADATSA Clients Eligible for Treatment: n=909)

Independent Variables	Significant Effect on Employment	Positive or Negative Effect	Client Condition on Independent Variable
Age	n.s.		
Education	.02	+	> High School
Gender	n.s.		
Ethnicity	n.s.		
Drug Choice	n.s.		
Prior Employment	.001	+	Employed Before Treatment
Completion of All Treatment	.02	+	Completed All Treatment

n.s. - not significant at the .05 level for specified independent variables controlling for the possible effects of all others using logistic regression

The factors that were not significantly related to employment were age, gender, ethnicity, and drug choice.

Gender is not significantly related to post-treatment employment, although this may be due to the small number of women in the sample. The effect of treatment completion on employment, however, is visible in both gender groups.

The percentages of clients employed at least half time during the first two quarters after treatment by the different levels of the variables is shown on Table 8.3.

Table 8.3
Percent Employed at least Half-Time During the First Two Quarters After Treatment

	Eligible But Treatment Not Mutually Accepted n = 72	Not Started Any Treatment n = 183	Dropped Out of Primary Treatment n = 214	Completed Only Primary Treatment n = 133	Completed All Treatment n = 253
Education					
Less than High School	10%	19%	24%	16%	17%
High School Graduate*	0%	18%	4%	22%	35%
More than High School*	4%	13%	42%	8%	44%
Employment Before Treatment					
Not Employed	9%	7%	7%	0%	19%
Employed*	2%	22%	26%	23%	38%
Age					
Less than 30	0%	23%	26%	25%	38%
30 - 39	12%	15%	17%	15%	30%
40 +	4%	15%	14%	0%	23%
Ethnicity					
White	8%	24%	19%	20%	28%
Black	0%	9%	37%	4%	34%
Other	0%	0%	0%	25%	40%
Sex					
Men*	2%	15%	19%	16%	29%
Women	13%	32%	26%	23%	36%
On Public Assistance Before Treatment*	0%	15%	16%	14%	31%
Primary Drug					
Alcohol*	3%	16%	11%	12%	32%
Hard Drugs**	8%	17%	39%	32%	27%

* Effect of variables on employment significant at .05 level using logistic analysis. This technique permits testing the statistical significance of each value of an ordinally scaled independent variable on a dichotomous dependent variable.
** Heroin, opiates, synthetics, amphetamines, cocaine, hallucinogens

EMPLOYMENT RESULTS BY TREATMENT PATH

Some treatment paths may be more successful than others in terms of client employment after treatment. It should be noted that any differences may not be attributable to treatment success, but to the type of clients who tend to be placed in such different paths. With this in mind, one would expect that the least severe outpatient clients would do better in employment than the inpatient clients, who in turn would do better than longer term clients. However, this is not the case.

Differences in employment between completers and non-completers is higher among clients in residential programs, and almost non-existent among outpatient clients. This is true both for any employment (Figure 8E) and for full time employment (Figure 8F).

Long term residential and MICA clients do as well as or better than intensive inpatient path clients.

Among the three inpatient paths that have some residential treatment, the 30/60/90 path has the highest level of employment among completers, for either any employment or almost full time employment.

These findings seem to suggest that residential programs do better than outpatient ones. However, the particularly high rate of employment for treatment programs having a recovery house component should be noted (Figures 8E and 8F). This suggests that the secondary, reintegration phase, of treatment offered by recovery houses may be important for obtaining employment among these clients.

PUBLIC ASSISTANCE OUTCOMES

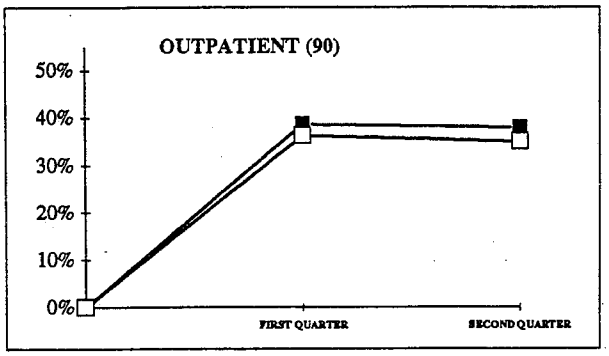
Historically important in the implementation of the ADATSA program, and still a concern of program administrators, is whether ADATSA clients switch to other public assistance caseloads after treatment. In the past, General Assistance-Unemployable (GAU) especially has grown when chemical dependency programs have been cut, because GAU accepts clients incapacitated by physical/mental conditions, excluding those with chemical dependency as an incapacity condition. This question was investigated in three different ways:

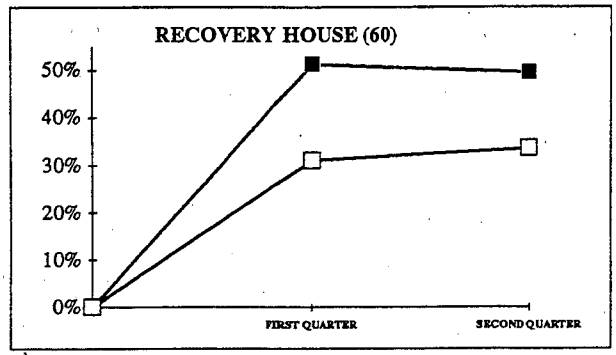
First, the change in GAU use after treatment (or drop-out) was examined.

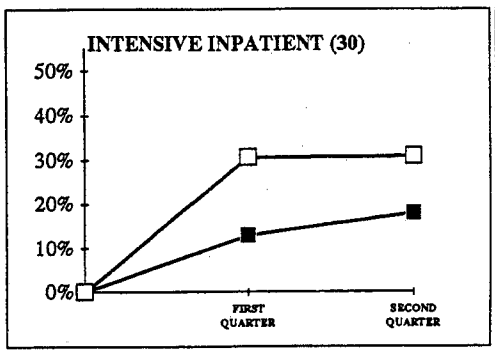
Second, the trends for all public assistance programs were analyzed to see whether shifts occurred between programs.

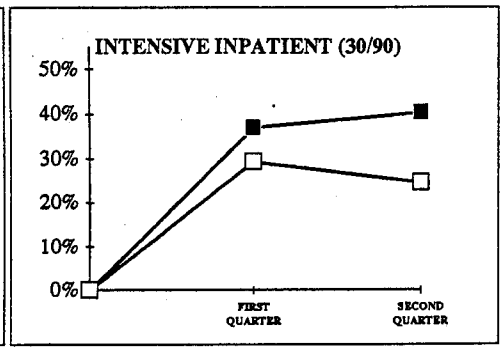
Lastly, the use of GAU by clients completing treatment in different treatment paths was analyzed to see if certain treatment paths are more likely to get clients off public assistance.

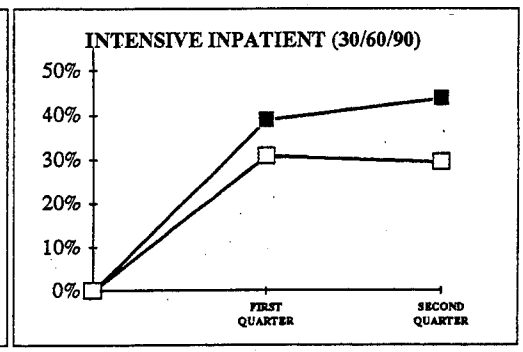
Figure 8E
Completers v. Non-Completers
Any Employment

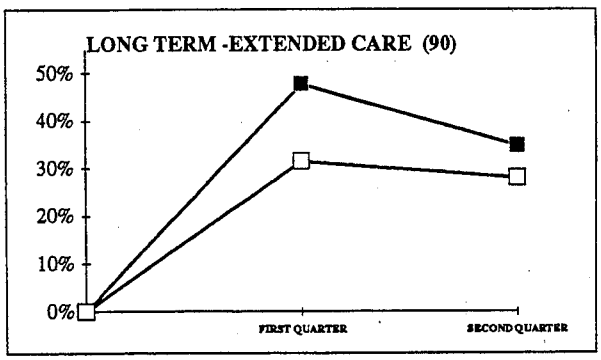


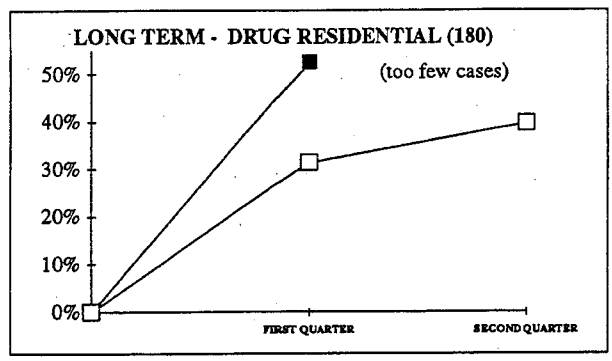


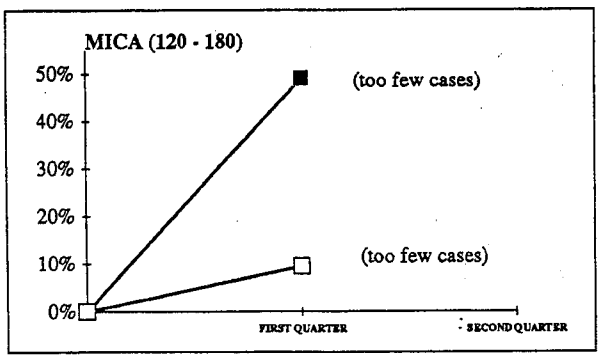










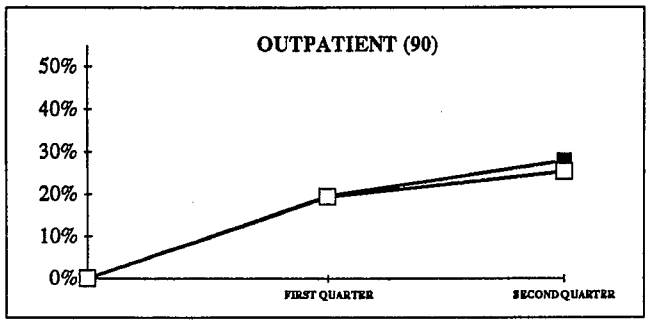


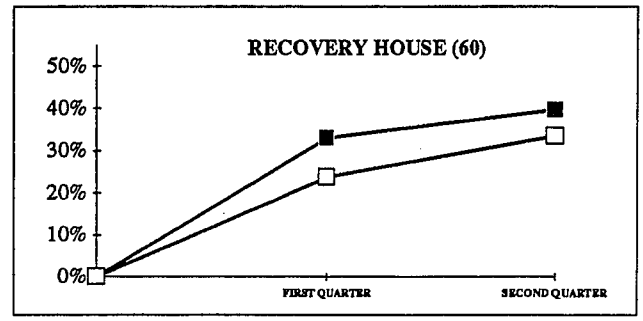
■ Completed Primary or All Treatment Phases

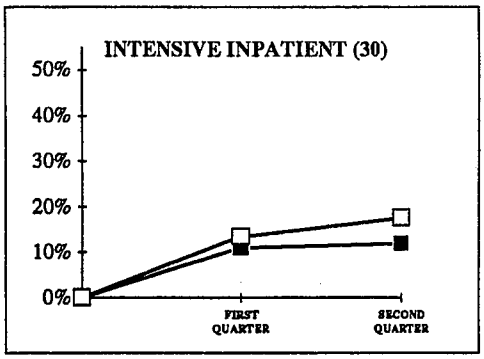
□ Not Started or Dropped Out of Primary Treatment

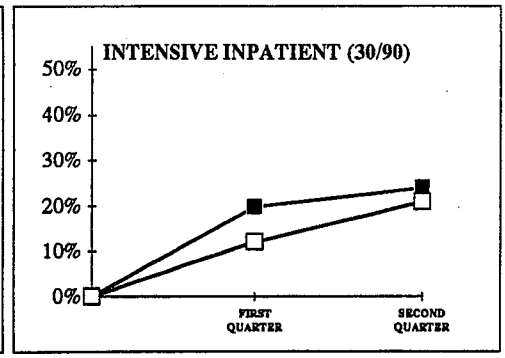
Figure 8F

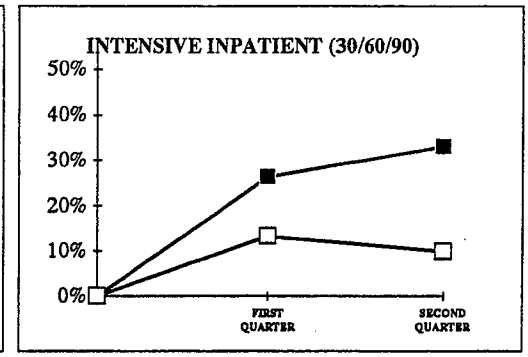
Completers v. Non-Completers
Full-time Employment

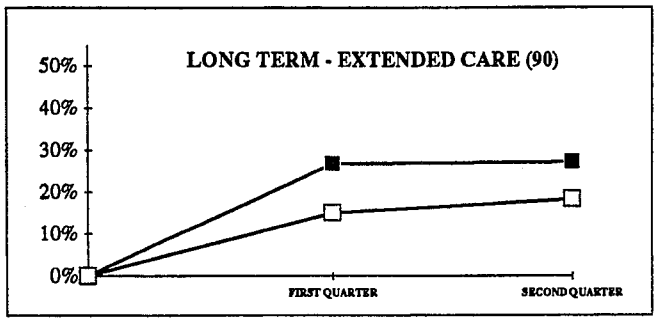


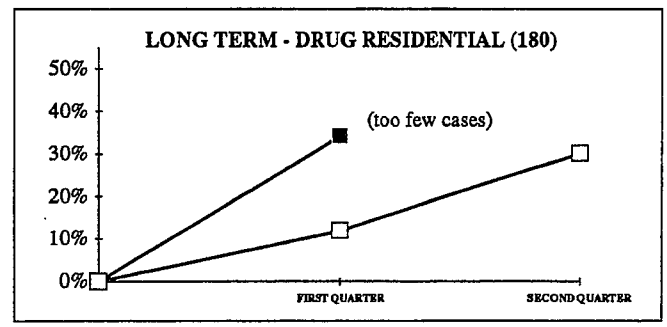


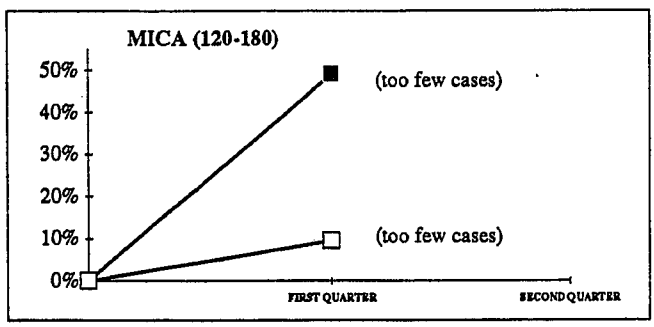


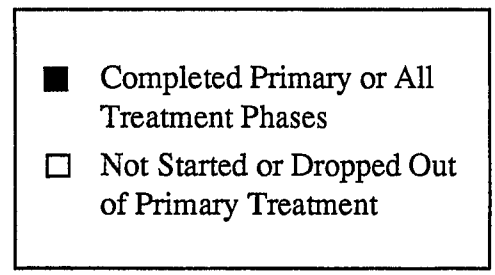








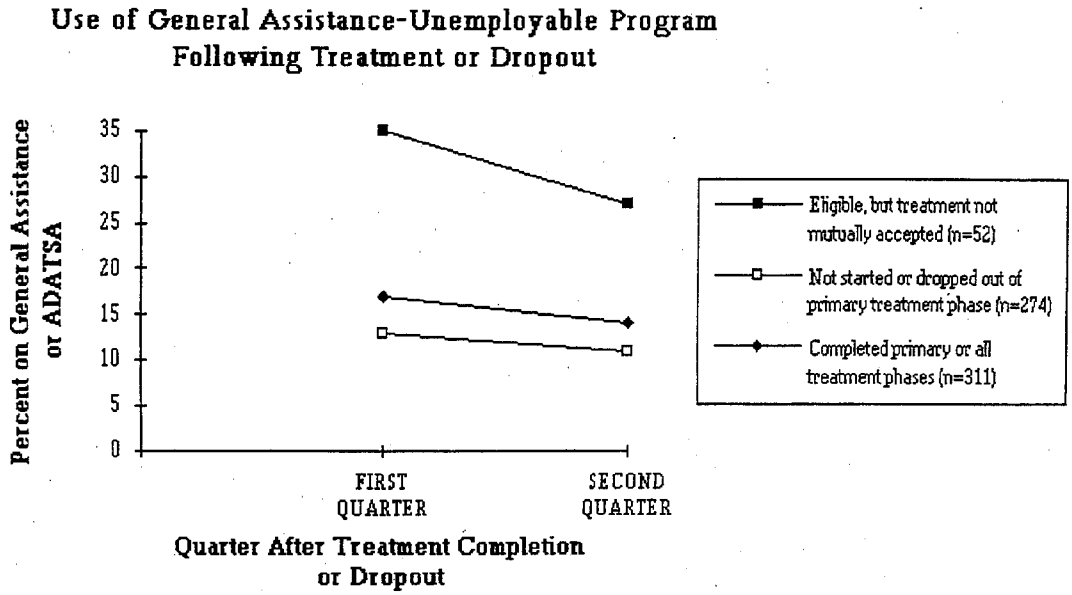




OVERALL TRENDS

The data show decreases in the use of General Assistance-Unemployable (GAU) by all ADATSA-eligible clients (Figure 8G). Even for persons who did not accept treatment, GAU use drops from 35% during the first quarter after treatment or drop-out, to 27% one quarter later. For those who accepted but did not appear for treatment or who dropped out of treatment, GAU use drops from 13% the first quarter after drop-out to 11% the next quarter. For those who complete at least primary treatment, GAU use drops from 17% the first quarter post-treatment to 14% one quarter later.

Figure 8G

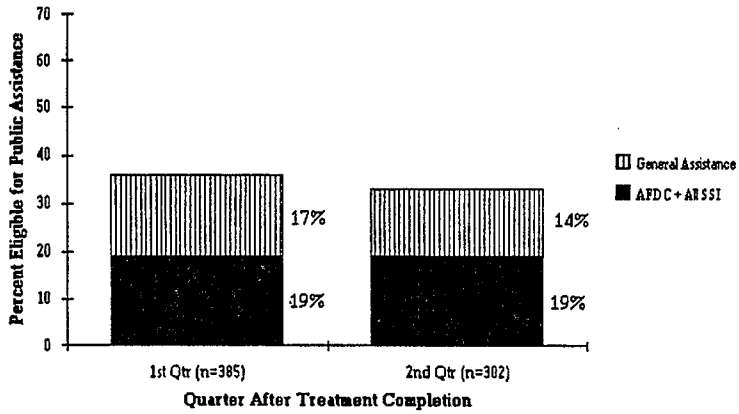


The percent of clients eligible for AFDC and SSI remains fairly stable over the first two quarters post treatment (Figure 8H). With two exceptions, clients in all treatment paths become eligible for GAU less after treatment than they did before treatment (see Figure 8I). The two exceptions are the outpatient program and the extended care programs.

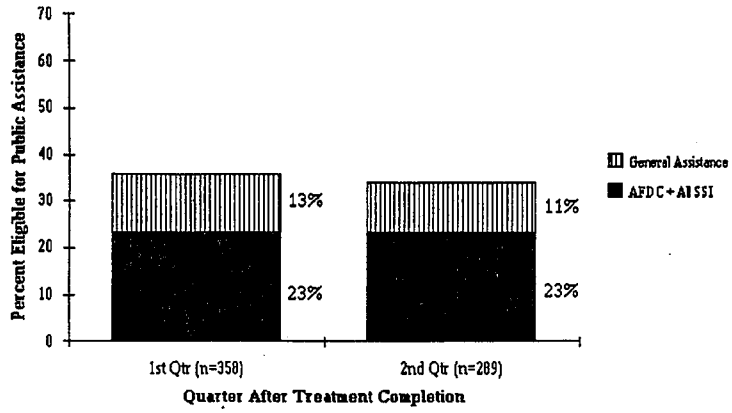
Longer treatment paths (30/60/90, Long Term Drug Residential, and MICA) show the greatest decrease in GA-U grants. These treatment paths also show the greatest success in getting clients who complete treatment into employment.

Figure 8H
Percent of Clients on Public Assistance After ADATSA Support Ends

Among Clients Completing Primary or All Treament Phases



Among Clients Who Did Not Start or Dropped Out of Primary Treatment



Among Clients Eligible, but not Mutually Accepted

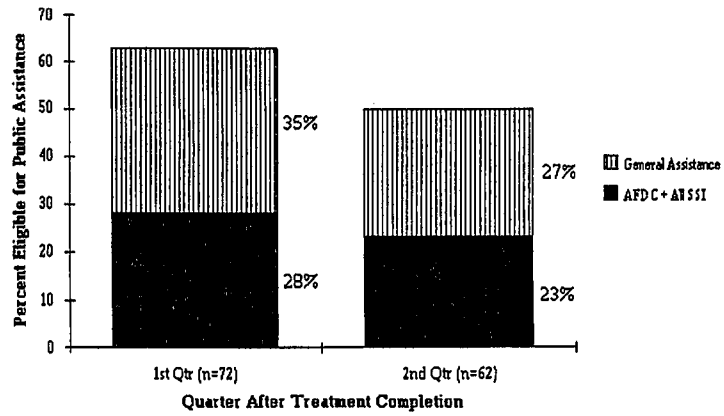
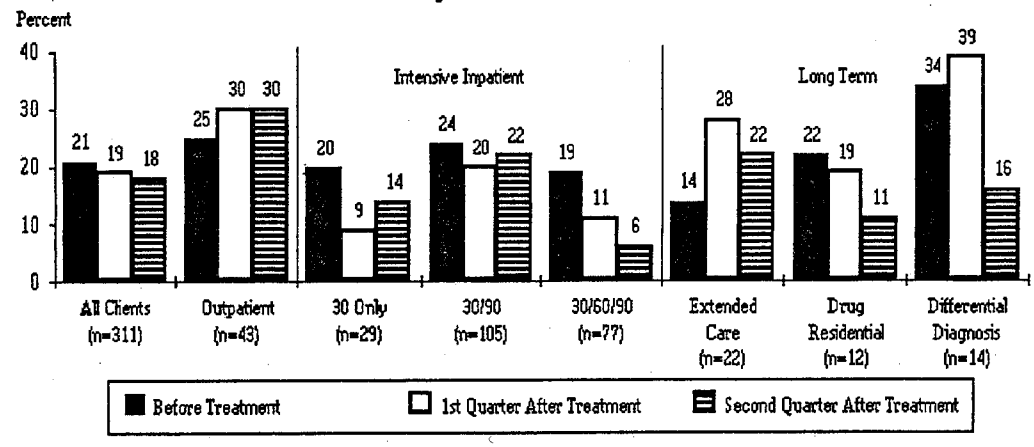


Figure 8I

General Assistance-Unemployable Eligibility for Individuals in Five Quarters Prior to ADATSA Treatment and in the First Two Quarters Post ADATSA by Treatment Paths



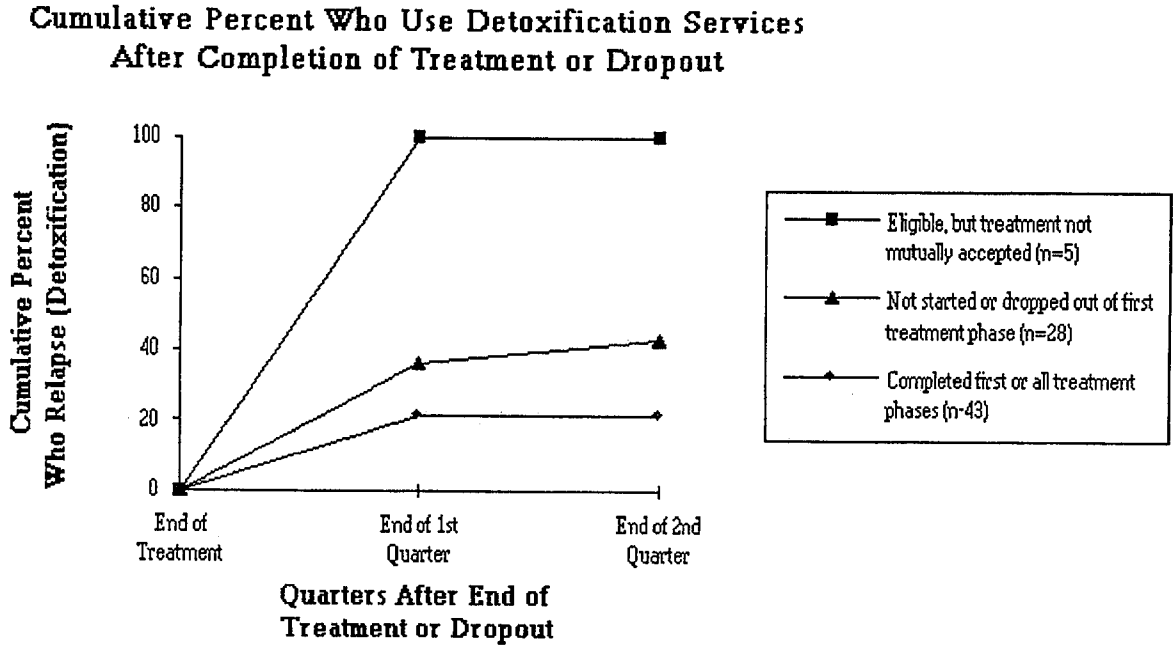
DETOXIFICATION RE-ENTRY

Evidence from a sample of previous users of detoxification services allowed a tentative study of resumption of substance abuse by measuring the incidence of detoxification services after treatment.[6] Clients completing at least the primary phase of treatment have a significantly lower relapse rate as measured by detoxification use (see Figure 8J). Twenty percent of those who completed at least primary treatment re-used detoxification services, compared to 40% of non-completers and non-starters. One hundred percent of those who did not accept or were not accepted for treatment re-used detoxification services.

Caution should be used in generalizing these findings since the sample sizes are very small. Furthermore, use of detoxification services measures only severe relapses for public inebriates or those seeking help for severe intoxication. Nonetheless, the data show clear and consistent patterns across the two quarters.

[6] Among the 1,118 applicants in the study population, 76 had used SAMS-reported detoxification services prior to coming to ADATSA. Thier post-ADATSA use of detoxification services is shown in Figure 8J.

Figure 8J



RE-ENTRY INTO ANY DASA SERVICE PROGRAM

The sample of ADATSA clients accepted for treatment were tracked for a period of 12 months on the Substance Abuse Management System's files. These files contain information on the clients' re-entry into various types of services provided by the Division of Alcohol and Substance Abuse. These include chemical dependency treatment (by treatment modality; inpatient or outpatient), detoxification, and methadone treatments. These programs are funded by various sources, often non ADATSA. Table 8.4 presents the proportion of clients re-entering treatment by type of service program entered and by the degree to which clients completed their originally planned treatment program.

Table 8.4
Percent of Clients Re-entering DASA Service Programs From All Funding Sources

(For a period of 12 months for a sample of ADATSA clients accepted for treatment in the fall of 1989, after they did not show up, dropped out or completed their originally planned treatment program as reported by the Substance Abuse Management Systems (SAMS).)

	Did not show up for Tx Program	Dropped out of primary Tx Program	Completed only primary Tx Program	Completed All Tx Programs		Total
				Not used up all eligible time*	Used up all eligible time	
Treatment Only						
Outpatient only	4	17	16	21	16	16
Inpatient/Outpatient	24	11	8	5	4	11
Detox + Treatment						
Outpatient only	1	0	5	1	1	1
Inpatient/Outpatient	4	4	1	1	3	3
Detoxification Only						
1 Episode	0	2	4	0	0	1
2 or more Episodes	1	3	2	3	1	2
Methadone	0	2	2	0	0	1
All Re-entries	34	39	38	31	25	35
No Re-entries	66	61	62	69	75	65
	100	100	100	100	100	100
N =	147	215	133	206	46	747

Note: This information was obtained from SAMS during the period when SAMS was in a transition phase.

Note: Tables in Appendix 8 present re-entry findings separately by type of funding: funding totally by ADATSA, partially by ADATSA, and finally, by non ADATSA sources.

The major findings from Table 8.4 are the following:

- 25% of clients completing all treatment programs (and using up all eligible ADATSA time) re-enter DASA-funded service programs within a year after treatment.

- Two-thirds of these re-entries involve starting an outpatient program . Tables in the Appendix show that re-entry into outpatient treatment is not funded by ADATSA. Outpatient care was recommended by Panel Review professionals as necessary continuing support after ADATSA-funded treatment ends.

SUMMARY

In the immediate post-treatment period, ADATSA clients completing at least some treatment are more likely to be employed than those who do not enter treatment. This is true even after accounting for the effects of selected background factors.

After treatment, ADATSA clients who completed at least primary treatment were less likely to be on GAU.

Of the clients who re-entered detoxification services, the proportion of those who completed treatment was smaller than those who did not.

Among clients completing all ADATSA treatment, 25% re-enter within a 12-month period, but mainly for continued outpatient support.

EMPLOYMENT OUTCOMES AFTER SUPPLEMENTAL VOCATIONAL SERVICES: CLIENTS OF THREE PILOT PROGRAMS

9

The ADATSA legislation recommended vocational services for chemically dependent clients in recovery to help them obtain or regain employment. The effectiveness of available vocational services for this population, however, has been questioned.[1]

Three pilot programs were established to provide vocational services designed for chemically dependent clients. This chapter compares the post-treatment employment of clients of these three pilot vocational programs to that of ADATSA clients who did not receive such vocational services.

THE THREE VOCATIONAL PROGRAMS

Rapid Rehabilitation Resolution (RRR) is located in Spokane. This program administers services of the Division of Vocational Rehabilitation, excluding long-term training. Clients are referred by chemical dependency treatment counselors while still receiving care. If eligible for Vocational Rehabilitation services, they receive aptitude testing, vocational counseling and guidance, access to job listings, etc. They may receive short-term training such as re-certification. If, however, a client needs longer training, he/she is referred to a different Vocational Rehabilitation counselor. Services are provided rapidly while the client is still in chemical dependency treatment and covered by ADATSA. No extra services or client stipend extensions are provided. 130 RRR clients were studied.

ADATSA Cooperative Employment Program (ACEP) is located in Seattle. Clients are served after finishing chemical dependency treatment. Clients are screened by an ADATSA counselor at or near the end of the chemical dependency treatment. They usually receive two-month ADATSA coverage extension and usually complete the Vocational Rehabilitation program in that period. They attend a motivational workshop with other recovering clients, which (in nine 90-minute sessions) covers asset identification and job-seeking skills. They receive an extension of ADATSA outpatient services, including a stipend, usually for five weeks. Normal Bureau of Vocational Rehabilitation services (again excluding long-term training) are provided. 227 ACEP clients were studied.

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[1] Charles J. Morgan, et al, February, 1990, Intensive Protective Payee for Chemically Dependent Indigents: An evaluation of the ADATSA Intensive Protective Payee Pilot Project, Office of Research and Data Analysis, DSHS, Olympia, Washington.

The **Vocational Opportunity Training/Education Program (VOTE)** is located on the campus of Pierce College in Tacoma. VOTE is a 6-week intensive program (3 days a week, 6 hours a day), that provides job-seeking skills in the context of support for the recovering addict. The program has a high staff/client ratio and provides a wider variety of services, from character/aptitude assessment, through all job-seeking skills. VOTE has other potentially important factors. It has a high staff-to-client ratio, and it places high consideration on the quality of the client's recovery process during screening. The program has links with the state Employment Security Division, and has access to other services of a college campus. Clients receive intensive job-seeking skills training, along with significant support and counseling about chemical dependency recovery. This six-week long program is funded by DASA. A total of 398 VOTE clients were studied.

METHODS

The clients from these three programs were compared to ADATSA clients who did not receive vocational services. A total of 167 clients were studied in the comparison group. Comparison cases were selected from the sample of ADATSA clients if they had completed chemical dependency treatment and if they lived in the same geographic areas served by the three programs.

This study replicates an earlier study[1] with the following changes:

1. more cases were used,
2. a longer post treatment period was analyzed,
3. more background information on clients including education and drug use was analyzed,
4. instead of matching clients demographically, a multivariate analysis was used to assess the effects of these variables.

In this analysis, employed persons are defined as people employed in Washington State whose employers reported their earnings to the Employment Security Division. Those who worked out of state and those who worked informally are not included. The effect of these exclusions on a state-wide basis is not known but, in the case of Spokane, it may be significant because of its location close to the Idaho border.

Prior employment means any employment during the five quarters before assessment. At least half-time employment (50% or more) was selected as the variable to be analyzed post treatment, because it measures the ability of a client to support himself/herself, assuming minimum wage. 88 hours of work a month at minimum wage approximates the single-person grant in Washington's public assistance programs.

This half-time employment was measured in two ways:

1) Short term employment: half-time in either the first or second quarter after treatment and vocational services

[1] Charles J. Morgan, et al, February, 1990, Intensive Protective Payee for Chemically Dependent Indigents: An evaluation of the ADATSA Intensive Protective Payee Pilot Project,Office of Research and Data Analysis, DSHS, Olympia, Washington

2) Long term employment: half-time or more consistently for up to 15 months after treatment and vocational services.

Short term employment is measured exactly the same way as half-time employment in Chapter 8. Long term employment is measured in a more conservative way than in Chapter 8. The intent here is to measure more consistent, long term employment as implied in the goals of the pilot vocational services programs.

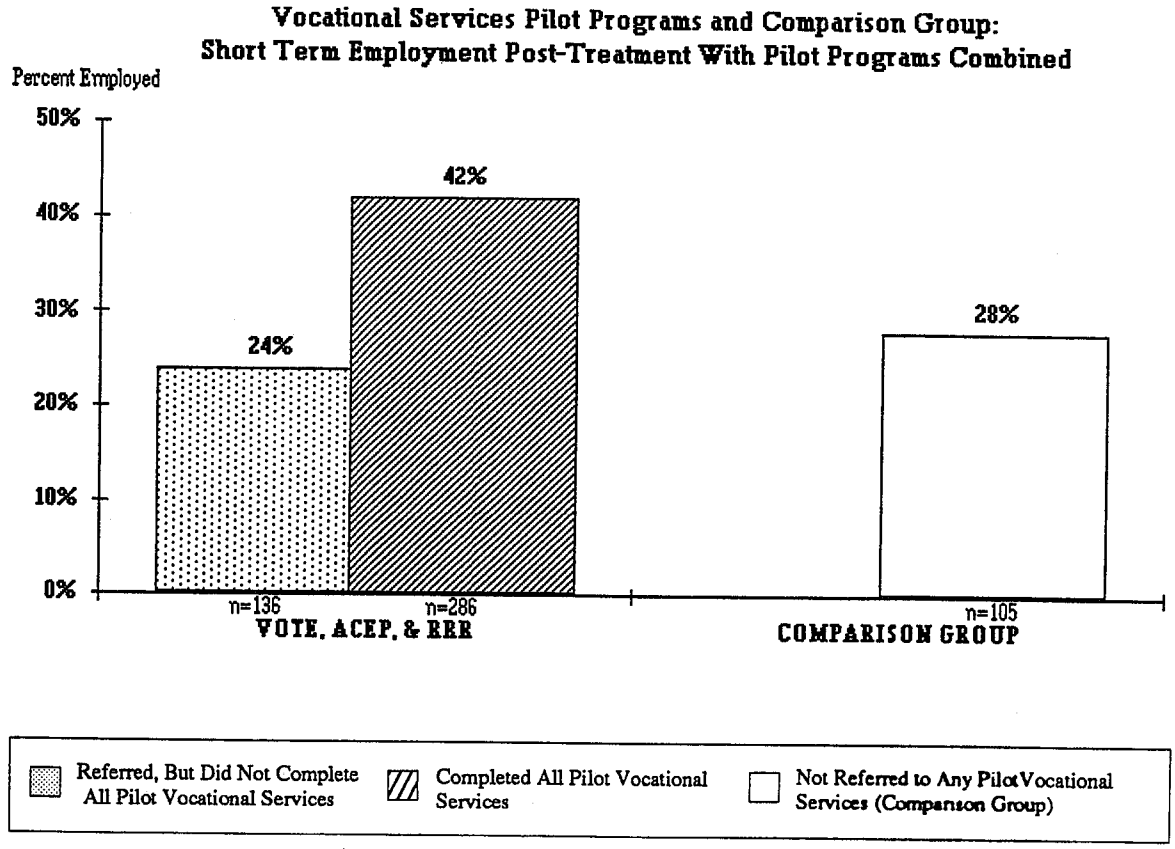
This long term employment is used for subsequent statistical tests of effects of vocational services. The employment outcomes discussed in Chapter 8 refer to the general sample of ADATSA clients. Data reported in this chapter on ADATSA clients relate specifically to a comparison group sub-sample of the general sample of ADATSA clients. Because this comparison group is a sub-sample selected specifically for geogaphic congruence with treatment groups, the data reported in this chapter is not comparable to that in Chapter 8.

Post-treatment employment was not a goal for ADATSA client who are also AFDC grant recipients. Because of this, they were eliminated from further analysis. Clients with only medical coverage were retained in the analysis. There were no SSI (disabled) clients in the sample.

MAJOR FINDINGS

1. During the short term post-treatment period (6 months after), up to 42% of clients completing pilot vocational programs were employed as compared to 28% of the comparison group (Figure 9A); ACEP clients had 50% and VOTE and RRR each had 39% employed (Figure 9B).
2. In the long term (up to 15 months after treatment), VOTE completers had 24% employed and ACEP had 17% employed (Figure 9C). There was no difference between RRR and the comparison group in the long term.
3. In both the short and long term, clients that were referred to but did not complete pilot vocational services had lower employment than completers.These differences were significant at 0.01 level.
4. Long term employment outcomes were not significantly related to work experience, prior welfare status, ethnicity, age, education, or type of drug used.

Figure 9A

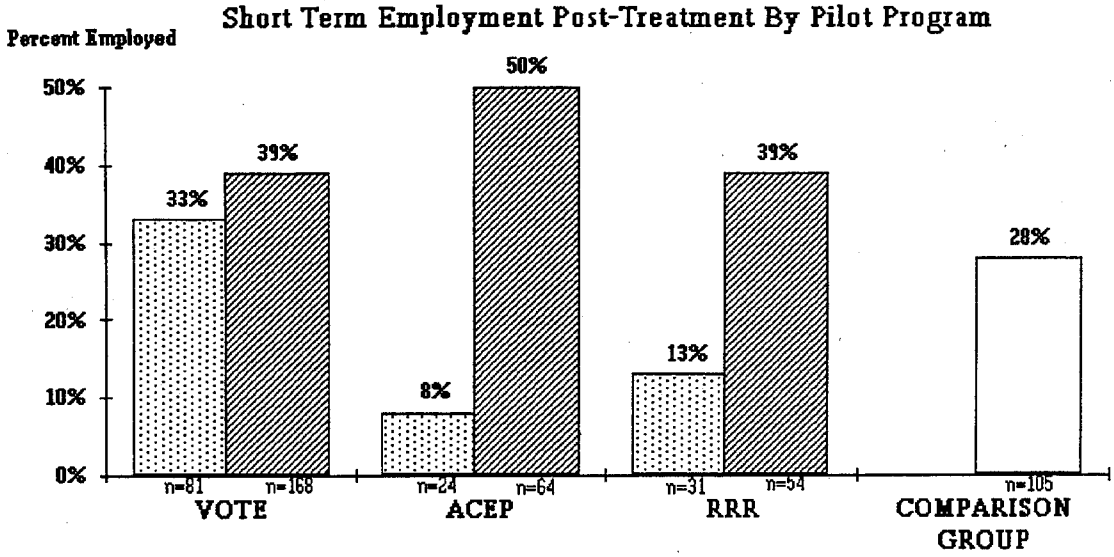


Note: Short term employment is measured as working half-time or more in one of the first two quarters (6 months) after treatment and vocational services.

Comparison group did not receive any pilot vocational services but completed at least primary chemical dependency treatment.

Figure 9B

Vocational Services Pilot Programs and Comparison Group:
Short Term Employment Post-Treatment By Pilot Program

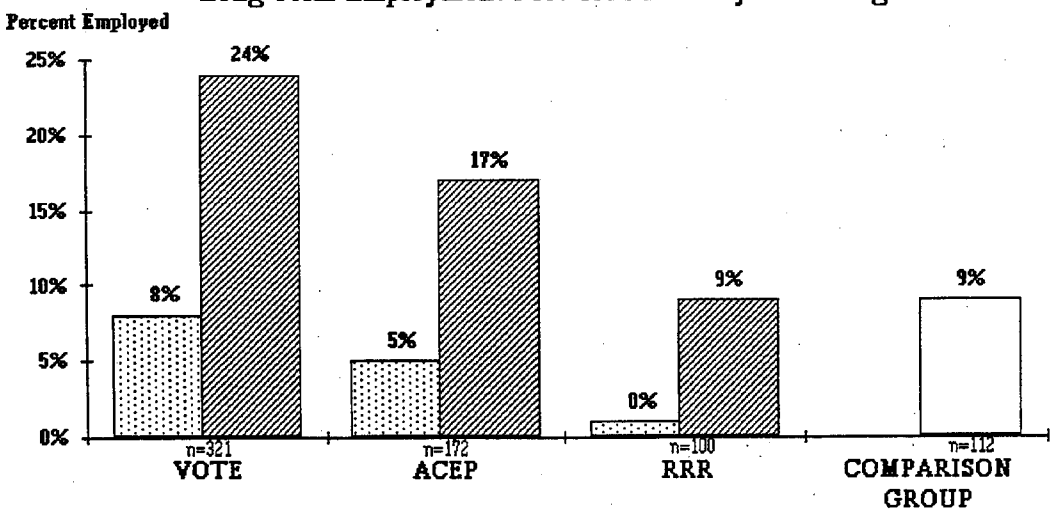


Note: Short term employment is measured as working half-time or more in one of the first two quarters (6 months) after treatment and vocational services.

Comparison group did not receive vocational services but completed at least primary chemical dependency treatment.

Figure 9C

Vocational Services Pilot Programs and Comparison Group:
Long Term Employment Post-Treatment By Pilot Program



Note: Long term employment is measured as working half-time or more consistently for up to 15 months after treatment and vocational services.

Comparison group did not receive vocational services but completed at least primary chemical dependency treatment.

RESULTS

EFFECT OF VOCATIONAL SERVICES CONSIDERING BACKGROUND FACTORS IN ISOLATION

A number of background variables such as work experience, age, gender, ethnicity, and education are commonly thought to be related to employment. Chi-square tests were used to determine the significant effects of these variables on long-term post-treatment employment in the ADATSA population. **No significant and consistent association was found between these background variables and employment outcomes.** That is, some variables are significant within one or two groups, but none is significant across all groups (see Table 9.1). Even work experience (employment immediately prior to treatment) **did not have** a significant and positive impact on post-treatment employment among the sample, contrary to the trend among all ADATSA clients (Chapter 8).

EFFECT OF VOCATIONAL SERVICES CONSIDERING BACKGROUND FACTORS SIMULTANEOUSLY

Multivariate analyses were conducted to test whether long term employment was significantly different for clients of the different programs, controlling for the effects of other variables. Gender and marital status were eliminated from the analysis because there were too few women and too few married clients. None of the background variables was significantly related to employment outcomes when other variables were statistically controlled (Table 9.2).

ACEP and VOTE clients are significantly more likely to be substantially employed than the comparison group.

Employment during the five quarters preceding chemical dependency treatment was not significantly related to post-treatment employment when the other variables were controlled.

FACTORS WHICH MAY AFFECT THE FINDINGS

Besides the vocational programs themselves, two other factors may influence the results:

Geography- Employment rates were expected to vary with the job market and local economy. When clients in the comparison group were analyzed across geographic areas, however, there were no significant regional variations. The relatively low long-term employment rates observed for the RRR program may be an underestimate of the actual rates. Spokane and Whitman county residents may be employed in Idaho. Since this study did not include employment data from other states, employment rates in the Spokane area may be underestimated to an unknown extent.

Table 9.1
Percent Employed Long Term, Half-Time or More Post-Treatment by Background Variables

	VOTE	RRR	ACEP	Comparison Group
Number of Cases	321	100	172	112
Education				
Less than High School	19%	7%	4%	6%
High School Grad	20%	8%	16%	11%
More than H.S.	22%	0%	17%	9%
Employed Before Treatment				
Not recently Employed	15%	0%	11%	13%
Recently Employed	22%	9%	13%	8%
Employed Less Than 50%	21%	6%	13%	8%
Employed More Than 50%	15%	6%	12%	14%
Age				
Less than 30	20%	9%	9%	8%
30 - 39	20%	5%	15%	10%
40+	18%	4%	13%	9%
Ethnicity				
Black	11%		13%	12%
Native American	14%			
White	16%	6%	12%	6%
Other	23%	7%	14%	17%
Sex				
Male	21%	6%	13%	7%
Female (a)	17%	9%	13%	15%
Marital Status				
Single	19%	5%	11%*	9%
Married	21%		36%*	11%
Drug Use				
Alcohol	17%	5%	13%	11%
Drugs(a)	22%			
Both	24%	15%	17%	10%
Alcohol Treatment				
Some				14%
All	20%	9%	13%	0%
Vocational Training				
No Services				9%
Some Services	8%*	0%	5%*	
All Services	24%*	9%	17%*	

* Statistically significant at the .05 level, using logistic analysis. This technique permits testing the statistical significance of each value of an ordinally scaled independent variable on a dichotomous dependent variable.

(a) Numbers are too small to be reliable

Table 9.2

Results of Multivariate Analysis: Significance Levels for Variables Tested for Their Independent Effects on the Likelihood of at Least Half-Time Long Term Employment Post-Treatment

(Clients of All Pilot Programs and of Comparison Group: n=705)

Independent Variables	Significant Effect on Employment	Positive or Negative Effect	Client Condition on Independent Variable
Age	n.s.		
Education	n.s.		
Ethnicity	n.s.		
Drug Choice	n.s.		
Prior Employment	n.s.		
Prior Welfare	n.s.		
Completion of All Vocational Services	.01	+	Completed All Services
Pilot Programs: VOTE and ACEP	.00	+	Client Received VOTE or ACEP Services

n.s. - Not significant at the .05 level for specified independent variables controlling for the possible effect of all others using logistic regression.

Selection bias- All three vocational service programs attempt to screen out both people who don't need vocational services and people who will not benefit from such services. This kind of selection could conceivably account for the results presented here. VOTE, for example, screens explicitly for the quality of the client's recovery process and, in doing so, may select clients who are more likely to succeed in employment in the long term.

This study has attempted to eliminate selection biases in a social and demographic sense. Characteristics like age, ethnicity, education, and job experience were not significantly related to post-treatment employment in this study. Some "likely-to-succeed" variables that were not measured were psychological ones. Quality of recovery, used by VOTE, is an example of this kind of variable. This study has shown that if quality of recovery (or some similar variable) is an important predictor of long term recovery, including employment, it is randomly distributed across social and demographic groups of clients.

DISCUSSION OF RESULTS

When treatment has a positive outcome, then more treatment (within limits) is predicted to have more positive results. This phenomenon, called dose response, is observed here. RRR, the program which offers Vocational Rehabilitation services only, has the lowest percent substantially employed long term. ACEP, which offers Vocational Rehabilitation services plus a motivational and skills workshop, has the second best percent employed long term. VOTE, which offers more services has the best long term employment percentage.

VOTE's success, however, may be due to qualitative factors: VOTE is unique among the three programs for its attention to the addiction recovery process, its staffing, and locational advantages.

SUMMARY

Clients completing any of the three pilot vocational program had higher short term employment. ACEP and VOTE clients were more likely to be employed long term than the comparison group of ADATSA clients and RRR clients. Long term employment was not significantly related to ethnicity, age, education, work experience, prior welfare status, or type of drug used.

SHELTER CLIENTS: WHAT BECAME OF THEM?

10

The Washington State Legislature restricted eligibility for the ADATSA shelter program effective July 1, 1989. This chapter attempts to determine the consequences of this action for a group of 670 shelter clients who were likely to have become ineligible for services under the new regulations.

Eighteen months after the legislation, only 1% out of the original 670 were still shelter clients. What happened to the others? Three hypotheses about the current status of the rest of these clients 18 months later were explored:

1. They shifted to other sources of public assistance.
2. They eliminated their need for public assistance by earning a sufficient income.
3. They were either serving prison terms or had died.

It is conceivable that some clients may have simply moved away or become homeless. The difficulty in tracking those clients limited this study to the above options.

METHODS

Shelter client data from a previous ORDA study of Intensive Protective Payees were matched with four data bases:[1]

1. Office of Financial Management data, to measure use of public assistance during the 18 months after July, 1989;
2. Office of Employment Security data, to determine employment over the same period;
3. Department of Corrections, to determine how many clients may be incarcerated or under community supervision (parolees, probationers); and
4. Vital Records data, to determine how many died.

Clients were tracked in these data bases for 18 months after July 1, 1989. The results are presented at three successive 6-month intervals: 1/31/90, 7/31/90, and 1/31/91.

Employment was measured as any amount of work in each of the 6-month intervals.

MAJOR FINDINGS

1. Former shelter clients used public assistance progressively less over the 18 month period: from 56% in the first six months to 36% in the third six months.
2. Only 6% to 20% of shelter clients were employed, and they earned an average income of about $50 a month.
3. Very few were in state prisons, and even fewer had died.

[1] Intensive Protective Payee for Chemically Dependent Indigents: An Evaluation of the ADATSA Intensive Protective Payee Pilot Project, Charles J. Morgan, et al. February, 1990, Office of Research and Data Analysis, DSHS, Olympia, Washington.

USE OF PUBLIC ASSISTANCE

When use of public assistance was analyzed for three six-month periods, the following trends were found:

1. a decline in the use of all types of public assistance,
2. a significant decline in the use of ADATSA funds, and
3. an unexpected decline in the use of GAU and AFDC (Table 10.1).

About 70% of these former shelter clients were using public assistance in July, 1989. Six months later, only half of these clients were still receiving such assistance. By January, 1991, this figure dropped to 36% (Figure 10A).

It was expected that the new eligibility requirements might just move clients from the shelter program to other kinds of public assistance, but this was not the case. Use of GAU and AFDC declined significantly (Table 10.1). This finding is true across all demographic groups.

The profile of people who stayed on public assistance did not change over this 18-month period (Table 10.2), implying that those who remained on public assistance were not different from those who did not stay.

Table 10.1
Shelter Clients Public Assistance Utilization by Assistance Program for 18 Months Starting August, 1989

	First Six Months 1/31/90 n = 670	Second Six Months 7/31/90 n = 670	Last Six Months 1/31/91 n = 670
All Programs*	56%	45%	36%
AFDC	6%	5%	4%
GA-U	20%	17%	14%
Disability	14%	12%	11%
ADATSA	14%	10%	6%
Other	2%	1%	0%

* 70% were using public funds at the time of shelter restriction.
Program used in last six months determined program eligibility.

Figure 10A

Situation of Ex-Shelter Clients Eighteen Months After July 1, 1989

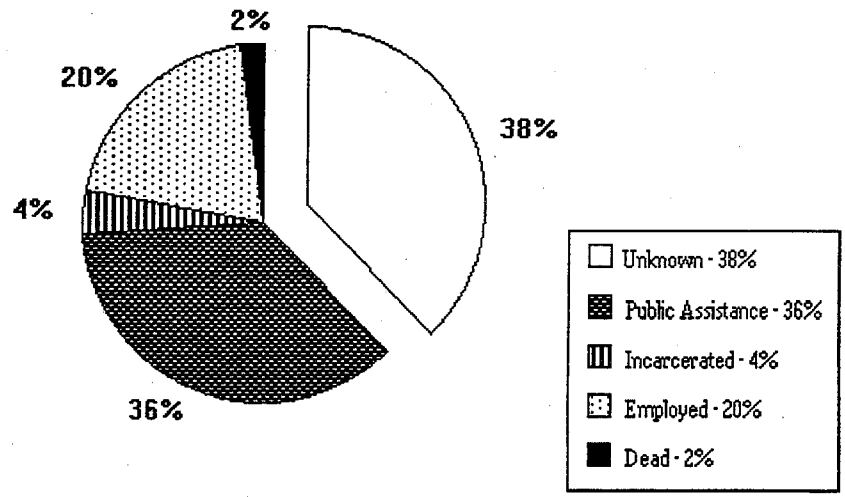


Table 10.2
Profile of Former Shelter Clients Active on Public Assistance Over 18 Months

	8/1/89 n=469	1/21/90 n=376	7/31/90 n=302	1/31/91 n=241
Gender				
Male	76%	74%	72%	72%
Female	24%	26%	28%	28%
Age Range*				
20 - 30	20%	19%	19%	19%
30 - 40	43%	44%	44%	45%
40 - 50	24%	24%	23%	22%
50 +	13%	13%	14%	14%
Median Age*				
Male	39	39	40	39
Female	33	33	34	34
Ethnicity				
White	64%	64%	65%	64%
Black	27%	27%	26%	28%
Other	9%	9%	9%	8%

* Age was calculated as of August 1, 1989

DEMOGRAPHIC PROFILE OF SHELTER CLIENTS ACTIVE ON PUBLIC ASSISTANCE

Since the need for shelter is sometimes associated with being much older, male, and a minority, it is instructive to briefly review the demographic characteristics of these former shelter clients.

Former shelter clients are predominantly male, white, and in their thirties. One of four are women and one of three are members of ethnic minorities. Blacks are the largest ethnic minority. Ages range from twenties to fifties, but 43% are in their thirties. Male shelter clients tend to be older, with a median age of 39; women have a median age of 33.

EMPLOYMENT AND INCOME

The study found that:

1. only 6-7% of these clients were employed at any time during the first year,
2. 20% managed to attain any employment by the end of the 18-month period, and
3. none of these clients earned more than $270 per month and the average income was about $50 a month (Table 10.3).

Table 10.3
Reported Employment and Earnings

	1/31/90	7/31/90	1/31/91
Reported Any Employment	6%	7%	20%
Reported Earnings/Month			
<$56	3%	3%	11%
$56 - 167	3%	3%	6%
$167 - 277	0%	1%	3%

During the first year, employment rates were very low (6%-7%). Between the twelfth and eighteenth month, however, the employment rate rose to 20%. Income remained marginal through the period. Table 10.3 shows the percentage of clients in each of three monthly income categories. In the first year no clients earned more than $167 a month.

Income increased during the last six months. The percentage of clients earning between $56 and $277 per month rose from 3% to 9% during the last six months, while the percentage of clients earning less than $56 per month rose from 5% to 20%. These former shelter clients did not become economically independent.

INCARCERATION AND DEATH

The final expectation that many of these former shelter clients were serving terms in prisons or had died also proved largely incorrect. Among this group of 670 former shelter clients, 4% were serving prison terms and 2% had died. However, it should be noted that information on incarceration in county jails is not easily available and was not used in this study. This means that clients in prisons or jails may be underestimated. Furthermore, Vital Records did not have information on the whole 18 month period so the number of clients who died may also have been underestimated.

FORMER SHELTER CLIENTS NOT ACCOUNTED FOR

Thirty-eight percent of former shelter clients were not found in any of the four state data bases examined; Public Assistance, Employment, Incarceration or Death Records. These former shelter clients may have left the state, be living with family members, friends or in shelters. Some may be incarcerated in county or mnicipal jails and others are probably homeless. Finally, it is possible that some of these clients are informally employed, without being reported to the state.

SUMMARY

Sixty-two percent of the former shelter clients were traced. By the end of the 18-month period, a little over one-third were receiving some form of public assistance. About 20% had worked at some point, but their income was negligible. Finally, incarceration and death accounted for about 6% (Figure 10A). The remaining 38% are not accounted for.

CONCLUSION

11

TREATMENT OF ADDICTION

Addiction to alcohol and other drugs is physical as well as psychological. In addition, it is a lifelong problem. Research shows that only about one third of people addicted to any substance (including nicotine and food) are likely to achieve abstinence after any one treatment intervention. Most persons will require more than one treatment to be successful[1] (see Appendix 11). The ADATSA population is severely dependent and lacks resources such as employment, income, social support, and housing. This population may be expected to have more than average difficulty remaining sober and to require more than one or two treatments to do so.

PERFORMANCE AND OPPORTUNITIES

Within the constraints of available funding the ADATSA program shows many favorable results:

1. Treatment completion rates compare favorably with rates in other states.[2]
2. On the whole, the ADATSA program does not favor or impede treatment completion by any particular group of clients.
3. Tentative findings on detoxification relapse rates and re-entry into DASA services suggest that treatment completion is associated with more and longer abstinence and that clients re-enter mainly for continued outpatient support.
4. Clients completing treatment are more likely to be employed in the immediate post-treatment period, and
5. Extra vocational services, designed for ADATSA clients, improve the probability of employment in the short and long term.

One implication of these findings is that if more appropriate vocational services are funded, more ADATSA clients will become employed post-treatment.

This study found that few characteristics increase the chance of treatment completion: using alcohol only, having one prior treatment episode, or being older (50+). Furthermore, few background characteristics were found to affect the likelihood of employment post-treatment other than completing treatment and obtaining extra vocational services. The implication is that attempts to resolve capacity problems by restricting access to those more likely to succeed on the basis of characteristics studied in this report are not justifiable.

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[1] Richard Catalano, et al, 1988, op cit

[2] Division of Alcohol and Substance Abuse, April 1991. National Survey on Select Treatment and Prevention Issues.

PROBLEMS AND CONSTRAINTS

A number of problems exist in the ADATSA System:

1. A lack of capacity to serve clients eligible for treatment with consequent long wait periods and considerable placement in less appropriate treatment paths;
2. Insufficient auxiliary services such as dental care;
3. Limited safe and sober housing, particularly in the reintegration phase of treatment; and
4. Inappropriately short treatment length, particularly in the aftercare phase, according to the results of the peer review.

The study of bed utilization shows that the system is at capacity, except for outpatient programs. However, placing more clients in outpatient treatment is not a solution since they are not likely to succeed if they receive only three months of outpatient treatment. Because the system is operating at more than capacity, attempts to shorten waiting periods without increasing capacity cannot succeed. Within overall capacity constraints attempts to solve one problem may result in other problems not being addressed. For example, a reallocation of beds/slots resulting in a substantial increase in Recovery House beds at the expense of other paths may result in the inability to fulfill the needs for more MICA and Long Term Residential beds.

GENERAL CONCERN AND FURTHER RESEARCH

When one views the treatment of addiction as a process including multiple treatment episodes, as indicated earlier, a general point becomes clear from the results of this study:

The lack of support services for clients during and between treatment episodes is troubling because it could increase the number of treatment interventions necessary for clients to reach longer term abstinence or longer term reduced use. These support services include transitional housing, appropriate vocational services and continued aftercare as recommended by the Peer Panel Review professionals.

Follow-up studies of clients for a longer time and across more than one treatment episode are necessary to indicate rates of more permanent treatment success. Longer term success in employment rates can also be tested by comparing clients who received extra vocational services with those who did not.

Furthermore, it is also necessary to conduct a cost benefit study of the system which includes not only the savings attributable to long-term abstinence but also the interim cost savings included when clients stop using public assistance and/or become employed even temporarily between treatment episodes[3].

[3] DASA has already funded such a follow-up and cost-savings study covering 18 months after finishing treatment. The report will be available December 1992.

Appendixes

APPENDIX 1

APPENDIX 1A

CHAPTER 406[1]

(Substitute House Bill No. 646)

Alcoholism and Drug Addiction

Treatment and Support Act

AN ACT Relating to alcoholism and drug addiction treatment and shelter and general assistance - unemployable; amending RCW 74.04.005. 74.08.280, 74.09.010, and 74.09.035; and adding a new chapter to Title 74 RCW.

Be it enacted by the Legislature of the State of Washington:

NEW SECTION. Sec 1. This chapter may be cited as the alcoholism and drug addiction treatment and support act.

NEW SECTION. Sec. 2. The legislature finds:

1. There is a need for reevaluation of state policies and programs regarding indigent alcoholics and drug addicts;

2. The practice of providing a cash grant may be causing rapid caseload growth and attracting transients to the state;

3. Many chronic public inebriates have been recycled through county detoxification centers repeatedly without apparent improvement;

4. The assumption that all individuals will recover through treatment has not been substantiated;

5. The state must modify its policies and programs for alcoholics and drug addicts and redirect its resources in the interests of these individuals, the community, and the taxpayers;

6. Treatment resources should be focused on persons willing to commit to rehabilitation; and

7. Shelter assistance is an essential service necessary to prevent homelessness and meet the basic needs of indigent alcoholics and drug addicts.

NEW SECTION. Sec. 4. A program of treatment and shelter for alcoholics and drug addicts who meet the eligibility requirements is established within the department of social and health services. The eligibility requirements for the treatment and shelter program as set forth in eligibility requirements for the general assistance program as set forth in RCW 74.04.005. However, persons who are unemployable solely due to alcohol or drug addiction shall be eligible for services under this chapter, to the extent of available funds, instead of the general assistance--unemployable program. This program shall consist of:

(1) Client assessment services;

(2) A treatment program for alcoholics and drug addicts;

(3) A shelter program for indigent alcoholics and drug addicts;

(4) Assistance in making application for enrollment in the federal supplemental security income program under the social security administration act;

[1] Washington Laws, 1987 Chapter 406, pp. 1561-1563.

and

(5) Medical care services as defined in RCW 74.09.010

NEW SECTION. Sec. 5. (1) The department shall provide client assessment, treatment, and support services. The assessment services shall include diagnostic evaluation and arranging for admission into treatment or supported living programs.

(2) The department shall assist clients in making application for supplemental security benefits and in obtaining the necessary documentation required by the federal social security administration for such benefits.

NEW SECTION. Sec. 6. (1) The department shall provide alcohol and drug treatment services within available funds for indigent persons eligible under this chapter who are incapacitated from gainful employment due to drug or alcohol abuse or addiction. The treatment services may include but are not limited to:

(a) Intensive inpatient treatment services;

(b) Recovery house treatment;

(c) Outpatient treatment and counseling, including assistance in obtaining employment, and including a living allowance while undergoing outpatient treatment. The living allowance shall be administered on the clients' behalf by the outpatient treatment facility or other social service agency designated by the department. The department is authorized to pay the facility a fee for administering this allowance.

(2) No individual may receive treatment services under this section for more than six months in any two-year period: PROVIDED, That the department may approve additional treatment and/or living allowance as an exception.

NEW SECTION. Sec. 7. The department shall establish a shelter assistance program to ensure the availability of shelter for persons eligible under this chapter. The department may contract with counties and cities for such shelter services....

APPENDIX 1B
WAC 388-40 (Rev 1041)

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

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On Revision Control Sheet, note the date Revision 1041 was entered.

REMOVE	INSERT
Chapter 40, Rev. 956 (Entire Chapter)	Chapter 40, Rev. 1041 (Entire Chapter)

This revision updates entire chapter of WAC 388-40. The latest changes to Chapter 40 are noted by shaded text. Changes are as follow:

WAC 388-40 is amended to clarify the department's implementation of the Alcoholism and Drug Addiction Treatment and Support Act and payment criteria for detoxification services. Permanent adoption of this rule change effective 11/23/90.

Specific sections affected are:

388-40-010	388-40-055	388-40-090
388-40-090	388-40-091	388-40-100

CHAPTER 388-40 WAC

ALCOHOL/DRUG PROGRAMS

WAC

WAC 388-40-010 AMD 11/23/90 Rev 1041

ALCOHOLISM AND DRUG DETOXIFICATION PROGRAM--ELIGIBLE PERSONS.

(1) The department shall consider a persons eligible for three-day detoxification services for acute alcoholic condition or five-day detoxification services for acute drug addiction if:

(a) The person is a grant, medical, or supplemental security income (SSI) beneficiary; and

(b) Persons whose combined nonexempt income and/or resources do not exceed the aid to families with dependent children (AFDC) payment standards; and

(c) The person has not transferred resources within two years prior to the date of application without having received adequate consideration according to the provisions under WAC 388-28-461.

(2) The department shall exempt the following resources for the alcoholism and drug detoxification program:

(a) A home.

(b) Household furnishings and personal clothing essential for daily living.

(c) Other personal property used to reduce need for assistance or for rehabilitation.

(d) A used and useful automobile.

(3) The department shall not exempt the following resources:

(a) Cash;

(b) Marketable securities; and

(c) Any other resource not specifically exempted that can be converted to cash.

(4) The department shall deduct or exempt the following from income:

(a) Mandatory deductions of employment.

(b) Total income and resources of a noninstitutionalized SSI beneficiary.

(c) Support payments paid under a court order.

(d) Payments to a wage earner plan specified by a court in bankruptcy proceedings, or previously contracted major household repairs when failure to make such payments will result in garnishment of wages or loss of employment.

(5) The department shall not require the recipient receiving detoxification services to incur a deductible as a factor of eligibility for the covered period of detoxification.

(6) (a) The department shall determine eligibility for the detoxification program on the basis of information shown on the department's application forms.

(b) The department shall require supplemental forms, verification procedures, and/or face-to-face interviews only in cases where there is a specific reason for requiring further verification of eligibility.

(7) When the department is notified within ten working days of the date detoxification began, certification shall cover this period if all eligibility factors are met.

(8) The department shall continue the effective period of eligibility from the date detoxification treatment began through the end of the month in which the recipient completed the three-day or five-day treatment.

(9) The department shall pay for detoxification services for medical assistance recipients only under the following conditions:

(a) Such services must be directly related to detoxification; and

(b) Such services are performed only by a certified detoxification center or a general hospital contracted with the department to perform these services.

[Statutory Authority: 90-21-125 (Order 3089), filed 10/23/90. 89-18-025 (Order 2851), filed 8/29/89. 1987 c 406. 87-18-006 (Order 2526), §388-40-010, filed 8/21/87. Statutory Authority: RCW 74.08.090. 82-20-023 (Order 1884), §388-40-010, filed 9/29/82; 81-10-011 (Order 1643), filed 4/27/81.]

WAC 388-40-020 **AMD 9/28/89 (EMERG 7/1/89) Rev 927**

ALCOHOLISM AND DRUG ADDICTION TREATMENT AND SUPPORT ACT (ADATSA)--PROGRAM DESCRIPTION.

(1) The Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) is a legislative enactment providing state-financed treatment and support to indigent alcoholics and drug addicts.

(2) The purpose of ADATSA is to assist in the rehabilitation of those alcoholics and drug addicts who can benefit from treatment, and to provide a program of shelter services for those whose diseases have resulted in incapacitating physiological or cognitive impairments.

[Statutory Authority: 89-18-025 (Order 2851), filed 8/29/89. 1987 c 406. 87-18-006 (Order 2526), §388-40-020, filed 8/21/87.]

WAC 388-40-030 **AMD 9/28/89**
(EMERG 2/24/89, 2/28/89, 5/26/89, 7/1/89)
ADATSA SERVICES. **Rev 927**

(1) The department shall provide ADATSA services provided for by legislative appropriation and only to the extent each service conforms to all conditions and limitations set by the department.

(2) Persons qualifying for the ADATSA program may be eligible for:

(a) Alcohol/drug treatment services and support as described under WAC 388-40-090 and 388-40-095; or

(b) Shelter services as described under WAC 388-40-100.

(3) Persons eligible for ADATSA are also eligible for medical care services described under WAC 388-86-120.

[Statutory Authority: 89-18-025 (Order 2851), filed 8/29/89. 1987 c 406. 87-18-006 (Order 2526), §388-40-030, filed 8/21/87.]

WAC 388-40-040 **AMD 9/28/89**
(EMERG 7/1/89)
FINANCIAL ELIGIBILITY REQUIREMENTS. **Rev 927**

(1) An applicant/recipient (A/R) of ADATSA shall:

(a) Be eighteen years of age or older,

(b) Be a resident of the state of Washington as defined in WAC 388-26-055 and either a United States citizen or alien who:

(i) Is lawfully admitted for permanent residence; or

(ii) Is otherwise permanently residing in the United States under color of law; or

(iii) Has been granted temporary residency status under the Immigration Reform and Control Act.

(c) Furnish the department with the applicant's Social Security number. If the applicant cannot furnish a Social Security number because it has not been issued or is not known, the applicant shall apply for a number prior to authorization of assistance. The applicant shall provide the Social Security number to the department upon receipt.

(d) Meet the same income and resource criteria as for the general assistance-unemployable (GA-U) program, except persons excluded from GA-U under WAC 388-37-010 because they are recipients of federal aid may be eligible for ADATSA treatment services.

(2) A/Rs placed in an alcohol or drug congregate care facility shall meet the payment and procedural requirements set forth in WAC 388-15-568. However, the department shall not require recipients receiving services in an intensive inpatient alcoholism/drug treatment program of thirty days or less to participate in the cost of care.

(3) The department shall require recipients with income in excess of the clothing and personal incidental standard to contribute that excess toward the cost of their care in a recovery house, extended care recovery house, or long-term care or drug residential treatment facility beginning the month following the month of admission. The department shall compute this participation amount according to the rules applicable to the program under which the benefits are received.

[Statutory Authority: 89-18-025 (Order 2851), filed 8/29/89. RCW 74.50.010. 88-13-110 (Order 2635), §388-40-040, filed 6/21/88. 1987 c 406. 87-18-006 (Order 2526), §388-40-040, filed 8/21/87.]

WAC 388-40-050 **AMD 1/1/90 Rev 956**

INCAPACITY REQUIREMENTS FOR ADATSA TREATMENT.

(1) The department may grant ADATSA treatment services, within the current appropriation, to an alcoholic or drug addict, if otherwise eligible, whose chemical dependency is severe enough to render the applicant incapable of gainful employment.

(2) In order to qualify for ADATSA treatment services, an applicant shall:

(a) Meet the criteria for Psychoactive Substance Dependence In the Diagnostic and Statistical Manual of Mental Disorders (third edition revised), published by the American Psychiatric Association, referred to below as the DSM III-R, for a psychoactive substance class other than nicotine, either mild, moderate, or severe;

(b) Be incapacitated and unable to work. Incapacity shall exist if the applicant meets one or more of the following:

(i) Currently pregnant or up to two months post partum; or

(ii) Diagnosed as at least moderately psychoactive substance dependent and referred for treatment by child protective services; or

(iii) Diagnosed as severely psychoactive substance dependent and currently an intravenous drug user; or

(iv) Diagnosed as severely psychoactive substance dependent and has a prior diagnosis of severe psychoactive substance dependency by an assessment center or at least one prior admission to a department-approved alcohol/drug treatment or detoxification program; or

(v) Diagnosed as severely psychoactive substance dependent and has had two or more arrests for offenses directly related to the chemical dependency; or

(vi) Determined incapacitated for the purpose of eligibility for ADATSA shelter within the past six months; or

(vii) Lost two or more jobs during the last six months as a direct result of chemical dependency; or

(viii) Admitted to a department-approved outpatient treatment program during the last six months and the outpatient treatment provider certifies the treatment recipient is not benefiting from outpatient treatment and needs more intensive chemical dependency treatment services.

(3) Notwithstanding subsection (2) of this section, an applicant meeting the following criteria shall not be eligible for ADATSA treatment when the applicant:

(a) Is not clearly diagnosed as currently dependent on psychoactive substances other than nicotine; or

(b) Has abstained from alcohol and drug use for at least the last ninety days, excluding days spent while incarcerated; or

(c) Has gainfully employed in a job in the competitive labor market at any time during the last thirty days. "Gainfully employed" means performing in a regular and predictable manner an activity for pay or profit. Gainful employment shall not include work in a department-approved sheltered workshop or sporadic or part-time work, if the individual, due to functional limitation, is unable to compete with unimpaired workers in the same job.

(4) A current recipient of ADATSA treatment services successfully participating in outpatient treatment shall be considered incapacitated through completion of planned treatment, even if the recipient:

(a) Becomes employed;

(b) Abstains from alcohol or drug use; or

(c) Has full or partial remission of psychoactive substance abuse dependence.

(5) A department designated chemical dependency assessment center shall determine incapacity based on alcoholism or drug addiction. The assessment center is the department's sole source of medical evidence required for the diagnosis and evaluation of alcoholism/drug addiction and its effects on employability. The department shall:

(a) Require a current assessment, in writing, for all ADATSA applicants; and

(b) Pay the costs of assessments needed to determine eligibility.

[Statutory Authority: 89-24-037 (Order 2908), filed 12/1/89. 89-18-025 (Order 2851), filed 8/29/89. 1987 c 406. 87-18-006 (Order 2526), §388-40-050, filed 8/21/87.]

WAC 388-40-055 **AMD 11/23/90 Rev 1041**

INCAPACITY REQUIREMENTS FOR ADATSA SHELTER.

(1) If otherwise eligible, the department shall provide ADATSA shelter services, within the current appropriation, to an alcoholic and/or drug addict whose chemical dependency has resulted in an incapacitating physiological or cognitive impairment.

(2) To meet shelter incapacity standards, an applicant shall meet the following conditions:

(a) Be actively addicted, as determined by the assessment center, "active addiction" for shelter purposes means use of alcohol or drugs by a diagnosed alcoholic or drug addict within the sixty-day period immediately preceding the latest assessment center evaluation; and

(b) Have resulting physiological or organic damage, or have resulting cognitive impairment not expected to dissipate with sixty days of sobriety or detoxification.

(i) To qualify on the basis of physical impairment, the physiological or organic damage must have at least a severity rating of "03" defined under WAC 388-27-110.

(ii) To qualify on the basis of cognitive impairment, the applicant must have at least a moderate impairment of ability to understand, remember, and follow complex instructions, plus an overall moderate impairment in ability to learn new tasks, to exercise judgment and make decisions, and to perform routine tasks without undue supervision.

(3) The licensed physician, licensed clinical psychologist or mental health professional (as defined by RCW 71.05.020) shall support the diagnosis and severity of the physiological or cognitive impairment with documented, objective and current medical evidence.

[Statutory Authority: 90-21-125 (Order 3089), filed 10/23/90. 89-18-025 (Order 2851), filed 8/29/89.]

WAC 388-40-060 **AMD 9/28/89 (EMERG 7/1/89) Rev 927**

ELIGIBILITY DETERMINATION AND REVIEW--TIME FRAME.

The department shall:

(1) Make a decision confirming or denying eligibility for ADATSA shelter within forty-five days of the date of application, except in circumstances beyond the control of the agency such as failure or delay in securing necessary information or documentation on the part of the applicant.

(2) Redetermine incapacity and financial and medical eligibility for ADATSA shelter at least every six months.

(3) Provide adequate and advance notice of adverse action in accordance with WAC 388-33-376.

[Statutory Authority: 89-18-025 (Order 2851), filed 8/29/89. 1987 c 406. 87-18-006 (Order 2526), §388-40-060, filed 8/21/87.]

WAC 388-40-070 **NEW 9/20/87 Rev 769**

SSI REFERRAL REQUIREMENTS.

(1) Any applicant/recipient whom the department determines may be potentially eligible for Supplemental Security Income (SSI) must:

(a) Make application for SSI, and

(b) Assign the initial SSI payment to the department of social and health services up to the amount of ADATSA assistance provided to the recipient pending approval of the SSI application.

(2) The department shall assist ADATSA applicants/recipients in making application for SSI and in obtaining the necessary documentation required by the Social Security Administration to establish eligibility.

[Statutory Authority: 1987 c 406. 87-18-006 (Order 2526), §388-40-070, filed 8/21/87.]

WAC 388-40-080 **AMD 9/28/89**
(EMERG 2/24/89, 2/28/89, 5/26/89, 7/1/89)
ADATSA ASSESSMENT CENTERS--ROLE. **Rev 927**

(1) ADATSA assessment centers shall:

(a) Be responsible for diagnostic evaluation and treatment placement; and

(b) Not be responsible for providing direct treatment.

(2) The assessment center shall, in accordance with standards set forth under chapter 275-19 WAC, conduct a face-to-face diagnostic assessment of the applicant to:

(a) Determine if the applicant is chemically dependent;

(b) Determine if the applicant meets incapacity standards for treatment under WAC 388-40-050; and

(c) Determine whether the incapacitated applicant is willing, able, and eligible to undergo a course of ADATSA treatment.

(3) Once the treatment applicant's financial and medical eligibility is established, the assessment center shall:

(a) Develop an ADATSA treatment plan;

(b) Arrange all placements into ADATSA treatment taking into account the treatment priorities set forth under WAC 388-40-091;

(c) Provide the applicant with written notification of the applicant's right to return to the community service office (CSO) at any time while receiving ADATSA treatment. This includes, but is not limited to, those situations where the ADATSA recipient is discharged from any inpatient, recovery house, or outpatient facility or agency providing services under contract to the department;

(d) Provide the applicant with written notification of the applicant's right to request a fair hearing to challenge any action affecting eligibility for ADATSA treatment;

(e) Provide ongoing case monitoring of treatment services; and

(f) Notify the community services office promptly of all placement or eligibility status changes.

[Statutory Authority: 89-18-025 (Order 2851), filed 8/29/89. RCW 74.08.090. 89-01-093 (Order 2740), §388-40-080, filed 12/21/88. RCW 74.50.010. 88-13-110 (Order 2635), §388-40-080, filed 6/21/88. 1987 c 406. 87-18-006 (Order 2526), §388-40-080, filed 8/21/87.]

WAC 388-40-090 **AMD 11/23/90 Rev 1041**

ADATSA TREATMENT MODALITIES--DESCRIPTION OF SERVICES, REQUIREMENTS, AND LIMITATIONS.

(1) The department shall offer ADATSA treatment services to an eligible A/R incapacitated by alcoholism or drug addiction, subject to:

(a) Availability defined under WAC 388-40-030(1); and

(b) Priority classifications set forth under WAC 388-40-091.

(2) The department shall limit treatment services to a maximum of six months in a twenty-four month period. The twenty-four month period begins on the date of initial entry into treatment.

(3) The assessment center shall determine a course of treatment based on an individual assessment of alcohol/drug involvement, and treatment needs in accordance with RCW 70.96A.100(2) and the procedures under WAC 275-19-185.

(4) Treatment may consist of residential and/or outpatient services.

(5) The department shall limit residential treatment to the following services:

(a) Intensive inpatient treatment, not to exceed thirty days per admission;

(b) Recovery house treatment, not to exceed sixty days per admission;

(c) Extended care recovery house treatment, not to exceed ninety days;

(d) Long-term care residential treatment, not to exceed one hundred eighty days;

(e) Drug residential treatment, not to exceed one hundred eighty days.

(6) An A/R shall qualify for up to ninety days of direct outpatient treatment services if the assessment center determines residential treatment is not necessary or appropriate. The assessment center shall base this determination on clinical or medical factors indicating the likelihood of an A/R's success in a less structured primary treatment modality. Such

factors may include an assessment of former treatment history, the number of detoxification admissions, and the chronicity, and degree of incapacity of the A/R. The assessment center shall also consider social factors such as the availability of social support systems, family support, and stable living arrangement when evaluating the individual's ability to benefit from primary outpatient treatment.

(7) No recipient shall receive more than ninety days of ADATSA outpatient treatment in a twenty-four-month period, if referred:

(a) Directly to outpatient treatment; or

(b) Following a residential placement.

(8) The department shall terminate an ADATSA recipient who withdraws or is discharged from treatment for any reason. The recipient must reapply and/or be referred to the assessment center if further ADATSA treatment services are required.

(a) A recipient dropping out of treatment in the intensive inpatient phase may be required to repeat this phase.

(b) A recipient dropping out of treatment during the recovery house or outpatient phase may be required to return to the modality from which the recipient dropped out or may be required to enter intensive inpatient treatment if, in the clinical judgment of the assessment center, a more structured form of treatment seems warranted. The assessment center shall refer to inpatient or residential treatment those recipients demonstrating an inability to remain abstinent in outpatient treatment.

(c) A recipient absent from inpatient treatment or other residential services for less than seventy-two hours may, at full discretion of the providing program director, shall reenter that program without being considered as having dropped out and without being required to apply for readmittance through the assessment center.

(9) An ADATSA recipient terminating treatment shall not be eligible for benefits beyond the month in which treatment services end. Regulations regarding advance and adequate notice still apply, but an ADATSA treatment recipient is not eligible for continued assistance pending a fair hearing as provided in WAC 388-33-377.

[Statutory Authority: 90-21-125 (Order 3089), filed 10/23/90. 89-18-025 (Order 2851), filed 8/29/89. RCW 74.50.010. 88-13-110 (Order 2635), §388-40-090, filed 6/21/88. 1987 c 406. 87-18-006 (Order 2526), §388-40-090, filed 8/21/87.]

WAC 388-40-091 **AMD 11/23/90 Rev 1041**

AVAILABILITY OF TREATMENT--PRIORITY GROUPS.

(1) The assessment center shall, in assigning residential admission, give first priority to a pregnant woman and a parent having a child in the home. In addition, the assessment center shall provide priority access to ensure residential treatment admissions for:

(a) A person referred through the children's protective services (CPS) program; and

(b) An intravenous (IV) drug user.

(2) In assigning outpatient admissions, the assessment center shall give first priority to a pregnant woman and a family with a child for whom access to Title XIX outpatient treatment is unavailable. In addition, the assessment center shall provide priority access to ensure outpatient admission for:

(a) A person completing residential treatment; and

(b) A person referred through CPS; and

(c) An intravenous drug user.

(3) The department may deny ADATSA treatment services to a client having access to another source of state approved comparable chemical dependency treatment, when such treatment is not at additional cost to the client.

[Statutory Authority: 90-21-125 (Order 3089), filed 10/23/90. 89-18-025 (Order 2851), filed 8/29/89.]

WAC 388-40-095 **NEW 7/22/88**
(EMERG 5/4/88)

ADATSA TREATMENT--LIVING ALLOWANCE. **Rev 832**

(1) ADATSA recipients in residential treatment shall be eligible for an allowance based on the department's current payment standard for clothing and personal incidentals.

(2) ADATSA recipients in the outpatient treatment modality shall be eligible for a treatment stipend for housing and other living expenses.

(a) The department shall base the stipend amount on the current payment standard for public assistance recipients;

(b) The department shall issue this stipend directly to the outpatient facility as custodial (protective) payee; and

(c) The department shall not authorize the use of any treatment stipend to pay for shelter in a dormitory setting not requiring sobriety as a condition of residence.

[Statutory Authority: RCW 74.50.010. 88-13-110 (Order 2635), §388-40-095, filed 6/21/88.]

WAC 388-40-100 AMD 11/23/90 Rev 1041

ADATSA SHELTER SERVICES.

(1) Subject to provisions under WAC 388-40-0301, the department shall provide shelter services to eligible ADATSA A/Rs meeting the incapacity criteria under WAC 388-40-055.

(2) "Shelter services" or "shelter assistance" means shelter for an ADATSA recipient in a facility under contract with the department to provide room and board in a supervised living arrangement, normally in a group or dormitory setting. The department shall limit ADATSA shelter services to shelter assistance in the contracted facilities unless the recipient resides in a county described under subsection (3) of this section.

(3) A recipient residing in a county where no contracted shelter bed is available may receive shelter assistance in independent housing, subject to the following provisions:

(a) The recipient shall, as a condition of continued eligibility, move to a contracted shelter bed when available. "Availability" means the existence of a vacant shelter bed, rather than whether or not a particular A/R is accepted or rejected from a shelter facility based on disciplinary problems;

(b) The recipient shall receive the monthly shelter assistance payment through an intensive protective payee defined under WAC 388-40-110; and

(c) The department shall provide assistance for independent housing only to a recipient residing in a permanent residential structure. The recipient must also have a deed of purchase, rental agreement, or other verifiable written agreement between the recipient and the person or entity to whom the recipient is obligated for shelter costs or from whom the recipient is receiving supplied shelter.

(4) The department shall base the amount of assistance for independent housing and basic needs on the appropriate payment standard in WAC 388-29-100(3) (a) or (b). For recipients in a contracted shelter facility, the department shall provide an allowance for clothing and personal incidentals based on the standard in WAC 388-29-130.

(5) The department shall terminate a recipient receiving contracted shelter services when the recipient is discharged from the facility for disciplinary reasons or if the recipient subsequently leave shelter without notice for more than seventy-two hours.

(6) The department shall continue benefits for a recipient requesting a fair hearing within the advance notice period before termination is to occur under WAC 388-33-377.

[Statutory Authority: 90-21-125 (Order 3089), filed 10/23/90. 89-18-025 (Order 2851), filed 8/29/89. RCW 74.08.090. 89-01-093 (Order 2740), §388-40-100, filed 12/21/88. RCW 74.50.010. 88-13-110 (Order 2635), §388-40-100, filed 6/21/88. 1987 c 406. 87-18-006 (Order 2526), §388-40-100, filed 8/21/87.]

WAC 388-40-110 **AMD 9/28/89 (EMERG 7/1/89) Rev 927**

ADATSA PROTECTIVE PAYEE REQUIREMENTS.

(1) The department shall pay the assistance needs of recipients receiving outpatient treatment or shelter assistance by protective payee or vendor payment.

(a) The protective payee for an outpatient recipient shall be the same agency providing outpatient treatment.

(b) The protective payee for a shelter recipient in independent housing shall be an agency under contract with the department to provide intensive protective payee services described under subsection (3) of this section; and

(c) The protective payee for a shelter recipient residing in a contracted shelter facility shall be the facility operator. The facility operator shall have the authority to use personal discretion on the method of disbursing the recipient's clothing and personal incidental money each month.

(2) The protective payee for an outpatient recipient shall have the authority and responsibility to make decisions about the expenditure of outpatient treatment stipends. Disbursement of funds shall be made first to assure the basic needs of shelter, utilities, food, clothing, and personal incidentals are met.

(a) The protective payee for a recipient in outpatient treatment shall encourage the recipient to participate in the decision-making process as a means of developing good money management, budgeting, and decision-making skills. The amount of control or latitude exercised shall depend upon the recipient's status in treatment and the judgment of the protective payee as to how responsible the recipient has become.

(b) The outpatient protective payee may use discretion on the method of disbursing to the recipient any cash balance remaining from the recipient's monthly assistance warrant. The protective payee has the authority to apportion any remaining funds to the recipient at regular intervals throughout the month.

MANUAL A CHAPTER 40: ALCOHOL/DRUG PROGRAMS WAC 388-40-110 (cont.)

(3) The intensive protective payee for a shelter recipient shall provide case management services as well as sufficient control of monthly shelter expenditures as necessary assuring the recipient's basic needs are met and preventing the diversion of assistance toward purchase of alcohol or drugs. The intensive protective payee shall:

(a) First disburse a payment for shelter and utilities, such as a check directly to the landlord, mortgage company, utility company, etc.;

(b) Pay all vendors directly for goods or services provided to or for the recipient, including personal and incidental expenses; and

(c) Make exceptions only where unusual circumstances prevent direct payment and the recipient is unlikely to divert the money to purchasing alcohol or drugs.

(4) A shelter recipient in independent housing has the right to request a change of intensive protective payees within the county if dissatisfied with the department's selection of a particular intensive protective payee. If the department determines good cause exists for the change, it shall reassign the recipient to another intensive protective payee if available.

(5) In the event the recipient and/or protective payee relationship is terminated for any reason, the protective payee shall return any remaining funds to the department.

[Statutory Authority: 89-18-025 (Order 2851), filed 8/29/89. RCW 74.50.010. 88-23-020 (Order 2723), §388-40-110, filed 11/7/88; 88-13-110 (Order 2635), filed 6/21/88.]

APPENDIX 2

SAMPLING

The sampling method for assessment center directors is similar to that used to select the sample of ADATSA clients. Assessment centers were stratified by size into three strata, large, medium and small, depending on the number of assessments performed. The probability of directors being interviewed varied by size of stratum. The larger the center the more likely were directors to be interviewed.

All the directors of the 11 large assessment centers operating at the time (Spring 1991) were interviewed. These large centers account for about 91% of all assessments done in the state. Random samples were selected from medium and small centers. About one out of three directors of medium sized centers and one out of five directors of the smallest centers were interviewed. These medium and smaller centers accounted for 8% and 1% respectively, of all assessments performed (see Table A2.1).

Overall, 50% of all assessment center directors were interviewed. However, the

Table A2.1
Sampling of Assessment Center Directors

Assessment Center Strata	Total Directors	# Directors Sampled	% Directors Sampled
Large Centers (91 or more, accounting for 91% of total assessments)	11	11	100%
Medium Centers (10-90, accounting for 8% of total assessments)	14	5	36%
Small Centers (10 or less, accounting for 1% of total assessments)	11	2	18%
Total Centers	36	18	50%

sampling method adopted guaranteed that the directors interviewed represented centers where almost all (95%) assessments were performed. At the same time this sampling method provided a sufficiently large voice to medium and smaller centers.

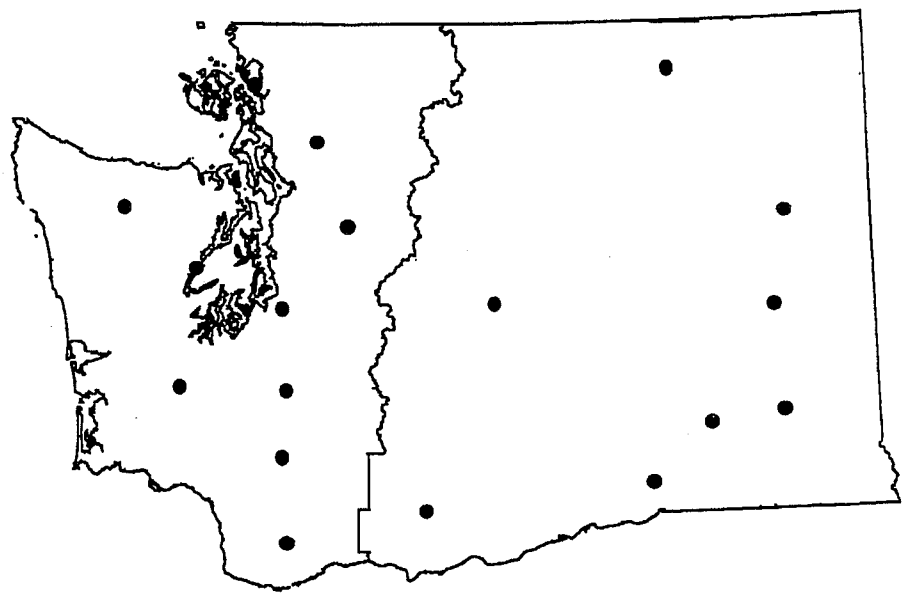
For large centers, all directors were interviewed. Medium and smaller centers perform only 9% of the assessments. For these centers 36% and 18% of the directors were sampled respectively.

Since the sampling method does not guarantee equal representation for all directors, the findings are presented by stratum when the data differ by stratum.

Geographic Distribution

The sample of assessment center directors was stratified by the size of the centers, giving weight to larger centers. These centers are located mainly in populated areas of the state west of the mountains. However if the state is divided into west and east, 56% (10 out of 18) of the centers sampled would be in the west and 44% (8 out of 18) in the east (see Figure A2A).

Figure A2A
Assessment Center Director Interview Sample



Note: In order to guarantee respondents' anonymity county boundaries are not presented and locations are approximate within Eastern and Western Washington.

APPENDIX 3

SAMPLING

Number of Treatment Agency Programs Serving ADATSA Clients

In the fall of 1989 there were 99 treatment programs contracted to service ADATSA clients. Thirty-nine programs involved residential care. Sixty were outpatient programs.

Interviews were conducted, whenever possible, with both the program manager and the agency director of sampled agency programs.

Inpatient Program Sampling

Inpatient programs were stratified into five different modalities: Intensive Inpatient, Long Term Residential, Extended Care, Differential Diagnosis, and Recovery House. Within each modality, a random sample of 50% of the programs was sought. The exceptions to this rule included the differential diagnosis program (only one exists in the state) and the extended care programs (only two exist). In these cases all program directors were interviewed.

The resulting overall sampling proportion was 49%, with 19 of the 39 inpatient programs directors interviewed (see Table A3.1).

Table A3.1

Sampling of Treatment Agencies by Treatment Modality

Treatment Agency	Population*	# Visited	% Sampled
Intensive Inpatient	15	7	47%
Long Term Residential	6	3	50%
Extended Care	2	2	100%
Differential Diagnosis	1	1	100%
Recovery House	15	6	40%
Total Inpatient	**39**	**19**	**49%**
Large Outpatient (20 or more clients)	16	5	31%
Medium Outpatient (6 to 19 clients)	21	7	33%
Small Outpatient (5 or less clients)	23	8	35%
Total Outpatient	**60**	**20**	**33%**
Total Overall	**99**	**39**	**39%**

* This population includes all treatment programs contracted by the Division of Alcohol and Substance Abuse to provide treatment to ADATSA clients in the fall of 1989.

Outpatient Program Sampling

Outpatient programs were stratified into three levels, large, medium, and small, based on the number of ADATSA clients contracted to be served. Large programs have 20 or more clients, medium programs have 6 to 19, and small programs have 5 clients or fewer. Of the 60 outpatient programs, 16 are large, 21 medium, and 23 small.

From these three categories, 5, 7, and 8 agencies respectively were selected for the sample. The overall sample size was 33% (see Table A3.1).

Geographic Distribution

Inpatient Programs

Inpatient facilities are highly concentrated in larger urban areas: 56% in three counties (King, Pierce, and Spokane), and 79% in seven counties largely located west of the mountains (King, Pierce, Whatcom, Clark, Kitsap, Spokane and Yakima). However, the study sample represents 48% (13 out of 27) of inpatient programs in the West and 50% (6 out of 12) programs in the East (see Figure A3A).

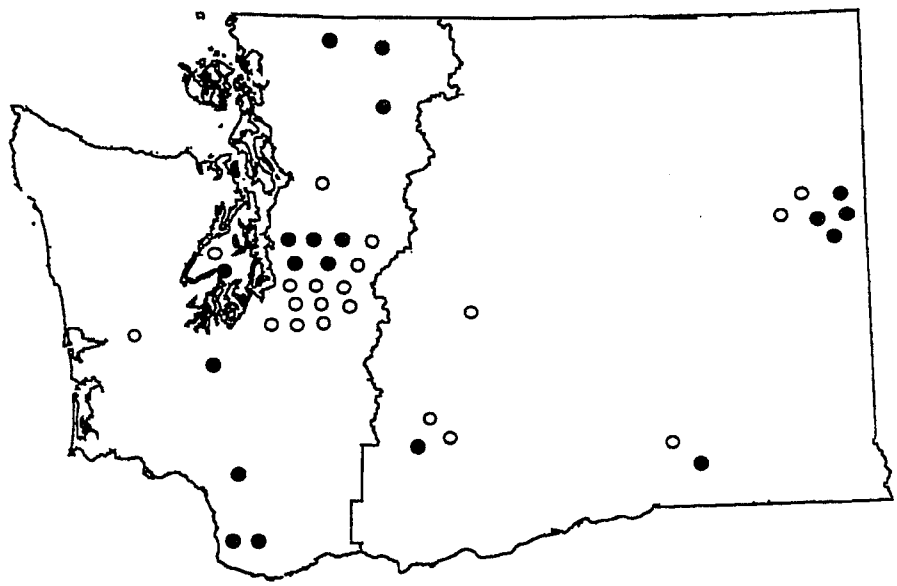
Outpatient Programs

Almost every county has at least one outpatient program in order to facilitate the client's recovery in his/her community of residence.

In the West ,the sampled outpatient programs were located in 47% of the counties: 9 out of 19. In the East, the sampled outpatient programs were distributed in 50% of the counties: 10 out of 20 counties (see Figure A3B).

Figure A3A

Inpatient Treatment Agencies Director Interview Sample



[1] This population includes all treatment programs contracted by the Division of Alcohol and Substance Abuse to provide treatment to ADATSA clients in the fall of 1989.

Figure A3B
Outpatient Treatment Agencies Director Interview Sample

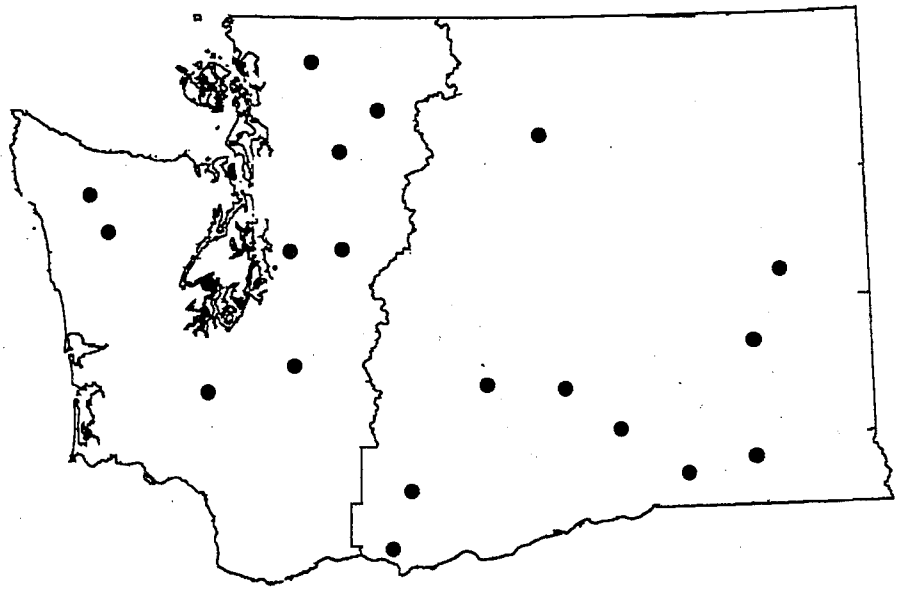
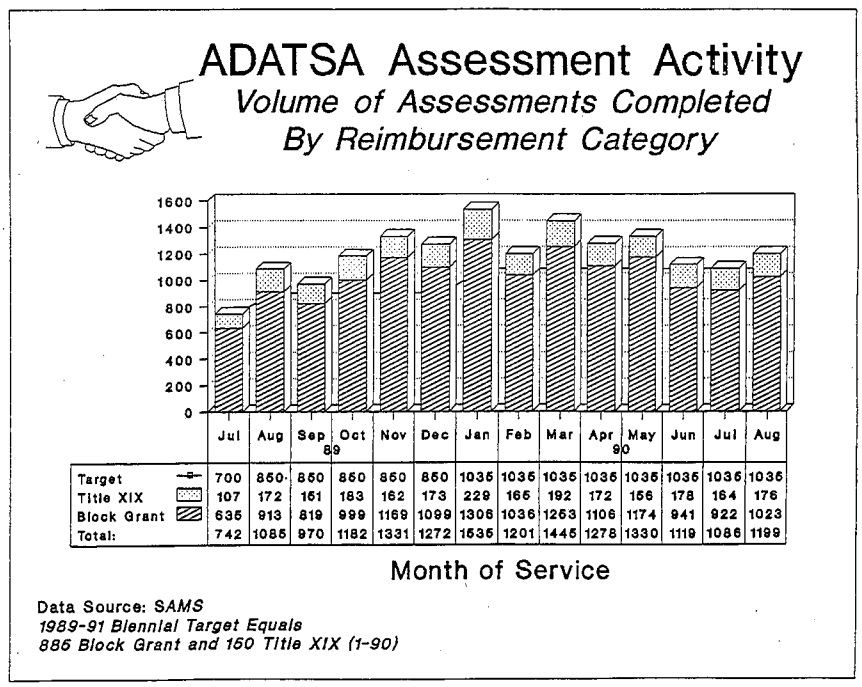
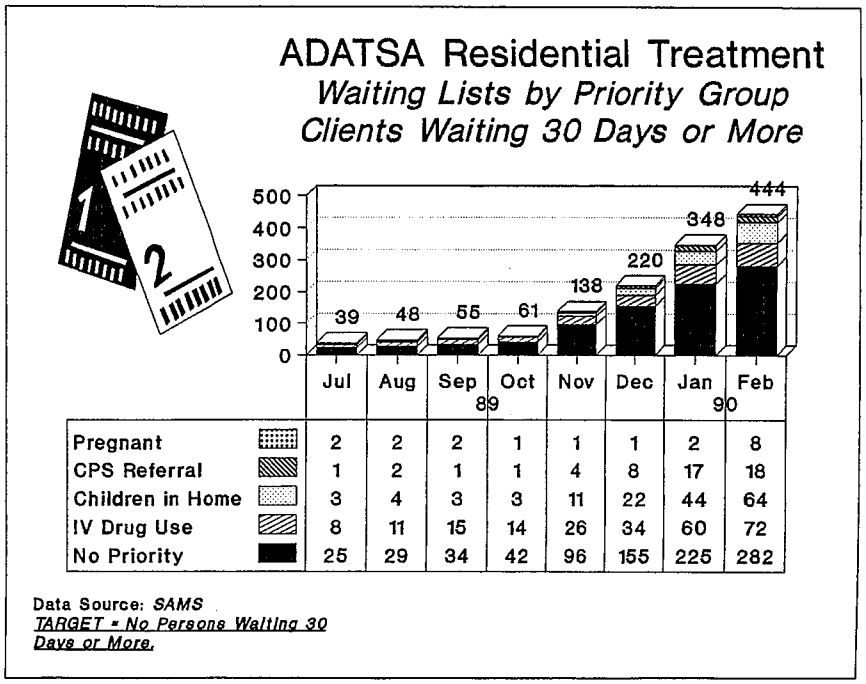


Figure A3C
Increase in Monthly Assessments After Fall of 1989



Source:Management Indicators Program Status Report, DSHS Division of Alcohol and Substance Abuse, December 13, 1990

Figure A3D
Increase in Waiting Lists After the Fall of 1989



Note:The waiting time as measured by clients waiting 30 days or more remained relatively stable in the four month period, August 1 to November 30. It did increase rather dramatically thereafter.

Source:Management Indicators Program Status Report, DSHS Division of Alcohol and Substance Abuse, March, 1990

APPENDIX 4

SAMPLING OF ADATSA CLIENTS

Definition of population: The population was defined as all persons assessed for chemical dependency at all Assessment Centers across the state during the period August 1 through November 30, 1989. (Shelter clients were assessed during an earlier period.)

Population List: The study used monthly lists compiled by Assessment Centers. These were either lists of appointments for assessment for potential clients referred by Community Service Offices or monthly lists of actual assessments.

Sampling Time Period: The time period of 4 months, August 1 through November 30, 1989 was selected for two reasons:

1. Four months was a large enough period to minimize seasonal differences in clients and to allow a large enough population in small assessment centers; and
2. August 1 was closest to July 1, 1989, date of effectiveness of the new ADATSA regulations while allowing one month's time for the implementation of these new regulations.

Sampling Frame: A two-stage cluster random sample stratified by size of assessment center was selected. In order to maximize representation and minimize cost of data gathering, sampling fractions were directly proportional to size for assessment centers and inversely proportional to size for clients within assessment centers.

Stage 1: Assessment Center Sampling.

In the fall of 1989 there were thirty-seven assessment centers in the state, one in each of the thirty-nine counties, except for two counties. The sample was stratified into four strata by size of assessment centers. About 67% of all assessments were conducted in the four largest assessment centers and 91% in the top twelve assessment centers. Therefore, all the twelve top centers were included in the sample. Fifty percent of medium size centers and 36% of the smallest centers were randomly selected. This provided a total sample of 23 centers (see Table A4.1).

Table A4.1

Stage 1: Sampling of Assessment Centers Stratified by Size

(August 1 to November 30, 1989)

Assessment Centers	Population	# Sampled	% Sampled
Very Large Centers (301 or more assessments)	4	4	100%
Large Centers (91-300 assessments)	8	8	100%
Medium Centers (11-90 assessments)	14	7	50%
Small Centers (10 or less assessments)	11	4	36%
Total Assessment Centers	37	23	62%

Note: The number of clients in each assessment center in the state was determined by a census conducted by project staff. The census data and the data provided by the Substance Abuse Management System differed by an average of 8%.

Stage 2: Client Sampling Within Selected Assessment Centers.

The proportion of clients selected for the sample from each assessment center was inversely proportional to size: up to 100% in small centers and as low as 10% in large centers. This procedure guaranteed a large sample even in small centers where the population was very low. In the largest center, even a 10% sample provided a sufficiently large sample size: 194 clients (see Table A4.2).

Table A4.2

Stage 2: Sampling of Clients by Assessment Center Selected and by Stratum

(August 1 to November 30, 1989)

Clients in Selected Centers	Population	# Sampled	% Sampled	Average % Sampled
Very Large Centers (301+)	1855 557 542 324	194 94 80 66	10% 17% 15% 20%	13%
Large Centers (91-300)	202 188 182 174 116 108 108 93	68 52 62 55 54 53 55 53	33% 28% 34% 32% 47% 49% 51% 57%	39%
Medium Centers (11-90)	52 46 35 31 20 17 14	52 45 35 27 20 17 13	100% 98% 100% 87% 100% 100% 100%	97%
Small Centers (0-10)	10 5 5 3	10 5 5 3	100% 100% 100% 100%	100%
Total in Selected Centers	4687	1118		24%

Table A4.3

Stages 1 and 2 Combined: Client Sample Compared to Client Population by Stratum

(August 1 to November 30, 1989)

Clients Assessed in all Centers	Population	# Sampled	% Sampled
Very Large Centers (4 centers: 301+)	3278	434	13%
Large Centers (8 centers: 91-300)	1171	452	39%
Medium Centers (14 centers: 11-90)	396	209	53%
Small Centers (11 centers: 0-10)	62	23	37%
Total (37 centers)	4907	1118	23%

Stage 1 and Stage 2: Combined Sampling Results.

The end result of these sampling techniques is to provide large enough samples in strata with few cases but many different locations and economically small samples in strata with many clients and few locations.

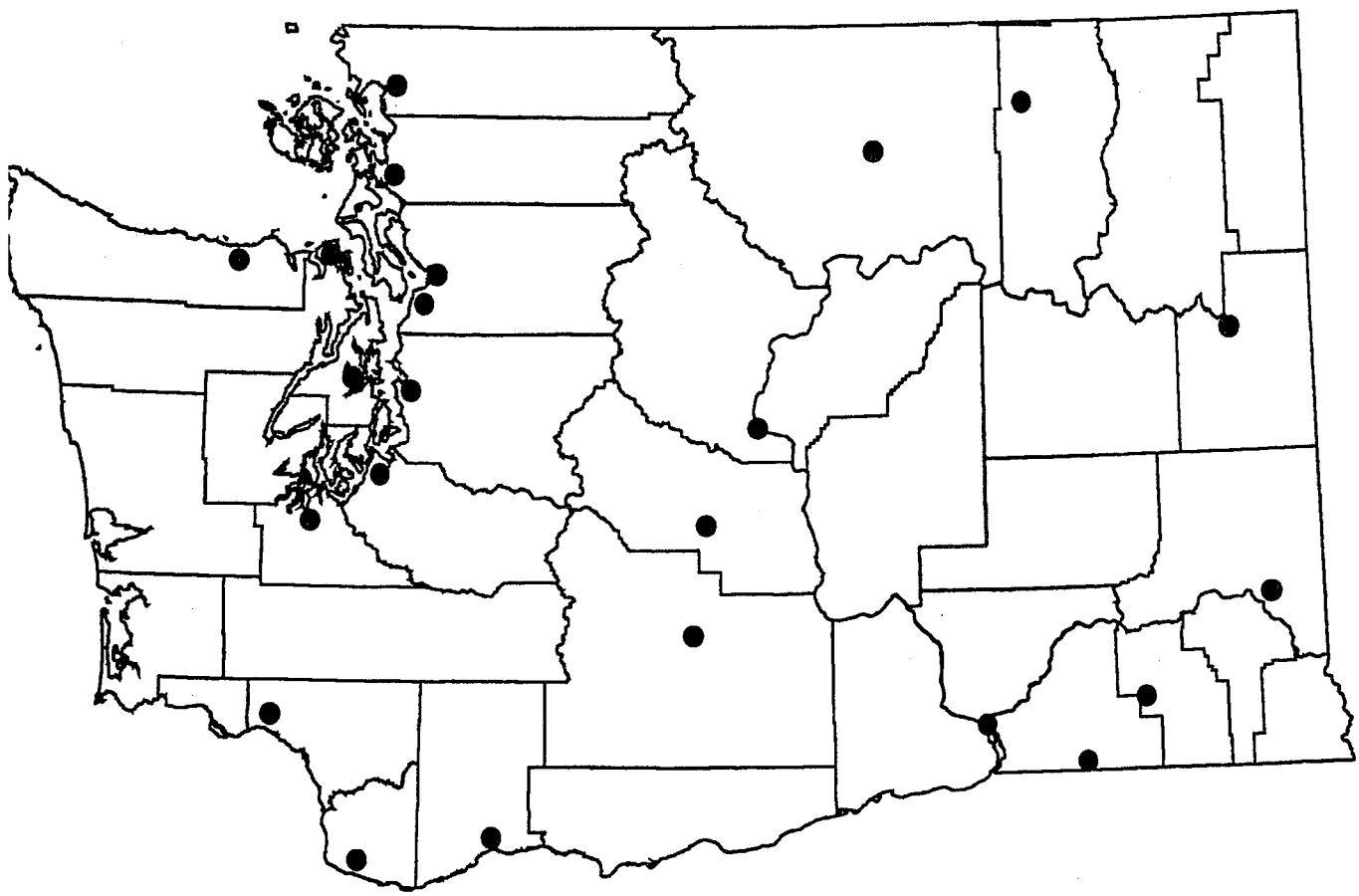
The resulting sampling fractions for clients in each stratum range from 13% to 53% (see Table A4.3). Since the sampling fractions are not the same for each stratum or for each assessment center, a weighting procedure is necessary. The weighting procedure created a sample of the same number of 1118 clients, while guaranteeing that each client represented the same proportion of clients in the population.

In other words, this procedure made the sample representative without artificially increasing the sample size. Therefore, the statistical confidence of estimates based on this weighted sample is not artificially inflated.

GEOGRAPHIC DISTRIBUTION OF ASSESSMENT CENTERS IN THE CLIENT SAMPLE

The sampling of assessment centers by size described above resulted in a geographically dispersed sampling. East of the mountains, 55% of all counties and 56% of all assessment centers were sampled. In the western part of the state, 68% of both counties and assessment centers were sampled (see Figure A4A). This east/west difference exists because 100% of the largest centers were sampled, and these are located mostly in Western Washington. The weighting procedure described above adjusted the amount any client contributes to the analysis, correcting for both over- and under-sampling. Thus, all ADATSA clients are equally represented in the sample.

Figure A4A
Assessment Center Client Sample



APPENDIX 5

Panel Selection Procedures

The goal of the peer panel review was to bring together a work group of qualified professionals to participate in the peer panel review process. It was determined that a workable panel size would be from 12 to 20, providing at least four groups of three and at most five groups of four. The result was firm commitments to participate from 15 individuals, allowing five groups of three.

The requisite qualifications were based on years and scope of experience and professional reputation. The hope was to find people with both administrative and counseling experience who were knowledgeable about the system and the clients and who could commit to and work well with their teams. The average years of administrative experience for the group is five years and the average years of treatment experience is eight.

Many factors of representation were also considered:

1. **Representation by modality and treatment type.** Of the fifteen, nine worked primarily as treatment or assessment counselors and six were administrators. Three of the panelists came from assessment centers and twelve from treatment agencies. Due to the education and experience of the panel, several members had multiple treatment/assessment experience. The composition of the twelve treatment agency panelists was as follows: two outpatient; two inpatient; three Long Term Residential; two Mentally Incapacitated/Chemically Addicted; one outpatient and inpatient; two inpatient and Long Term Residential.
2. **Regional representation.** The fifteen panelists represented seven different counties including two in Eastern Washington.
3. **Representation of both sexes was also deemed important.** There were seven women and nine men on the panel.
4. **Ethnic representation** included white, Native American, African American and Hispanic.
5. **Treatment philosophy** does not vary greatly among professionals working with ADATSA clients, primarily focusing on the disease concept. Two panel members, however, worked exclusively with MICA clients and four were from the addict help addict programs.

The five teams of three were set up to have at least three different modalities represented in each team. The one team that did not have an assessment center representative had as their outpatient representative a counselor who was primarily involved as an assessment counselor at the treatment agency.

Client Selection Procedures

Ninety-three cases were initially gathered from nine counties:

There was further selection of 60 cases (12 cases from each of the five distinct treatment paths). The cases with the most complete information were selected and the profile characteristics were cross-referenced with client background characteristics discussed to ensure proper representation (age, sex, ethnicity, living arrangements, education and public assistance).

Two of the 12 cases from each of the treatment paths were selected as common cases to be reviewed by all five teams. The other 10 cases from each treatment path were team-specific cases (reviewed by only one team). Each of the teams, therefore, received 10 common cases (including two from each treatment path) and 10 team-specific cases (including two from each treatment path).

Table A5.1
Client Cases for Panel Review

County	Cases	Percent of Total
Cowlitz	15	16%
Clark	19	20%
King	31	33%
Grays Harbor	2	2%
Kitsap	4	4%
Whatcom	2	2%
Yakima	1	1%
Clallam	9	10%
Pierce	10	11%
Total	**93**	**100%**

Figure A5A

ILLUSTRATIVE TIME LINE AND EXPLANATION OF PROCEDURES PRESENTED AT THE PROCEDURAL MEETING

SELECT & CONTACT	MAIL	PROCEDURAL MEETING	MAIL	INDIVIDUAL REVIEW	FAX	TALLY RESULTS	FAX	WORKING MEETING	FINAL EVALUATION	MAIL
FIRST WEEK OF MAY	**13TH-15TH MAY**	**26TH MAY**	**31ST MAY - 4TH JUNE**	**5TH - 10TH JUNE**	**11TH JUNE**	**12TH - 17TH JUNE**	**18TH JUNE**	**25TH & 26TH JUNE**	**26TH - 30TH JUNE**	**END OF JULY**
COLLECT PANEL NOMINEES AND DETERMINE PANEL COMPOSITION	SEND INFORMATION TO PANELISTS ABOUT * Letter of Introduction * Summary of Procedures 1) Discussion issues: 2) Client information issues 3) Time issues	WHOLE-GROUP SESSION TO REVIEW & AGREE ON COMFORT WITH * Appropriateness of Tx path definitions * Recognize expertise & specialties of panelists * Preference of Blind / Non-Blind review process * Availability of sufficient information to place client * Revise proposed schedule & finalize Working Meeting date(s)	SEND MATERIALS TO PANELISTS * Team 1 - 1st 12 cases to each of 3 panelists * Team 2 - 2nd 12 cases to each of 3 panelists * Team 3 - 3rd 12 cases to each of 3 panelists * Team 4 - 4th 12 cases to each of 3 panelists	REVIEW AT HOME & COMPLETE RESPONSE SHEET * Place each client in one of foure ADATSA Treatment paths. * Note client-specific recommendations for needed improvements or additions to ADATSA Tx program.	RETURN ANSWERS FAX completed response forms to us.	REVIEW INDIVIDUAL RECOMMENDATIONS 1) Tally intra-team consensus on each initial client placement 2) Tally team agreements w/ actual assessment center Rx 3) Note verbatim, case-by-case improvements to ADATSA programs	FAX RESULTS TO INDIVIDUAL PANELISTS	SMALL GROUP DISCUSSION & WORKSHOP 1) Discuss intra-team consensus, allow for adjustments & reasons for agreements & disagreements 2) Discuss team agreement & disagreement with actual assessment center Rx 3) Allow team to discuss client-specific recommendations & summarize consensus when possible RECONVENE IN LARGE GROUP FOR SUMMARY & CLOSING COMMENTS	DATA ANALYSIS AND REPORT WRITING 1) Summarize intra-team agreements & disagreements 2) Tally consensus agreements and dis-agreements w/ actual ADATSA assessment centers 3) Summarize consensus on team-recommended improvements	SEND PRELIMINARY RESULTS TO PANELISTS

oChanged to **five** at procedural meeting, see Treatment Path Definitions in Appendix

Table A5.2

Frequency Tables of Recommendations of Most Appropriate Treatment Path Compared to Actual Placements

Team-Specific Cases (n=50)

Panel Recommendations

ACTUAL TREATMENT PATH PLACEMENTS OF CLIENTS BY ASSESSMENT CENTER COUNSELORS

	OP	30/90	30/60/90	LTR	MICA	TOTAL FREQ.
OP	**2**	1	1	3	3	10
30/90	-	**1**	4	5	-	10
30/60/90	-	-	**6**	3	1	10
LTR	-	-	3	**6**	1	10
MICA	-	-	-	-	**10**	10
TOTAL FREQ.	2	2	14	17	15	50

Common Cases (n=10)

Panel Recommendations

ACTUAL TREATMENT PATH PLACEMENT OF CLIENTS BY ASSESSMENT CENTER COUNSELORS

	OP	30/90	30/60/90	LTR	MICA	TOTAL FREQ.
OP	**1**	-	-	-	-	1*
30/90	-	**-**	1	1	-	2
30/60/90	-	-	**1**	1	-	2
LTR	-	-	-	**2**	-	2
MICA	-	-	-	-	**2**	2
TOTAL FREQ.	1	0	2	4	2	9*

□ Frequencies in these cells represent agreement between panel recommendations and actual placement

Table A5.3

Frequency of Consensus or Majority Decisions Following Working Meeting in Team Recommendations for Most Appropriate Treatment

Team-Specific Cases*

	Intra-team consensus (3:3 panelists)	Intra-team majority (2:3 panelists)	Total of Recommendations
MICA	15	0	15
LTR	17	0	17
30/60/90	12	2	14
30/90	0	2	2
OP	2	0	2
TOTAL	**46**	**4**	**50***

*Each case was reviewed by only one team

Common Cases*

	Intra-team consensus	Intra-team majority	Rejections	Total of Recommendations
MICA (2 cases)	9	1	0	10
LTR (4 cases)	18	2	0	20
30/60/90 (2 cases)	10	0	0	10
30/90 (0 cases)	0	0	0	0
OP (1 case)	4	1	0	5
Rejected (1 case)	0	0	5	5
Total	**41**	**4**	**5**	**50***

*The original number of common cases was 10. all the panelists unanimously rejected one case for lack of relevant information. This reduced the possible number of recommendations by five, from 50 to 45. Also two teams were unable to make a recommendation on criteria. This reduced the total number of recommendations to 43.

Table A5.4
Specific Choices of Criteria for Recommendations of Treatment Path
Team-Specific Cases

CATEGORY: CRITERIA LIST	MICA		LTR		30/60/90		30/90		OP		ALL	
RECOMMENDATIONS BY TX PATH	15	%	17	%	14	%	2	%	2	%	50	%
Mental Issues	15	100	1	7	-	-	-	-	-	-	16	32
Category Total:	15	100	1	7	-	-	-	-	-	-	16	32
Drug History:												
Pattern of Use	7	46	7	41	7	50	1	50	1	50	23	46
Drug(s) of Choice	1	7	4	24	2	14	-	-	-	-	7	14
Length of Use	3	20	3	18	4	29	-	-	-	-	10	20
Frequency of Use	3	20	3	18	2	14	-	-	-	-	8	16
Method of Use	-	-	2	12	-	-	-	-	-	-	2	4
When Last Used	-	-	1	6	-	-	1	50	1	50	3	6
Other: Describe	1	7	1	6	-	-	-	-	-	-	2	4
Category Total:	15	100	21	123	15	107	2	100	2	100	55	110
Other Issues:												
Behavior Issues (violence)	-	-	-	-	-	-	-	-	-	-	-	-
Physical Issues	2	13	5	29	2	14	-	-	1	50	10	20
Other: Describe	-	-	-	-	-	-	-	-	-	-	-	-
Category Total:	2	13	5	29	2	14	-	-	1	50	10	20
Family of Origin:												
General Family Influence	-	-	2	12	-	-	-	-	-	-	2	4
Family Chemical Dependency	-	-	-	-	1	7	-	-	-	-	1	2
Family Abuse History	1	6	-	-	-	-	-	-	-	-	1	2
Family Mental History	1	7	-	-	-	-	-	-	-	-	1	2
Category Total:	2	13	2	12	1	7	-	-	-	-	5	10
Previous Treatment Experience	6	40	5	29	3	21	2	100	1	50	17	34
Category Total:	6	40	5	29	3	21	2	100	1	50	17	34
Life Skills:												
Combined Life Skills	-	-	1	6	5	36	-	-	-	-	6	12
Coping Skills	-	-	1	6	1	7	-	-	-	-	2	4
Legal History	3	20	4	23	3	22	-	-	-	-	10	20
Employment Status	1	7	-	-	1	7	-	-	-	-	2	4
Control Skills	-	-	1	6	-	-	-	-	-	-	1	2
Motivation	-	-	-	-	1	7	-	-	1	50	2	4
CPS Involvement	-	-	-	-	1	7	-	-	-	-	1	2
Other: Describe	-	-	1	6	1	7	-	-	1	50	3	6
Category Total:	4	27	8	47	13	94	-	-	2	100	27	54
Support System:												
Combined Support	1	70	5	29	5	36	2	100	-	-	13	26
Family Support	-	-	-	-	-	-	-	-	-	-	-	-
Sober Household or Neighborhood	-	-	1	6	3	21	-	-	-	-	4	8
Other: Describe	-	-	3	18	-	-	-	-	-	-	3	6
Category Total:	1	7	9	53	8	57	2	100	-	-	20	40
OVERALL TOTAL:	45	300	51	300	42	300	6	300	6	300	150	300

Note: Teams were asked to choose the three most important criteria for each of their recommendations: Therefore, overall frequency of choices is 150 and total percent is 300% for the 50 cases reviewed.

Table A5.5
Specific Choices of Criteria for Recommendations of Treatment Path
Common Cases

CATEGORY: CRITERIA LIST	MICA		LTR		30/60/90		30/90		OP		ALL	
RECOMMENDATIONS BY TX PATH	10	%	15	%	11	%	4	%	3	%	43	%
Mental Issues:	5	50	1	7	-	-	-	-	-	-	6	14
Category Total:	5	50	1	7	-	-	-	-	-	-	6	14
Drug History:												
Pattern of Use	3	30	4	26	8	73	-	-	-	-	15	35
Drug(s) of Choice	-	-	4	27	-	-	-	-	-	-	4	9
Length of Use	4	40	3	20	-	-	3	75	-	-	10	23
Frequency of Use	2	20	1	7	1	9	1	25	-	-	5	11
Method of Use	-	-	3	20	1	9	-	-	-	-	4	9
When Last Used	-	-	-	-	-	-	-	-	3	100	3	7
Other: Describe	-	-	-	-	1	9	-	-	-	-	1	2
Category Total:	9	90	15	100	11	100	4	100	3	100	42	98
Other Issues:	-	-	-	-	-	-	-	-	-	-	-	-
Behavior Issues (violence)	-	-	-	-	1	9	-	-	-	-	1	2
Physical Issues	5	50	4	27	1	9	15	25	-	-	11	26
Other: Describe	5	50	-	-	-	-	-	-	-	-	5	12
Category Total:	10	100	4	27	2	18	1	25	-	-	17	40
Family of Origin:												
General Family Influence	-	-	-	-	-	-	-	-	-	-	-	-
Family Chemical Dependency	-	-	1	6	1	9	1	25	-	-	3	7
Family Abuse History	-	-	1	7	-	-	-	-	-	-	1	2
Family Mental History	-	-	-	-	-	-	-	-	-	-	-	-
Category Total:	-	-	2	13	1	9	1	25	-	-	4	9
Previous Treatment Experience:	1	10	8	53	7	64	1	25	3	100	20	47
Category Total:	1	10	8	53	7	64	1	25	3	100	20	47
Life Skills:												
Combined Life Skills	1	10	1	7	-	-	1	25	-	-	3	7
Coping Skills	-	-	-	-	-	-	-	-	-	-	-	-
Legal History	-	-	3	20	3	28	-	-	-	-	6	14
Employment Status	-	-	2	13	-	-	1	25	-	-	3	7
Control Skills	-	-	-	-	-	-	-	-	-	-	-	-
Motivation	-	-	-	-	1	9	-	-	2	67	3	7
CPS Involvement	-	-	4	27	2	18	-	-	-	-	6	14
Other: Describe	-	-	-	-	-	-	-	-	-	-	-	-
Category Total:	1	10	10	67	6	55	2	50	2	67	21	49
Support System:												
Combined Support	3	30	3	20	4	37	1	25	-	-	11	26
Family Support	1	10	-	-	-	-	1	25	-	-	2	15
Sober Household or Neighborhood	-	-	1	6	2	18	1	25	1	33	5	11
Other: Describe	-	-	1	7	-	-	-	-	-	-	1	2
Category Total:	4	40	5	33	6	55	3	75	1	33	19	44
OVERALL TOTAL	30	300	45	300	33	300	12	300	9	300	129	300

Note: Teams were asked to choose the three most important criteria for each of their recommendations.

Table A5.6

ADATSA Treatment Path Definitions:

Initially, four treatment paths were selected and presented to the panelists in the procedural meeting. The panelists discussed whether they could recommend placements into these paths on the basis of available client information. They then decided to add one important variation of the 30/60/90 path--the 30/90 path. The panelists argued that this path was becoming more common due to lack of recovery house beds.

OUTPATIENT - A treatment path in which ADATSA clients are placed in intensive outpatient treatment for primary care to be followed by outpatient phase III or aftercare (total time not to exceed 90 days).

INPATIENT FOLLOWED BY OUTPATIENT "30/90"- A treatment path in which ADATSA clients are initially placed in a 30-day intensive inpatient treatment program for primary care to be followed directly by outpatient treatment (not to exceed 90 days Outpatient treatment time).

INPATIENT "30/60/90" - A treatment path in which ADATSA clients are initially placed in a 30-day intensive inpatient treatment program for primary care followed by a 60-day recovery house, and aftercare outpatient treatment (not to exceed 90 days Outpatient treatment).

LONG-TERM RESIDENTIAL - A treatment path consisting of an extended-stay drug residential (not to exceed 180 days) or extended-care recovery house (not to exceed 90 days). This primary treatment may be followed by recovery house care and outpatient care, if all 180 days are not used in the residential treatment.

MICA/DIFFERENTIAL DIAGNOSIS - A treatment path for clients of questionable mental status beginning with a 28-day treatment and diagnostic program. This program may be extended by 90 days to total 120 days MICA treatment. It may also be followed by recovery house and/or outpatient treatment, with a mental health component, until the total 180 days have been used up.

Table A5.7

Most Appropriate Treatment Duration of First Two Out of Three Phases, Overall Recommended Duration, and ADATSA-Funded Recommended Duration by Treatment Path

OP

Duration of Treatment	# of Months	Number of Recommendations	%*	Mean # of Months
Phase I (Primary)	3 1	1 1	50 50	2
Phase II (Reintegration)	3 6	1 1	50 50	4
Total of All 3 Phases	9 **12** 24	1 **3** 1	20 **60** 20	14
ADATSA-Funded Portion of All 3 Phases	**6** 9 24	**3** 1 1	**60** 20 20	10

Note 1: For all parts of Table A5.7 the underlined numbers are modal frequencies, modal percentages and corresponding modal duration categories.

Note 2: All team recommendations on duration are counted in these tables: These include both unique and common cases whether consensus recommendations or not. This was done so as to maximize number of cases to identify modal frequency categories.

* The numbers in the cells in the Percent (%) Column each total 100%.

Table A5.7 (cont.)

30/90

Duration of Treatment	# of Months	Number of Recommendations	%	Mean # of Months
Phase I (Primary)	1 3	4 1	80 20	2
Phase II (Reintegration)	2 3 6	1 2 1	25 50 25	3
Total of all 3 Phases	12 18	4 1	80 20	13
ADATSA-Funded Portion of All 3 Phases	9 12	3 2	60 40	10

30/60/90

Duration of Treatment	# of Months	Number of Recommendations	%	Mean # of Months
Phase I (Primary)	1 2 3 6	20 2 1 1	83 9 4 4	1
Phase II (Reintegration)	2 3 6 9	14 7 2 1	58 29 9 4	3
Total of all 3 Phases	**6** **9** **12** 18 24	2 4 3 9 7	8 16 12 36 29	17
ADATSA-Funded Portion of All 3 Phases	4 6 9 12 24	1 4 1 14 3	4 18 4 61 13	12

Table A5.7(cont.)

LTR

Duration of Treatment	# of Months	Number of Recommendations	%*	Mean # of Months
Phase I (Primary)	1	1	3	
	2	1	3	
	3	6	19	
	4	**14**	**44**	
	6	10	31	4
Phase II (Reintegration)	2	1	3	
	3	11	35	
	4	2	7	
	6	**15**	**48**	
	9	2	7	5
Total of all 3 Phases	**3**	1	3	
	18	**17**	**55**	
	24	13	42	20
ADATSA-Funded Portion of All 3 Phases	6	3	7	
	9	3	10	
	12	**17**	**55**	
	18	1	3	
	24	2	7	12

MICA

Duration of Treatment	# of Months	Number of Recommendations	%*	Mean # of Months
Phase I (Primary)	**1**	**10**	**42**	
	3	5	21	
	4	5	21	
	6	4	16	3
Phase II (Reintegration)	2	5	21	
	3	**14**	**58**	
	4	1	4	
	5	1	4	
	6	3	13	3
Total of all 3 Phases	**4**	1	5	
	10	1	5	
	12	4	17	
	18	3	13	
	24	**14**	**61**	20
ADATSA-Funded Portion of All 3 Phases	4	2	10	
	10	1	5	
	12	**16**	**80**	
	24	1	5	12

Table A5.8
Frequency and Percentage of Critically Needed Additional Services in Each Treatment Phase

ADDITIONAL SERVICES FOR TEAM SPECIFIC CASES	Phase I		Phase II		Phase III	
	#	%	#	%	#	%
Physical Services:						
General services	7	14	3	6	-	-
Physical exam/care	22	44	1	2	-	-
Monitoring of medications	1	2	1	2	-	-
Eye exam/care	-	-	2	4	-	-
HIV Positive tx	1	2	-	-	-	-
Pain control options	1	2	-	-	-	-
Acupuncture	-	-	-	-	-	-
Dental exam/care	-	-	-	-	-	-
Other:	-	-	-	-	-	-
Category Total:	32	64	7	14	-	-
Additional Counseling:						
General counseling	5	10	3	6	-	-
Mental health svcs/eval	-	-	2	4	2	4
HIV education and testing	3	6	-	-	-	-
Behavioral mod (inc.violence)	3	6	-	-	-	-
Work on grief loss issues	-	-	3	6	1	2
U.A. Testing	-	-	-	-	2	4
Anger management	-	-	1	2	-	-
Assertiveness training	-	-	1	2	-	-
Antabuse/deterrent meds	-	-	1	2	-	-
Budgeting skills	-	-	-	-	1	2
Gender specific svcs.	1	2	-	-	-	-
Work on family issues	-	-	1	2	-	-
Reassessment svcs	-	-	-	-	-	-
Methadone/maintenance meds.	-	-	-	-	-	-
Work therapy	-	-	-	-	-	-
Work on abuse issues:	-	-	-	-	-	-
Spouse/couples therapy	-	-	-	-	-	-
Eating disorders	-	-	-	-	-	-
Discrimination issues	-	-	-	-	-	-
Play Therapy	-	-	-	-	-	-
Other:	2	4	1	2	1	2
Category Total:	14	28	13	26	7	14

Table A5.8 (cont.)

ADDITIONAL SERVICES FOR TEAM SPECIFIC CASES	Phase I		Phase II		Phase III	
	#	%	#	%	#	%
Vocational Development:						
General vocational	-	-	9	18	7	14
DVR School	-	-	3	6	3	6
Job search skills	-	-	2	4	1	2
GED	-	-	1	2	-	-
Career testing	-	-	1	2	1	2
Volunteer position	-	-	-	-	-	-
Other:	-	-	1	2	-	-
Category Total:	-	-	17	34	12	24
Social Development:						
General social	-	-	2	4	3	6
Parenting skills and crisis support	1	2	4	8	-	-
NA/AA or other fellowship	-	-	3	6	-	-
Clean and sober residence/neighborhood	-	-	-	-	-	-
Recreational activities	-	-	-	-	-	-
ACOA	-	-	-	-	-	-
Other:	1	2	1	2	1	2
Category Total:	2	4	10	20	4	8
Financial Support:						
General financial	-	-	-	-	1	2
Housing	-	-	-	-	20	40
AFDC/SSI/GA-U	-	-	1	2	4	8
Protective payee	-	-	-	-	1	2
Daycare	-	-	-	-	-	-
Other support:	-	-	-	-	-	-
Category Total:	-	-	1	2	26	52
Missing Information:	2	4	2	4	1	2
OVERALL TOTAL:	50	100	50	100	50	100

Table A5.8 (cont.)

ADDITIONAL SERVICES FOR COMMON CASES	Phase I		Phase II		Phase III	
	#	%	#	%	#	%
Physical Services:						
General services	9	21	-	-	1	3
Physical exam/care	5	12	2	5	-	-
Monitoring of medications	2	5	-	-	1	2
Eye exam/care	-	-	-	-	-	-
HIV Positive tx	2	5	-	-	-	-
Pain control options	1	2	-	-	-	-
Acupuncture	-	-	-	-	-	-
Dental exam/care	1	2	1	2	-	-
Other	-	-	-	-	1	2
Category Total:	20	47	3	7	3	7
Additional Counseling:						
General counseling	5	12	2	5	2	5
Mental health svcs/eval	2	5	-	-	-	-
HIV education and testing	2	5	-	-	-	-
Behavioral mod (inc.violence)	4	9	-	-	-	-
Work on grief loss issues	1	2	2	5	-	-
U.A. Testing	-	-	-	-	2	4
Anger management	-	-	1	2	-	-
Assertiveness training	-	-	-	-	-	-
Antabuse/deterrent meds	-	-	-	-	-	-
Budgeting skills	-	-	1	2	-	-
Gender specific svcs	-	-	-	-	-	-
Work on family issues	-	-	5	12	2	5
Reassessment svcs	-	-	-	-	-	-
Methadone/maintenance meds	-	-	-	-	-	-
Work therapy	-	-	-	-	-	-
Work on abuse issues	-	-	-	-	-	-
Spouse/couples therapy	-	-	-	-	3	7
Eating disorders	1	2	-	-	-	-
Discrimination issues	-	-	1	2	-	-
Play Therapy	-	-	-	-	-	-
Other	2	5	-	-	-	-
Category Total:	17	40	12	28	9	21

Table A5.8 (cont.)

ADDITIONAL SERVICES FOR COMMON CASES	Phase I		Phase II		Phase III	
	#	%	#	%	#	%
Vocational Development:						
General vocational	-	-	1	2	8	19
DVR School	-	-	2	5	4	9
Job search skills	-	-	-	-	-	-
GED	-	-	-	-	1	2
Career testing	-	-	2	5	2	5
Volunteer position	-	-	2	5	-	-
Other	-	-	-	-	-	-
Category Total:	-	-	7	17	15	35
Social Development:						
General social	-	-	6	14	2	5
Parenting skills and crisis support	1	2	2	5	1	2
NA/AA or other fellowship	-	-	-	-	1	2
Clean and sober residence/neighborhood	-	-	-	-	2	5
Recreational activities	-	-	1	2	1	2
ACOA	-	-	-	-	-	-
Other	1	2	-	-	-	-
Category Total:	2	4	9	21	7	16
Financial Support:						
General financial	-	-	-	-	-	-
Housing	-	-	4	9	2	5
AFDC/SSI/GA-u	-	-	1	2	2	4
Protective payee	-	-	-	-	3	7
Daycare	-	-	2	5	-	-
Other support	-	-	-	-	-	-
Category Total:	-	-	7	16	7	16
Missing Information:	4	9	5	11	2	5
OVERALL TOTAL	43	100	43	100	43	100

APPENDIX 6

COMPARISON OF PANELISTS' CRITERIA TO EXPECTED CHARACTERISTICS OF CLIENTS IN DIFFERENT TREATMENT PATHS

Selected characteristics were tested for significance for specific paths and are shown in tables in the following pages. Appendix tables after this section show all demographic variables as well as histories of drug use and legal involvement for all treatment paths.

Extremely Dependent Clients

Counselors first identify clients with extreme dependence as outlined in Chapter 6.

For Drug Residential clients, extreme dependence means frequent use of hard drugs. There is a prevalence of hard drug use among clients in Drug Residential, but also in 30/60/90 and the 30/90 paths (Table A6.1).

For Extended Care clients, extreme dependence means frequent use of alcohol and a long history of use, including more treatment failures and more physical problems as a result of extreme addiction. Extended Care clients are significantly more likely to be older, have a longer drug use history, more treatment failures and more physical problems than those in less intensive paths (see Table A6.2). Clients with the next highest proportions of these characteristics were found in the outpatient path.

MICA clients may be either alcohol or drug users but the deciding factor in placement is evidence of mental illness. A family history of mental illness is also more prevalent in this path (Table A6.3). Drug Residential and Extended Care clients show a greater percent of mental/emotional problems than other non-MICA clients (Table A6.3). The higher prevalence of mental/emotional problems in these paths was expected due to placement of MICA-type clients in these treatment paths, because of the lack of MICA beds.

Table A6.1
Drug Residential Clients Compared to Clients in Other Less-Intensive/Residential Paths: Prevalence of Hard Drug Use

	Outpatient (n=109)	Intensive Inpatient		Drug Resid. (n=41)	All Clients (n=600)
		30/90 (n=159)	30/60/90 (n=106)		
Drug of Choice					
Cocaine	16%	25%	24%	47%	24%
Heroin	11%	7%	6%	13%	6%
Amphetamines	1%	2%	4%	3%	2%
Subtotal "Hard Drugs"	O 28%	O 34%	O 34%	63%	O 32%
Marijuana/Hashish	6%	6%	5%	10%	6%
Other Drugs	1%	3%	0%	10%	2%
Subtotal Other Drugs	7%	9%	5%	20%	8%
Alcohol and Other	34%	30%	35%	14%	34%
Alcohol Only	31%	25%	22%	3%	23%
Subtotal Alcohol	65%	55%	57%	17%	57%
Don't Know	0%	2%	4%	0%	3%
Total	100%	100%	100%	100%	100%

O <0.01 statistically significant at the 99% confidence level

These significance levels are based on a maximum-likelihood analysis-of-variance providing Chi-Square significance tests for each group of clients and for all clients compared to MICA clients.

Table A6.2
Extended Care Clients Compared to Clients in Other Less-Intensive/Residential Paths:

	Outpatient (n=109)	Intensive Inpatient		Extended Care (n=47)	All Clients (n=600)
		30/90 (n=159)	30/60/90 (n=106)		
Median Age	32	* 30	* 30	35	* 31
# of Years of Use (median)	• 16	* 15	• 16	18	* 15
Prior Admission to Detox					
Yes	O 34%	O 28%	O 36%	58%	O 32%
Prior Treatment					
3 or more	O 23%	O 11%	O 15%	46%	O 20%
One or None	* 52%	O 74%	O 63%	36%	O 62%
Physical Problems					
Yes	* 15%	O 14%	O 11%	31%	O 15%

○ <0.01 statistically significant at the 99% confidence level

✱ <0.05 statistically significant at the 95% confidence level

● <0.10 statistically significant at the 90% confidence level

These significance levels are based on a maximum-likelihood analysis-of-variance providing Chi-Square significance tests for each group of clients and for all clients compared to MICA clients.

Table A6.3
MICA Clients Compared to Clients in Other Paths: Prevalence of Mental/Emotional Problems

	Outpatient	Intensive Inpatient		Long Term			All Clients
	(n =109)	30/90 (n=159)	30/60/90 (n=106)	Extended Care (n=47)	Long Term (n=41)	MICA (n=24)	(n=600)
Mental/Emotional Problems Yes	○ 17%	○ 12%	○ 13%	29%	* 24%	45%	○ 18%
Family History of Mental Problems Yes	○ 8%	● 18%	* 20%	● 15%	20%	36%	○ 16%

○ <0.01 statistically significant at the 99% confidence level

* <0.05 statistically significant at the 95% confidence level

● <0.10 statistically significant at the 90% confidence level

These significance levels are based on a maximum-likelihood analysis-of-variance providing Chi-Square significance tests for each group of clients and for all clients compared to MICA clients.

Less Chemically Dependent Clients

If no evidence of extreme dependence has been identified, then the decision tree outlined earlier implies that counselors try to find characteristics associated with successful treatment in less intensive paths, outpatient and 30/90. The panelists identified the following criteria as appropriate:

1) Strong motivation for treatment
2) The length of previous abstinence
3) A sober household or neighborhood
4) A strong support system.

The expectation is that clients with strong motivation, previous lengthy abstinence, sober surroundings and/or strong support are more likely to be placed in Outpatient or 30/90 treatment. Those without these characteristics are more likely to be placed in the 30/60/90 path.

The only indicators of motivation and support in the sample data are the criminal justice and living situation data. Court-ordered assessment and probation/parole status were used in the analysis. The data show fewer court-ordered clients and fewer probation/parole clients in the Outpatient and 30/90 paths (Table 6.5).

Previous criminal justice involvement may indicate less positive social support for recovery among peers. The data show fewer clients with criminal justice involvement in Outpatient and 30/90 paths (Table 6.4)

Table A6.4
30/60/90 Clients Compared to Other Less-Intensive/Residential Paths

	Outpatient (n=109)	30/90 (n=159)	30/60/90 (n=106)	All Clients (n=600)
Assessment Court Ordered Yes	○ 19%	* 24%	35%	○ 25%
Ever Charged with Driving While Intoxicated Yes	○ 35%	51%	61%	○ 47%
On Probation or Parole Yes	* 28%	* 29%	41%	* 31%
Ever Arrested or Charged Yes	○ 61%	○ 73%	88%	○ 75%
Family History of Chemical Dependency Yes	○ 78%	* 82%	91%	* 85%

○ <0.01 statistically significant at the 99% confidence level
✱ <0.05 statistically significant at the 95% confidence level
● <0.10 statistically significant at the 90% confidence level

These significance levels are based on a maximum-likelihood analysis-of-variance providing Chi-Square significance tests for each group of clients and for all clients compared to MICA clients.

OTHER TREATMENT PATHS NOT DEALT WITH BY THE PEER PANEL

30-Only and Recovery House Paths

These two treatment paths were not dealt with by the panelists review process, but are shown to exist in the study sample. This means that hypothesized characteristics of clients in these paths cannot be derived and tested based on panelists criteria. However, tentative explanations are proposed, inductively, based on the sample data and observations of the panelists behavior during their case reviews.

The pattern of the proportions of women and AFDC mothers in different paths suggests that women tend to be placed disproportionately in less intensive, shorter paths: that is, in variants of the 30/60/90 path and in the Recovery House path. The one exception is the Drug Residential path, which does have programs and beds for families and children. (Table A6.5).

Observations of panelists suggest a reluctance of counselors to place women with children in inpatient treatment unless housing is available for the children. They are also concerned to place women in safe housing promptly, whenever housing is available, particularly in cases of pregnancy and CPS referrals. The combination of these concerns may explain counselors' choice of a Recovery House path or shorter 30-only path, particularly if these women can obtain outpatient treatment from other funding sources.

Table A6.5
Percent of Women and AFDC Mothers by Treatment Path

	OP	Rec House	Intensive Inpatient			Long Term			All Clients
			30 Only	30/60	30/60/90	Extended Care	Drug Resid.	Dual Diag.	
% Women	23%	55%•	41%•	46%o	33%	25%	43%*	36%	37%
% AFDC	9%	14%	21%o	17%*	9%	8%	14%	20%	14%

○ <0.01 statistically significant at the 99% confidence level
✱ <0.05 statistically significant at the 95% confidence level
● <0.10 statistically significant at the 90% confidence level

These significance levels are based on a maximum-likelihood analysis-of-variance providing chi-square significance tests for each group of clients and for all clients compared to MICA clients.

Table A6.6
Profiles By Treatment Path*
(For Clients Accepting Treatment and Being Accepted for Treatment)

TREATMENT PATH	OUTPATIENT (n=132)	RECOVERY HOUSE (n=29)	INTENSIVE INPATIENT 30/60/90 (n=124)	INTENSIVE INPATIENT 30/90 (n=179)	INTENSIVE INPATIENT 30 (n=131)	LONG TERM EXTENDED CARE RECOVERY HOUSE (n=62)	LONG TERM RESID'L DRUG (n=60)	LONG TERM DIFF'L. DIAGNOSIS (MICA Client) (n=27)
MEDIAN AGE	32	28	30	30	29	35	34	33
ETHNICITY								
White	59%	70%	70%	75%	69%	75%	66%	76%
Black	24%	8%	15%	20%	12%	15%	27%	8%
Native American	9%	17%	9%	5%	16%	5%	5%	8%
Hispanic	4%	-	4%	-	3%	-	2%	-
Asian	4%	-	2%	1%	-	5%	-	-
SEX								
Men	76%	51%	69%	55%	57%	71%	57%	66%
Women	24%	49%	31%	45%	43%	29%	43%	34%
Pregnant Among Women	12%	16%	12%	17%	11%	-	-	-
MARITAL STATUS								
Married	19%	14%	11%	15%	19%	15%	17%	19%
Not Married	78%	84%	88%	84%	81%	85%	83%	81%
EDUCATION								
Less Than High School	33%	47%	53%	40%	48%	47%	32%	34%
High School/GED	37%	40%	32%	41%	42%	34%	44%	27%
Post High School	26%	10%	14%	19%	9%	19%	19%	39%

* In this and all other tables in Appendix 6 percentages in each cell may not add up to 100%, because missing values or "don't know" answers are included in the computations but not presented in the table.

Table A6.7

Substance Abuse History By Treatment Path

(For Clients Accepting Treatment and Being Accepted for Treatment)

TREATMENT PATH	OUTPATIENT (n=132)	RECOVERY HOUSE (n=29)	INTENSIVE INPATIENT 30/60/90 (n=124)	INTENSIVE INPATIENT 30/90 (n=179)	INTENSIVE INPATIENT 30 (n=131)	LONG TERM EXTENDED CARE RECOVERY HOUSE (n=62)	LONG TERM RESID'L DRUG (n=60)	LONG TERM DIFF'L. DIAG. (MICA Client) (n=27)
DRUG OF CHOICE								
Alcohol Only	29%	22%	23%	24%	18%	25%	2%	21%
Alcohol & Other Drugs	37%	35%	35%	33%	40%	50%	30%	44%
Cocaine	16%	41%	24%	23%	22%	16%	36%	27%
Heroin	9%	0%	6%	7%	3%	3%	12%	0%
Marijuana/Hashish	6%	2%	4%	6%	9%	4%	11%	5%
Amphetamines	1%	0%	4%	2%	5%	0%	2%	0%
Other Drugs	1%	0%	0%	2%	1%	2%	7%	3%
AGE AT FIRST USE	17	16	15	16	15	15	19	16
# OF YEARS OF USE	17	13	16	15	13	20	12	16
FAMILY HISTORY OF CHEMICAL DEPENDENCY								
Yes	77%	94%	92%	83%	86%	97%	89%	75%
No	21%	4%	7%	16%	11%	1%	10%	17%
PRIOR ADMISSION TO DETOX								
Yes	35%	31%	34%	28%	26%	56%	18%	36%
No	65%	69%	66%	72%	74%	44%	82%	64%
PRIOR TREATMENT								
None	21%	9%	29%	38%	38%	19%	37%	32%
One	32%	35%	33%	35%	32%	23%	30%	30%
Two	22%	30%	20%	11%	15%	21%	13%	8%
Three	8%	9%	12%	6%	8%	12%	10%	12%
Four+	14%	14%	4%	7%	5%	25%	10%	18%

Table A6.8

Criminal Justice Involvement By Treatment Path

(For Clients Accepting Treatment and Being Accepted for Treatment)

TREATMENT PATH	OUTPATIENT (n=132)	RECOVERY HOUSE (n=29)	INTENSIVE INPATIENT			LONG TERM		
			30/60/90 (n=124)	30/90 (n=179)	30 (n=131)	EXTENDED CARE RECOVERY HOUSE (n=62)	RESID'L DRUG (n=60)	DIFF'L. DIAGNOSIS (MICA Client) (n=27)
ON PROBATION OR PAROLE								
Yes	27%	47%	38%	28%	25%	20%	29%	41%
No	62%	48%	54%	65%	68%	61%	62%	57%
ASSESSMENT COURT-ORDERED								
Yes	19%	43%	33%	23%	25%	13%	26%	15%
No	69%	42%	47%	60%	60%	70%	61%	75%
EVER CHARGED WITH DRIVING WHILE INTOXICATED								
Yes	35%	56%	59%	50%	44%	56%	28%	29%
No	48%	44%	32%	44%	51%	39%	64%	47%
EVER ARRESTED OR CHARGED								
Yes	65%	73%	87%	73%	71%	79%	83%	84%
No	26%	25%	10%	20%	22%	16%	17%	16%

Table A6.9

Additional Problems and Needs By Treatment Path

(For Clients Accepting Treatment and Being Accepted for Treatment)

TREATMENT PATH	OUTPATIENT (n=132)	RECOVERY HOUSE (n=29)	INTENSIVE INPATIENT 30/60/90 (n=124)	INTENSIVE INPATIENT 30/90 (n=179)	INTENSIVE INPATIENT 30 (n=131)	LONG TERM EXTENDED CARE RECOVERY HOUSE (n=62)	LONG TERM RESID'L DRUG (n=60)	LONG TERM DIFF'L. DIAGNOSIS (MICA Client) (n=27)
MENTAL/EMOTIONAL PROBLEMS								
Yes	17%	16%	12%	15%	20%	33%	22%	50%
No	82%	79%	85%	82%	77%	64%	75%	50%
FAMILY HISTORY OF MENTAL PROBLEMS								
Yes	7%	15%	17%	18%	15%	15%	23%	35%
No	82%	74%	70%	77%	75%	76%	68%	57%
PHYSICAL PROBLEMS								
Yes	16%	7%	16%	14%	16%	29%	15%	27%
No	84%	90%	83%	82%	82%	68%	83%	73%
LIVING ARRANGEMENTS								
Relatives	35%	40%	30%	38%	36%	24%	36%	33%
Unrelated Household	23%	15%	22%	26%	25%	17%	25%	36%
Alone	23%	16%	18%	20%	18%	38%	18%	18%
Homeless - Shelter	15%	14%	13%	10%	13%	8%	17%	5%
Homeless - Streets	4%	14%	15%	3%	6%	14%	2%	8%
PUBLIC ASSISTANCE								
None	58%	63%	55%	50%	43%	57%	58%	32%
General Assistance	22%	6%	17%	19%	14%	20%	15%	25%
AFDC Grant (Family Related)	9%	12%	9%	17%	19%	9%	12%	18%
SSI Grant (Disability Related)	2%	4%	1%	1%	5%	2%	1%	16%
Other	8%	13%	11%	11%	13%	12%	7%	10%

Table A6.10

Profiles By Treatment Path

(For Clients Starting Treatment)

TREATMENT PATH	OUTPATIENT (n=109)	RECOVERY HOUSE (n=21)	INTENSIVE INPATIENT			LONG TERM		
			30/60/90 (n=106)	30/90 (n=159)	30 (n=92)	EXTENDED CARE RECOVERY HOUSE (n=47)	RESID'L DRUG (n=41)	DIFF'L. DIAGNOSIS (MICA Client) (n=24)
MEDIAN AGE	32	30	30	30	29	35	34	33
ETHNICITY								
White	60%	71%	73%	74%	65%	71%	67%	73%
Black	20%	15%	11%	22%	15%	17%	23%	9%
Native American	10%	17%	10%	3%	17%	6%	7%	9%
Hispanic	5%	-	4%	-	2%	-	3%	-
Asian	5%	-	1%	1%	-	7%	-	-
SEX								
Men	77%	45%	67%	54%	59%	75%	57%	64%
Women	23%	55%	33%	46%	41%	25%	43%	36%
Pregnant Among Women	18%	20%	12%	17%	10%	-	-	-
MARITAL STATUS								
Married	18%	17%	12%	13%	17%	10%	16%	18%
Not Married	78%	79%	87%	85%	83%	90%	84%	82%
EDUCATION								
Less Than High School	30%	49%	51%	39%	49%	46%	28%	32%
High School/GED	39%	32%	33%	42%	41%	35%	44%	30%
Post High School	26%	13%	15%	18%	8%	19%	21%	38%

Table A6.11

Substance Abuse History By Treatment Path

(For Clients Starting Treatment)

TREATMENT PATH	OUTPATIENT (n=109)	RECOVERY HOUSE (n=21)	INTENSIVE INPATIENT			LONG TERM		
			30/60/90 (n=106)	90/90 (n=159)	30 (n=92)	EXTENDED CARE RECOVERY HOUSE (n=47)	RESID'L DRUG (n=41)	DIFF'L. DIAGNOSIS (MICA Client) (n=24)
DRUG OF CHOICE								
Alcohol Only	31%	20%	22%	25%	21%	32%	3%	21%
Alcohol & Other Drugs	34%	42%	35%	30%	39%	41%	14%	47%
Cocaine	16%	38%	24%	25%	22%	21%	47%	27%
Heroin	11%	0%	6%	7%	3%	2%	13%	0%
Marijuana/Hashish	6%	0%	5%	6%	8%	10%	10%	2%
Amphetamines	1%	0%	4%	2%	2%	3%	3%	0%
Other Drugs	1%	0%	0%	3%	2%	0%	10%	3%
AGE AT FIRST USE	17	16	16	16	15	15	20	16
# OF YEARS OF USE	16	13	16	15	14	18	12	14
FAMILY HISTORY OF CHEMICAL DEPENDENCY								
Yes	78%	92%	91%	82%	89%	96%	85%	82%
No	20%	6%	8%	18%	8%	1%	15%	9%
PRIOR ADMISSION TO DETOX								
Yes	34%	31%	36%	28%	25%	58%	15%	38%
No	66%	69%	64%	72%	75%	42%	85%	62%
PRIOR TREATMENT								
None	22%	13%	32%	37%	37%	17%	28%	29%
One	30%	37%	31%	37%	34%	19%	30%	33%
Two	21%	14%	22%	11%	15%	18%	18%	9%
Three	9%	13%	11%	5%	7%	15%	12%	11%
Four+	14%	20%	4%	6%	4%	31%	12%	18%

Table A6.12

Criminal Justice Involvement By Treatment Path

(For Clients Starting Treatment)

TREATMENT PATH	OUTPATIENT (n=109)	RECOVERY HOUSE (n=21)	INTENSIVE INPATIENT 30/60/90 (n=106)	INTENSIVE INPATIENT 30/90 (n=159)	INTENSIVE INPATIENT 30 (n=92)	LONG TERM EXTENDED CARE RECOVERY HOUSE (n=47)	LONG TERM RESID'L DRUG (n=41)	LONG TERM DIFF'L DIAGNOSIS (MICA Client) (n=24)
ON PROBATION OR PAROLE								
Yes	28%	43%	41%	29%	20%	26%	41%	36%
No	63%	50%	52%	66%	76%	53%	51%	62%
ASSESSMENT COURT-ORDERED								
Yes	19%	34%	35%	24%	24%	17%	36%	9%
No	71%	51%	44%	60%	63%	64%	45%	64%
EVER CHARGED WITH DRIVING WHILE INTOXICATED								
Yes	35%	49%	61%	51%	43%	59%	36%	21%
No	50%	51%	35%	45%	50%	38%	57%	52%
EVER ARRESTED OR CHARGED								
Yes	61%	62%	88%	73%	71%	80%	91%	82%
No	29%	35%	12%	21%	22%	17%	9%	18%

Table A6.13

Additional Problems and Needs By Treatment Path
(For Clients Starting Treatment)

TREATMENT PATH	OUTPATIENT (n=109)	RECOVERY HOUSE (n=21)	INTENSIVE INPATIENT 30/60/90 (n=106)	INTENSIVE INPATIENT 30/90 (n=159)	INTENSIVE INPATIENT 30 (n=92)	LONG TERM EXTENDED CARE RECOVERY HOUSE (n=47)	LONG TERM RESID'L DRUG (n=41)	LONG TERM DIFF'L. DIAGNOSIS (MICA Client) (n=24)
MENTAL/EMOTIONAL PROBLEMS								
Yes	17%	17%	13%	12%	18%	29%	24%	45%
No	83%	75%	84%	85%	81%	71%	71%	55%
FAMILY HISTORY OF MENTAL PROBLEMS								
Yes	8%	18%	20%	18%	14%	15%	20%	36%
No	80%	66%	66%	79%	76%	73%	72%	55%
PHYSICAL PROBLEMS								
Yes	15%	9%	11%	14%	16%	31%	11%	29%
No	85%	86%	87%	82%	83%	69%	87%	71%
LIVING ARRANGEMENTS								
Relatives	34%	39%	30%	37%	37%	28%	37%	30%
Unrelated Household	23%	22%	23%	26%	23%	13%	31%	38%
Alone	24%	12%	19%	21%	17%	34%	16%	20%
Homeless - Shelter	15%	20%	11%	9%	16%	7%	11%	3%
Homeless - Streets	4%	7%	15%	4%	7%	19%	3%	9%
PUBLIC ASSISTANCE								
None	59%	55%	55%	49%	40%	65%	52%	30%
General Assistance	23%	8%	17%	20%	15%	12%	19%	21%
AFDC Grant (Family Related)	9%	14%	9%	17%	21%	8%	14%	20%
SSI Grant (Disability Related)	0%	5%	2%	1%	4%	7%	-	18%
Other	7%	18%	9%	11%	15%	12%	6%	11%

Table A6.14

Profiles By Treatment Path

(For Clients completing At Least Primary Treatment)

TREATMENT PATH	OUTPATIENT (n=47)	RECOVERY HOUSE (n=12)	INTENSIVE INPATIENT 30/60/90 (n=91)	INTENSIVE INPATIENT 30/90 (n=132)	INTENSIVE INPATIENT 30 (n=41)	LONG TERM EXTENDED CARE RECOVERY HOUSE (n=31)	LONG TERM RESID'L DRUG (n=15)	LONG TERM DIFF'L. DIAGNOSIS (MICA Client) (n=17)
MEDIAN AGE	33	30	31	31	30	33	34	28
ETHNICITY								
White	55%	82%	71%	70%	56%	76%	68%	60%
Black	24%	4%	13%	25%	16%	14%	19%	13%
Native American	6%	15%	12%	4%	26%	9%	13%	13%
Hispanic	5%	-	4%	-	-	-	-	-
Asian	10%	-	-	1%	-	-	-	-
SEX								
Men	73%	33%	69%	57%	45%	79%	47%	60%
Women	27%	67%	31%	43%	55%	21%	53%	40%
Pregnant Among Women	0%	22%	10%	14%	2%	0%	-	-
MARITAL STATUS								
Married	22%	20%	11%	14%	24%	10%	23%	26%
Not Married	78%	80%	88%	84%	76%	90%	77%	74%
EDUCATION								
Less Than High School	19%	55%	51%	34%	45%	60%	27%	34%
High School/GED	48%	30%	32%	47%	44%	29%	26%	26%
Post High School	29%	11%	16%	19%	7%	12%	32%	40%

Table A6.15

Substance Abuse History By Treatment Path

(For Clients completing At Least Primary Treatment)

TREATMENT PATH	OUTPATIENT (n=47)	RECOVERY HOUSE (n=12)	INTENSIVE INPATIENT 30/60/90 (n=91)	INTENSIVE INPATIENT 30/90 (n=132)	INTENSIVE INPATIENT 30 (n=41)	LONG TERM EXTENDED CARE RECOVERY HOUSE (n=31)	LONG TERM RESID'L DRUG (n=15)	LONG TERM DIFF'L. DIAGNOSIS (MICA Client) (n=17)
DRUG OF CHOICE								
Alcohol Only	41%	25%	21%	27%	29%	39%	0%	33%
Alcohol & Other Drugs	30%	49%	37%	29%	43%	33%	15%	33%
Cocaine	9%	26%	23%	24%	11%	23%	63%	26%
Heroin	9%	0%	6%	6%	2%	5%	10%	0%
Marijuana/Hashish	9%	0%	6%	6%	11%	0%	4%	3%
Amphetamines	1%	0%	5%	2%	0%	0%	0%	0%
Other Drugs	1%	0%	0%	3%	1%	0%	8%	5%
AGE AT FIRST USE	16	15	15	16	15	16	19	15
# OF YEARS OF USE	18	13	17	15	15	18	13	14
FAMILY HISTORY OF CHEMICAL DEPENDENCY								
Yes	77%	96%	93%	78%	96%	95%	84%	74%
No	18%	4%	7%	21%	3%	5%	16%	13%
PRIOR ADMISSION TO DETOX								
Yes	42%	21%	38%	27%	19%	60%	19%	29%
No	58%	79%	62%	73%	81%	40%	81%	71%
PRIOR TREATMENT								
None	20%	7%	34%	35%	33%	19%	19%	26%
One	33%	48%	32%	39%	43%	19%	45%	44%
Two	22%	13%	21%	12%	17%	22%	9%	13%
Three	13%	14%	9%	3%	6%	10%	13%	3%
Four+	11%	18%	4%	7%	1%	30%	14%	13%

Table A6.16

Criminal Justice Involvement By Treatment Path

(For Clients completing At Least Primary Treatment)

TREATMENT PATH	OUTPATIENT (n=47)	RECOVERY HOUSE (n=12)	INTENSIVE INPATIENT 30/60/90 (n=91)	INTENSIVE INPATIENT 30/90 (n=132)	INTENSIVE INPATIENT 30 (n=41)	LONG TERM EXTENDED CARE RECOVERY HOUSE (n=31)	LONG TERM RESID'L DRUG (n=15)	LONG TERM DIFF'L. DIAGNOSIS (MICA Client) (n=17)
ON PROBATION OR PAROLE								
Yes	25%	36%	42%	31%	26%	35%	32%	26%
No	67%	53%	52%	62%	67%	55%	58%	71%
ASSESSMENT COURT-ORDERED								
Yes	17%	36%	31%	25%	32%	19%	27%	13%
No	74%	50%	49%	58%	59%	69%	53%	73%
EVER CHARGED WITH DRIVING WHILE INTOXICATED								
Yes	34%	60%	58%	48%	50%	57%	45%	13%
No	49%	40%	34%	49%	36%	38%	55%	47%
EVER ARRESTED OR CHARGED								
Yes	55%	52%	88%	74%	70%	81%	100%	74%
No	33%	45%	12%	20%	23%	14%	0%	26%

Table A6.17

Additional Problems and Needs By Treatment Path

(For Clients completing At Least Primary Treatment)

TREATMENT PATH	OUTPATIENT (n=47)	RECOVERY HOUSE (n=12)	INTENSIVE INPATIENT 30/60/90 (n=91)	INTENSIVE INPATIENT 30/90 (n=132)	INTENSIVE INPATIENT 30 (n=41)	LONG TERM EXTENDED CARE RECOVERY HOUSE (n=31)	LONG TERM RESID'L DRUG (n=15)	LONG TERM DIFF'L DIAGNOSIS (MICA Client) (n=17)
MENTAL/EMOTIONAL PROBLEMS								
Yes	16%	20%	14%	8%	18%	29%	10%	31%
No	84%	76%	83%	89%	79%	71%	80%	69%
FAMILY HISTORY OF MENTAL PROBLEMS								
Yes	10%	13%	19%	19%	17%	17%	21%	40%
No	66%	80%	69%	78%	75%	71%	70%	47%
PHYSICAL PROBLEMS								
Yes	6%	7%	13%	14%	20%	31%	15%	13%
No	94%	90%	86%	83%	77%	69%	85%	87%
LIVING ARRANGEMENTS								
Relatives	34%	27%	31%	35%	44%	36%	36%	31%
Unrelated Household	23%	33%	22%	25%	21%	10%	24%	40%
Alone	19%	13%	20%	22%	14%	39%	22%	16%
Homeless - Shelter	24%	21%	12%	11%	14%	2%	10%	0%
Homeless - Streets	0%	7%	14%	4%	7%	14%	5%	13%
PUBLIC ASSISTANCE								
None	59%	48%	54%	50%	41%	71%	62%	26%
General Assistance	20%	6%	17%	20%	14%	7%	4%	31%
AFDC Grant (Family Related)	8%	20%	9%	15%	24%	12%	23%	26%
SSI Grant (Disability Related)	-	3%	2%	1%	3%	2%	-	13%
Other	11%	23%	9%	12%	11%	7%	3%	3%

Table A6.18

Profiles By Treatment Path
(For Clients Completing All Treatment)

TREATMENT PATH	OUTPATIENT (n=47)	RECOVERY HOUSE (n=10)	INTENSIVE INPATIENT 30/60/90 (n=40)	INTENSIVE INPATIENT 30/90 (n=67)	INTENSIVE INPATIENT 30 (n=41)	LONG TERM EXTENDED CARE RECOVERY HOUSE (n=22)	LONG TERM RESID'L DRUG (n=13)	LONG TERM DIFF'L. DIAGNOSIS (MICA Client) (n=14)
MEDIAN AGE	33	29	31	31	30	32	33	29
ETHNICITY								
White	55%	86%	67%	78%	56%	77%	63%	57%
Black	25%	-	13%	17%	16%	20%	22%	14%
Native American	6%	14%	20%	5%	26%	3%	16%	14%
Hispanic	5%	-	-	1%	-	-	-	-
Asian	10%	-	-	-	-	-	-	-
SEX								
Men	73%	33%	66%	62%	45%	78%	49%	55%
Women	27%	67%	34%	38%	55%	22%	51%	45%
Pregnant Among Women	0%	27%	9%	18%	2%	0%	-	-
MARITAL STATUS								
Married	21%	11%	15%	15%	24%	7%	27%	30%
Not Married	79%	89%	85%	82%	76%	93%	73%	70%
EDUCATION								
Less Than High School	18%	64%	51%	36%	45%	57%	20%	21%
High School/GED	48%	22%	28%	40%	44%	34%	26%	29%
Post High School	29%	14%	20%	23%	7%	9%	38%	28%

Table A6.19

Substance Abuse History By Treatment Path

(For Clients Completing All Treatment)

TREATMENT PATH	OUTPATIENT (n=47)	RECOVERY HOUSE (n=10)	INTENSIVE INPATIENT 30/60/90 (n=40)	INTENSIVE INPATIENT 30/90 (n=67)	INTENSIVE INPATIENT 30 (n=41)	LONG TERM EXTENDED CARE RECOVERY HOUSE (n=22)	LONG TERM RESID'L DRUG (n=13)	LONG TERM DIFF'L. DIAGNOSIS (MICA Client) (n=14)
DRUG OF CHOICE								
Alcohol Only	42%	26%	23%	39%	29%	24%	0%	40%
Alcohol & Other Drugs	30%	48%	22%	18%	43%	44%	12%	20%
Cocaine	9%	26%	31%	28%	11%	32%	62%	30%
Heroin	9%	0%	7%	1%	2%	0%	12%	0%
Marijuana/Hashish	9%	0%	8%	7%	11%	0%	5%	4%
Amphetamines	1%	0%	6%	4%	0%	0%	0%	0%
Other Drugs	0%	0%	0%	0%	1%	0%	9%	6%
AGE AT FIRST USE	16	16	17	17	15	17	20	16
# OF YEARS OF USE	18	11	16	15	15	16	10	13
FAMILY HISTORY OF CHEMICAL DEPENDENCY								
Yes	77%	100%	89%	79%	96%	100%	81%	70%
No	18%	0%	10%	20%	3%	0%	19%	15%
PRIOR ADMISSION TO DETOX								
Yes	42%	22%	43%	21%	19%	68%	22%	34%
No	58%	78%	57%	79%	81%	32%	78%	66%
PRIOR TREATMENT								
None	21%	5%	31%	33%	33%	2%	22%	30%
One	33%	44%	39%	41%	43%	17%	41%	36%
Two	22%	16%	18%	14%	17%	24%	10%	13%
Three	13%	14%	10%	3%	6%	14%	16%	19%
Four+	11%	22%	2%	1%	1%	42%	12%	15%

Table A6.20

Criminal Justice Involvement By Treatment Path

(For Clients Completing All Treatment)

TREATMENT PATH	OUTPATIENT (n=47)	RECOVERY HOUSE (n=10)	INTENSIVE INPATIENT 30/60/90 (n=40)	30/90 (n=67)	90 (n=41)	LONG TERM EXTENDED CARE RECOVERY HOUSE (n=22)	RESID'L DRUG (n=13)	DIFF'L DIAGNOSIS (MICA Client) (n=14)
ON PROBATION OR PAROLE								
Yes	25%	40%	31%	34%	26%	39%	38%	30%
No	67%	56%	64%	60%	67%	54%	50%	66%
ASSESSMENT COURT-ORDERED								
Yes	17%	36%	28%	23%	32%	20%	32%	15%
No	73%	51%	53%	56%	59%	70%	45%	66%
EVER CHARGED WITH DRIVING WHILE INTOXICATED								
Yes	33%	57%	55%	61%	50%	53%	53%	15%
No	49%	43%	35%	37%	36%	47%	47%	39%
EVER ARRESTED OR CHARGED								
Yes	55%	55%	83%	78%	70%	91%	100%	70%
No	33%	45%	17%	13%	23%	9%	0%	30%

Table A6.21

Additional Problems and Needs By Treatment Path

(For Clients Completing All Treatment)

TREATMENT PATH	OUTPATIENT (n=47)	RECOVERY HOUSE (n=10)	INTENSIVE INPATIENT 30/60/90 (n=40)	INTENSIVE INPATIENT 30/90 (n=67)	INTENSIVE INPATIENT 30 (n=41)	LONG TERM EXTENDED CARE RECOVERY HOUSE (n=22)	LONG TERM RESID'L DRUG (n=15)	LONG TERM DIFF'L. DIAG. (MICA Client) (n=14)
MENTAL/EMOTIONAL PROBLEMS								
Yes	16%	18%	17%	8%	18%	24%	12%	36%
No	84%	82%	81%	90%	79%	76%	76%	64%
FAMILY HISTORY OF MENTAL PROBLEMS								
Yes	10%	16%	19%	15%	17%	9%	24%	30%
No	66%	80%	66%	82%	75%	91%	66%	55%
PHYSICAL PROBLEMS								
Yes	6%	8%	10%	15%	20%	27%	17%	15%
No	94%	92%	88%	83%	77%	73%	83%	85%
LIVING ARRANGEMENTS								
Relatives	34%	24%	42%	33%	44%	44%	31%	36%
Unrelated Household	22%	29%	14%	29%	21%	7%	28%	50%
Alone	19%	16%	25%	25%	14%	35%	21%	19%
Homeless - Shelter	25%	22%	4%	12%	14%	2%	12%	0%
Homeless - Streets	0%	9%	15%	1%	7%	12%	5%	0%
PUBLIC ASSISTANCE								
None	59%	47%	54%	54%	41%	66%	61%	14%
General Assistance	20%	0%	18%	13%	14%	9%	-	36%
AFDC Grant (Family Related)	8%	20%	6%	15%	24%	10%	27%	29%
SSI Grant (Disability Related)	-	4%	4%	1%	3%	3%	-	14%
Other	1%	29%	6%	13%	11%	9%	3%	7%

APPENDIX 7

CALCULATIONS OF TOTAL NUMBER OF CLIENTS REFERRED FOR ASSESSMENT

Lists of appointments for assessments were available for 61% of the assessment centers sampled. From these lists, estimates of the total number of appointments were derived for each stratum and for the total sample of clients. However, since appointments lists included some repeated no-shows and some no-shows followed later by actual assessments, the number of appointments could not be equated to the number of referred clients. Therefore all multiple appointments were counted so as to identify unique clients from the lists of appointments. On average 90% of the appointments were made by a unique set of referred clients. The other 10% of the appointments constituted multiple appointments by some of the referred clients.

APPENDIX 8

How Employment Was Measured

The employment data were obtained from the Department of Employment Security's unemployment insurance data base. Virtually all Washington state employees - private, public, and non-profit - now report nearly every employee's hours and earnings to this data base. The data are reported for each calendar quarter, such as for January - March, 1990. (The crucial link to this employment file is the person's correct Social Security number.)

Not included in this data base are out-of-state employment, and "off-the-books" informal earnings. Even so, we know of no more complete, more reliable data base for employment.

Employment data were sought for all 896 persons in the study who had applied and were eligible for ADATSA treatment. Employment records for the period July, 1987 and September, 1990 were found for 75 percent of this group.

For each eligible person, we identified the date on which they completed or left the treatment program. One month was then allowed for the person to find a job. The data presented in the text represent each person's employment in the first and second full calendar quarters following that one month of opportunity.

For example, a person who left his/her treatment program on December 20, 1989 was allowed one opportunity month until January 20, 1990. That person's first calendar quarter for employment data was therefore the next full calendar quarter, namely, April-June, 1990.

How Use of Public Assistance Was Measured

Public assistance data were obtained from the Office of Financial Management's public assistance eligibility file. The data include persons receiving income grants through General Assistance (GA), ADATSA, Aid to Families with Dependent Children (AFDC), and Supplemental Security Income (SSI).

Detoxification Re-entry as a Measure of Resumption of Substance Abuse

It is difficult to find out about clients' resumption of substance abuse after completion of treatment or drop out. Such events are seldom recorded in client records. The data would be hard to obtain even by re-contacting every client, which this study did not do.

A very limited set of relapse data were available. These are the individually identified detoxification episodes reported to the department's Substance Abuse Management System (SAMS). However, many ADATSA clients do not use such publicly-funded detoxification units reporting to SAMS.

This analysis, therefore, was limited to those relatively few persons who had used detoxification units reporting to SAMS at any time prior to starting their ADATSA treatment. Among the 1,118 applicants in the study population, 76 had used SAMS-reported detoxification services prior to coming to ADATSA. The outcome of interest was: To what extent do these persons again use detoxification services after ADATSA treatment or drop out?

Table A8.1
Percent of Clients Re-entering DASA Service Programs Totally Funded by ADATSA

(For a period of 12 months for a sample of ADATSA clients accepted for treatment in the fall of 1989, after they did not show up, dropped out or completed their originally planned treatment program as reported by the Substance Abuse Management Systems (SAMS).)

	Did not show up for Tx Program	Dropped out of primary Tx Program	Completed only primary Tx Program	Completed All Tx Programs		Total
				Not used up all eligible time*	Used up all eligible time	
Treatment Only						
Outpatient only	1	4	5	3	0	3
Inpatient/Outpatient	11	6	4	3	3	6
Detox + Treatment						
Outpatient only	0	0	0	0	0	0
Inpatient/Outpatient	0	0	0	0	0	0
Detoxification Only						
1 Episode	0	0	0	0	0	0
2 or more Episodes	0	0	0	0	0	0
Methadone	0	0	0	0	0	0
Total ADATSA Funded Re-entries	12	10	9	6	3	9
N =	147	215	133	206	46	747

* "Not used up all eligible time" is defined as 27 or more days of time remaining in the six months of treatment eligibility.

Note 1: This information was obtained from SAMS during the period when SAMS was in a transition phase.

Note 2: This table cannot be interpreted as showing that treatment has the effect of reducing ADATSA-funded re-entry. Lower re-entry rates reported here may be a function of limited eligibility time for certain types of clients. Eligibility to ADATSA-funded treatment is restricted to six months for every two year period. Two years have not yet elapsed for those clients using up all their eligible time. Those clients who did not use up their treatment time are eligible for a more limited range of services due to the shorter remaining period of eligibility.

Note 3: Overall rates of re-entry are probably under-estimated by a factor of 12 to 23%. Data for ADATSA clients completing their original treatment were obtained directly from Assessment Center files and are almost 100% complete. Later re-entry information was obtained from SAMS. In the fall of 1989 detoxification and treatment services were under-reported to SAMS by a factor of 49% and 23% respectively. In the fall of 1990 the under-reporting rate for treatment services decreased to an estimated 12% based on DASA's audits.

Note 4: Re-entry may be attributed to wrong clients up to 20% of the time. In August of 1989, DASA checked clients with similar SAMS identities to verify whether they were the same or different persons. Since that time no further checks have been made. A computer match was accomplished by ORDA, which minimizes this error. However, this error cannot be eliminated completely without verifying client identities with the service providers reporting these services.

Table A8.2

Percent of Clients Re-entering DASA Service Programs Partially Funded by ADATSA

(For a period of 12 months for a sample of ADATSA clients accepted for treatment in the fall of 1989, after they did not show up, dropped out or completed their originally planned treatment program as reported by the Substance Abuse Management Systems (SAMS).)

	Did not show up for Tx Program	Dropped out of primary Tx Program	Completed only primary Tx Program	Completed all Tx Programs		Total
				Not used up all eligible time*	Used up all eligible time	
Treatment Only						
Outpatient only	0	1	0	0	0	0
Inpatient/Outpatient	5	3	0	0	1	2
Detox + Treatment						
Outpatient only	0	0	1	0	0	0
Inpatient/Outpatient	4	2	1	0	0	2
Detoxification Only						
1 Episode	0	0	0	0	0	0
2 or more Episodes	0	0	0	0	0	0
Methadone	0	1	0	0	0	0
Total Partially Funded ADATSA Re-entries	9	7	2	0	1	4
N =	147	215	133	206	46	747

* "Not used up all eligible time" is defined as 27 or more days of time remaining in the six months of treatment eligibility.

Note 1: This information was obtained from SAMS during the period when SAMS was in a transition phase.

Also, see Notes 3 and 4 in Table A8.1.

Table A8.3
Percent of Clients Re-entering DASA Service Programs Not Funded by ADATSA

(Title 19 and County Block Grants)

(For a period of 12 months for a sample of ADATSA clients accepted for treatment in the fall of 1989, after they did not show up, dropped out or completed their originally planned treatment program as reported by the Substance Abuse Management Systems (SAMS).)

	Did not show up for Tx Program	Dropped out of primary Tx Program	Completed only primary Tx Program	Completed All Tx Programs		Total
				Not used up all eligible time*	Used up all eligible time	
Treatment Only						
Outpatient Only	3	13	11	18	16	12
Inpatient/Outpatient	8	2	4	2	0	3
Detox + Treatment						
Outpatient only	1	0	3	1	1	1
Inpatient/Outpatient	0	1	0	1	3	1
Detoxification Only						
1 Episode	0	2	4	1	1	2
2 or more Episodes	1	3	2	1	0	2
Methadone	0	1	2	0	0	0
Total Non ADATSA Funded Re-entries	13	22	26	24	21	21
N =	147	215	133	206	46	747

* "Not used up all eligible time" is defined as 27 or more days of time remaining in the six months of treatment eligibility.

Note 1: This information was obtained from SAMS during the period when SAMS was in a transition phase.

Also, see Notes 3 and 4 in Table A8.1.

APPENDIX 9

Sample Selection:

Controls

The client data base discussed in Chapter 4 was the source of our comparison group. The original sample contained clients who were assessed in ADATSA centers between August 1989 and December 1989. From that data base, clients for this study's control group were selected to be comparable to clients in the vocational services groups. First, clients were eliminated from the comparison group if they did not live in one of the six counties near the ACEP, RRR, or VOTE centers. Secondly, clients were eliminated from the control group if they did not complete at least some portion of the chemical dependency treatment program. Eliminating clients for these two reasons reduced the sample from 1221 to 162 (see Table A9.1).

Table A9.1
Samples in Three Vocational Pilot Programs and in the Comparison Group

NUMBER OF CASES	ACEP	RRR	VOTE	Comparison Group	Total
Original	321	239	621	1221	2402
In geographic area	319	234	509	521	1583
Completed some chemical dependency treatment	319	234	509	162	1224
With employment information, excluding AFDC grant recipients	172	100	323	74	669
Weighted hours, employment data, with hours and without AFDC	172	100	321	112	705

Experimental Groups

Client data were supplied by the staff of the three vocational programs. We eliminated people who received vocational services before the fourth quarter of 1987 or after the third quarter of 1990, because these people could not have employment data from the Employment Security Division records for the 12 quarters of 1988, 1989 and 1990.

Univariate Analysis: Background Factors

The four groups differed significantly on most of the background variables studied (see Table 9.1 in Chapter 9). The only background variable not significantly different across the groups was employment before chemical dependency treatment.

Major differences include:

ACEP and RRR had more men, compared to VOTE and the comparison group.

VOTE and RRR had more whites than ACEP and the comparison group.

VOTE had more clients under 30.

RRR had more clients with less than high school completion.

RRR had more clients with alcohol-only addictions.

ACEP had more clients who received assistance pre-treatment.

Bivariate Analysis

While the groups differed significantly on a variety of background variables, these variables did not significantly affect post-treatment employment. We used chi-square analysis to evaluate the significance of these variables (see Table 9.2 in Chapter 9).

Sex: The biggest differences were in the control group, where women were more likely than men to be employed post-treatment.

Ethnicity: There were no significant relationships between ethnicity and employment outcomes for any of the treatment groups or for the controls.

Age: There were very few clients in their teens or over fifty. Within the limited age range, differences in employment were not significant.

Education: Among RRR clients, those with more than a high school education were less likely to be employed post-treatment.

Marital status: There were very few married clients, which reduces the likelihood of finding significant differences. Among ACEP clients, those who were married were more likely to be employed half-time or more.

Drug of choice: Differences in employment outcomes were not significant across groups.

Geography: Among the comparison group, there were no significant variations across the three major metropolitan areas studied. The controls, therefore, were analyzed as one group rather than three.

Because most of the variables available were either categorical in nature, or assumed to be categorical in effect, we decided not to use multiple regression, which assumes a normal distribution of both dependent and independent variables. Instead, a multivariate procedure designed for categorical variables was used.

Further Research

Some critics of vocational rehabilitation for the ADATSA population believe that its effect, if any, lasts less than a year. The most potentially significant addition to this analysis would be to follow clients for a longer period of time after treatment. Because the analysis was limited to clients who had completed chemical dependency treatment, the number with data for even four quarters post treatment was too small to analyze across groups.

It might also be illuminating to try to find those clients who did not appear in either the employment or public assistance systems post-treatment. Client records could be reviewed and linked to data from the Department of Corrections. Linking client social security numbers to out-of-state employment systems, however, would probably be very expensive and not necessarily rewarding, except in the case of Idaho, where Spokane and Whitman County residents may work.

Other measures of post-treatment employment could be used, such as average wages earned per month, length of time between treatment and first post-treatment employment, and length of time continuously employed post-treatment.

Because a number of chemically dependent people do not get jobs even after vocational rehabilitation, the cost/benefit of these programs should be measured. To succeed in returning even a fraction of the chemically dependent population to self-sufficiency may outweigh the costs of the whole program in economic, not to mention, human terms.

APPENDIX 11

INTERVENTION STRATEGIES OF ADDICTION

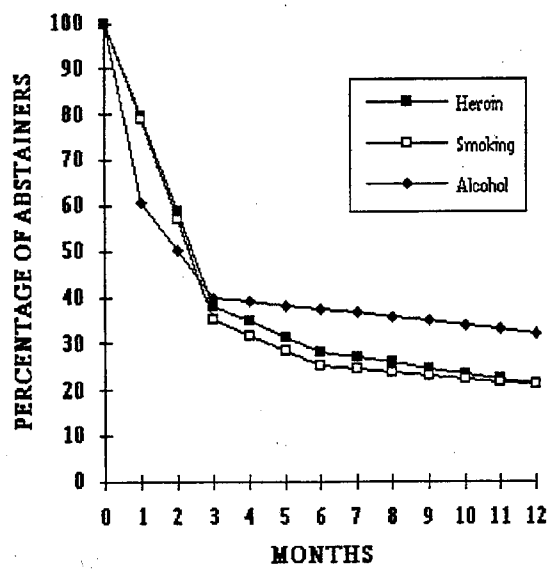
The traditional method of treating addiction involved one long and radical intervention with high expectations of success. Research showed limited success of such an approach (see figure A11A for expected abstention rates after one treatment intervention in the case of smoking, alcohol and heroin addictions).

The conceptualization of addiction shifted from a curable condition to a lifelong psychological and physical tendency (chemical dependency) requiring multiple interventions to maximize the likelihood of both temporary and long term remission (see figure A11B for a visual representation of these two different strategies).

Summary research findings on successful quitting rates for smoking show only 15 percent quitting on the first intervention attempt, 25 percent on the second attempt, and growing more slowly to about 40 percent by the seventh attempt (see figure A11C). Similar summary results are not available for drug addiction due to the few studies conducted over a very long period (10-15 years are necessary) and the difficulty in following-up such persons over such a long time span.

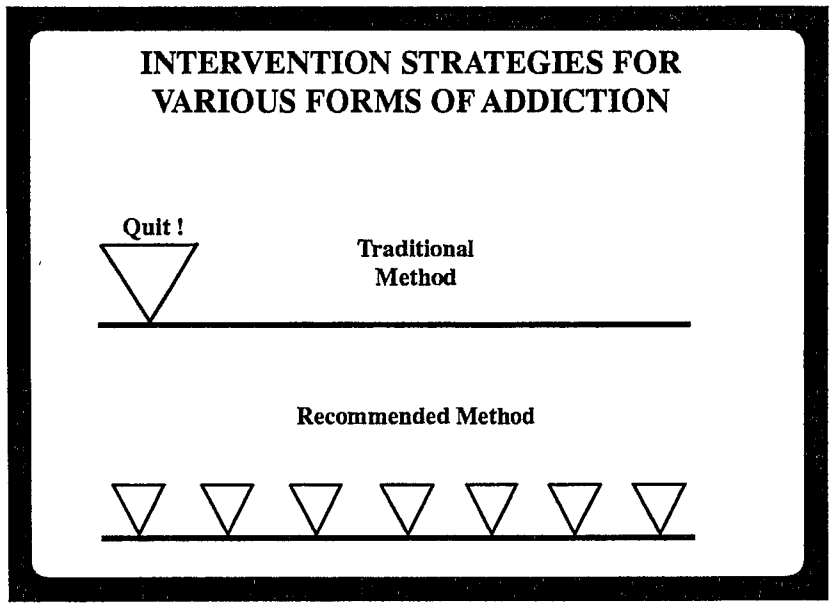
Figure A11A

RELAPSE RATE OVER TIME



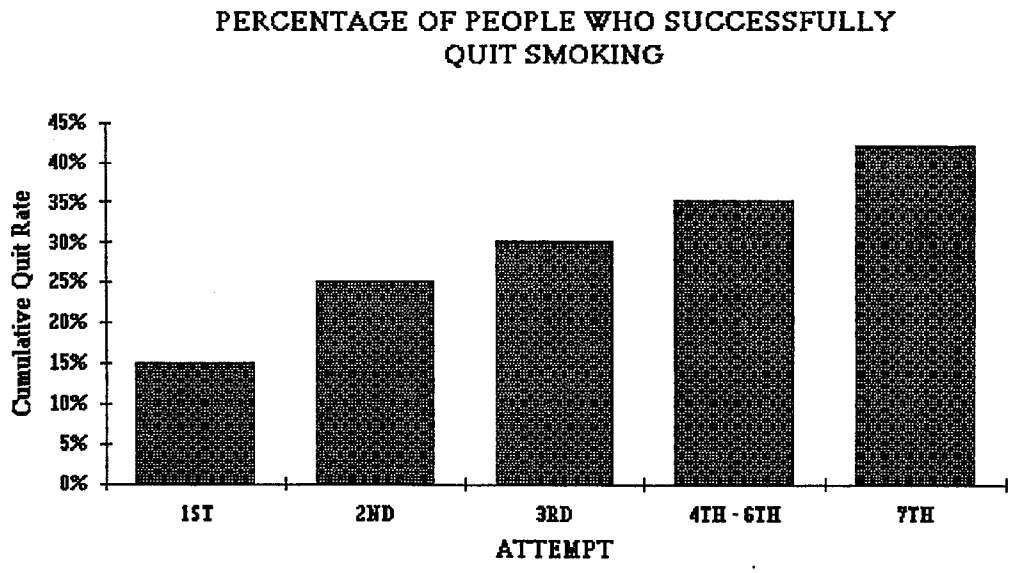
Source: Richard Catalano et al., op.cit.

Figure A11B



Source: Slide presentation accompanying U.S. federal trainer's manual:

Figure A11C



How to Help Your Patient Stop Smoking, Trainer's Guide, U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health.

References

Catalano, R,F., M.O. Howard, J.D. Hawkins, and E.A. Wells. Relapse in the Addictions: Rates, Determinants, and Promising Relapse Prevention Strategies. The Health Consequences of Smoking: Nicotine Addiction, Washington D.C., 1988.

Division of Alcohol and Substance Abuse, Washington State Department of Social & Health Services (Ken Stark, Director), National Survey on Select Treatment and Prevention Issues, Olympia, Washington, April, 1991.

Laws of Washington State, Volume 2, Chapter 406, 1987.

Management Indicators Program Status Report, DSHS Division of Alcohol and Substance Abuse, December 13, 1990.

Management Indicators Program Status Report, DSHS Division of Alcohol and Substance Abuse, March, 1990.

Morgan, C.J., A. Lowin, C. Hansen, J. Wirth, and R. Harrington, Intensive Protective Payee for Chemically Dependent Indigents: An Evaluation of the ADATSA Intensive Protective Payee Pilot Project, Office of Research and Data Analysis, DSHS, Olympia, Washington February, 1990, Report 04-02, 25 pp.

U.S. Department of Health and Human Services, How to Help Your Patient Stop Smoking, Trainer's Guide, Public Health Services, National Institutes of Health.

Walsh, D.C., R.W. Hingson, D.M. Merrigan, S.M. Levenson, L.A. Cupples, T. Hearen, G.A. Coffman, C.A. Becker, T.A. Barker, S.K. Hamilton, T.G. McGuire, and C.A. Kelly. A Randomized Trial of Treatment Options for Alcohol-Abusing Workers. The New England Journal of Medicine, September 12, 1991.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