Report of the Alcohol and Drug System Capacity Workteam

November 29, 1999

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I. Charge to the Workteam

1. Determine the impact of various levels of secure alcohol and drug treatment (InterChange at 70, 200, 300 beds) upon the adult alcohol and drug treatment continuum.

2. Make recommendations regarding proper balance in the adult alcohol and drug treatment continuum.

II. Summary of Findings

1. There is enough demand in the criminal justice system to fill InterChange at 300 beds. In FY98-99 there were 42,300 bookings. ADAM samples (Alcohol and Drug Abuse Monitoring--a federally funded national monitoring program) show that 72% of inmates tested at booking were positive for drugs. ADAM staff estimate that approximately 85% of those who test positive are in need of treatment. ADAM monitoring does not test for alcohol, which shows an even stronger association with crime than drugs, especially violent crime.

   There are approximately 10,000 inmates under supervision by the Department of Community Justice at any one time--7,500 for a felony violation and 2,500 for misdemeanors. There are 5,200 to 6,300 new cases coming under supervision per year. A centralized assessment and referral system is being planned to better assess and coordinate the treatment needs of this population. Initial estimates are that 4,000-5,000 of these will need some form of treatment.

2. There is currently $19.1 million in alcohol and drug services for adults (which includes $131,300 for prevention) and an additional $3.5 million in A&D services for youth (which includes $117,466 for prevention). Adult treatment capacity is fully utilized in most community contracts and directly operated programs. There is little or no capacity in adult community contracts to absorb graduates from InterChange without displacing other clients.

3. Nearly all individuals who successfully complete InterChange are expected to require various levels of outpatient alcohol and drug treatment. About 50% of InterChange graduates are expected to also need alcohol and drug free housing. About 28% of Interchange graduates are expected to need mental health care to supplement a base level of outpatient alcohol and drug treatment.

4. Individuals who complete InterChange are not expected to require residential treatment. Since an estimated 50% of InterChange admissions would have gone into community residential treatment, there will be a net reduction in community residential treatment beds needed by this subgroup of offenders. Other offender groups, such as inmates leaving IJIP (In-Jail Intervention Program at Inverness Jail) and the current wait list of other clients for residential placements are expected to fill any freed up residential beds.

The increased cost of outpatient treatment, alcohol and free drug housing, and mental health continuing care for individuals who complete InterChange is shown in Table 1.

Table 1

Estimated Cost of InterChange at Different Bed Capacities	**70 Beds** Operating Cost ($105/day*)	**200 Beds** Estimated Operating Cost @ $105/day	**300 Beds** Estimated Operating Cost @ $105/day
InterChange Operations	**$2,681,909**	**$7,665,000**	**$11,497,500**
Outpatient	$76,416	$225,427	$338,141
A&D Free Housing Operational Cost	$80,300	$863,225	$1,455,438
A&D Free Housing Startup Costs	$200,000	$860,000	$1,450,000
Mental Health	$103,682	$305,862	$458,793
Continuing Care Subtotal	**$460,398**	**$2,254,514**	**$3,702,371**
TOTAL	**$3,142,307**	**$9,919,514**	**$15,199,872**

* Operating cost of InterChange at $105/ day ($2,681,909/70 beds/365 days/year) includes $80,000 for case management for persons who complete the program.

5. There is considerable evidence in national evaluation literature that continuing care is a critical component for jail based alcohol and drug treatment programs. Because of this evidence, the Work Team strongly recommends that Multnomah County not invest in secure alcohol and drug treatment unless appropriate continuing care is available for persons who complete those programs. A brief review of the literature supporting this conclusion is included in Appendix 2.

III. Recommendation

Based on the literature cited in Appendix 2, we recommend that the most cost-effective expansion of A&D treatment for offenders is to fund both the secure alcohol and drug treatment facility (InterChange) along with the continuing care needed for individuals who successfully complete the program. The work team does not take a position on whether or not to fund 200 versus 300 beds at InterChange; this is primarily a decision of how much funding is available and of fiscal priorities. However, it is clear that there are enough offenders to fill 300 beds at InterChange.

If there are not enough funds for both InterChange at 300 beds and its associated continuing care, it would be best to fund fewer InterChange beds and use the savings generated to fund the required continuing care.

IV. What Is Multnomah County Spending on Alcohol and Drug Treatment?

Multnomah County is spending $25.6 million during FY2000 for alcohol and drug treatment. There may be small amounts of additional funds in other departments, such as Aging and Disability Services, that are used for alcohol and drug services. For the purposes of this study the focus was on the three departments shown in Table 2.

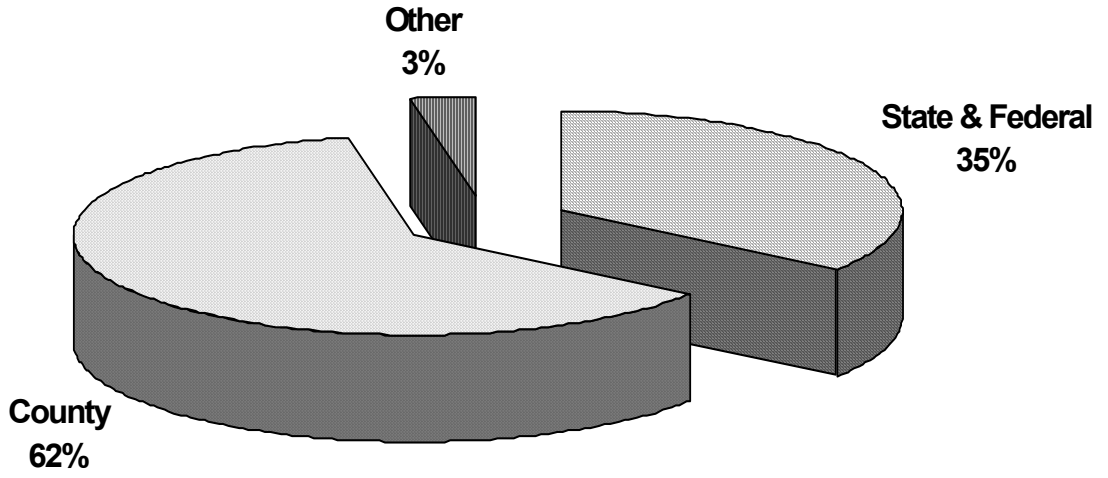
Table 2
Summary of Multnomah County FY2000 Alcohol and Drug Budget

Department	Youth Services	Adult Services	Administration/ Operations/ Information Systems/ Other	TOTAL
Community Justice	$154,424	$8,910,830	$613,673	$9,678,927
Community and Family Services	$3,387,592	$9,230,711	$2,382,225	$15,000,529
Sheriff's Office	0	$944,248	----------	$944,248
Total	$3,542,016	$19,085,789	$2,995,898	25,623,704

Additional detail showing how these funds are allocated between community contracts and directly operated programs is shown in Appendix 1.

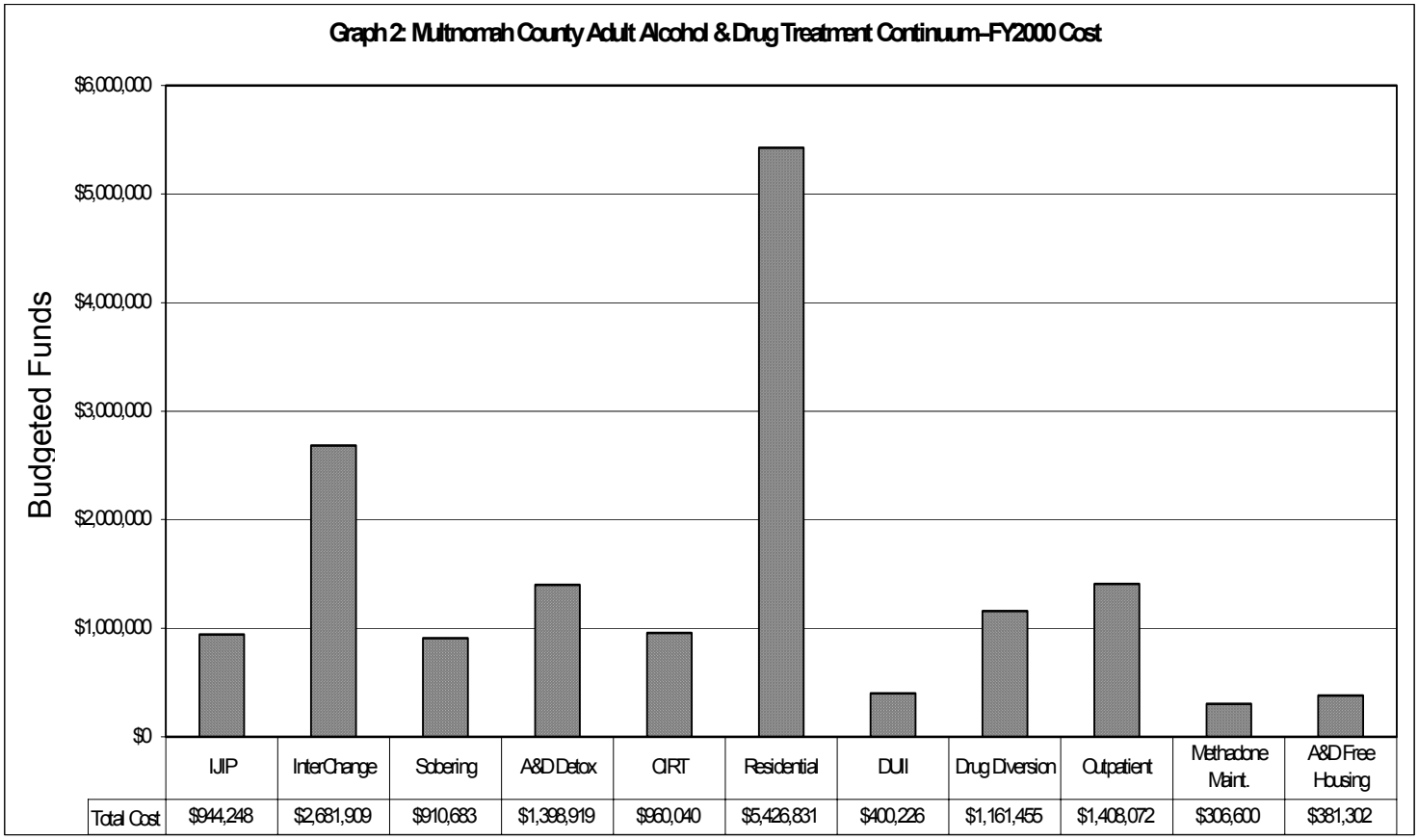
There is a common misconception that most of these funds are supplied from State and Federal sources. This is not true. Overall, the County contributes about $15.9 million in County funds--62% of the total. This is due in part to the high investment of County funds in the Department of Community Justice and the Sheriff's Office where County funds are 94% of the alcohol and drug budget. However, even in the Department of Community and Family Services, the County contributes 39% of the alcohol and drug budget.

Graph 1: Multnomah County FY2000 Alcohol and Drug Budget



V. What Does This Investment Buy?

The remainder of this report focuses on the $19.1 million available for adult services. Most of the treatment services provided by these funds, except for $1.8 million in centralized assessment and referral, and $131,300 in prevention activities are displayed in the Graph 2.



A few explanatory notes are in order.

1. IJIP is the In-Jail Intervention Program at Inverness Jail. It has operated since November 1994. IJIP was evaluated when it was located at the Multnomah County Detention Center and was shown to significantly increase the likelihood that inmates complete residential treatment upon their release from jail.

2. InterChange is the new 70-bed secure alcohol and drug treatment facility that opens in November 1999 at the Washington County jail.

3. The Sobering Station at Hooper is to provide a safe environment for inebriated clients who are no longer aware of person/place/time, or are somewhat combative, until they can be safely released--sometimes in a matter of hours. Clients are brought to the Sobering Station by law enforcement personnel (in lieu of being incarcerated) or by CHIERS. Sobering is not considered an entry point to treatment and recovery. Sobering is considered "public safety".

4. A&D Detox is detoxification services, primarily at Hooper Detox Center. It is considered an entry point to treatment and recovery. The length of stay (LOS) is 5-7 days. It is anticipated that the client will enter the most appropriate treatment (CIRT, Residential, or Outpatient) after detoxification.

5. CIRT is Community Intensive Residential Treatment. It combines residential care with intensive treatment. Average LOS (completers and non-completers) is 45 days for criminal justice referrals and 53 days for self or social services system referrals.

6. Residential treatment offers less extensive treatment than CIRT, therefore, it is cheaper to provide. More funds are spent on residential treatment than on any other treatment modality. It generally has a waiting list for entry. Average LOS is 50 days for criminal justice referrals and 46 days for self or social service system referrals.

7. DUII is treatment for offenders arrested for Driving Under the Influence of Intoxicants. It is an outpatient modality. Drivers are expected to pay for the first 40 hours of DUII treatment, so it is largely self supporting.

8. Drug Diversion is primarily provided by the STOP program at InAct--a community provider. This program has been evaluated and been shown to be cost-effective. Average LOS is more than a year for those who complete (394 days) and about 225 days overall.

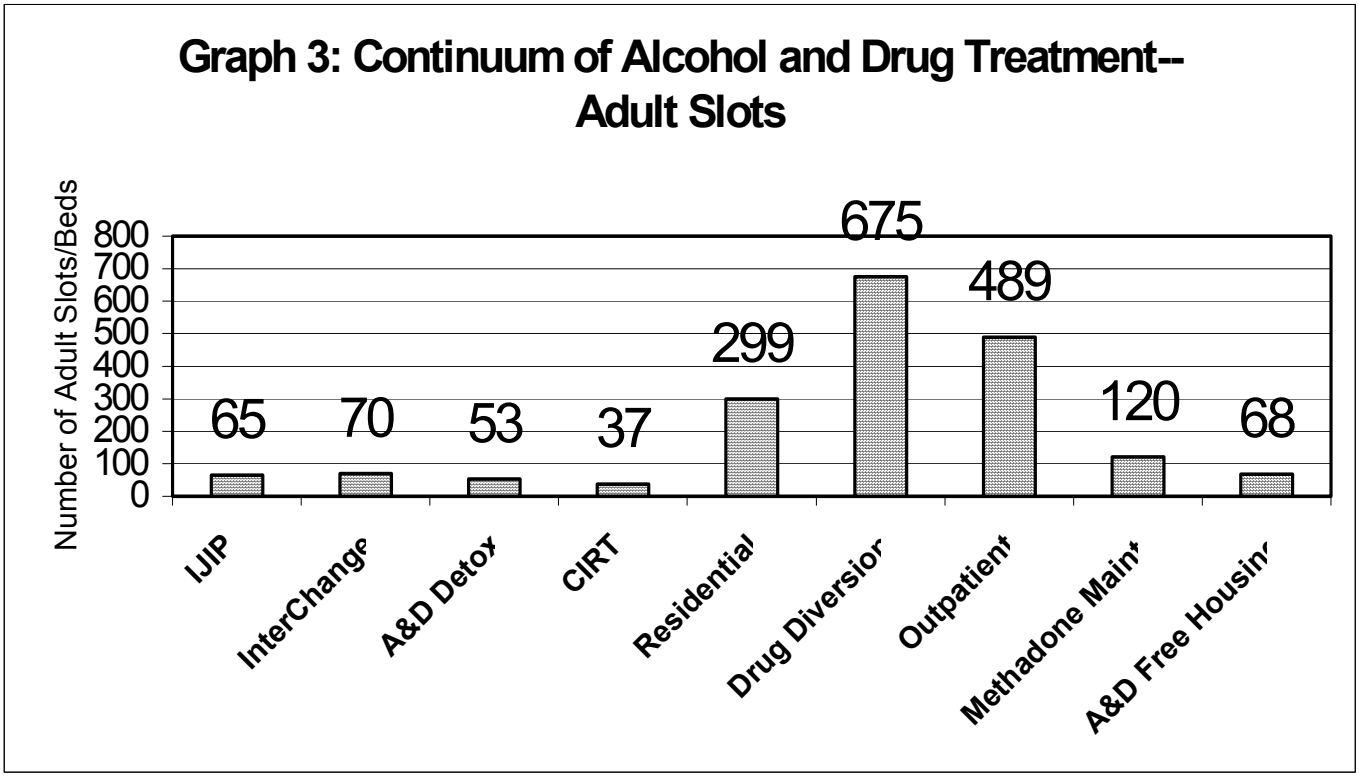
9. Outpatient treatment is actually used by more clients than any other treatment modality (See Graph 4--page 8). Less funds are spent on it because it is much cheaper to provide than residential treatment. As a general rule, it is more cost-effective for the County to provide outpatient treatment unless the client is unable to maintain sobriety without being in a residential placement. Average LOS is 103 days for criminal justice referrals and 76 days for self and social service system referrals. This includes a large number who choose to terminate early. The stay for those who complete averages 181 days.

10. Methadone maintenance is of importance due to the growth of opiate use in the community. Opiate abuse now exceeds alcohol abuse as the primary drug of clients entering detoxification. Very few of the referrals to methadone maintenance come through the criminal justice system; most enrollees are self referrals. Average LOS is 543 days.

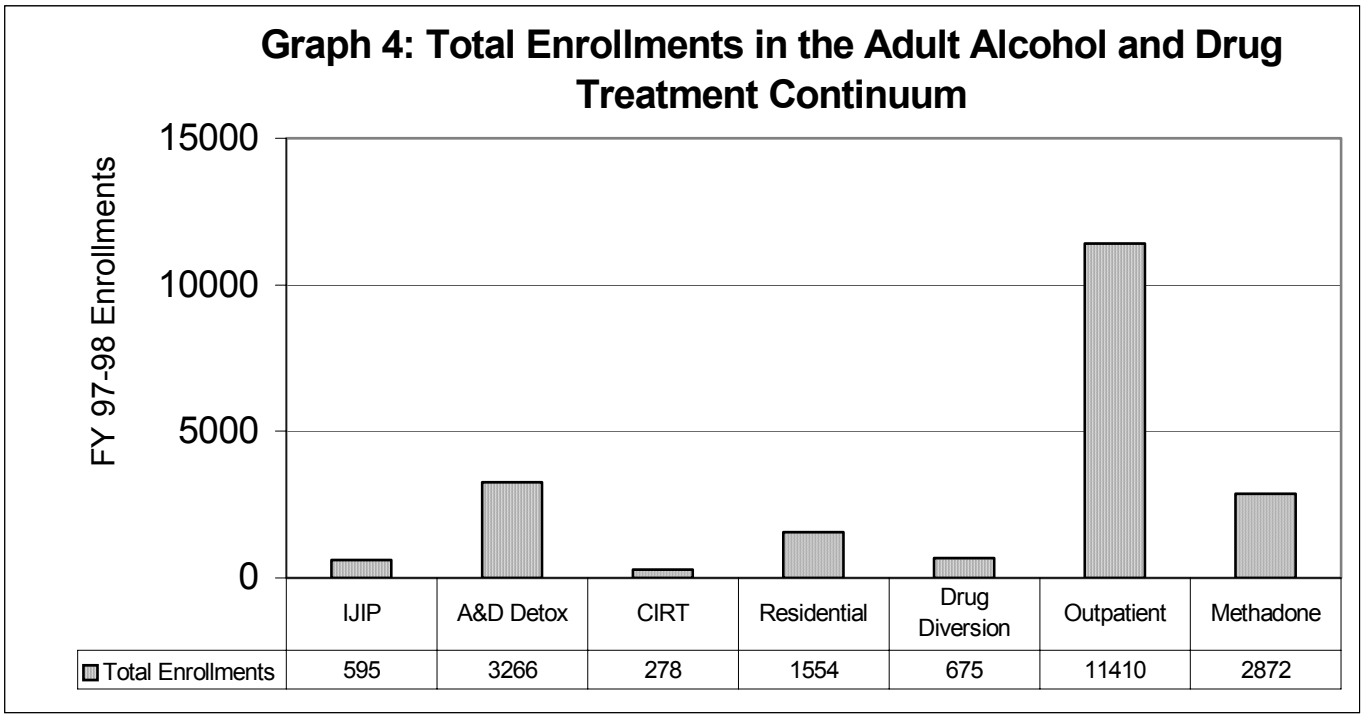
11. Alcohol and drug free housing is important to maintain sobriety in clients leaving residential treatment who do not have a stable housing arrangement. It is estimated that about 50% of clients who complete InterChange will require alcohol and drug free housing. Central City Concern provides 469

units of alcohol and drug free housing (permanent and transitional). The County provides primary support through contracts for 68 units.

Graph 3 shows the number of slots currently contracted for most of the treatment modalities. It should be remembered that these are the slots for which the county pays; community treatment providers have other slots paid for by other resources. For example, InAct--the provider of STOP drug diversion receives about 15% of its resources from client fees, 50% from Multnomah County, 15% directly from the State Office of Alcohol and Drug Abuse Programs (OADAP), and 20% from federal grants. It is also important to realize that the rates the County pays are offset to some extent by other funding sources available to providers. The exact amount of this "subsidy" to County rates could be calculated from provider financial reports to the County but was not ready at the time of the publication of this document.



Graph 4 shows the number of clients who enrolled in the adult treatment continuum during FY97-98; FY98-99 data is not currently available. The data is primarily from CPMS (Client Process Monitoring System), which is maintained by OADAP. The Volunteers of America (VOA) accepts no State dollars so their clients are not on CPMS. For the purposes of this study, VOA data has been added to the County CPMS files.

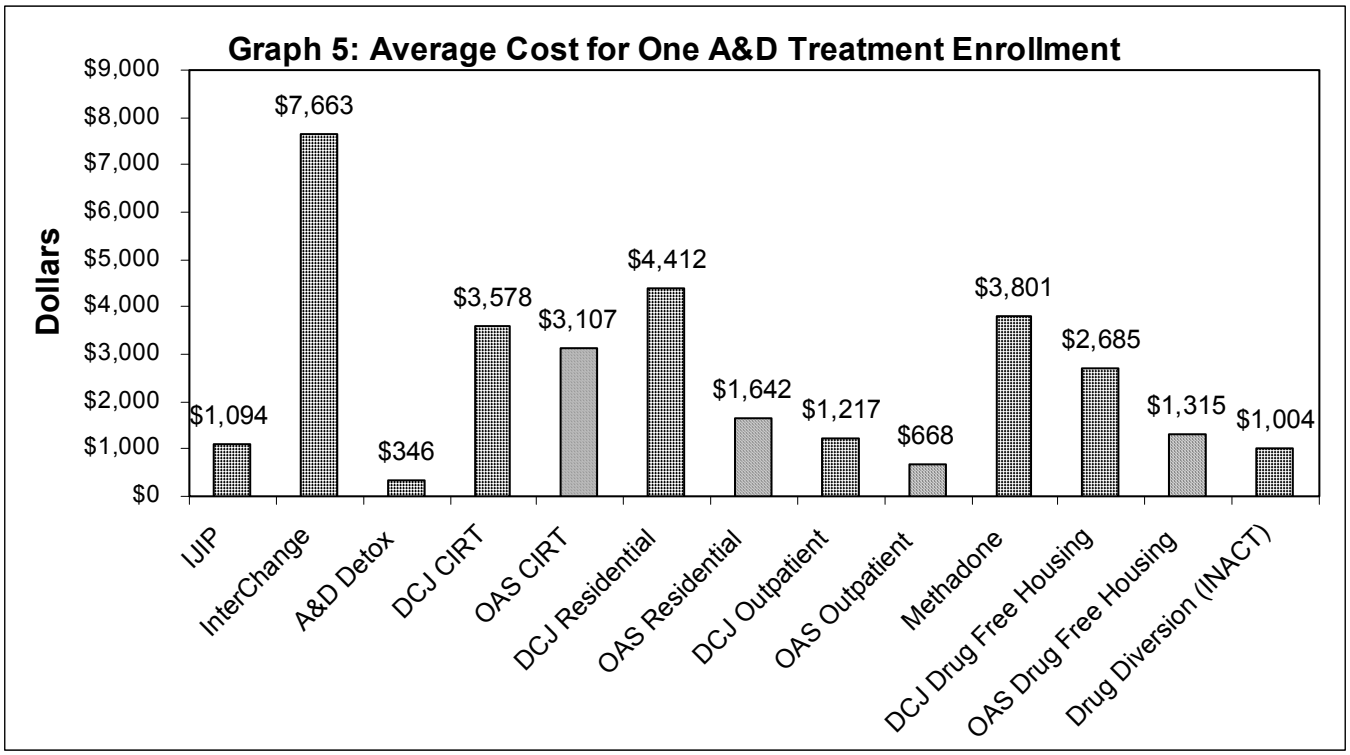


It is important to realize that the County does not pay for all of the clients shown in Graph 4. If a provider accepts any State (OADAP) money, they must enroll all their clients in CPMS.

Graph 4 assumes significance in relation to Graph 2--the display of where County dollars go. Despite the fact that most County dollars support residential care, a relatively small number of clients are served there. Despite their relatively low cost, detoxification, outpatient treatment, and methadone maintenance serve the largest number of clients.

This highlights the data shown on Graph 5--the cost of an enrollment. The cost of an enrollment is a function of two things--the daily rate and the average number of days that a client stays in that facility. It is clear from Graph 5 that InterChange will be the most expensive part of the treatment continuum in terms of cost per enrollment. The length of stay at InterChange is calculated at 73 days[1], which is an average of those expected to successfully complete and those not expected to successfully complete the program. Successful completers are expected to stay about 120 days; unsuccessful offenders will stay less. Not knowing in advance who will be successful, the average cost to send an offender to InterChange is $7,663. As with the other modalities, successful completers cost more while persons who drop out early cost less.

[1] 70 beds at InterChange X 365 days/year = 25,550 bed days/year divided by 350 expected enrollments per year.



Note: DCJ = Department of Community Justice Contracts. OAS = Office of Addictions Services, Department of Community and Family Services

Graph 5 also highlights the difference in rates paid by the Office of Addictions Services versus Department of Community Justice (DCJ). OAS rates are determined in large part by the State Office of Alcohol and Drug Abuse Programs (OADAP). As most of the DCJ money is from the County, rates can be set that are more realistic in terms of actual costs to providers and for the types of services that the County desires for a correctional population.

VI. The Impact of InterChange on the Community Treatment Continuum

The Board asked the A&D System Capacity Workteam to estimate the impact of the opening of InterChange on the above treatment continuum. To do so required a number of assumptions:

1. No one who completes InterChange will require community residential treatment. InterChange is the residential component. Half of the persons entering InterChange will be persons who would not have entered community residential treatment; their need for alcohol and drug treatment would not have been met. The continuing care that InterChange completers require will add to the number of persons being served in the community. The other half of the people entering InterChange would probably have been referred to community

residential treatment but will be referred to InterChange instead. By diverting these persons to InterChange there will actually be a net reduction in the number of persons trying to enter community residential treatment.

The Workteam did a survey of community residential treatment providers to see what proportion of their clients were currently involved with the criminal justice system. The results showed that 100% of the beds of Department of Community Justice residential providers were filled with criminal justice system clients. The surprise is that 56% of Office of Addictions Services (OAS) residential provider beds were also filled with criminal justice clients. Overall, 73.6% of all community residential beds were filled with criminal justice clients. It is clear that the Board has a valid concern with criminal justice clients displacing other types of clients from community residential treatment.

Initial calculations by OAS are that the existing waiting list for community residential care may be greatly reduced or eliminated once InterChange opens. If this holds true, then the opening of InterChange will have a positive impact on the community residential system.

2. All persons who successfully complete InterChange will require continuing care coordination and alcohol and drug outpatient treatment. The InterChange program has an $80,000 contract to pay for some of this care coordination. The Department of Community Justice Day Reporting Center and probation/parole officers can provide some additional supervision and services coordination. It is expected that the Oregon Health Plan (OHP) and/or fees paid by clients will pay for a base level of outpatient alcohol and drug treatment for the 76% of InterChange completers who are expected to be OHP eligible. Additional County funds need to be provided for the 24% of InterChange completers who are not OHP eligible. An additional outpatient treatment/care coordination allowance is needed for the 28% of InterChange completers who are expected to have serious mental health problems. The 28% figure is based on the profile of offenders applying to the IJIP program.

3. The major impact of InterChange upon the community treatment system will be from the estimated 50% of clients who need transitional alcohol and drug free housing. The Department of Community Justice has an advisory committee of alcohol and drug providers who reviewed this and other assumptions made in calculated the impact of InterChange. The providers estimated that up to 80% of InterChange completers would require alcohol and drug free housing, however, it is not at all clear what percentage of InterChange completers would accept the restrictions associated with such housing; 50% is a conservative estimate of need for alcohol and drug free housing.

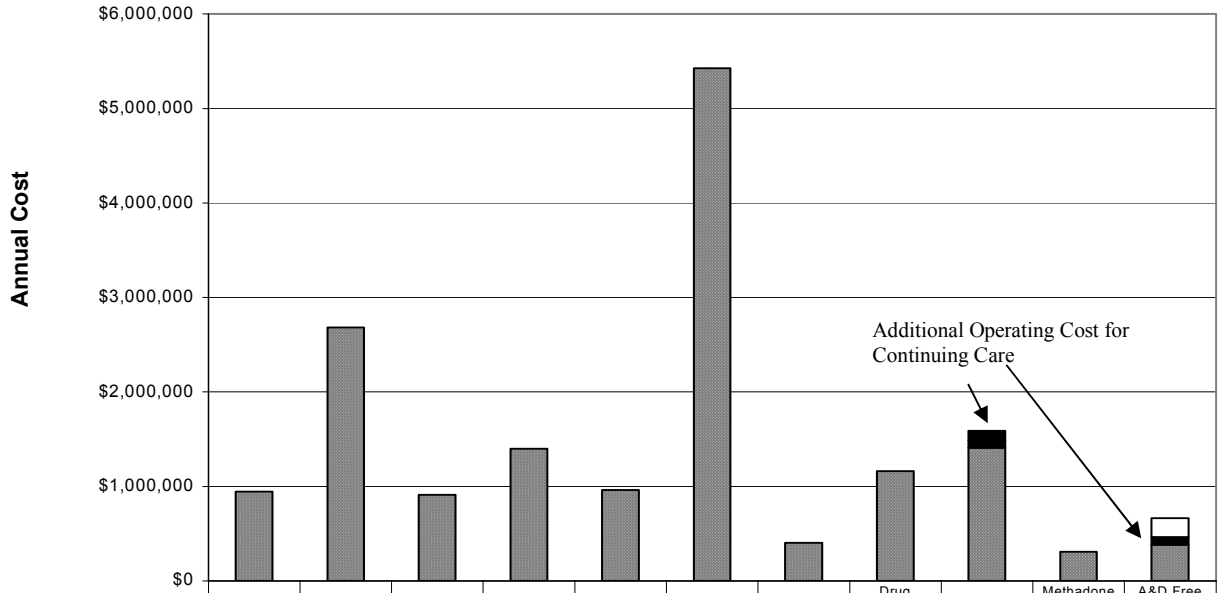
Appendix 3 shows the detail of how these assumptions were used to calculate the figures shown in Table 1 (page 3 of this report). Despite the Board's desire for a data-based decision, it is clear that a long trail of assumptions is needed to estimate the impact of InterChange. There was considerable disagreement within the Workteam and between the Workteam and alcohol and drug providers over what level of continuing care might be needed by InterChange completers. National research shows that such continuing care is critical, but does not say exactly what that level of care should be.

The Workteam can demonstrate that there are continuing care needs for InterChange completers that are not part of the current budget. Failure to provide for these needs most likely means that the investment in InterChange--the most expensive treatment modality in the adult alcohol and drug treatment continuum--might be wasted on many offenders. It is also clear that future expansions of InterChange at the Rivergate site will require a substantial investment in continuing care.

The estimates for the cost of continuing care given in this report should be considered a placeholder. They are sufficient to allow the Board to decide if it is feasible within the proposed public safety levy limit to fund InterChange, and its required continuing care. By the time the actual levy is constructed in early 2000, graduates will be leaving InterChange. At that time there will be firmer data on the percentage of completers who need mental health care and alcohol and drug free housing. There will be sufficient time to explore various transition housing models and their costs. Based on this work, the estimates of InterChange continuing care costs can and should be adjusted.

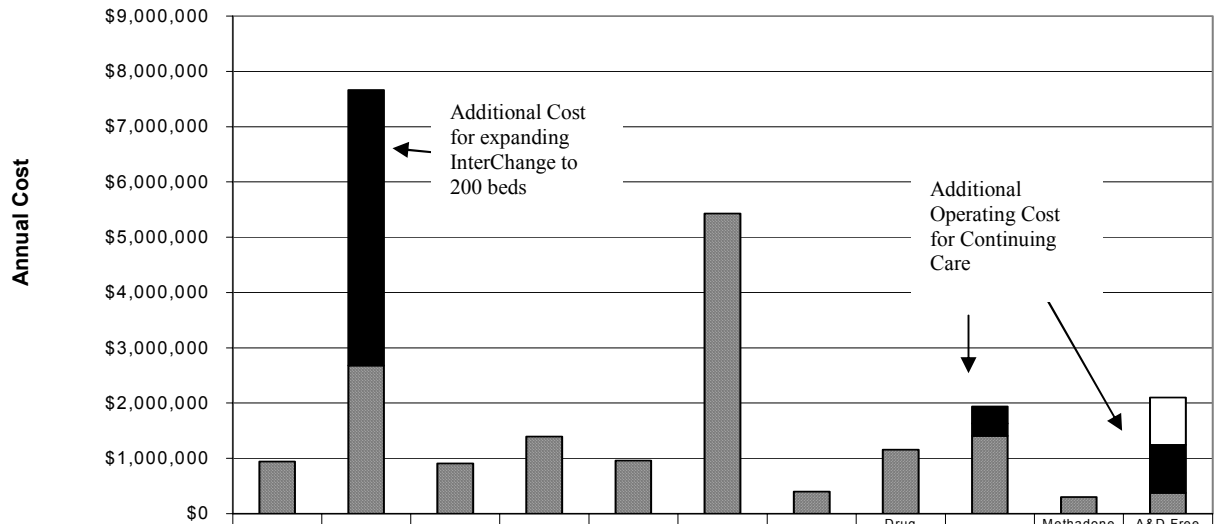
The following graphs demonstrate the impact of InterChange at 70, 200, and 300 beds given current assumptions. All costs are annual operational costs, with the exception of the white layer on alcohol and drug free housing that shows first year start up costs. The graphs demonstrate that as InterChange is scaled up from 70 to 200 and 300 beds that the **most** significant impact on the adult treatment continuum is not via increased continuing care needs but in shifting the balance in the continuum from an array of services to heavier reliance on secure alcohol and drug treatment--the most expensive cost per enrollment modality in the treatment system.

Graph 6: Impact of InterChange at 70-Beds on the Adult Community Treatment Continuum



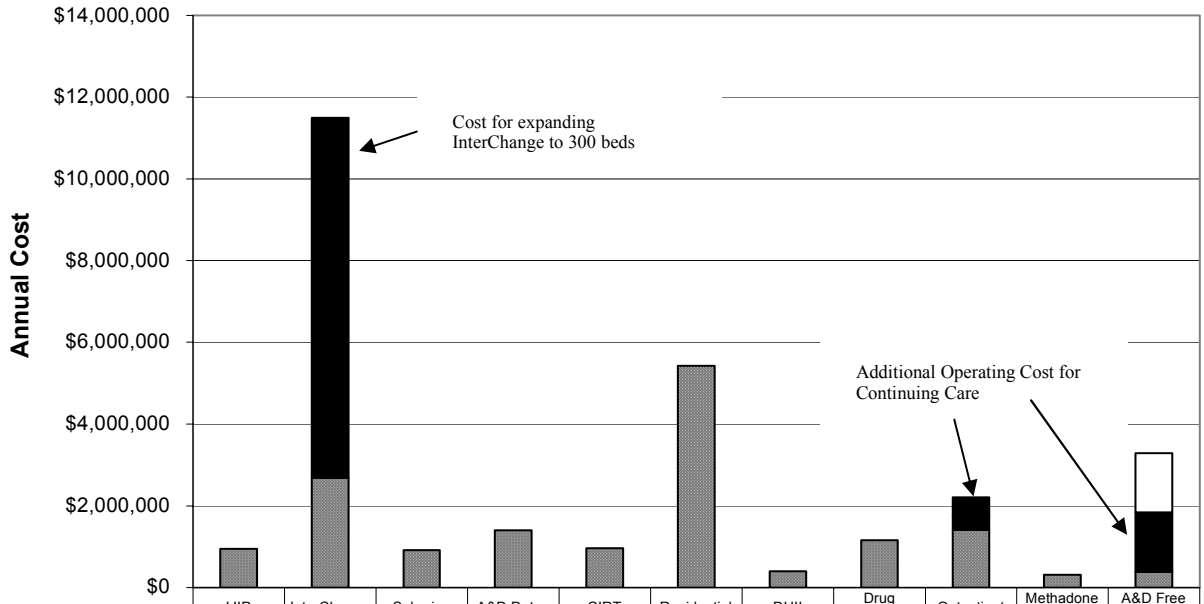
	IJIP	InterChange	Sobering	A&D Detox	CIRT	Residential	DUII	Drug Diversion	Outpatient	Methadone Maint.	A&D Free Housing
Housing Start-up											$200,000
InterChange A&D Free Housing Operations											$80,300
InterChange Mental Health Outpatient Supplement									$103,682		
InterChange non-Medicaid Outpatient									$76,416		
FY2000 Base Cost	$944,248	$2,681,909	$910,683	$1,398,919	$960,040	$5,426,831	$400,226	$1,161,455	$1,408,072	$306,600	$381,302

Graph 7: Impact of InterChange at 200-Beds on the Adult Community Treatment Continuum



	IJIP	InterChange	Sobering	A&D Detox	CIRT	Residential	DUII	Drug Diversion	Outpatient	Methadone Maint.	A&D Free Housing
InterChange Additional Cost for 200 Beds		$4,983,091									
Housing Start-up											$860,000
InterChange A&D Free Housing Operations											$863,225
InterChange Mental Health Outpatient Supplement									$305,862		
InterChange non-Medicaid Outpatient									$225,427		
FY2000 Base Cost	$944,248	$2,681,909	$910,683	$1,398,919	$960,040	$5,426,831	$400,226	$1,161,455	$1,408,072	$306,600	$381,302

Graph 8: Impact of InterChange at 300 Beds on the Adult Community Treatment Continuum

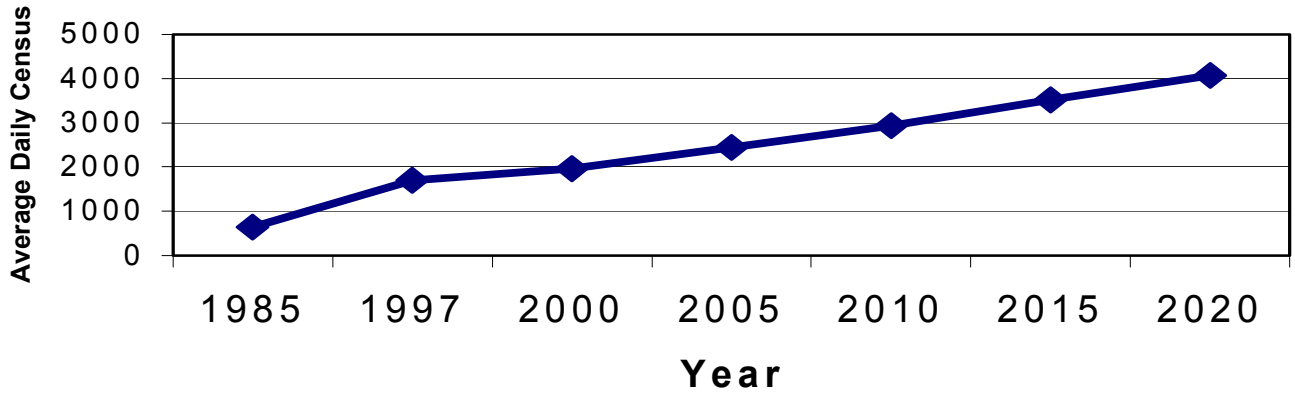


	IJIP	InterChange	Sobering	A&D Detox	CIRT	Residential	DUII	Drug Diversion	Outpatient	Methadone Maint.	A&D Free Housing
InterChange Additional Cost for 200 Beds		$8,815,591									
Housing Start-up											$1,450,000
InterChange A&D Free Housing Operations											$1,455,438
InterChange Mental Health Outpatient Supplement									$458,793		
InterChange non-Medicaid Outpatient									$338,141		
FY2000 Base Cost	$944,248	$2,681,909	$910,683	$1,398,919	$960,040	$5,426,831	$400,226	$1,161,455	$1,408,072	$306,600	$381,302

VII. Is Heavy Investment in InterChange a Good Idea?

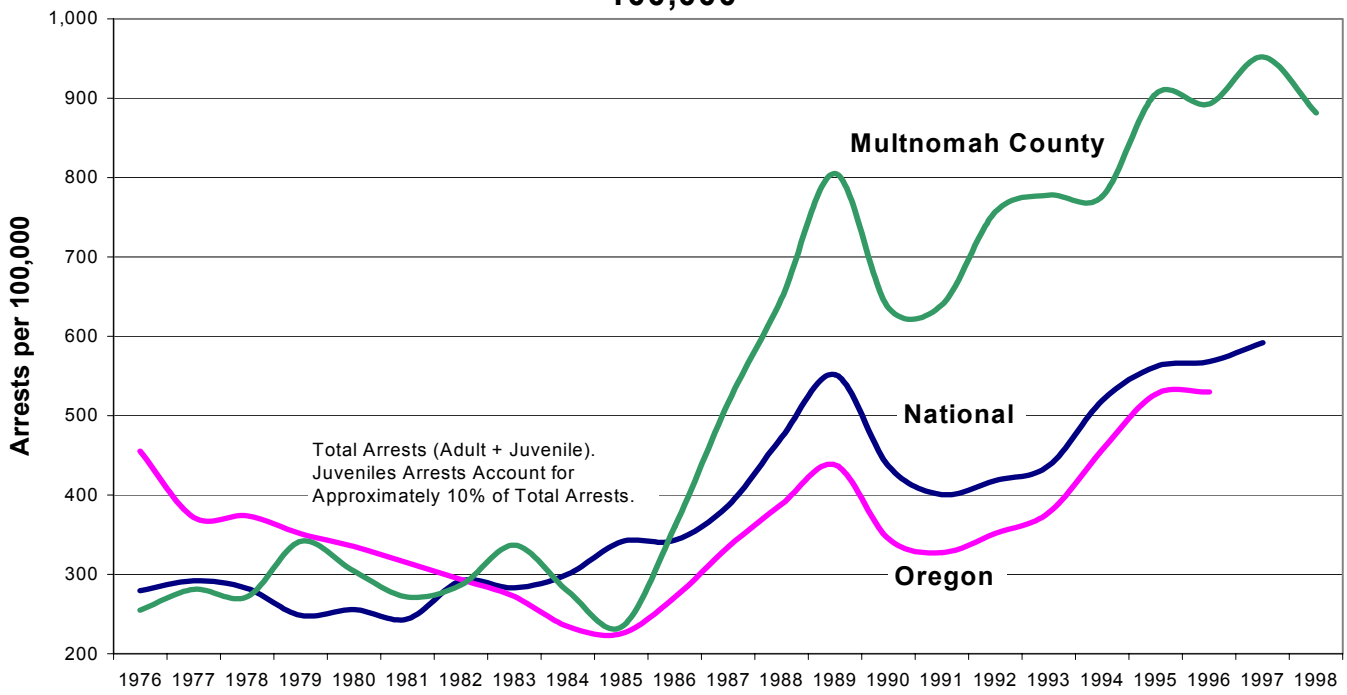
The daily cost of care at InterChange--$105 per day--is about the same as the cost of keeping an inmate in jail for a day. Graph 9 shows the current projection of jail space needs by the Multnomah County Sheriff's Office.

Graph 9: Actual and Projected Jail Beds Multnomah County Sheriff's Office



Although there are risks in extending any trend line into the future, it is probable that in the short run there will be a need for the additional beds at the Rivergate site--either as jail beds or as InterChange treatment beds. Although the headlines are full of declining crime rates, this is of serious "index crimes". Primary drug arrests in Multnomah County remain at high levels, as shown in Graph 10.

Graph 10: National, State, & Local Primary Drug Arrests per 100,000



Primary drug arrests refers to the most serious charge for which an offender is charged. Arrests are standardized per 100,000 persons.
Source: LEDS & Uniform Crime Report

The InterChange program offers an opportunity to spend the same amount of money that the County will probably spend anyway, at about the same daily rate, in a way that has been demonstrated in national research to reduce future recidivism. Whether the impact on recidivism will be enough to forestall future growth in local jail bed needs remains to be seen. It is clear that the cost-effectiveness of the InterChange program needs to be followed closely.

Despite the obvious need for alcohol and drug treatment in the offender population, the question remains whether the large potential investment in InterChange is balanced in relation to the rest of the adult alcohol and drug treatment continuum. National research clearly demonstrates that secure alcohol and drug treatment is compromised unless adequate continuing care is available. Graphs 6, 7, and 8 demonstrate clearly that relative to the investment in InterChange, the investment in continuing care is small. Whether the estimated investment in continuing care is

adequate to maintain the treatment gains at InterChange needs to be tracked by several years of local evaluation.

It will take several years to construct the Rivergate facility. By the time the Rivergate facility is open, its beds will be needed--as jail beds or as secure alcohol and drug treatment beds. By then we will have a better idea of whether our estimates for continuing care are adequate. If they are not, the levy should be constructed with enough flexibility to allow a shift from operating 300 InterChange beds to 200 beds with adequate continuing care.

Appendix 1

Additional Detail of Multnomah County FY2000 Alcohol and Drug Budget

Depart-ment	Community Contracts	Directly Operated Programs	Miscel-laneous	Administration, Operations, Info Systems, Personnel, Materials and Supplies, etc.	TOTAL
DCJ	$6,228,921--adults $154,424--youth	$2,681,909 (InterChange)		$613,673	$9,678,927
DCFS-adults	*$7,350,470* *(excludes $803,477 for gambling treatment)*	*$1,880,241* *(Central Intake; DUII assessment & tracking)*			*$9,230,711*
DCFS-youth	*$1,845,840*	*$1,541,752* *(Touchstone)*			*$3,387,592*
DCFS--Total	$9,196,310	$3,421,993	$379,137 (Regional Drug Initiative)	$2,003,088	$15,000,529 excludes $803,477 for gambling treatment
MCSO		$944,248 (IJIP)			$944,248
TOTAL	**$15,579,655**	**$7,048,150**	**$379,137**	**$2,616,761**	**$25,623,703**
Percent of Total	**61%**	**28%**	**1%**	**10%**	**100%**

For Community Justice, the amount available is taken directly from program pages in the printed budget with a small addition for youth contracts that are not shown separately in the budget. For the Sheriff's Office, the total shown here comes directly from the budget. For both of the above departments, reconciliation to the budget is an easy task.

The Department of Community and Family Services (DCFS) presents more of a challenge as it receives a considerable number of dollars in state funds for both mental health and addictions treatment, including administration funds. Not all of these state funds show clearly under mental health or alcohol and drug programs in the DCFS budget. Approximately $2.0 million of state funds are shown under administration in other parts of the DCFS budget. In order to fully account for state funds made available to the County the administrative dollars must be counted. The total funding shown for alcohol and drug treatment in this report includes an allocated portion of state administrative funds that have been allocated to alcohol and drug.

Appendix 2

A BRIEF REIVEW OF SECURE ALCOHOL AND DRUG TREATMENT EVALUATION FINDINGS

Effectiveness of Aftercare

Community-based drug treatment after release from a secure alcohol and drug treatment program reduces rearrest rates. This finding holds true for male and females adult inmates as well as incarcerated juveniles.

- In an outcome evaluation of a jail-based drug treatment program in Cook County, Illinois, male respondents who were *not* placed in a community drug treatment program following release from jail were *twice as likely to be rearrested* compared to those program participants who did enter such a program (Swartz and Lurigio 1999; Swartz, Lurigio, and Slomka 1996).

- Juveniles who complete a community drug treatment program following secure alcohol and drug treatment have fewer arrests and fewer felony arrests than juveniles who did not receive these services (Altschuler, Armstrong, and MacKenzie 1999; Sontheimer and Goodstein 1993).

- Researchers evaluating the Amity Program in the Pima County, Arizona, jail found that women completing aftercare following the program had rearrest rates *twenty-one percent lower* than women who did not receive community aftercare services. Programs in Delaware and California found even greater reductions among aftercare completers of 23 percent and 26 percent, respectively (Office of National Drug Control Policy 1996).

Reductions in recidivism are maximized by combining 90 to 150 days of jail-based drug treatment with community drug treatment upon release from jail.

- Half of the offender clients who participated in the aforementioned Cook County program for thirty days or less had been rearrested within *four months* of their release from jail.

- In contrast, half of the offender clients who had participated in that same jail-based program for 90 to 150 days followed by community drug treatment had been rearrested approximately *20 months* after release - a difference of 1.5 years between the two groups (Swartz and Lurigio 1999; Swartz, Lurigio, and Slomka 1996).

- While there is growing consensus that community aftercare enhances the positive effects of jail-based drug treatment (Inciardi 1996; Lipton 1996) the

recommended length of stay in aftercare varies from six months (Lipton 1998) to eighteen months (Inciardi, Martin, Butzin, Hooper, and Harrison 1997).

Continuity of programming goals and activities between jail-based drug treatment and community-based drug treatment is critical to participants' aftercare completion.

- Evidence suggests that the more favorably inmates view the secure alcohol and drug program and the greater the similarity between the goals and activities of the community-based aftercare program and the secure program, the higher the completion rate of aftercare upon release from jail (Lipton 1998).

The Cost-Effectiveness of Aftercare

- Aftercare services can reduce the cost of incarcerating an individual by reducing the likelihood of rearrest and subsequent reincarceration (Swartz and Lurigio 1999; Office of National Drug Control Policy 1996; Swartz, Lurigio, and Slomka 1996).
- For example, a 1992 study found that the cost of treating 150,000 drug users in California was $209 million. Approximately $1.5 billion was saved while these same individuals were in treatment and *in the first year after their treatment.* Most of these savings were from reductions for the incarceration of drug-related crimes (CALDATA 1994).
- Furthermore, aftercare services can reduce the cost of long-term drug-related health illnesses by reducing the frequency and intensity of drug use by an individual over the course of his or her lifetime (CALDATA 1994; Langenbucher 1994).

What exactly constitutes aftercare?

- Aftercare itself constitutes a blend of surveillance and treatment services. The typical aftercare package includes drug and alcohol testing (e.g., urinalysis), maintaining contact with a parole/probation officer, and continued participation in drug treatment (Altschuler, Armstrong, and MacKenzie 1999.) Drug treatment can take place in either residential or outpatient settings, depending on the discretion of the judge and/or the inmate's plea at the time of sentencing (e.g., agreeing to community treatment for a lesser sentence.) There is not consensus in the literature at this time as to the specific types of aftercare needed by various types of offenders.

References:

Altschuler, David M., Troy L. Armstrong, and Doris Layton MacKenzie. "Reintegration, Supervised Release, and Intensive Aftercare." Office of Juvenile Justice and Delinquency Prevention. *Juvenile Justice Bulletin,* July 1999.

CALDATA. 1994. *Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment.* July.

Inciardi, James A. 1996. "A Corrections-Based Continuum of Effective Drug Abuse Treatment." *National Institute of Justice Research Preview.* June.

Inciardi, J.A., S.S. Martin, C.F. Butzin, R.M. Hooper, and L.D. Harrison. 1997. "An effective model of prison-based treatment for drug-involved offenders." *Journal of Drug Issues* 27(2):261-278.

Langenbucher, James. 1994. "Offsets are not Add-Ons: The Place of Addictions Treatment in Health Care Reform." *Journal of Substance Abuse* 6:117-122.

Lipton, Douglas S. 1996. "Prison-Based Therapeutic Communities: Their Success with Drug-Abusing Offenders." *National Institute of Justice Journal.* February.

_____. 1998. "Principles of Correctional Therapeutic Community Treatment Programming for Drug Abusers." Paper presented at the ONDCP Consensus Meeting on Treatment in the Criminal Justice System. New York, New York.

Office of National Drug Control Policy. 1996. *National Drug Control Strategy: Strengthening Communities Response to Drugs and Crime.* Washington, D.C.: United States Government Printing Office. [see also http://www.ncjrs.org]

Sontheimer, H., and Goodstein, L. 1993. "Evaluation of juvenile intensive aftercare probation: Aftercare versus system response effects." *Justice Quarterly* 10(2):197-227.

Swartz, James A., Arthur J. Lurigio, and Scott A. Slomka. 1996. "The Impact of IMPACT: An Assessment of the Effectiveness of a Jail-Based Treatment Program." *Crime & Delinquency* 42(4):553-573.

Swartz, James A. and Arthur J. Lurigio. 1999. "Final Thoughts on IMPACT: A Federally Funded, Jail-Based, Drug-User Treatment Program." *Substance Use & Misuse,* 34(6):887-906.

Appendix 3:
Estimated Impact of InterChange Upon Multnomah County Alcohol and Drug Treatment Continuum

What % of IC Completers do you think will need mental health continuing care? **28%** (enter a whole number)
What % of IC Completers do you think will need A&D housing for 6 months? **50%** (enter a whole number)
The InterChange Calculator has now estimated the cost of continuing care.

	InterChange Bed Capacity		
InterChange	***70***	***200***	***300***
Intake	350	985	1480
Completions	200	590	885
Assume that approximately 60% of referrals will successfully complete.			
Post InterChange Treatment Need Assumptions			
1) Among persons requesting admission to IJIP, 28% have a major mental health problem. Provider input is that InterChange should estimate a higher percentage.			
2) Seventy-six percent of non-DUII and non-Drug Court Criminal Justice Clients are eligible for the Oregon Health Plan (OHP), based on their reported income. (CPMS data)			
3) Assume that 1/2 of IC enrollments would have gone to community treatment before InterChange.			
4) Assume that 1/2 of IC enrollments are new persons being served and will add to community treatment need.			
The Impact of InterChange (IC) on the Community Treatment Continuum			
Impact of IC on Community Residential Treatment	**-175**	**-493**	**-740**
Reduced enrollments in community residential TX due to use of IC instead of community residential.			
Assume 1/2 of IC enrollments would have gone to community residential but will use IC instead.			
Assume no savings. Reduced IC need will be offset by IJIP completers and residential wait list.			
Outpatient A&D treatment needs for IC completers:			
All IC completers will need outpatient treatment that includes case management.			
Case management is not part of currently funded outpatient A&D treatment			
Case management for IC completers will **in part** be provided by DCJ's Day Reporting Center. and $80,000 for case management/transition services in the IC budget.			
Assume that the OHP will pay for outpatient treatment A&D treatment for 76% of IC completers.			
Add an allowance for the 24% of IC completers who are non-Medicaid eligible.			
Outpatient Allowance for Non-Medicaid eligible completers:			
Number of non-Medicaid eligible completers:	48	142	212
Number of non-Medicaid outpatient slots:	24	71	106
Cost of non-Medicaid outpatient slots: $3,184/slot/yr	**$76,416**	**$225,427**	**$338,141**
A&D Free/Transitional Housing enrollments by IC completers			
Housing is in scarce supply. All IC completers need new slots			
Estimate that __% of completers will need A&D free/transitional housing for average of 1/2 year each			
#completersX % needing housing/ 2 completers/year/slot = # slots needed			
MCRC Transition Beds Available	40	40	40
A&D Free Housing	10	107.5	181.25
Total Slots	50	147.5	221.25
A&D Free Housing Cost			
at $22/day X 30 beds X 365 days/year	**$80,300**	**$863,225**	**$1,455,438**
Cost of A/D Transition Housing Startup	**$200,000**	**$860,000**	**$1,450,000**
Mental Health slots needed by IC completers			
Estimated at __% of completers			
# OHP Covered clients @ 76% are eligible	43	126	188
#Non-OHP covered @ 24%	13.44	40	59
# completers requiring mental health care	56	165.2	248
Cost of MH enhancement to outpatient services*			
OHP estimated @$100/month	**$55,271**	**$163,051**	**$244,576**
Non-OHP estimated @ 300/month	**$48,411**	**$142,811**	**$214,217**
TOTAL $ IMPACT ON COMMUNITY TREATMENT	**$460,398**	**$2,254,514**	**$3,702,371**

***Mental Health formula for cost figures:**
Current MH cost is $393/month, of which 200 is covered by OHP; $193 by DCJ.
The acuity of InterChange completers will be less, so $300 per month is a reasonable rate.
Use $300 per month for non-OHP covered; $100/month DCJ cost for OHP covered ($200 OHP + $100 DCJ)
Formula = # needing care X # slots needed X monthly cost X number of months per slot
Revision 1 extends the length of outpatient treatment from 180 days post discharge to 245 days