

STATE OF COLORADO



Colorado Department of Human Services

people who help people

OFFICE OF BEHAVIORAL HEALTH AND HOUSING

Deborah L. Trout, Ph.D., Director

Ken Cole, Deputy Director

ALCOHOL AND DRUG ABUSE DIVISION

4055 S. Lowell Boulevard

Denver, Colorado 80236

Phone 303-866-7480

TDD 303-866-7479

FAX 303-866-7481

www.cdhs.state.co.us

Janet Wood

Director



Bill Owens

Governor

Marva Livingston Hammons

Executive Director

THE COSTS AND EFFECTIVENESS OF ALCOHOL AND DRUG ABUSE PROGRAMS IN THE STATE OF COLORADO

**REPORT TO
THE GENERAL ASSEMBLY
HOUSE AND SENATE COMMITTEES
ON HEALTH AND HUMAN SERVICES**

**Submitted by
The Alcohol and Drug Abuse Division
Colorado Department of Human Services**

October 31, 2005

Table of Contents

	Page
1. Executive Summary.....	3
2. Introduction.....	4
3. Overview of the Alcohol and Drug Abuse Division.....	4
Mission Statement.....	4
Services: Treatment and Prevention.....	4
Presentations.....	6
State Statutory Authority.....	6
Staffing.....	6
4. The Growing Problem: Alcohol and Substance Abuse in Colorado.....	6
Colorado Statistics.....	6
Colorado Youth In Crisis.....	7
National Reports on Youth Substance Abuse.....	8
Colorado/US Comparison.....	9
Comparison of Colorado with Other Frontier States.....	11
What this Problem Costs.....	11
5. Client Demographics.....	13
Overview.....	13
Demographic Summary.....	13
Generational Drug Habits.....	14
Demographics.....	14
6. Service Utilization.....	17
7. Barriers to Treatment.....	18
8. Benefits of Substance Abuse Treatment and Prevention.....	19
9. Prevention and Treatment Outcomes.....	21
Prevention Outcomes, FY05.....	21
Treatment Outcomes, FY05, Admission to Discharge Change.....	22
Factors Relating to Achievement of Treatment Goals.....	23
10. Service Costs.....	24
Treatment Cost Per Client.....	24
11. Resources.....	25
Revenue and Expenses.....	25
Collaborations.....	27
Tracking Civil Forfeiture (SB 03-133).....	28
12. Treatment and Service Gaps.....	29
13. Special Reports.....	30
Methamphetamine in Colorado.....	30
Pregnant Women in Substance Abuse Treatment.....	31
Native Americans in Substance Abuse Treatment.....	32
Clients with Mental Health Issues in Substance Abuse Treatment.....	34
Recovery – Stories from the Front.....	35
Support for Katrina Victims.....	42
14. Research and Special Projects.....	42

	Prevention.....	42
	Treatment	44
15.	Strengthening the Operation/Plans for the Future.....	47
16.	Recommended Legislation in the Field of Alcohol and Drug Abuse	48
17.	Division Contacts.....	50
18.	Appendix A: Detailed Tables and Graphs of Client Demographics.....	51
19.	Appendix B: Service Utilization.....	55
20.	Appendix C: Barriers to Treatment.....	58
21.	Appendix D: Prevention and Treatment Outcomes.....	59
22.	Appendix E: Factors Related to Achievement of Treatment Goals.....	63
23.	Appendix F: Methamphetamine in Colorado	64
24.	Appendix G: Co-occurring Clients	71
25.	Endnotes.....	76

The Costs and Effectiveness of Alcohol and Drug Abuse Programs in Colorado, FY05

1. EXECUTIVE SUMMARY

- Substance abuse in the State of Colorado is a significant health, social, public safety and economic problem. Prevention and treatment are crucial public safety measures.
- Substance abuse continues to be a problem in Colorado, although rates of use have declined since 1979 because of prevention, treatment and enforcement.
- Prevention and treatment are effective in reducing the amount of substance abuse in Colorado. Substance abuse is a preventable behavior and addiction is a treatable disease.
- It is more economical to prevent or treat a substance abuse problem than to deal with its impact on the individual or society.
- Resources to provide substance abuse prevention and treatment are limited; the problem far outpaces the resources.
- Incarceration is an ineffective and costly way to control drugs.
- Treatment not only saves lives, it saves money.
- During FY05, treatment resulted in a 19 percentage point increase from admission to discharge in abstinence from substance use.

2. INTRODUCTION

The Alcohol and Drug Abuse Division (ADAD) submits this report to the General Assembly House and Senate Committees on Health and Human Services in compliance with:

A) Colorado Revised Statutes 25-1-210 as amended by House Bill 00-1297

“25-1-210. Reports. The division shall submit a report not later than November 1 of each year to the house and senate committees on health, environment, welfare, and institutions on the costs and effectiveness of alcohol and drug abuse programs in this state and on recommended legislation in the field of alcohol and drug abuse.”

B) Colorado Revised Statute 16-13-311 (a) (VII) (B) from SB 03-133

“The remaining amount (50% of the post-fee portion from sale of forfeited property) to the managed service organization contracting with the department of human services, alcohol and drug abuse division serving the judicial district where the forfeiture proceeding was prosecuted to fund detoxification and substance abuse treatment. Money appropriated to the managed service organization shall be in addition to, and shall not be used to supplant, other funding appropriated to the department of human services, alcohol and drug abuse division.

The alcohol and drug abuse division in the department of human services shall prepare an annual accounting report of moneys received by the managed service organization pursuant to section 16-13-311 (3) (a) (VII) (B), including revenues, expenditures, beginning and ending balances, and services provided. The alcohol and drug abuse division shall provide this information in its annual report pursuant to section 25-1-210, C.R.S.”

3. OVERVIEW OF THE ALCOHOL AND DRUG ABUSE DIVISION

ADAD, a statutorily designated division within the Department of Human Services, is composed of administrative, fiscal, treatment, prevention and data sections that arrange for, monitor, support and report on substance abuse prevention and treatment services statewide.

Mission Statement

The mission of ADAD is to develop, support and advocate for comprehensive services to reduce substance use disorders and to promote healthy individuals, families and communities.

Services

The Division’s Treatment-Quality Improvement and Prevention Sections support the mission by carrying out the following responsibilities.

Treatment

- Monitors Federal Block Grant-funded contracts with 4 managed service organizations (MSOs) that subcontract with 37 treatment providers with 193 sites in 6 geographical areas of Colorado for alcohol and other drug treatment services with emphasis on the following population of substance abusers:
 1. Involuntarily committed individuals
 2. Pregnant women who inject drugs
 3. All other pregnant women who use substances
 4. All others who inject drugs
 5. Women with dependent children
 6. Drug-dependent persons at risk for HIV
 7. Drug-dependent persons at risk for Tuberculosis
 8. Recipients of Aid to the Needy and Disabled
 9. Referrals from Child Welfare
 10. Minors/adolescents

Prevention

- Promotes an understanding that substance abuse can be prevented and creates an awareness that communities can take action to address this and related concerns.
- Promotes the implementation of effective, research-based prevention strategies and approaches that are implemented in an age, gender and culturally appropriate service delivery system.
- Establishes and maintains linkages with State, federal, local, private and business/industry to reduce substance abuse in Colorado.
- Sets the standards for quality substance abuse prevention services.

11. Criminal Justice referrals
12. Persons with a mental health diagnosis
13. Indigent DUI convictions.

- Writes and enforces alcohol and other drug treatment program licensing standards for 276 treatment providers (including the 37 MSO-funded providers) who operate 624 treatment sites throughout Colorado.
- Licenses agencies to furnish treatment and specialized services of varying intensities and durations through a range of treatment modalities including:
 - Residential non-hospital detoxification
 - Medically managed detoxification (residential and outpatient)
 - Opiate replacement treatment (e.g., Methadone and Buprenorphine maintenance)
 - Therapeutic communities
 - Intensive and transitional residential treatment
 - Intensive and traditional outpatient treatment.
- Investigates complaints and critical incidents involving licensed treatment providers.
- Manages the statewide involuntary commitment process for persons legally committed to the Division by the court because they pose a danger or are incapacitated due to the abuse of alcohol or other drugs.
- Maintains a central registry of 2,646 active and 7,269 inactive clients and tracks approximately 2,500+ new admissions per year in opiate replacement treatment programs to lower the risk for multiple enrollments and diversion of controlled substances.
- Develops and expands specialized substance abuse services for pregnant women and women with dependent children to ensure that barriers to treatment services are identified and reduced or eliminated for these women, and to promote the implementation of essential ancillary services such as linkage to prenatal care, other medical and dental care, medical care for children, mental health care, childcare during treatment, transportation to medical appointments and treatment, etc.
 1. Special Connections – a partnership between ADAD and the Department of Health Care Policy and Financing to provide specialized residential and outpatient treatment and related services to Medicaid-eligible substance abusing pregnant women (approximately 337clients per year).
 2. Specialized Women’s Services – provides gender-specific treatment and services for substance-abusing women with dependent children and pregnant women not eligible for Medicaid.

Manages data for the Drinking Driver Program, recording court evaluations and assessments and tracking client completion of substance abuse education and/or treatment required before the client may reclaim their license from the Division of Motor

- Manages the Regional Alcohol and Drug Awareness Resources (RADAR) via a contract with the Center for Substance Abuse Prevention.
- Identifies research findings and best practices, and proactively shares this information with the community.
- Funds 84 contracts with 71 prevention contractors that target youth, adults, families and communities. Funded services include education, training, problem identification and referral, community and school-based strategies, information and environmental programs.
- Coordinates Statewide Substance Abuse Prevention Services with the Division of Prevention and Intervention in the Colorado Department of Public Health and Environment.
- Sponsors statewide prevention training opportunities
 - Training services for ADAD contractors
 - Substance Abuse Prevention Specialist Training
 - Regional Prevention Summits.
- Maintains a comprehensive evaluation system for its prevention contractors from 5 state agencies called CO KIT. Colorado is the first state in the nation to have a multi-agency, cross-discipline prevention evaluation system.

Vehicles.

Presentations

ADAD staff use every opportunity to educate others about substance abuse treatment, prevention, prevalence and incidence. During this fiscal year staff spent approximately 749 hours in 197 presentations to 11,237 individuals statewide.

State Statutory Authority:

Title 12, Article 22, Part 3 CRS*	Title 24, Article 1, Part 1 CRS
Title 16, Article 11.5, Part 1 CRS	Title 25, Article 1, Parts 2, 3 and 11 CRS
Title 16, Article 11.9, Part 1 CRS	Title 26, Article 1, Part 1 CRS
Title 16, Article 13, Part 3 CRS	Title 26, Article 2, Part 1 CRS
Title 17, Article 2, Part 2 CRS	Title 26, Article 4, Part 5 CRS
Title 17, Article 27.1, Part 1 CRS	Title 42, Article 2, Part 1 CRS
Title 17, Article 27.9, Part 1 CRS	Title 42, Article 3, Part 1, CRS
Title 18, Article 1.3, Part 2 CRS	Title 42, Article 4, Part 13, CRS
Title 18, Article 18, Part 3 CRS*	Title 43, Article 4, Part 4, CRS

*Authority derived from the Colorado Department of Human Services by executive delegation

Staffing: ADAD pays for 33 FTEs in the Colorado Department of Human Services.

4. THE GROWING PROBLEM: ALCOHOL AND SUBSTANCE ABUSE IN COLORADO

Colorado Statistics

- There are an estimated 253,400 substance abusers in Colorado in the 12 years of age and over population. That's about 6% of the general population.
- Colorado ranks 19% higher than the national average in per capita consumption of beverage alcohol. Only 4 other states (Alaska, Delaware, Nevada and Wisconsin) rank higher in per capita consumption than Colorado.¹
- According to the 2005 National Survey on Drug Use and Health (NSDUH)² Colorado ranked 1st among the 50 states in: illicit drug use other than marijuana in the past month; and cocaine use in the past year.
- The alcohol-related death rate per 100,000 population in Colorado increased from 24.1 in 2002 (1,082 deaths) to 26.5 in 2003 (1,141).³
- The drug-related death rate per 100,000 population in Colorado increased from 39.3 in 2002 (1,772 deaths) to 41.8 in 2003 (1,802).

**253,400
Coloradoans
currently abuse
alcohol or drugs.**

**Colorado ranks
19% higher than
the nation in
consumption of
alcohol.**

**Alcohol abuse is
Colorado's #1 drug
problem.**

- In 2003, 57% of DUI-caused crashes resulted in fatalities or injuries. When DUI was not the cause of the crash, only 30% resulted in fatalities or injuries.
- The number of DUI citations issued by the Colorado State Patrol increased from 8,200 in 2002, 8,600 in 2003, to 9,509 in 2004.
- In 2004 there were 764 calls to the Rocky Mountain Poison Control Center related to alcohol, 316 related to stimulants and amphetamines, and 120 related to cocaine.
- Clients discharged from treatment, DUI and detoxification programs during FY05 had primary responsibility for approximately 36,281 dependent children under the age of 18 (based on a unique number of clients).
- Approximately 80% of all clients who have a history of injecting drug use are infected with Hepatitis C, a chronic and sometimes fatal disease of the liver.
- The incarceration rate for drug-related offenses has increased 476% in the last decade, making drug offenders the fastest growing and largest category of felons in Colorado prisons.⁴
- In 2004 there were 2,304 emergency room visits related to alcohol in Denver, 1,549 related to alcohol in combination with some other drug, and 755 alcohol-related visits by youth under the age of 21.

Treatment, DUI and Detox Clients had responsibility for 36,281 dependent children.

Marijuana is the primary drug of adolescents, followed by alcohol.

One fourth of all youth in treatment were dependent on their drug.

Colorado Youth In Crisis

- There are an estimated 30,000 adolescent (ages 12-17) substance abusers in Colorado.
- In FY05 there were 2,369 clients under age 18 who were discharged from DUI, detoxification and treatment programs. This comprised only 8% of all adolescent substance abusers in Colorado.
- Of these 2,369 clients under the age of 18, 1,963 (83%) received treatment services, 205 (9%) were discharged from DUI programs and 201 (8%) received detoxification services.
- Of the 1,963 youth in treatment, 26% were diagnosed as drug-dependent.
- 41% were diagnosed with a mental health issue in addition to their substance abuse.
- The primary drug for treatment clients under 18 years of age was marijuana, followed by alcohol, with pockets throughout the state of significant crystal methamphetamine use.
- 60-80% of youth in the juvenile justice system have substance abuse issues.

Most teens who use alcohol, cigarettes and marijuana do so before they are 14.

Close to ½ of the adolescents in treatment had a mental health issue in addition to their drug problem.

- 42% of youth were referred into treatment by the criminal justice system.
- ADAD partnered with Channel 9 News, Urban Peak and the Daniels Fund to create a “Parents Are the Power” campaign. Included in this campaign are public service announcements, an informative website and opportunities for dialogue such as a chat room and 9-Line volunteers to answer phone calls. Both the TV spots and the web site provide information for parents about the dangers of substance abuse, treatment options and other supports available in Colorado to keep teens drug-free.
- Urban Peak, a licensed homeless and runaway youth shelter in Denver, participated in a Multi-City Collaborative Public Health Survey⁵ to gauge risk factors and substance abuse trends in homeless and runaway youth in Colorado. This survey of 706 youth found:
 - 81% of those interviewed were between the ages of 14 and 21;
 - 1/3 were White and 1/3 were African American;
 - 50% had attended more than 6 schools;
 - 14% had visited an emergency room, 1/3 of which were substance abuse-related;
 - 40% had been admitted to a mental health hospital;
 - 36% had attempted suicide;
 - 41% had used an illegal substance with a family member;
 - 30% had been in treatment for substance abuse;
 - 27% had traded sex for money, food, drugs, shelter or clothing;
 - 13% used intravenous drugs, and half of these shared needles or works;
 - 79% had used marijuana, 39% cocaine and ecstasy, 26% methamphetamine and 18% had used either heroin or OxyContin.

Parents are the Power to keep their children drug-free.

41% of homeless youth surveyed reported using an illegal substance with a family member.

In 2004 illicit drug use among ages 12-17 decreased by 9%.

National Reports on Youth and Substance Abuse

- In 2004 there was a 9% decline in illicit drug use among American youth between the ages of 12 and 17. (NSDUH)
- Non-medical use of prescription medications among young adults is an area of concern. (NSDUH)
- The 2003 Youth Risk Behavior Survey⁶ obtained information from 757 students in 23 public high schools in Colorado.
 - Almost half of the students surveyed in 9th through the 12th grades had used marijuana, and 1/4th had done so before the age of 13.
 - 13% had used cocaine, inhalants and methamphetamine.
 - Almost half had one or more alcoholic drinks in the past 30 days.
 - 29% were already binge drinkers, having 5 or more drinks of alcohol in a row.
 - 17% of students in the 11th and 12th grades drove vehicles while under the influence of alcohol.

Nationally there’s an increase in abuse of prescription medications.

1 out of 5 teens in the nation abused prescription drugs.

- One out of every 4 Colorado high school students rode 1 or more times in a vehicle driven by someone who had been drinking alcohol.
- The 17th annual national study of teen drug abuse by the Partnership for a Drug-Free America reported a new category of emerging substance abuse in America: increasingly teens are getting high through the intentional abuse of medications, and for the first time, teens were more likely to have abused a prescription painkiller than to have experimented with illicit drugs.⁷ Major findings included:
 - approximately 1 in 5 teens reported abusing Vicodine, 1 in 10 abused OxyContin;
 - 1 in 10 teens has tried prescription stimulants such as Ritalin or Adderall without a doctor's order;
 - 1 in 11 teens has intentionally abused over the counter cough medications;
 - teen abuse of prescription medications is higher than or equal to teen abuse of illicit drugs;
 - 50% of all teens believe using prescription medications to get high is "much safer" than street drugs;
 - 1/3 of teens say prescription painkillers are not addictive;
 - teens cited "ease of access" as the major factor related to an increase in prescription drug abuse;
 - more teens reported using inhalants to get high than in previous years;
 - data reported significant and sustained declines in the number of teens using tobacco and/or alcohol.
 - 37% reported experimenting with marijuana in 2004, compared to 42% in 1998; and
 - teens are more likely to report learning a lot about the risks of drugs from TV commercials than they are from their parents.
- The report Under the Counter: Diversion and Abuse of Controlled Prescription Drugs in the U.S.⁸ found that teens who abuse prescription drugs are:
 - Twice as likely to use alcohol;
 - 5 times as likely to use marijuana;
 - 12 times likelier to use heroin;
 - 15 times likelier to use Ecstasy; and
 - 21 times likelier to use cocaine,
 compared to teens who do not abuse such drugs.

1/3 of teens surveyed reported prescription painkillers are not addicting.

Teens who abuse prescription drugs are 21 times likelier to use cocaine than non-abusers.

Colorado/US Comparison

In 2004, an estimated 19.1 million Americans (8% of the total U.S. population aged 12 or older) were classified as current illicit drug users, 6.0 million persons were current users of psychotherapeutic drugs taken non-medically, and 121 million (50%) aged 12 or older were current drinkers.

Fifty-five million (23%) were binge drinkers (defined as five or more drinks on one occasion) and 16.7 million (7%) were binge drinkers on 5 or more days in a month. (NSDUH)

8% of the U.S. population aged 12 or older used illicit drugs.

- Colorado ranks 2nd in severity nationwide on the overall Substance Abuse Problem Index, 5th on the Alcohol Problem Index,⁹ and 13th in severity nationwide on the Drug Problem Index.
- Colorado spent the least on treatment, prevention and research of all the 47 states in a study conducted by Columbia University's National Center on Addiction and Substance Abuse, "Shoveling Up: The Impact of Substance Abuse on State Budgets, January 2001."¹⁰
- Colorado ranks last in the nation in terms of the state's 1998 investment in substance abuse prevention, treatment and research. For every \$100 spent on programs that address the wreckage of substance abuse in Colorado, only \$0.06 was spent on treatment, prevention or research. The average amount other states spent on treatment, prevention and research was \$3.70 per \$100 of spending.
- According to the 2004 NSDUH, Colorado ranked:
 - 339% higher than the national average for rate of treatment admissions for alcohol;
 - first in the nation with the highest illicit drug use other than marijuana in the past month (30 days prior to the survey);
 - second only to New Hampshire in highest amount of alcohol use in the past month;
 - in the top fifth of the nation for highest amount of illicit drug and marijuana use; and for
 - first-time marijuana use among persons aged 12 or older;
 - any illicit drug use other than marijuana in the past month;
 - cocaine use in the past year;
 - alcohol use in the past month among persons aged 12 or older, 18-25 and 26 or older;
 - binge alcohol use in the past month among persons aged 12 or older and 26 or older;
 - alcohol dependence or abuse in the past year among persons aged 26 or older;
 - illicit drug dependence in the past year among those aged 12 or older and 18-25;
 - persons needing but not receiving treatment for illicit drug use in the past year among those aged 12 or older, 18-25 and 26 or older;
 - persons needing but not receiving treatment for alcohol use in the past year among those aged 18-25 and 26 or older;
 - in the lowest fifth of the nation for those:

Colorado ranked 2nd in the nation on overall substance abuse but spent the least on treatment, prevention and research.

Colorado ranked last investment in substance abuse prevention and treatment.

Colorado had the highest rate in the nation for admissions to alcohol treatment.

The lower the perception of risk, the higher the probability of use.

- aged 12 or older, 18-25 and 26 or older who perceived smoking marijuana once a month as a great risk;
 - aged 12-17 who perceived great risk associated with having five or more alcoholic drinks once or twice a week.
- Substance use epidemiology has documented that the lower the perception that use involves risk, the higher the probability of use. (NSDUH)
- While adult and adolescent Coloradoans use illicit drugs at higher levels than the national average, overall drug use has declined over the past 20 years due to prevention, treatment and enforcement.¹¹

Colorado ranked in the lowest 5th of the nation for perception that marijuana use was a great risk.

Comparison of Colorado with Other Frontier States

Colorado was compared with the 10 other states identified as “frontier” on 11 performance indicators.¹² The frontier states include: Alaska, Arizona, Idaho, Montana, Nevada, New Mexico, North Dakota, South Dakota, Utah and Wyoming.

Colorado ranked 2nd highest of all the frontier states in use of illicit drugs.

- Colorado ranked:
 - highest in the rate of admissions for alcohol treatment (per 100,000 age 12 and up);
 - 2nd only to Alaska for the highest percent reporting use of any illicit drug;
 - 4th highest for binge alcohol use and for those needing but not receiving treatment;
 - 6th in rate of admissions for drug treatment admissions and in rate of deaths from chronic liver disease and cirrhosis; and
 - 7th out of 11 for alcohol-related traffic fatalities.

Colorado ranked 4th of all the frontier states for binge use of alcohol.

What This Problem Costs

- The estimated cost of substance abuse in the U.S. exceeds \$168 billion/year.¹³
- Societal costs include expenses related to: enforcement of drug laws, criminal behavior, lost productivity due to incarceration or criminal careers, property damage, victimization, illness and premature mortality, health care, domestic violence, child welfare and foster care, administrative and property loss related to vehicular crashes, criminal justice systems¹⁴
- As of December 31, 2004 there were 20,144 adult offenders incarcerated in Colorado’s Department of Corrections, 7,383 on parole and 225 youthful offenders. Seventy-eight percent of the prison population were identified as substance abusers.¹⁵
- According to the 2003 Colorado Department of Corrections Statistical Report,¹⁶ the cost of prison placement per day was: Adults, \$76.23 and Youth \$185.62.

Colorado was second only to Alaska in highest percent reporting illicit drug use.

Adult = 20,144 x .78 = 15,712 incarcerated substance abusers
15,712 x \$76.23 = \$1, 197,725 per day

Youth = 225 x .78 = 175 incarcerated youth substance abusers
175 x \$185.62 = \$32,483 per day

Total cost per day for incarceration of substance abusers = \$1,230,208.

- In addition, incarcerated substance users demonstrated higher levels of need than non-substance users in several areas: academic, vocational and psychological. Substance users were also more likely to be seriously mentally ill and/or developmentally challenged.
- Alcohol and drug abuse affects every Coloradoan by adding a substantial but frequently invisible financial burden to the tax load. The magnitude of public funds spent on the direct and indirect consequences of substance use and abuse is staggering. Of this burden, costs related to alcohol abuse and dependence greatly exceed that of all other drugs of abuse combined.¹⁷
- Dozens of Colorado public agencies have a role in some aspect of addiction control or clean up of its aftermath.
- Addiction drives up healthcare costs. ¼ of all people admitted to general hospitals have alcoholism, and 30% of emergency room patients are problem drinkers or drug users. These individuals are seeking medical attention for alcohol or drug-related illness or injury, not for their addiction problem.
- One case of Fetal Alcohol Syndrome (FAS), the leading preventable cause of birth defects and mental retardation in the nation, costs Colorado an average of \$870,000. Colorado has between 20 and 42 FAS births per year, an expenditure of \$17 million to \$37 million.

Alcohol use is involved in 30% of child abuse cases.¹⁸

- Among male alcoholics, 50 to 60% have been violent toward a woman partner in the year before treatment.
- In 2003, 42 per 100,000 Colorado residents died of drug related causes.¹⁹
- In 2003, 27 per 100,000 Colorado residents died of alcohol related causes in Colorado.
- 45% of a sample of both men and women booked into the Denver City Jail tested positive for at least one illegal drug, typically marijuana or cocaine.²⁰
- The White House Office of National Drug Control Policy found that between 1988 and 1995 Americans spent \$57 billion on illegal drugs. These funds would otherwise have been supported legitimate spending or savings by the user.²¹

The cost to incarcerate substance abusers in the Department of Corrections was more than \$1,230,000/day in 2003.

The effects of alcohol and drug abuse impacts every person in Colorado by increasing taxes.

Alcohol was involved in 30% of child abuse cases.

One case of FAS costs Colorado \$870,000.

People with untreated alcoholism seek emergency room attention 60% more often than the rest of the population, are nearly twice as likely to be hospitalized overnight, and stay in the hospital 3 days longer. One visit to an emergency room costs \$600 minimum.²²

National Estimates of Total Yearly Societal Costs of Illegal Drug Use and Alcohol Abuse

Substance	Cost
Illegal Drugs	\$168 billion in 2004 dollars
Alcohol	\$185 billion in 1998
Prescription Drug Abuse	Undetermined

Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers, February 2005
 Treatment Research Institute, University of Pennsylvania

5. CLIENT DEMOGRAPHICS: A COMPARISON BETWEEN TREATMENT, DUI AND DETOXIFICATION CLIENTS, AND LIMITED PREVENTION DATA

(Note: Numbers and percentages are rounded to the nearest whole number.)

Overview

While certain sections of this report are based on the number of Drug/Alcohol Coordinated Data System (DACODS) discharges for FY05, the following demographic data are based on the number of clients.

ADAD only recently began phasing in a requirement for DUI providers to submit DACODS data on their clientele. This process is not yet complete, so the number of DACODS for DUI clients is less than the number of DUI discharges.

Detailed tables and graphs of client demographics are located in Appendix A of this document.

Demographic Summary

Treatment Clients: The most common clients in treatment in FY05 were single, white male adults between the ages of 18 and 44 with a median age of 31. Approximately 50% achieved only a 12th grade education and more than a third worked full-time. The highest proportions were in treatment for alcohol, followed by marijuana. Sixty-three percent started using their primary drug before the age of 18 and had been using for an average of 14 years. These clients tended to be daily users of tobacco, had no prior treatment episodes, did not support children and were treated in MSO-contracted outpatient treatment services.

Detoxification Clients: Similar to those in treatment, clients in detox were also typically single, white male adults who were slightly older with a median age of 36. Seventy-one percent achieved only a 12th grade education and 40% worked full-time. Nearly all (91%) were in detox for alcohol abuse, which they typically started using before the age of 18. Detox clients had been using their primary substance for an average of 19 years. They also tended to use tobacco daily, had no prior treatment episodes, no children to support and were served in MSO-contracted residential non-medical detoxification units.

DUI Clients: DUI clients also tended to be single, white male adults with no dependent children. Their median age was 29 and this group was more likely to have a 12th grade education or higher (82%) and work full-time (65%). The majority received their DUIs for being under the influence of alcohol. These clients started using their primary substance before the age of 18 and had been using for an average of 15 years. Approximately half used tobacco daily and 64% had no prior treatment episodes.

Generational Drug Habits

Treatment data indicate that the “Y” generation, those born after 1981, are more likely to use marijuana as their primary drug. The “X” generation, those born between 1965 and 1981 are split between sedatives/tranquilizers (which most likely reflects the use of alcohol) and stimulants. More “Baby Boomers,” those born between 1946 and 1964, use sedatives/tranquilizers (alcohol), as does the senior cohort. See Appendix A, Table 1.

Demographics

Residents versus Non-residents

The overwhelming majority of clients in treatment, detox and DUI were Colorado residents. Less than 1% of clients in any of these service types were from out of state.

MSO versus Non-MSO

In 1997, Colorado changed its substance abuse treatment methodology to a managed care system. Managed Service Organizations (MSOs) provide oversight and quality assurance of services for clients receiving care in their subcontracted agencies. During FY05 all but one detox discharge and 77% of all treatment discharges were MSO-related. Conversely, 77% of DUI clients were treated in clinics licensed by ADAD but not monitored by MSOs.

Gender

The male to female ratio was 2:1 in treatment, 3:1 in DUI and 4:1 in detox. Based on a gender ratio of 1:1 in the Colorado population,²³ males are over-represented in all service types below except prevention. The gender breakdown in Colorado treatment was similar to national 2002²⁴ treatment numbers of 30% female and 70% males. See Appendix A, Graph 1.

The male to female ratio for detox was 4 to 1.

Pregnancy

Seven percent (n = 338) of females in treatment were pregnant, as were 2% of females in both DUI (n = 52) and detox (n = 88) for FY05. The 2000 census identified 2,135,278 females in Colorado and 63,917 births, indicating that at least 3% of the females in Colorado were pregnant during 2000. Note: proportions for this specific item are based on all females and not just those of childbearing age. Substance abusing pregnant women are a priority population for ADAD and over-representation in treatment reflects ADAD’s aggressive outreach efforts. See Appendix A, Graph 2.

7% of females in treatment in CO were pregnant, compared to 1% nationwide.

Nationally, SAMHSA’s Treatment Episode Data Set (TEDS) from 1992 to 2002 indicated that 1.3% of 15,300,000 individuals in treatment were pregnant.

In Colorado, 32% of DUI clients, and 21% of both treatment and detox clients were between the ages of 18-24.

Client Age

Clients in treatment and DUI tend to be younger (median ages of 30 and 29 respectively) than the state and national average of 34 years. Thirty-two percent of DUI clients were within the 18 – 24 year age group, compared to 21% in treatment. However, there were more clients under age 18 in treatment (13%) than in DUI (2%) and this may reflect the legal minimum driving age of 16.

Of the three groups, detox clients were the oldest (median age = 36). While 21% of clients in detox were within the 18 – 24 age category, less than 1% were under the age of 18. The low numbers

of minors in detox may be due to the limited capacity of detox centers to comply with facility requirements that would permit them to accept younger clients. Moreover, police often transport intoxicated youth to their homes, so these episodes are not captured in the data.

SAMHSA's TEDS concatenated data for 1992-2002 indicated 7.7% of treatment clients nationally were less than 18 years of age, and 92.3% were 18 and older.

Colorado's prevention programs focused strongly on youth. Youth composed 21% of all individuals who received prevention services in FY05. Monitoring the Future's²⁵ 2004 study found that nationally several drugs showed a decline in use, most notably marijuana, LSD, ecstasy, steroids and cigarettes. Two substances showed signs of increased use among youth: inhalants and OxyContin. Overall, 51% of American's youth have tried an illicit drug by the time they finish high school, nearly 30% have done so as early as the 8th grade. The Northern and Western regions of the country reported the highest proportions of students using any illicit drug. Alcohol use remains widespread among today's teens. 77% have consumed (more than just a few sips) alcohol by the end of high school, and 44% have done so by 8th grade. 60% of 12th graders and 20% of 8th graders in 2004 reported having been drunk at least once.

Nationally, use of several drugs by those 18-24 yrs of age has declined. But, inhalants and OxyContin use are increasing.

Client Race/Ethnicity

The largest proportions of clients in treatment, DUI and detox were White in FY05. Compared with the 2000 census figures for Colorado, Hispanics and American Indians were over-represented in all three of these substance abuse service types. Hispanics represented 17% and American Indians comprised 1% of Colorado's general population. In treatment, DUI and detox, Hispanics made up 23%, 25% and 32% and American Indians comprised 3%, 2% and 5% respectively of the clientele. The race/ethnicity breakdown in national TEDS data was: 58% White, 24% Black, 13% Hispanic and 2% American Indian. Comparatively, Colorado has fewer Blacks and more Hispanics. See Appendix A, Graph 3.

Hispanics and American Indians were over-represented in all treatment service types in Colorado.

Marital Status

Less than 25% of the clients in treatment, DUI and detox services were married, and half of the clients in each service type were single. Even fewer were separated, divorced or widowed. According to the Colorado 2000 census, 27% of the general population never married, 56% married, 2% separated, 5% widowed and 11% divorced. Compared to the census, it appears that single and widowed clients are over-represented in ADAD's data. See Appendix A, Graph 4.

Children

Thirty-eight percent of treatment, 31% of DUI and 30% of detox clients were responsible for children. The total number of children dependent upon clients in treatment, DUI and detox services was 12,202, 7,463 and 16,616 respectively. See Appendix A, Graph 5.

Highest School Grade Completed

For all three service types, the majority of clients had a high school degree or less. Twenty-five percent of the clients in treatment attained some college, compared to 31% in detox and 40% in DUI. According to the Colorado Census 2000, 53% of the general state population had some college and 11% had graduate course work. Thus clients receiving substance abuse treatment, detox and DUI services in FY05 were less educated than the general population. See Appendix A, Graph 6.

Clients in treatment had lower educational achievement.

Income

Fifty percent of treatment, 54% of detox and 83% of DUI clients indicated that wages were their primary source of income. Forty-four percent of treatment, 65% of detox and 93% of DUI were self-pay clients. Approximately half of both treatment and detox clients indicated they had no income at the time of admission. The median monthly incomes for treatment, detox and DUI were \$400, \$500 and \$1,200 respectively. When these are annualized, median income of clients is substantially smaller than that of \$47,000 for Colorado households in 1999 (Colorado Census 2000). See Appendix A, Graph 7.

50% of treatment and detox clients had no income at time of admission.

Number of Persons Living on Client's Income

Forty percent of treatment clients, 38% of DUI and 27% of detox clients indicated that their income supported someone in addition to themselves. See Appendix A, Graph 8.

Veteran Status

Only 7% of treatment, 9% of DUI and 12% of detox clients indicated they were veterans. The Colorado Census 2000 identified 14% of the general population as veterans.

Client Disability

Only 2% of both treatment and detox clients and 3% of DUI clients indicated they had one or more disabilities. While the largest proportion in all three service types reported disability as "other," the largest subset of identified disabilities for all was psychiatric disorders. These percentages are smaller than the 6% disability rate in the general Colorado population recorded by the Census 2000.

Tobacco Use

Compared to state and national population figures, cigarette smokers are greatly over-represented in ADAD's database. Sixty-nine percent of treatment, 62% of detox and 49% of DUI clients used tobacco daily compared to 19% of Colorado adults and 23% nationwide.²⁶

Prior Treatment Episodes

TEDS data for 2002 indicated that 56% of clients nationally had one or more previous encounters with the treatment system and 11% had 5 or more prior treatment episodes. In Colorado 57% of treatment clients had at least one prior encounter and 5% had 5 or more. Forty-four percent of Colorado's detox clients had one or more prior encounters and 16% had at least five. DUI programs in Colorado had the fewest clients who had prior treatment episodes (36% had one, 3% with five or more).

Transfer/Referral Source

Non-DUI Criminal Justice was the referral source for 43% of clients in both treatment and detox, a pattern similar to TEDS national referral data. As expected, the majority (76%) of DUI clients were referred from DUI-related criminal justice sources. Self-referrals in Colorado comprised 17% of both treatment and detox and 8% of DUI clients. Nationally 35% of all clients self-referred into treatment. Health care entities in Colorado, including substance abuse treatment providers, referred more clients to detox than treatment. Employer and educational agencies had minimal referrals and were combined with "Other" in the Graph 9, Appendix A.

Admission/Discharge Modality

Outpatient services was the most highly utilized modality for treatment clients, with 63% in traditional and 10% in intensive outpatient modalities. Eighteen percent of treatment clients were in some form of residential modality, including Therapeutic Community (TC), intensive, short-term intensive and transitional residential settings. All but 6 detox clients received care in residential (non-hospital) detox. See Graph 10, Appendix A.

Primary Drug Type

Alcohol abuse is Colorado's number one problem, followed by marijuana and methamphetamines. In the last 3 years Colorado providers have noted a switch from cocaine to methamphetamines because of price, availability and a longer lasting high.²⁷ National data for 2002 had more clients identify alcohol (59%) as their primary drug, followed by cocaine (18%) and opiates (12%). Nationally methamphetamine was only 1.4%. See Graph 11, Appendix A.

Alcohol, marijuana and methamphetamines are the primary drugs of abuse in Colorado.

6. SERVICE UTILIZATION

Prevention Services for FY05

Total Attendees/Participants Served: 66,225, a 4% decrease from FY04 (68,705)
Total Attendees Served by SINGLE Services: 61,579 (93%), a 2% increase from FY04 (60,491)
Total Participants Served by RECURRING Services: 4,646 (7%)
Total Participants Completing RECURRING Services: 4,646
Total Attendees/Participants Served by Gender: Female 36,776 (56%); Male 29,286 (44%)
The proportion of both females and males discharged from prevention in FY05 increased by 5% from FY04.

Forty-two providers supported with ADAD funds delivered prevention services to 13,667 Colorado youth.

Treatment Discharges FY05

The largest number of individuals was seen in detoxification, followed by the Drinking Driver program and then the combined treatment modalities. Research has shown that the longer an individual stays in substance abuse treatment the better their outcome. "Recidivism" in the addiction field is encouraged since any contact with treatment counselors supports a more positive long-term outcome. Thus the number of discharges is expected to be greater than the number of individuals.

In FY04 ADAD had 112,722 discharges from all service types. In FY05, this figure increased by 4% to total 117,243 discharges. In FY04, 55,928 individuals utilized ADAD's services, excluding Evaluation and Assessment (ADDSCODS). In FY05, this figure increased 18% to total 65,949 (also excluding ADDSCODS). See Table 1 in Appendix B.

The number of individuals served by ADAD in FY05 increased 18% from FY04.

Clients in treatment typically had 1 discharge each in FY05. Clients in detox had 2. There were 4 treatment discharges per 100,000 general population, 5 DUI, and 10 detox discharges per 100,000. See Table 2 in Appendix B.

The total number of treatment discharges increased in FY05 by 17% over FY04. The largest increases were in Intensive Outpatient (a 42% change) and Intensive Residential (a 36% change). See Table 3, Appendix B.

Overall, the total detox discharges increased in FY05 by 5% over FY04. See Table 4, Appendix B.

DUI discharges in FY05 decreased by 6% from FY04. See Table 5, Appendix B. The total number of DACODS submitted by DUI providers in FY05 increased 94% from FY04. This increase in DACODS is an artifact of ADAD phasing in a requirement for DUI providers to submit this data collection instrument. See Table 6, Appendix B.

Length of Stay

Length of stay by modality was examined using both the median and the average number of days. Opioid Replacement Therapy had, as expected, both the longest average length of stay (212 days) and median number of days (105), followed by Day treatment (100 days average, 80 days median) and Residential (57 days average and 32 median). Comparing average numbers for FY05 with FY04, Opioid Replacement Therapy increased by 27 days in FY05, and Day treatment increased by 26 days. The national 2002 median for Residential was 78, significantly higher than Colorado's median of 32. The national 2002 median for Opioid Replacement Therapy was 79 days, significantly less than Colorado's median of 105. Colorado's detox length of stay was 1 day for both the mean and the median, while the national median was 3 days. See Table 7, Appendix B.

Reason for Discharge

Ninety-two percent of detox clients completed their detoxification at the facility to which they were admitted. Five percent left against professional advice.

Across treatment modalities, 28% of FY05 discharges completed their treatment with no further treatment recommended; 22% completed treatment at that facility and were referred for more treatment; 23% left against professional advice; 12% were terminated by the facility and 7% were transferred to another facility. Thirty-five percent of clients in treatment left treatment by walking away or being terminated.

50% of clients completed their treatment; 35% did not.

7. BARRIERS TO TREATMENT

Number of Years Between First Use and Treatment – Client Readiness

The analysis of the number of years from first use to first treatment was based on treatment and detox data for only those clients who reported having no previous treatment episodes. As the charts below illustrate, addiction is a chronic disease that frequently takes years for personal recognition of the need for treatment. Clients in treatment averaged 12 years (median = 8 years) from first use of their primary drug until they entered treatment. Detox clients averaged 20 years (with a median of 20 years) from first use to first treatment. Graph 1 in Appendix C shows that for both modalities, those with alcohol as their primary drug take the longest time from first use to first treatment encounter.

Clients take an average of 12 years from first drug use to first treatment.

Public Barriers

- Public stigma and a negative perception of the field affect both clients and providers.
- Many fear personal loss if others (such as employers) find out about their need for or being in treatment.
- Many have greater fears of discovery while in treatment than while abusing substances.
- Few individuals in recovery are willing to share their

The social stigma related to substance abuse is often times worse than the stigma of mental illness.

experiences, resulting in largely silent and invisible advocates.

- Many still view addiction as a poor moral choice in which an individual voluntarily engages, instead of a chronic, relapsing disease of the brain.

Economic Barriers

- Insurance coverage is limited or non-existent for substance abuse prevention and treatment.
- Many who could benefit from treatment services also have other pressing needs, such as mental health care, medical care, housing, education and job training, employment assistance, legal assistance, etc.²⁸
- Youth learn quickly that they can make more money dealing drugs than they can in legitimate employment.
- Addiction counselors and staff are chronically underpaid, creating high staff turnover and disrupting established counselor-client rapport.
- Public policy frequently supports incarceration over treatment, limiting funding to support prevention and treatment.
- Poverty and the perception that one cannot afford treatment frequently delays health seeking behavior.

Physical Barriers

- Service locations may be geographically challenging to reach (e.g., mountain passes in winter).
- Limited transportation options frequently exist in rural areas.

Individual Barriers

- Clients often do not believe they have a problem that requires treatment. This denial may prevent or delay them from seeking treatment.
- There may be cultural reasons as well as a shortage of local, culturally responsive treatment settings that prevent or delay individuals from seeking treatment.

8. THE BENEFITS OF SUBSTANCE ABUSE TREATMENT AND PREVENTION

- The Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers, February 2005²⁸ states that nearly two decades of research finds that:
 - substance abuse treatment achieves clinically significant reductions in substance use and crime, and improvements in personal health and social function for many clients;
 - treatment effects include significant gains to both the client and to society;
 - available cost-benefit studies consistently found that economic benefits exceed treatment costs;
 - treatment benefits include reduced criminal behavior, increased employment and reductions in health care costs;
 - specific treatment approaches are more cost-effective than others, e.g., outpatient vs. inpatient treatment,

The economic benefits of treatment exceed treatment costs.

Treatment reduces substance use, criminal behavior, and health care costs.

although the latter may be more effective for high-risk clients;

- residential prison treatment is cost-effective only in conjunction with post-release aftercare services; and
- long-term benefits of treatment are probably understated, and more studies are needed to determine the long-term impact of treatment..

- **Tax Dollars**

- \$7 is saved for every dollar spent on alcohol and drug abuse treatment programs. (CALDATA Study)²⁹
- Investment in prevention/treatment programs produces significant cost savings in other, public funded programs.
- If Colorado sent substance abuse offenders to treatment instead of incarcerating them, Colorado could save \$900 per offender.³⁰
- Every \$1 spent on school-based drug prevention results in a cost savings of \$5.50.³¹
- Iowa State University researchers have conservatively estimated that the prevention of a single case of adult alcohol abuse produces an average savings of \$119,633 in avoided costs to society.
- The Office of National Drug Control Policy (ONDCP) has documented a direct correlation between increases in drug prevention investments and decreases in the prevalence of use/abuse. Programs show cost-benefit ratios in the range of 8:1 to 15:1 in reduced costs in crime, school and work absenteeism, as well as reduced need for and costs of substance abuse treatment.³²
- In Washington State, Medicaid medical cost savings averaged \$4500 per person for those in alcohol and drug treatment.³³
- In Oregon, treatment resulted in a 50% reduction in child welfare cases.³⁴
- Oregon experienced a \$5.60 savings in social programs for every dollar spent on treatment.
- 6 months in treatment in New York State produced tax savings of \$143 million.³⁵
- Clients on welfare declined 11% nationwide. (National Treatment Improvement 5-Year Evaluation Study)³⁶
- Homelessness dropped 43% nationwide. (National Treatment Improvement 5-Year Evaluation Study)

Treatment improves health and social functioning.

Every dollar spent on school-based drug prevention saves \$5.50.

Increase prevention services and use/abuse decreases.

Prevention of a single case of alcohol abuse saves \$119,633 in avoided costs to society.

Treatment resulted in a 50% reduction in child welfare cases.

- Inpatient mental health visits decreased 28% nationwide. (National Treatment Improvement 5-Year Evaluation Study)
- **Employment**
 - Colorado noted a 67% increase in employment following treatment. (Follow-up Study)³⁷
 - Employment increased 19% nationwide following treatment. (National Treatment Improvement 5-Year Evaluation Study)
 - Every dollar spent on Employee Assistance Programs saves businesses between \$5 and \$16. (Federal Department of Labor)
 - Ohio noted a 97% decrease in on-the-job injuries. (Ohio Alcohol and Drug Treatment Results)
- **Criminal Activity**
 - Colorado noted a 97% decrease in arrests for all offense categories following treatment. (Follow-up Study)
 - Colorado reported 46% of clients who had treatment completely abstained from alcohol or drugs. (Follow-up Study)
 - Criminal activity decreased 80% nationwide. (National Treatment Improvement 5-Year Evaluation Study)
- **Health**
 - Ohio noted a 58% decrease in hospital admissions and a 67% decrease in emergency room utilization. (4-Year Ohio Study)³⁸
 - Treatment reduces hospital admissions by 1/3 and significantly improves many primary health areas. (CALDATA)
 - In 1992, 5 treatment types cost California \$200 million, but saved approximately \$1.5 billion. (CALDATA)

Employment increased 19% nationwide following treatment.

In Colorado arrests decreased 97% following treatment.

Treatment reduced hospital admissions 58% and ER use by 67%.

9. PREVENTION AND TREATMENT OUTCOMES

Prevention Outcomes FY05

1. Statistically significant decreases ($p < .05$) were noted in 30 day use of cigarettes, alcohol, marijuana, inhalants, amphetamines and cocaine for surveyed youth ages 12 to 17 who had received prevention services.
2. Statistically significant increases ($p < .05$) were noted in:
 - disapproval of marijuana and other (LSD, cocaine, amphetamines and other illegal drugs) drug use for their age group
 - youth stating an intent to avoid alcohol

- the number of youth believing use of alcohol or marijuana was wrong for their age group
- the perception of risk related to smoking one or more packs of cigarettes, smoking marijuana regularly, taking 1 or 2 drinks daily, having 4 to 5 drinks nearly every day, having 4 to 5 drinks each weekend, occasional use of crack and regular use of cocaine.

Treatment Outcomes FY05, Admission to Discharge Change

Discharges from treatment modalities excluding Differential Assessments Only were used to calculate change from admission to discharge. Detox was excluded because its primary goal is to provide a safe, short-term environment in which the client may detoxify and then be referred to treatment. DUI was excluded because it focuses on reducing driving while intoxicated behaviors and not on overall substance abuse treatment. The total number of discharges used to calculate outcome data was 17,508.

More information regarding factors that may be related to treatment outcomes can be found in Appendix E.

Summary of Treatment Outcomes:

1. Sixty-one percent of clients discharged from substance abuse treatment had moderate to high achievement of treatment goals.
2. At admission 30% of treatment clients were assessed as having a current mental health issue. This declined to 24% at time of discharge.
3. Overall the severity of problems or issues with family, socialization, employment or school and medical or physical problems was reduced at discharge.
4. Use of primary drug decreased from admission to discharge.
5. The number of arrests, emergency department visits and hospital admissions all declined from admission to discharge.
6. Slight improvement was noted in employment status and living situation at discharge.

Progress towards Treatment Goals

During the treatment process substance abuse counselors partner with their clients to develop individualized treatment plans. These plans identify goals clients wish to attain from their treatment. At time of discharge, counselors and clients assess progress made toward these goals. For FY05 2/3rds of all treatment clients had made moderate to high progress toward their goals. For FY04, 29% had high achievement, 30% had moderate and 38% had minimal achievement towards progress goals. See Graph 1, Appendix D.

2/3rds of all treatment clients had moderate to high progress toward their treatment goals.

Use of Primary Drug at Admission and at Discharge

Perhaps the most critical measure of substance abuse treatment success is the change in frequency of drug use from admission to discharge. Graph 2 in Appendix D compares frequency of primary drug use within 30 days of admission to treatment with the frequency of use in the 30 days prior to discharge for FY05 Outpatient treatment clients. Only the Outpatient treatment modality data was used for this calculation, since outpatient clients, unlike those in a residential setting, have full access to their primary substance during treatment. See Graph 2, Appendix D.

In FY05 clients who reported no use of their primary substance increased 19 percentage points from admission to discharge. In FY04 this increase was 25 percentage points. See Table 1, Appendix D.

Mental Health Status

During FY05, 30% of clients in substance abuse treatment were assessed as having a current mental health issues at admission. This proportion declined to 24% at discharge.

Family Issues/Problems

Counselors assess the severity of several of the client's issues or problems at both admission and discharge, using terms defined in the DACODS User Manual. The percentage of clients with no or slight family issues at admission increased at discharge, and those with moderate and severe family issues decreased at discharge.

Severity of problems with family, socialization, education and medical/physical issues had all slightly improved at discharge.

Socialization Issues

The percentage of clients reporting no or slight socialization issues or problems at admission increased at discharge, and those with moderate to severe problems at admission decreased at discharge. Socialization is defined as the ability and social skills to form relationships with others. See Graph 4, Appendix D.

Education/Employment Issues

The proportion of clients without education or employment problems at discharge increased, as did those with slight problems. The number with moderate or severe problems decreased at discharge. See Graph 5, Appendix D.

Medical/Physical Issues

The number of clients without medical/physical problems at discharge remained the same from admission to discharge, while the proportion of clients with moderate and severe problems decreased at discharge. See Graph 6, Appendix D.

Employment Status and Living Situation

Slight increases occurred from admission to discharge in the proportions of clients working full-time and living independently. See Graph 7, Appendix D.

Arrests, Emergency Room and Hospital Admissions

From admission to discharge from treatment, decreases were noted in DUI/DWAI and Other arrests, medical and psychiatric emergency room visits and medical and psychiatric hospital admissions. See Table 2, Appendix D.

Factors Relating to Achievement of Treatment Goals

Of 17,508 discharges from treatment, 30% were assessed with high progress toward their treatment goals, 31% with moderate progress and 39% with minimal progress.

Adult clients assessed with high progress towards their treatment goals were more likely to:

- have been in treatment for more than 90 days;
- be married or divorced;
- have children;
- be in the older age groups;
- be in any ethnic group other than black;

Treatment success occurred more frequently for those clients who stayed in treatment more than 90 days.

- report using alcohol as their primary drug;
- have used their primary drug orally; and
- reside in the southeast or southwest regions of Colorado.

Adolescents were more likely than all adult age groups except 65+ to be high achievers.

Adolescents are higher achievers in treatment than adults.

Clients assessed as having minimal progress towards their treatment goals were more likely to:

- report using heroin as their primary drug;
- use injection as their route of drug administration;
- reside in Denver and Boulder.

For more detailed information on factors relating to the achievement of treatment goals, see Appendix E.

10. SERVICE COSTS

Treatment Cost Per Client

The Division pays only 39.5% (approximately) of the costs for services rendered by the Managed Service Organizations and their subcontractors.

Average Cost Per Client By Year for Treatment Services funded by The Division of Alcohol and Drug Abuse

Year	ADAD's* Average Cost/Client	Total** Average Cost/Client
2005	\$721	\$1,948
2004	\$715	\$1,551
2003	\$710	\$1,544
2002	\$687	\$1,494
2001	\$618	\$1,344
2000	\$584	\$1,270
1999	\$561	\$1,220
1998	\$542	\$1,178
1997	\$402	\$ 874
1996	\$390	\$ 848
1995	\$378	\$ 822

Total average cost for treatment per client per year was \$1,948.

Data assumptions: Detoxification services and costs are excluded.

*Data was generated from ADAD's funding database, using number of clients treated with ADAD monies.

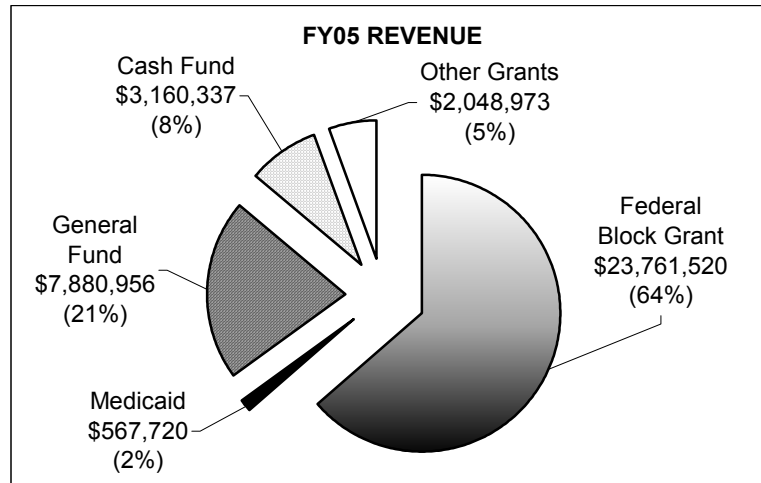
**Data reflects all clients, those funded by ADAD and those funded by self-pay or insurance.

Average costs per TANF client, for outpatient substance abuse services only, are \$2,100/year.

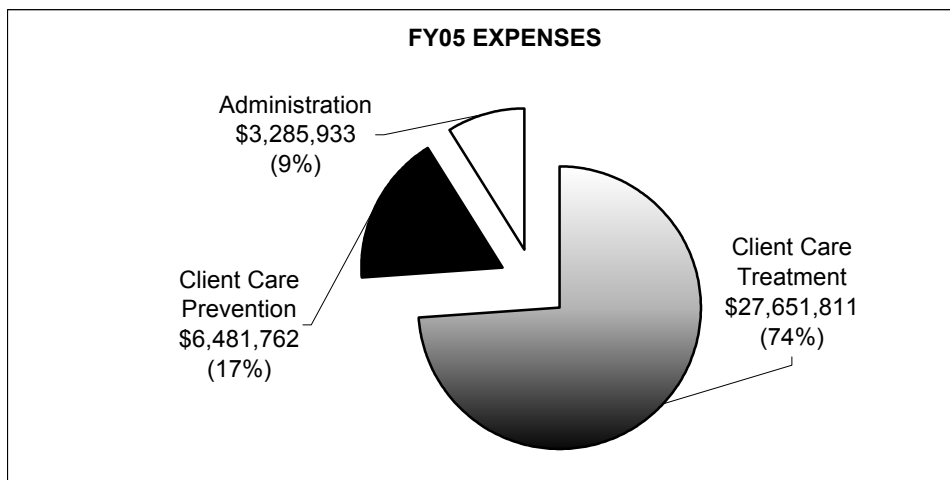
In 2002, publicly funded programs provided 31% of the total treatment episodes in the state of Colorado. Drinking and driving (DUI) programs provided 47%. Licensed, non-funded, non-Drinking-Driver programs provided the remaining 22%.³⁹

11. RESOURCES FY2005

ADAD Revenue and Expenses for FY05



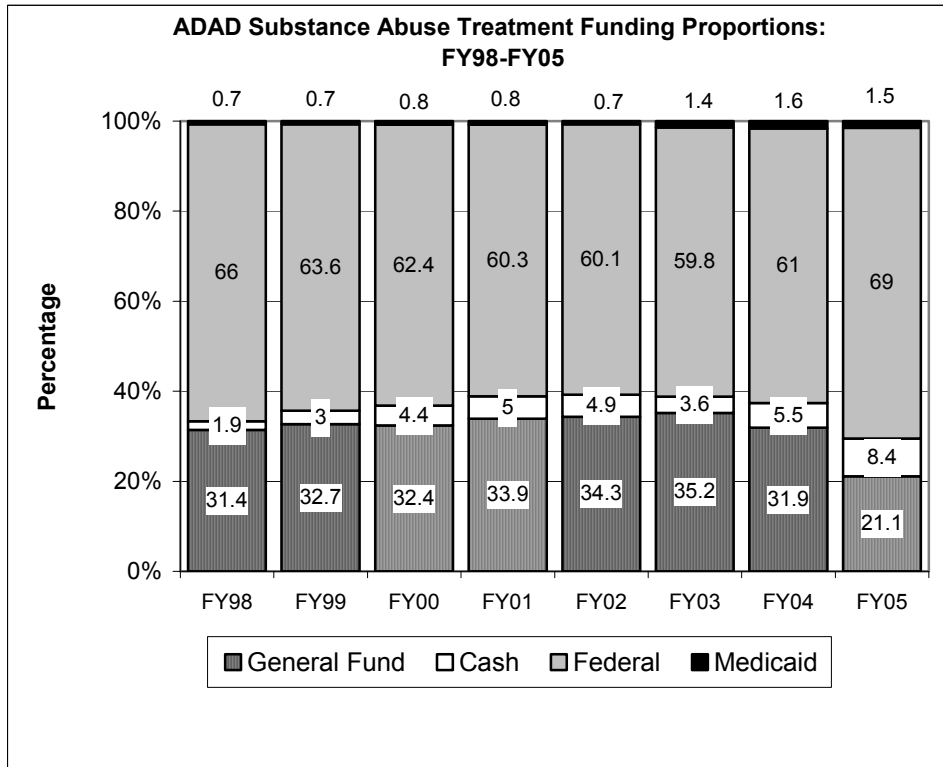
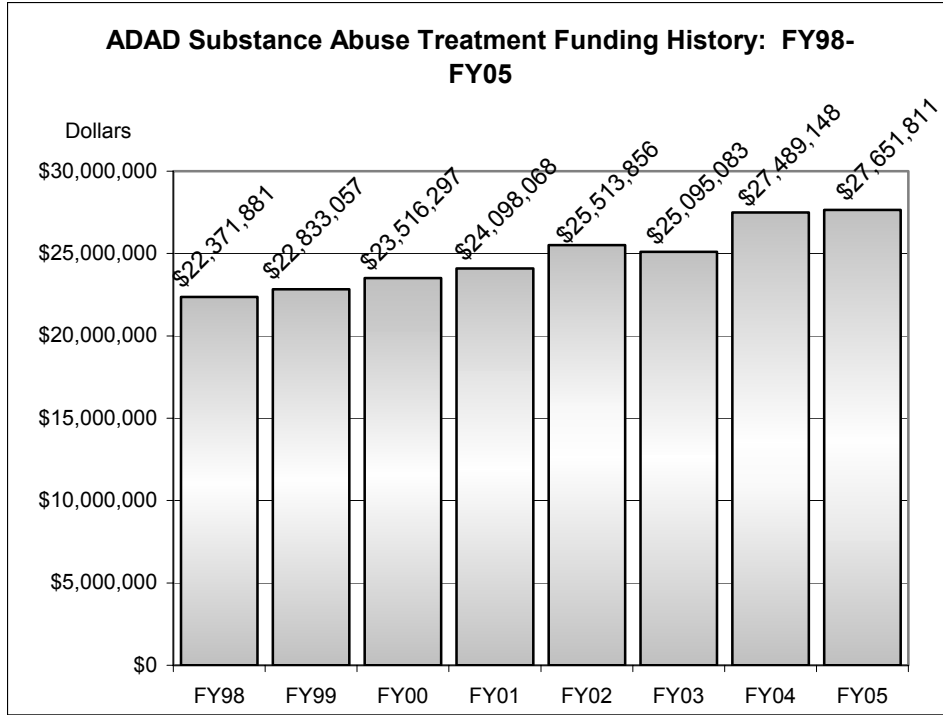
Total Revenue for FY05: \$37,419,506

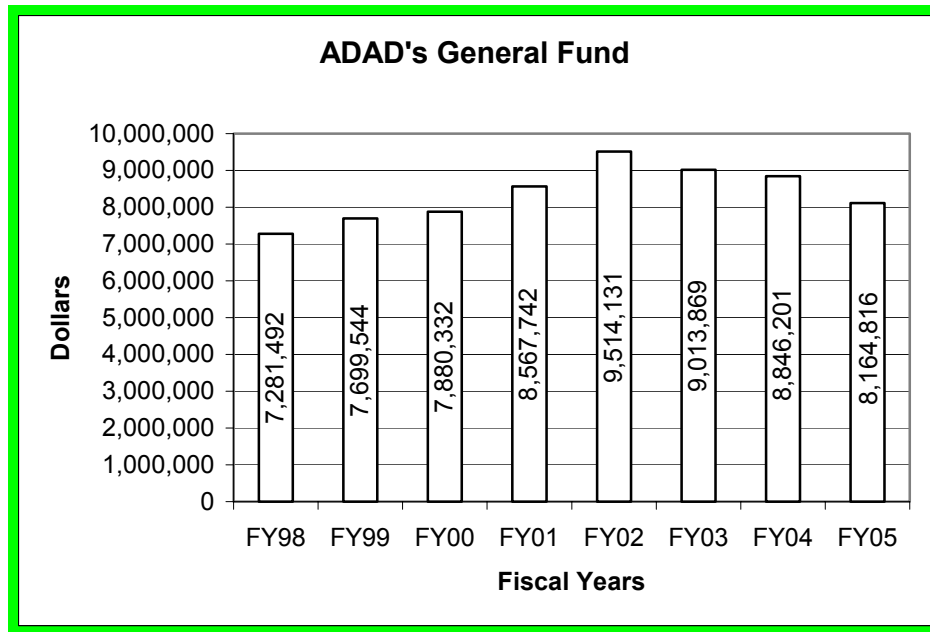


Total Expenses for FY05: \$37,419,506

The next three charts demonstrate:

- 1) ADAD's funding history for substance abuse treatment, from fiscal years 98 through 05;
- 2) the proportion of different funding sources; and
- 3) detail of ADAD's General Fund dollars.





Note: FY05 is the sum of General Fund plus ½ of Medicaid dollars.

Collaborations

- o Colorado Department of Human Services' divisions and agencies, especially the Division of Mental Health, Child Welfare, Division of Youth Corrections, Colorado Works, and Supportive Housing and Homeless Programs in the Office of Behavioral Health and Housing
- o Other State government offices and departments, including the Division of Regulatory Agencies, State Judicial, the Division of Criminal Justice in the Department of Public Safety, and the Departments of Corrections, Education, Public Health and Environment, Revenue, Health Care Policy and Financing, and Transportation
- o Ongoing collaboration among state agencies constituting the Prevention Leadership Council (C.R.S. 25-20.5) to implement a seamless interagency approach to the delivery of state and federally funded prevention programs. Colorado is the first state in the nation to have a multi-agency, cross-discipline evaluation system. Five state agencies that fund prevention services are now using this system. A web-based resource and indicator database is being developed primarily for communities to use. Communities will be able to readily see data regarding their county or community pertinent to prevention issues as well as what prevention resources are currently going to their county or community.
- o ADAD stakeholders, including treatment and prevention providers, persons in recovery, community leaders, media representatives, drug court personnel, county directors of Social/Human Services, judges, district attorneys, alcohol and drug evaluators, and probation and parole officers

ADAD partners with multiple entities to assure clients in all aspects of Colorado society have access to services and the opportunity for successful outcomes.

Colorado is the 1st state in the nation to have a multi-agency, cross-discipline evaluation system.

- University of Colorado Health Sciences Center and Signal Behavioral Health Network in the implementation of the National Institute on Drug Abuse's Clinical Trials Network
- National nonprofit organizations including the Legal Action Center, Research Society on Alcoholism, the North Charles Research and Planning Group, and the American Society of Addiction Medicine (ASAM)
- The Federal government, including the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Institutes of Health, National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, Office of Applied Studies, the Community Epidemiology Work Group, National Association of State Alcohol and Drug Abuse Directors, Office of National Drug Control Policy, and the Drug Enforcement Administration

ADAD partners with multiple agencies for a comprehensive response to emerging drugs such as methamphetamine.

Tracking Civil Forfeiture (SB 03-133) for 2005

- Judicial District 1 forwarded \$16,943.53 of forfeiture monies to Signal Behavioral Health, the MSO for the Denver metro area. There were no allocations from these funds in FY05.
- Judicial District 2 forwarded \$143,339.75 of forfeiture monies to Signal Behavioral Health. Signal allocated \$99,730.00 of these funds to 3 substance abuse providers within the district for adult group counseling, individual counseling, case management and urinalyses.
- Judicial District 4 forwarded \$47,424.50 of forfeiture monies to Connect Care, the MSO for the Colorado Springs area west to the Continental Divide. Connect Care management is currently in discussion about how to best use these monies for greatest client impact.
- Judicial District 8 forwarded \$16,078.38 of forfeiture monies to Signal Behavioral Health, the MSO for the northeast portion of Colorado. There were no allocations from these funds in FY05.
- Judicial District 12 forwarded \$5,900.70 of forfeiture funds to Signal Behavioral Health, the MSO for the Denver metro area. There were no allocations from these funds in FY05.
- Judicial District 17 forwarded \$20,364.51 of forfeiture monies to Signal Behavioral Health, the MSO for the Denver metro area and northeastern Colorado. There were no allocations from these funds in FY05.
- Judicial District 18 forwarded \$16,943.53 of forfeiture monies to Signal Behavioral Health, the MSO for the Denver metro area. There were no allocations from these funds in FY05.
- Judicial District 21 forwarded \$9,621.82 to West Slope Casa, the MSO for the western slope. These funds are reserved for Colorado West's Child and Family Program targeting adolescent substance abuse treatment and will be expended during FY05.
- No other Judicial Districts forwarded any monies to ADAD's MSOs in FY 2005.

- As legislated, the MSOs allocate these monies to substance abuse treatment and detoxification programs in the Judicial Districts in which the forfeiture proceedings were prosecuted. These monies are in addition to the appropriated funds through the Department of Human Services, ADAD and the MSOs.

12. TREATMENT AND SERVICE GAPS

According to NSDUH, Colorado ranks in the top fifth of the nation for:

- needing but not receiving treatment for illicit drug use in the past year among persons aged 18-25
- needing but not receiving treatment for alcohol use in the past year among persons aged 12 or older.

According to the last (1995) Colorado Household Survey:

- 81% of the Coloradoans abusing or dependent on substances are not in a treatment program, but
- only 3% of the abusing or dependent population not yet in treatment are ready to seek treatment.

ADAD estimates it would cost an additional \$10.5 million to close the current treatment gap for those wanting but currently not receiving treatment.⁴⁰

In ADAD's Special Connections Annual Report, March 2005,⁴¹ staff noted 65,429 births in Colorado in 2000, and estimated approximately 8%, or 5,103 pregnant women were substance users at that time. ADAD met 7% of this need by treating 338 pregnant women that fiscal year. This compared to 3% nationally.⁴²

NSDUH found that among pregnant women aged 15-44 nationally, 11% reported past month use of alcohol and 5% reported binge drinking in the past month;

Three multi-year studies on treatment gaps and daily management of the substance abuse issues in Colorado have identified several populations that require special effort to recruit and retain in treatment. These include:

- all abusing adolescents, especially pregnant female adolescent substance abusers with a focus on Hispanics;
- pregnant substance abusing females via outreach in physicians' offices and hospitals throughout the state;
- women substance abusers who have dependent children;
- the elderly who abuse prescription medications;
- migratory workers;
- persons who are homeless; and
- substance abusers in the southeastern part of Colorado, since studies indicate this is a high area of need.

Additionally studies have found that the public sector provides only a percentage (31%) of the treatment services needed in Colorado, and

An additional \$10.5 million would provide treatment for those wanting but not receiving it.

Substance abusing adolescents, especially pregnant teens, have a high need for treatment.

ADAD met 7% of the need for treatment for pregnant women, compared to 3% nationally.

Additional funding is needed for household surveys to identify service gaps and for follow-up studies to track long-term treatment outcomes.

expansion of public sector is critical to meet the needs of those individuals who require but currently are not in treatment.

Household surveys of Colorado's population should be administered on a regular basis, at least once per decade to determine areas of high need for both prevention and treatment and to assist in targeting limited resources for optimal effectiveness. Given limited resources, the cost of these surveys is prohibitive. ADAD is currently dependent on gleaning information from the federal national household survey, which does not provide region specific information.

ADAD management is acutely aware that regular follow-up surveys on clients need to be done to determine the post-discharge impact and continuing effects of treatment. Because of the difficulty of tracking transient populations and in part because of the stigma associated with this field, ADAD has found follow-up studies to be quite expensive to administer. Given current limited resources and the need for treatment in Colorado, ADAD has chosen not to divert funds away from direct client treatment services to perform a successful follow-up study at this time.

Determining the post-discharge impact of treatment is crucial but resource-intensive.

13. SPECIAL REPORTS

METHAMPHETAMINE IN COLORADO

Does Colorado have a methamphetamine problem?

Methamphetamine use is definitely a growing problem for Colorado that impacts many communities and burdens a broad spectrum of community services, including law enforcement, public safety, corrections, child welfare, social services, environmental clean-up and medical and mental health care. According to the Patterns and Trends in Drug Abuse: Denver and Colorado, 2004 report, most indicators for methamphetamine increased over the past few years: the number of methamphetamine-related emergency visits, hospital discharges, mortalities, arrests and Rocky Mountain Poison Control calls have all increased. Colorado treatment admissions for clients using methamphetamine as their primary drug have also increased dramatically, and methamphetamine is now the third most frequently reported drug, following alcohol and marijuana.

The October 3, 2005 issue of the Center for Substance Abuse Research (CESAR) weekly fax report indicated that overall 1.0 - 2.2% of Colorado's residents age 12 or older admitted to methamphetamine use in the past year.⁴³ This report also states: "it should be noted, however, that the average level of methamphetamine use across the U.S. (0.6%) remains substantially lower than those of almost all other illicit drugs, including marijuana (10.6%), prescription pain relievers used non-medically (4.7%), cocaine (2.4%), tranquilizers (2.1%) and hallucinogens (1.6%)."

Several studies are presented in this report. Note that ADAD's database is constantly being updated, so total numbers of clients may differ in different studies about the same time period.

Methamphetamine and Children in Selected Counties of Colorado

A special study of four Colorado counties, Adams, El Paso, Larimer and Weld, examined the interface of methamphetamine use and children. ADAD reviewed DACODS data for clients who were admitted in FY04 to residential, outpatient, methadone, STIRRT and Day treatment and reported primary or secondary use of methamphetamine. Overall, clients with children were more likely to:

- use TANF as their primary source of payment for treatment and
- be referred into treatment by the social services system.

Clients without children were more likely to be referred into treatment by the criminal justice system.

General Demographics

Another study completed by ADAD identified 17% of treatment clients (unique individuals) who reported methamphetamine as their primary drug of use in FY05. Meth users were more likely to be female, between the ages of 18 and 34, White, separated or divorced and have dependent children. Meth users were unlikely to be younger than 18 or older than 34 years of age, Black or Hispanic, or have educational attainment beyond high school. Meth users were less likely to be working or living independently, or be self-referrals into treatment. More meth users were likely to be referred into the treatment system by social services or non-DUI criminal justice. Meth-using clients were likely to have had prior treatment episodes and were enrolled in more intensive treatment modalities. They were likely to use tobacco products, be poly-substance users with drug dependency. Clients with meth as their primary drug were also inexplicably less likely to report using it in the 30 days prior to treatment admission. Methamphetamine users were more likely to have moderate to severe family, socialization and work/school issues or problems at admission.

Methamphetamine and Treatment Outcomes

Clients using methamphetamine were less likely to be discharged successfully with no further treatment recommendation and conversely were more likely to be discharged with further treatment recommended. When methamphetamine users were compared with non-meth substance users in treatment, there were no differences in the proportions of drop-outs or terminations, or in progress toward treatment goals. Data show that treatment outcomes for clients who report methamphetamine as their primary or secondary drug are as good as and in some cases better than outcomes for clients using other substances. Because at admission their family, social and work/school issues were of higher intensity they were still, at discharge, more likely to be assessed with those issues at discharge. However, the proportion of meth users employed full-time increased more from admission to discharge than non-meth users.

Fewer meth-using clients reported using their drug during their treatment episode. They were less likely to have DUI-related arrests or to have visited a medical emergency room prior to admission or during treatment. See Appendix F and ADAD's web site (www.cdhs.state.co.us/ohr/adad/index.html) under the Presentation and Reports tab for more detailed information about these studies.

PREGNANT WOMEN IN SUBSTANCE ABUSE TREATMENT

The following is based on the Special Connections Annual Report for July 1, 2003-June 30, 2004 that became available on March 1, 2005.

Special Connections is a collaboration between ADAD and the Department of Health Care Policy and Financing to provide Medicaid prenatal care and substance abuse treatment services for pregnant women in Colorado. To be eligible for enrollment in Special Connections women must be at high risk for poor birth outcomes due to substance abuse or dependence, eligible for Medicaid and willing to receive prenatal care during pregnancy.

Special Connections' goals are to:

- ❖ produce a healthy infant;
- ❖ reduce or stop the substance using behavior of the pregnant woman during and after the pregnancy;
- ❖ promote and assure a safe child-rearing environment for the newborn and other children; and
- ❖ maintain the family unit.

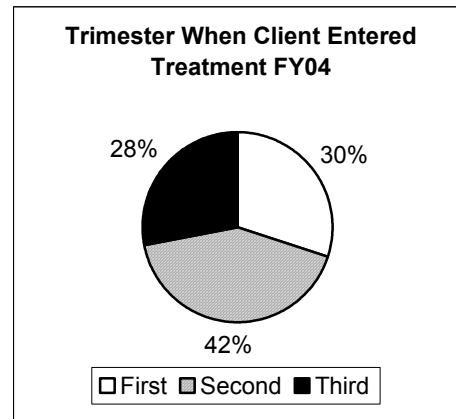
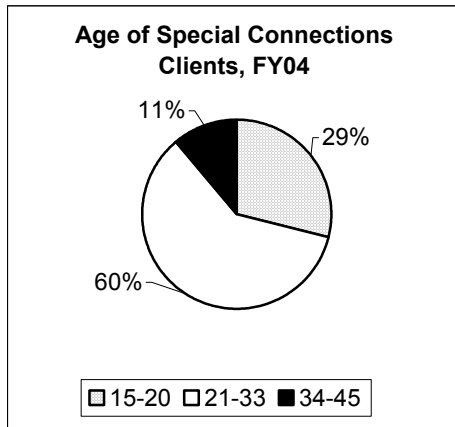
The full extent of the effects of prenatal drug exposure on a child is not known, however studies show that various drugs of abuse result in premature birth, miscarriage, low birth weight and a variety of behavioral and cognitive problems.⁴⁴ The average cost to the Colorado taxpayer of one low birth weight baby was \$6,362 in the year 2000.⁴⁵

Prevalence

In Colorado, the number of pregnant women in need of substance abuse treatment was estimated to be between 1,962 and 5,103 for FY04. In FY04 Special Connections served 334 women and collected information about 163 birth outcomes, indicating an overall treatment retention rate of 48%. Of these 163 births, 12 (7%) infants had low birth weight and 151 infants had normal birth weight, saving the taxpayer \$960,662.

Demographics

Race/ethnicity, marital status and educational level are not considered primary risk factors related to prenatal or neonatal health status.



Almost half of these women were referred into treatment by substance abuse providers (22%) or the criminal justice system (26%).

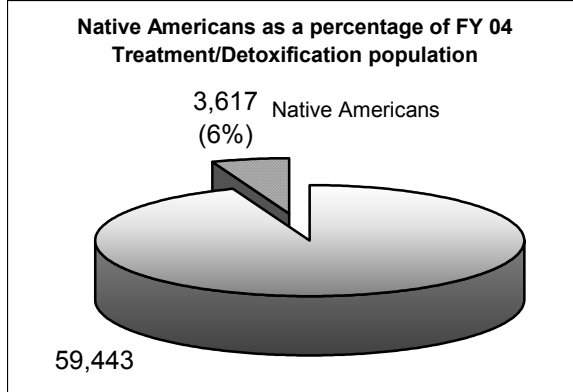
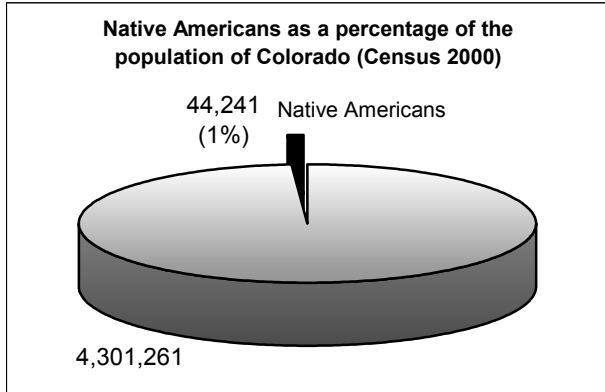
The full report is available on the ADAD web site (www.cdhs.state.co.us/ohr/adad/index.html) under the Presentation and Reports tab.

NATIVE AMERICANS IN TREATMENT

The following information is based on DACODS data compiled into a report titled: **Native Americans in Alcohol and Substance Abuse Detoxification and Treatment in Colorado, Fiscal Years 2003 and 2004**. March 1, 2005.

Prevalence in Detoxification and Treatment Services

In Colorado, Native Americans are over-represented in substance abuse treatment and detox services. They comprise only 1% of the entire Colorado population (Census 2000) but 6% of all clients receiving detoxification and treatment services in FY04.



Most Native American clients in detoxification or treatment services were located in the Denver metropolitan area. The male to female ratio for Native Americans in treatment for FY04 was 2:1; in detoxification this ratio was 6:1.

Demographics

The median age of Native American males in treatment was 10 years older than the age of the general treatment population irrespective of race or ethnicity. Alcohol was the primary drug for Native Americans followed by marijuana.

Native Americans were likelier than the general population in both treatment and detoxification combined to:

- ❖ report lower educational attainment levels;
- ❖ have had prior treatment episodes;
- ❖ be unemployed at admission;
- ❖ have no income;
- ❖ be referred into treatment by self-help groups;
- ❖ be homeless;
- ❖ use tobacco products daily;
- ❖ report beginning use of their primary drug before the age of 18;
- ❖ report having a mental health issue at admission;
- ❖ have used their primary substance (alcohol) daily in the 30 days prior to admission; and
- ❖ be diagnosed as dependent on their primary drugs.

50% of Native American clients in detox were homeless.

50% of Native Americans used tobacco daily, compared to 19% of the general treatment population and 23% of the nation.

Treatment Outcomes

Treatment services for Native American clients in FY04:

- ❖ significantly reduced the number of admissions to medical emergency departments;
- ❖ markedly decreased frequency of use of their primary drugs;
- ❖ were completed by 50% of all Native American clients with half of these being referred for further treatment in a different facility; and
- ❖ resulted in 1/3 of Native American clients reaching high achievement of their treatment goals, and 1/3 reaching moderate achievement; this corresponds closely to the achievement levels of the general treatment population.

75% of all Native American treatment clients were abstinent at discharge.

The full report is available on the ADAD web site (www.cdhs.state.co.us/ohr/adad/index.html) under the Presentation and Reports tab.

CLIENTS WITH MENTAL HEALTH ISSUES IN SUBSTANCE ABUSE TREATMENT

Prevalence, All Service Types

During FY05 there were 18,540 discharges from treatment, Of these, 32% (6,015) of all discharges met the criteria for co-occurring clients.

32% of all clients had co-occurring disorders

Treatment Demographics

The 6,015 discharges of co-occurring clients from treatment services were composed of 4,998 unique clients, a 1.2 discharge rate per person and 32% of the 15,572 unique clients in substance abuse treatment during FY05.

Small variations in demographic patterns were noted between the 4,998 co-occurring clients and the general treatment population. These variations indicated that co-occurring clients were slightly more likely to:

- ❖ be female;
- ❖ be under 18 years of age;
- ❖ be White;
- ❖ be educated beyond high school.
- ❖ have had prior treatment episodes;
- ❖ have been placed in more intensive treatment modalities;
- ❖ have used tobacco products daily;
- ❖ have dependent children;
- ❖ have moderate to severe problems with family, socialization, work or school and physical health;
- ❖ have used their primary drug within 30 days of admission and during treatment;
- ❖ have visited psychiatric and medical emergency rooms; and have been admitted to psychiatric and medical hospitals.

Clients with co-occurring disorders had more severe issues at admission

Co-occurring clients were slightly less likely to:

- ❖ be employed;
- ❖ be married; and
- ❖ have been referred into treatment by the criminal justice system.

Overall treatment outcomes for co-occurring clients were as good as outcomes for the general treatment population.

Treatment Outcomes

Outcomes of the 6,015 discharges of co-occurring clients were compared to the outcomes of the general treatment population.

Clients with co-occurring disorders were less likely to:

- ❖ complete treatment with no further treatment recommended; and
- ❖ have achieved high progress towards treatment goals.

Similar to the general treatment population, co-occurring clients had overall positive treatment outcomes. However, because they had more severe issues to address at time of admission to treatment, they were also more likely to be assessed with those issues at discharge. Overall, the degree of change from admission to discharge was greater for co-occurring clients.

The degree of positive change from admission to discharge was greater for clients with co-occurring disorders

The full report is available on ADAD's web site, Presentation and Reports tab (www.cdhs.state.co.us/ohr/adad/index.html).

RECOVERY – STORIES FROM THE FRONT

Members of Advocates for Recovery believe recovery from addiction is a process of gaining sobriety, hope and joy, and contributing to one's family and community as a healthy, productive person. There are many paths to recovery, and it flourishes in supportive communities, giving back what addiction has taken.

Thousands of people enter recovery every day. Their voices, their stories are rarely heard. Below are several stories of recovery by Coloradoans, which will give a human voice to the statistics about addiction and recovery. These stories were collected by Advocates for Recovery, a grassroots Colorado organization advocating for the recovery community, and by Signal Behavioral Health Network, the managed services organization for northeast and southeast Colorado and metropolitan Denver.

These individuals are willing to share their stories with anyone who cares about addiction and recovery. If you are interested in hearing their stories, please contact Erik Stone at Signal Behavioral Health Network at 303-639-9320, ext. 1015. He will be able to help you schedule opportunities to hear these stories. For more information about Recovery go to the ADAD web site at: www.cdhs.state.co.us/ohr/adad/index.html.

1. Dennis' Story

My name is Dennis Bergquist and I have been a client of Peer I therapeutic community since 8/6/02.

Prior to coming to Peer I my life was going nowhere but in circles. I knew I had skills and abilities, but my drug use kept getting in the way. I often felt hopeless and felt that there was no sense in trying to succeed. So in 1999 I moved to Denver from Boston in search of a fresh start. At that time, I made my first foray into recovery and did have some success. I was sober for over 2 ½ years and I thought I had my addiction under control. I was wrong. I relapsed and it was my worst one yet. It is said that addiction is a progressive disease and with that I would have to concur. As my addiction intensified so did my criminal behavior. My addiction drove my criminality and my criminality fed my addiction. Fortunately for me, I was rescued by the Denver Police Department. They arrested me on January 5th of 2002 for theft and possession of Crack cocaine. When it was all said and done, I was convicted of two new felonies bringing my total to five. The recommendation of the District Attorney's office was 4 years in the Colorado Department of Corrections. However, Judge Rappaport as she put it "took a chance on me." She sentenced me to 6 years of Community Corrections with the stipulation of completing Peer I. Unbeknownst to me, Judge Rappaport gave me the opportunity to change my life in a way I had never thought possible.

I had been sober for 2 ½ years and thought my addiction was under control. I was wrong.

The day I arrived at Peer I, I made a decision that this was going to be the first day of the rest of my life. Again, unbeknownst to me, I was receiving that fresh start that had originally lured me to Denver.

I spent the first year of my treatment in the residential phase of the program. I worked hard because that's the way it is done in a therapeutic community. I learned that, if you want something, you work hard to get it. I learned the value of honesty and integrity. I learned that life has its setbacks, but a setback need only be a setback and not a train wreck. I learned to help when help is needed, and I learned to ask for help when I needed it. With the support of the staff and my peers, I identified many of the deficiencies in my old lifestyle and made the necessary changes. I substituted criminal behavior with pro-social behavior. By the time I reached the outpatient phase of the program, I was confident that I now had the foundation in place that would allow me to succeed and keep succeeding.

I would like to share some of the wonderful things that have come to pass for me in the past two years. First and foremost, I have remained drug and crime free. I enrolled at the Metropolitan State College of Denver in pursuit of a bachelor's degree in Human Services with a concentration in Addiction Studies. I am currently a junior and carrying a 3.6 grade point average. I am presently the President of the Student Body at Metro State, a student body that consists of 22,000 students. I am a board member of the Colorado Student Association and work closely with several of our state legislators on issues that affect higher education in this state. I am employed by the University of Colorado and work as the accounts manager for the student newspaper.

(Since treatment) I have remained drug and crime free. I enrolled in College and have a 3.6 grade average. I am President of the Student Body. I am employed at the University...

One of the professors in the Criminal Justice department, who is aware of my past, asks me each semester to speak to her classes. The classes typically consist of students interested in or currently working in the criminal justice system. She asks me to speak to her classes because I have the ability to share the criminal's perspective on the criminal justice system. In one particular class, I shared with them that I had been convicted of five felonies. They were very upset by that fact that I had not been sent to prison. One student yelled out, "How many chances do you think a person should get before they are sent to prison?" I told her 'I didn't know'. I thought about it for a moment and said, "That's the tough question that all prosecutors and judges have to face everyday and I'm glad I'm not them." I told her I cannot speak for anyone but myself, but all I know for sure is that I needed one more chance. Then I asked the class a question. "Where do you think the last three years of my life would have been better spent, getting treatment for my addiction, in school pursuing a degree, working and paying taxes, or behind bars rotting and costing the taxpayer of Colorado roughly \$120,000 to house me?" The class went quiet.

I am not the only Peer 1 client who is succeeding at Metro State. Recently one of my peers received a \$2000 scholarship from the President's office of the college for achievement. He has a perfect 4.0 GPA and is quickly emerging as student leader on campus. There are many people on campus I would like to thank for their support but most of all I would like to thank them for judging me for what I am doing and not for what I did.

Recently I read in the Rocky Mountain News that one of our state legislators thought a bill should be introduced that would prohibit any one convicted of a felony from ever voting again in this state. His logic was that he did not feel that rapist and murderers should be allowed to elect our state leaders. I am here today to say that not everyone convicted of a felony is a rapist or a murderer. We are son and daughters, mothers and fathers, friends and co-workers, and many of us go on to become productive and successful members of the community.

I would like to thank Judge Rappaport for taking that chance on me. I would also like to thank all other the members of the criminal justice system who believe that people with a substance abuse problem want to change, and given the opportunity they can change. I will wrap this up by quoting Ken Gaipa, the director of the Peer 1 Therapeutic Community, who is often heard saying, "Treatment works". He's right and I know this to be true because treatment worked for me.
Dennis Bergquist

2. Lillas' Story

I was 31 when I entered recovery after 14 years of using. My drug of choice was "more," and I used whatever came my way. I learned to do whatever was necessary to get my drugs, and they took me some pretty low places – the alleys of Chicago, homelessness, illness, constant illegal activity, and all the places addicts know. When I took my problem to a counselor, she told me I

was “a strong woman” and could quit on my own. I spent 5 years trying to prove her right – without success.

By the time I got clean, I was basically unemployable and had given up all my dreams. I was stuck in an abusive marriage, lived 25 miles outside Fargo, N.D., and had a toddler and another baby on the way. After many years using in the bars and in public, my using had become hidden, and I covered it by being “a good mom” who as staying home to care for her children.

My husband entered treatment, and I ended up following a few months later. This time, a counselor who understood addiction convinced me that I couldn’t quit on my own.

I’ve been clean for 20 years. I eventually got out of my marriage and was a single parent for eight years. During that time, I went back to school and got a Master’s degree and a Ph.D. I’ve received several awards and a prestigious fellowship, and a number of my articles have been published. My kids are both grown now and doing well. My daughter – the baby I was pregnant with – has 5 years clean after her own rocky adolescence.

Drugs took me to some pretty low places – the alleys of Chicago, homelessness, illness, illegal activity...

I’ve been clean for 20 years. I went back to school and got a MA and Ph.D. My daughter has 5 years

I’ve gone to 12-Step meetings throughout my recovery and currently attend at least three meetings a week. I’ve also sought professional help for my co-occurring mental illness at times. I am active in my community and hold a responsible management position in the non-profit sector. I’m a home owner – who actually pays her bills! And I’m married to a wonderful man who has 21 years clean.

Most of all, I am content and satisfied with my life (most days) – and looking forward to continuing to live “just for today.”
Lilias Jarding

3. Pat’s Story

My father is a recovering alcoholic. I didn’t think it could happen to me. I didn’t really start drinking until I was in my late 20’s. I was divorced and raising 2 kids on my own. At first, it was just a 12 pack of beer on the weekends, then beer after work. I injured my back and discovered that, if I took a couple of my pain pills, it only took me a couple of beers to get a good buzz. For the next 6 years I held to not drinking too much so I could still go to work.

I was battling my ex-husband every year for custody of our son. When our son turned 12, I no longer had any money to fight for custody and I had to let him go live with his father. The night he left, I went and bought a four pack of wine coolers, that didn’t even begin to ease my pain. I remembered my brother’s drinking hard stuff when I was young and they would get really hammered. I liked margaritas so I thought I would try tequila. That did the trick for a little while, but soon it was pills, beer and tequila.

I didn’t think it could happen to me.

I began to realize I had a problem and decided to try AA. It was a small town and I was the only one there under 55. So I was attending AA and stopping on the way home for my fifth. By this time, I was drinking to keep from going into withdrawal, bottles were stashed all over, and my daughter was basically raising herself. Out of nowhere, my ex-husband sends our son back to

me when he was 15. Needless to say, my son found his own relief from alcohol. When I was not fighting with him, I was taking his alcohol and drinking it.

Some where in my drunken stupor, I knew I could not go on like this. I asked my best friend to take my daughter to my sister's. I knew that I had to do something but didn't know what. My friend says something about taking care of my animals first and I lost it. I think I blacked out. The next thing I remember is sitting on top of her with my fist ready to hit her. I thought, "I would rather be dead than to be the person I have become." Thank God my friend understood and took my daughter. The next morning I packed a bag not knowing where I was going. I stopped at the liquor store, got my bottle, and began driving. I decided to go to my youngest brother's. He lived out in the middle of nowhere and he drank. If I got there early enough, I could be hammered before he got there. Sitting out in my pickup behind his house, I cracked open my brand new bottle getting ready for the first taste of oblivion when he pulls up 2 hours early. I remember telling him that I didn't want any one to know I was here, but that I was going to drink and when I was done I would know what I was going to do. I drank that bottle and found a gallon of tequila in his fridge and finished it off. I remember thinking I am still alive.

I would rather be dead than be the person I have become...

One of my older brothers lived in Greeley and I knew they had a detox unit there so I told him to take me there. My first run at sobriety I did well. I had 90 days sober and was thinking I had a chance. I went to my home town to spend the weekend with my parents. One of my older brothers said he needed to talk to me. This is when my hell really started. This brother had sexually abused me while I was growing up. He was mad because I had told my daughter about the baby I had given up and that it was his, and she had told his daughter. First off I didn't tell her, my ex-husband did and when she asked me I had told her the truth. It was not my fault he hadn't been honest with his kids. I held it together for a couple more weeks until out of the blue comes another "blast from the past" - the son I had given up was trying to locate me. I lost it and didn't care about anything I wanted to die and the only way I was going to get there was through that bottle. I was willing to take anything in my way out.

My family had no choice but to try and stop my insanity. They initiated an involuntary commitment on me. I thought how dare they, growing up they weren't concerned about my well being and who in the hell is Yolanda Gray and how can she judge me when she doesn't even know me. There were several months yet of my continuing to drink and tear up my family and anyone else who got in my way.

Yolanda Gray put me in the Circle program in Pueblo. For the first time in my life, I knew that if I didn't get it I would be dead. I was able to totally commit to me. I worked on my behaviors, my PTSD, depression, the sexual abuse issues, the fact that I am a lesbian and had stayed in the closet for the past ten years. I opened up and became honest about my drinking, sexual orientation, acknowledged that I was responsible for the rest of my life. I know that I am one of the lucky ones. People I met in treatment have died; others are still out there using.

A year after I left the Circle program, I was driving a cab in Denver when I picked up a passenger with a disability. He asked me to stop by a liquor store. I did but then he asked me if I would place his order for him. His order was a pack of Marlboro 100's and a quart of vodka. It hit me that I could not ever do that again. I went home and asked God what he wanted me to do. The next morning I was at the airport and bought a paper something I had never done before. When I opened it, the ad from Arapahoe House jumped out at me. Two weeks

I now have 5 ½ years sober, a job I love and am getting to enjoy watching my grandsons grow up.

later I began working for them. Two months later, I answered the phone at work and on the other end was Yolanda Gray. At first, I was in shock but then I recovered and thanked her for saving my life. I now have 5 ½ years sober, a job I love and am getting to enjoy watching to grandsons grow up. I continue to thank Yolanda Gray and ADAD for giving me my life back.
Pat Headley, Case Manager, Arapahoe House - Proud

4. Tami's Story

So how do I write a story of my addiction that started 30 years ago? Just simply copy someone else's? Aren't we all alike anyway? No, we are NOT! Every story is unique, every story is important, because it is ours and ours alone, we individually lived the horror of everyday being the same as the last, another day of a prison we allowed to be built around us. Each brick validated by the promise of the pain being taken away. And it did. But only to be brought back seven fold.

The pattern continues until one of only two things happen...DEATH or JAIL...BUT I'm one of the lucky ones who found a 3rd choice - Denver Health!! I have now been clean for five years three months and one day and I have the wonderful people employed at Denver Health to thank. And I do on a daily basis in my blessings. I now realize how unique I am, how important I am. It took work, patience and discipline, but I am becoming my authentic self and a person I look at with a smile in the mirror each morning, thanking God I woke up with a clear mind, people I love, people that love me, and a chance to live without running from the horror of my growing up and the chaos that occurred during that time. That I now have the strength, the tools, and most of all the DESIRE to face my demons and say I'm NOT letting you take ANY MORE of my life away. And how could I NOT with the army of people at Denver Health fighting on my side!

The pattern continues until one of two things happen – DEATH or JAIL... I'm one of the lucky ones. I have now been clean for 5 years, 3 months and 1 day.

I am currently under the care of a very wise, caring, brilliant and insightful counselor/therapist/ teacher that has helped me get over another hurdle in my recovery. It's one of learning to live, or how to live without drugs of some sort. I didn't realize that you can quit using, but continue to exist how you were. Seeing yourself as "JUST another recovering addict", counting days, not knowing or being too afraid to "get back out there." And that's exactly what Nachshon has helped me to learn. With this new found confidence and courage to realize how individual I am, how unique and important I am, I give you my story.... in a nutshell, of course!

Age 14 is my first year of clear memories of hell. I was molested by my stepfather. Please don't picture your average pot bellied drunk on the north corner. He's Mr. Roger's neighbor - help the community, support the family, white collar V.P. I began drinking, smoking pot etc... Then of course how do you feel even better? SEX! After all at least I'm consenting, right??! I'm the one in control!! First of many many many lies I would tell myself. I spent the next 8 years going from boyfriend to boyfriend, overlapping usually, and experimenting with pot, LSD, different varieties of speed with a statement of "At least I'm not doing HEROIN." Ahhhh the karmic humor of it all.... I married at 23 (marriage #1) after a \$7,000 wedding, doing coke in the bathroom (Yes before the ceremony too) and being naked with most of the wedding party in the honeymoon suite, not sure if I'd made love to my husband. I realized I had to be a faithful, loving wife! Couldn't do it, so I bailed after

Age 14 is my first year of clear memories of hell. I was molested by my stepfather. I began drinking, experimenting with pot, LSD, coke...

8 months. Another 6 years of cocaine and sex. Again the scene is not of grungy panhandling stereotype. It is me being a successful cosmetologist, dating great looking "preps" (yes were in the 80's) with great looking trust funds. Living in Vail, expensive except for the drugs. Buy one, do me, get one free!

Thought I had an epiphany one day and down the mountain I came with more lies of change. Met my #2 husband, had my first son, thought I had it in the bag! Certainly my love for this child will keep me on the straight and faithful! Not! I had a wonderful, loving, responsible, caring, hard working, supportive (OH HOW BORED I WAS) husband, and this beautiful perfect God given son.... So why not have an affair with a drug addict drunken asshole! What? Doesn't everyone sabotage wonderful things and hurt undeserving people out of boredom? I'm still not getting it! I'm bored because I don't know how to do this white picket fence thing. I need to be hit, hurt, beat, drugged up and drunk to be alive! Another divorce! What a surprise, I know! Now I've gone back to work with a fantastic office job and I've discovered how wonderful and far more classy "scripts" were. A nurse I ran around with gave me some "percs" for a wicked "coke hangover". So now I can party and still put on a conservative face. In a bar, I meet #3! Lo and behold he's an alcoholic. A fine looking, romantic, functioning alcoholic. Just like my Grandpa and Uncle who were the only two male role models I had who I loved dearly. Both are now dead from alcohol.

For the next 5 years, I accelerate drastically on the prescriptions. At least I'm not doing HEROIN! I played all the games, said all the lies. I even had to keep a log of doctors and pharmacies and which fake ailments went with each. During this time, I gave birth to my second son. I kept it clean for both of my pregnancies. For that I am proud. For the first two years and then some, my second son's life was doctors and pharmacies. Or a mommy so sick she called Daddy home from work! Flu again!!!.... But see Daddy didn't mind, didn't want to realize, because as long as I was there, I wasn't on his ass about drinking!! The pain meds made me tolerate ANYTHING! ... It's ALL COOL, go get my pills! The more he drank, the more pills I took! Not his fault for my actions! It was my decision to take the drugs. I accept full responsibility for my actions! ALL of them. I'm just glad I learned before death and/or jail why I was making all these bad choices! And how I learned and made the promise to myself that wasn't a lie was the sad eyes and tired voice of a 2 ½ year old... "Mama, I don't wanna go to the doctors today, I wanna go weweeeee (swing)."

For the next 5 years I accelerate drastically on the prescriptions.

I went to Denver Health-April 27, 2000. There were a few slaps across the face that last few weeks of using, but that one was the grand finale! For the next 5 years 3 months and 1 day, I have been working on becoming and STAYING a clean and sober authentic person. And come to find out prescription pain meds are a form of HEROIN! Can be even worse.... Oh the lies we can convince ourselves of. And I could justify ANYTHING! There are SO many level, steps or whatever works for you to go through to recover and stay that way. It's not about taking your medicine and going on with your day. It takes away the physical addiction. But the mental addiction is the way it all began. The physical just joined in. It takes learning why, accepting the things that we can never take back and/or change. The serenity prayer... I finally get it. Then learning how to "start over" halfway through your life, when LOTS of bridges may have been burned and a lot of people gone. Learning to get out in the world and function without feeling "different" or "not as good as." And when the lies, the way of life, what you've done, who you've done come crashing down from the land of "f ____ it" to land of reality, it takes a lot not to run for your favorite rose colored glasses, A.K.A. drugs or alcohol! Most people relapse without support or "dosing" only. That only keeps the physical hold. (Which

I had to keep a log of which ailments went with which doctor.

don't get me wrong, is HELL, wishing for death) But the mental needs too! The guidance and knowledge I've received at Denver Health is priceless! Many times I've come close to going to the nearest "drug store" but there was ALWAYS someone to talk it out with me. Through groups and meeting people that were on the same boat as you, you realize you are NOT alone. It does get better and you have a reason to be clear headed!

I hope I've given some idea of my journey. When I came to Denver Health, I was treated with kindness and care. I was given encouragement that things could and would get better. I'm glad and beyond thankful that they were there. If not, I know that either by death or jail, my sons would be without their mama! They are becoming really great people and don't have to worry about losing their mom, only their homework! Thank you with sincerity.
Tami Puccini

The guidance and knowledge I received at Denver Health is priceless! There was always someone to talk it out with me.

5. A Story of Recovery

I am a 22 year old single mother of two boys, ages 6 and 4, and am expecting a baby in August. I am also a recovering drug addict/alcoholic. I was a client in the SuBebe Program at Denver Area Youth Services (DAYS) during my first two pregnancies and have returned to SuBebe for additional assistance with my drug and alcohol issues.

The first time I attended SuBebe was in 1999 and my drug of choice was marijuana. I dropped out of the program due to the fact that I felt I did not have a problem with drugs.

The first time I attended SuBebe was in 1999 and my drug was marijuana. I dropped out due to the fact that I felt I did not have a problem with drugs. I went back when I became pregnant again...

I went back into the program when I became pregnant the second time, during which time I was involved in an abusive relationship. I showed up for group the night after my boyfriend hit me in the face, chipped my tooth and kicked me in the stomach. When my counselor tried to give me the help that I needed and took me to the hospital, I refused to talk to the police or any of the Investigators because they wanted me to prosecute my boyfriend. I got scared of what my partner would do to me again so I dropped out of the program a second time. The counselors from DAYS would call and come by my house and leave notes for me to contact them, however I would not return their calls and refused to have any contact with them. I married my boyfriend in 2002 despite the fact that he continued to beat me. We stayed together until 2003.

I started experimenting with methamphetamine.

Over the years I started experimenting with methamphetamine and crack/cocaine and pretty soon I was smoking crack on a daily basis. I continued to smoke crack for a year and then found out I was pregnant for the third time. I continued to use drugs for another month after finding out I was pregnant until I got to the point where I knew "enough was enough". I came back to DAYS in April of this year because I knew that I needed a support system and did not want to relapse. Now I realize that my children and my life are much more important than using drugs.

When I was asked to write this letter, I agreed because I want people

People can change, but without treatment programs a lot of people will not be successful at recovery.

to know that if a person wants to change, they can. But, without the programs such as DAYS and other treatment programs, I believe a lot of people will not be successful at recovery. Thank you for reading my story. This single mom is changing!

Story provided by Maggie MacFarlane of DAYS in June 2005; name withheld at client request.

These stories are available in their entirety on the ADAD web site under the Recovery tab. A note of caution: the stories posted on the web site are unedited and may contain language that some may find offensive. The ADAD web site is located at: <http://www.cdhs.state.co.us/ohr/adad/index.html>

SUPPORT FOR KATRINA VICTIMS

The Alcohol and Drug Abuse Division's Disaster Response Coordinator (DRC) is responsible for organizing the provision of substance abuse treatment services during local, state and national disasters that impact Colorado. When the evacuees from Hurricane Katrina began to arrive in Colorado, the DRC arranged for substance abuse counselors from ADAD-licensed agencies across Denver to provide services on-site at Lowery Air Force Base. The DRC arranged for self-help groups, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), etc. to offer meetings, schedules and books to the evacuees. Since Colorado is expecting many of these evacuees to remain in the state, the DRC has been involved in arranging for a wide array of continuing services, with applicable monitoring of quality of care.

14. RESEARCH AND SPECIAL PROJECTS

PREVENTION

- **Prevention Summits**

ADAD is participating with the Prevention Leadership Council (PLC) to plan a summit in January 2006 to present the accomplishments of PLC prevention professionals working in education, health, mental health and substance abuse. The PLC is responsible for implementing C.R.S. 25-20.5-102, The Prevention, Intervention and Treatment Services for Children and Youth Act.

- **Diffusion Consortium Project**

The second 5-year cycle funding for the Diffusion Project was initiated in April 2003 and funded by the National Institute on Drug Abuse (NIDA), the Center for Substance Abuse Prevention (CSAP), the U.S. Department of Education (USED) and the Office of Juvenile Justice and Delinquency Prevention (OJJDP). This project established a seven state consortium. In Colorado, an experimental community has been chosen to study the prevention of youth substance abuse through the development and funding of the Communities That Care operating system. Outcomes will be compared with a similar control community that is not implementing that system of training and technical assistance. Prevention staff participate in regularly scheduled conference calls, annual meetings and in the Advisory Committee that provides assistance to 12 community action plans in the seven states to ensure both the experimental and control communities participate in student surveys.

- **Traffic Safety for Youth**

ADAD and the Colorado Department of Transportation (CDOT) developed an interagency partnership to prevent underage drinking. This project targeted youth 14 -18 years of age, emphasized the prevention of drinking and driving, and riding with someone who has been drinking. CDOT supplied funding for 3 high-need communities to do a readiness assessment. This partnership completed its objectives in September 2004 and the results were used to develop action plans in each community.

- **Persistent Drunk Driving (PDD)**

PDD education funds support programs intended to deter persistent drunk driving or to educate the public on the dangers of persistent drunk driving, with particular emphasis on young drivers.

- In FY05 14 Colorado counties were funded, based on juvenile-alcohol and DUI related arrest rates. Each county received \$10,000-\$15,000 from a total allocation of \$210,000.
- In FY05, 53% of the population who received PDD prevention services was between the ages of 12 and 20. A substantial increase in the percent of persons aged 25-44 was noted as a result of increased focus on parents (from 10% in FY04 to 21% in FY05) and their roles in monitoring youth substance use and driving behaviors.
- In FY05, 21,000 individuals received PDD prevention services, compared to 14,000 in FY04. For those programs that provided direct services to youth, 30-day alcohol use decreased from 38% to 27%, as did marijuana use (22% to 11%). Only 4.8% of the population reported using amphetamines at the beginning of the program, and by the program end this decreased to less than 1%.
- PDD funds were used to:
 - train an additional 148 addiction counselors in FY05 in the use of a model DUI curriculum, bringing the total number of counselors trained to almost 900;
 - train Alcohol and Drug Evaluation Specialists who conduct evaluations on DUI/DWAI offenders for the courts;
 - update and distribute brochures on the Ignition Interlock Program;
 - support a media campaign and educational worksite program in the San Luis Valley and Steamboat Springs, both areas at high risk for repeat DUI offenders, to interrupt the pattern of repeat offenses; and
 - complete an evaluation of the system for handling DUI/DWAI cases in Colorado; the final report, completed in 2004, includes recommendations for improving outcomes in DUI/DWAI cases.

- **Law Enforcement Assistance Funds (LEAF)**

Legislation created a surcharge on drunk and drugged driving convictions to help pay for enforcement, laboratory charges and prevention. In FY05 Judicial allocated \$250,000 of the surcharge dollars to ADAD to establish community-based impaired driving prevention programs for these mandated populations: the general population; teachers of youth; health professionals; and law enforcement. In LaPlata, the Summit/Lake partnership, Chaffee and Mesa counties, prevention programs focused on 13 -16 year old drinkers already at high risk for becoming impaired drivers. Program activities included life skills training, job skill preparation and substance-free recreational activities. These activities have resulted in a significant improvement in youth behavior. In Summit county, another project involving educators, health care providers and youth ages 5 to 26 targeted social norms and resulted in a dramatic decrease in DUI arrests. Law enforcement, public safety officers and local non-profit agencies enthusiastically collaborated with ADAD on these projects.

- **SYNAR and Funding Impact**

The federal block grant requires Colorado maintain enforcement activities to reduce underage access to tobacco. Non-compliance (exceeding a predetermined sales rate of 20% to youth) with SYNAR will result in a penalty of 40% of the Block Grant (approximately \$8 million for Colorado). ADAD works closely with the Department of Revenue and the Department of Public Health and Environment to conduct enforcement activities. Current compliance checks and analyses show that Colorado meets all Synar requirements. The non-compliance rate for 2005 was 12%.

- **Capacity Development**

ADAD formed a workgroup of representatives from state agencies that provide prevention services to address standards and competencies for coordinated capacity development (previously called workforce development). This task falls under the purview of the Prevention Leadership Council. The goal was to develop a research-based process that assures the availability of quality training and technical assistance to the prevention workforce in Colorado. In FY05 this planning group developed the tool and process for assessing the application of the

Uniform Minimum Standards and Agency Core Competencies. This process will be standard across agencies and will be used to determine training and technical assistance needs. The tool is scheduled to be piloted in FY06.

- **Prevention Peer Review**

ADAD and the Colorado Association of Alcohol and Drug Service Providers (CAADSP) developed a prevention peer review process to promote continuous quality improvement of prevention programs. This process was based on research, literature and past experience. CAADSP also conducted annual peer review site visits of treatment programs in accordance with federal block grant requirements.

- **Higher Education Initiatives**

ADAD continued to increase its efforts to address underage drinking in higher education by collaborating with the Colorado Alcohol and Drug Educator (CADE) network and the federally funded Center for College Health and Safety's Higher Education Center for Alcohol and Drug Prevention. In FY05 ADAD funded the Bacchus and GAMMA Peer Education Network to provide state coordination services for CADE. This contract, which will be continued in FY06, provides training, resources, information and support for campus professionals responsible for alcohol and drug prevention and health promotions at two and four year institutions of higher education in Colorado. An ADAD prevention staff member and the CADE coordinator attend the annual Statewide Initiative Leadership Institute funded by the Center for College Health and Safety's Higher Education Center.

- **Strategic Prevention Framework, State Incentive Grant (SPF SIG)**

Colorado was one of twenty states awarded the SPF SIG on September 30, 2004. The SPF SIG is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP) and brings approximately \$2,350,000 to Colorado each year for five years. It is based on interagency collaboration and ADAD is the lead agency for the Governor's office. The SPF SIG was designed to build capacity and infrastructure at State and community levels, reduce substance abuse-related problems in communities and prevent the onset and reduce the progression of substance abuse, including underage drinking. In the first year of the grant a state epidemiological workgroup (SEW) conducted an assessment of highest need areas in Colorado. A SPF SIG Advisory Council then used this data to prioritize these areas as potential funding sites and partners. Collaboration with these areas will begin in January 2006.

TREATMENT

- **The Interagency Advisory Committee on Adult and Juvenile Correctional Treatment**

(IACAJCT) continues to work collaboratively to improve the supervision and treatment of offenders. Four sub-committees of cross-agency staff: Juvenile and Adult, Screening and Assessment, Treatment, and Research work on the following projects, respectively: 1) improve the quality and utility of standardized juvenile and adult screening, assessment instruments and procedures used by the member agencies; 2) improve the quality of offender specific curriculum; and 3) establish a cross system response to the evaluation of interagency program data and program effectiveness. The IACAJCT oversees the Drug Offender Surcharge budget and the implementation of SB03-318.

- **Drug Offender Surcharge**

The Drug Offender Surcharge Fund (HB 91-1173) (DOS) levies fines on offenders who are arrested on felony drug abuse charges. These fines fund interagency efforts to improve community safety and reduce criminal recidivism by increasing the amount and effectiveness of supervision, substance abuse treatment, research and training specifically designed for the offender population.

- **Short Term Intensive Residential Remediation (STIRR) and Related Programs**
 In cooperation with local treatment providers, ADAD offers a range of services for adult offenders. STIRR is an intensive residential substance abuse treatment program with continuing care services for adult male and female offenders who have severe levels of alcohol/drug-related criminal behavior. Treatment through the STIRR program offers offenders an alternative to imprisonment, and is funded with Colorado Drug Offender Surcharge Funds as well as block grant funding. Arapahoe House, Inc. in Denver operates a 20-bed 14-day intensive residential program for adult males, with a 5-week aftercare component. Crossroads Managed Care Systems in Pueblo operates a 10-bed, 14-day intensive residential program for adult males and females (separate programs) with a 9 to 28 week outpatient/aftercare component.
- **Web Infrastructure Treatment System (WITS)**
 During FY05 ADAD evaluated CSAT's practice management, data collection and analysis system for substance abuse treatment providers, to determine if it would be feasible for Colorado to implement WITS in addition to or as a replacement for TMS. The evaluation process involved the MSOs, Information Technology Services (ITS) staff, treatment providers and ADAD management and data staff. WITS is C#, .net technology, and has been successfully implemented in and customized for several states. In spite of CSAT's generous offer of technical assistance for a year, ADAD determined that ongoing technical support for WITS in Colorado would be problematic and chose to remain with TMS.
- **Drug Control and System Improvement Program (DCSIP)**
 The Intensive Offender Outpatient (IOO) program provides outpatient substance abuse treatment services for male and female offenders. This program is funded through the Division of Criminal Justice, Colorado Department of Public Safety. IOO provides participants with cognitive behavioral skills necessary to remain free of both addictive and criminal behavior. Arapahoe House has implemented the program in Denver as offender-specific outpatient services.
- **Strategies for Self Improvement and Change (SSIC) Training Program**
 Funded through Drug Offender Surcharge Funds, the Center for Interdisciplinary Studies has developed a treatment curriculum designed for substance abusing offenders. Since its inception, over a thousand counselors in Colorado have received training in SSIC. The curriculum is a standardized and research-based treatment approach that addresses criminal thinking of male and female adult offenders as well as their substance abuse treatment needs. It includes a gender-specific provider's guide for female offenders. Additional funding from the Office of Juvenile Justice supported the development of a parallel cognitive restructuring and coping skills curriculum for high-risk adolescent offenders called Pathways to Self-Discovery, first implemented this year.
- **Database Infrastructure Grant**
 ADAD completed the last and final year of a 3-year grant from CSAT to support data infrastructure. Grant monies funded 1 FTE Data and Business Analyst whose tasks included aligning TMS functions and output with ADAD's business needs and federal requirements such as the impending National Outcome Measures (NOMS) and State Outcome Measures Management System (SOMMS). These grant funds allowed ADAD to: improve information response time and the quality and accuracy of information submitted to requestors, including the federal agency funding the block grant; decrease the error rate from a historically high number (thousands) to essentially zero in the federally required, monthly submission of the Treatment Episode Data Set (TEDS); train new providers in the use of TMS and the submission of DACODS data; continue to implement components of the original design plan for TMS; and prepare the technology required to comply with NOMS and SOMMS.
- **ADAD Forums**
 ADAD hosts two statewide informational forums annually to share the latest research, outcome studies and best clinical practices with those interested in substance abuse treatment and prevention in Colorado. Overall evaluations for both forums were "excellent."

- 1) **Understanding Brain Chemistry, Addictions and the Role of Nutrition**
on February 10, 2005
Jean Armour, BSN, LPC, CACIII and Executive Director of Pyramid Consulting presented "The Delicate Balance of the Brain; What It Does, How It Does It, and How Substances Disrupt It."
Laurie K. Mischley, ND, University Health Clinic Specialty Care & Research Center presented "The Role of Nutrition in Substance Abuse Treatment: the Biological Component in the Bio-Psycho-Social Model of Addiction."

- 2) **Intersection of Childhood Trauma, Addiction and Mental Health** on July 14, 2005
Robert Anda, MD, MS, and Co-Principal Investigator of the Adverse Childhood Experiences (ACE) Study presented "Findings from the Adverse Childhood Experiences Study."
Nancy VanderMark, MSW, CACIII and Lead Researcher at the Colorado Social Research Associates presented "Results of the Women and Violence Study."
Several Guest Speakers presented "Voices of Experience: Women with Lived Experience of Trauma, Substance Abuse and Mental Illness."

The forum topic planned for calendar year 2006 is "Women DUI Offenders." Instead of a second forum ADAD will be offering providers an in-depth training in Medicaid, to prepare them to participate in the Medicaid substance abuse treatment programs.

- **Follow-up Studies and Recidivism**

ADAD periodically conducts follow-up studies to examine how well clients have maintained goals achieved during treatment (e.g., drug abstinence).

- In 1992 ADAD studied 868 clients discharged from publicly funded treatment programs in FY1990, between 9 and 23 months post discharge. Findings included:
 - 36% of clients reported full or part time employment at admission, compared to 60% at time of follow-up
 - 59% of clients had prior arrests of any kind at admission, but only 19% reported any arrests at time of follow-up
 - 62% reported no use of their primary drug at follow-up, while 46% reported complete abstinence from alcohol and/or drugs at time of follow-up
 - 76% were not readmitted to any substance abuse treatment program
 - 75% of all clients interviewed reported they experienced positive changes in their substance use
 - About half (46%) felt that employment status and living situation (52%) had changed for the better

- In 1998 ADAD conducted a similar follow-up study on 277 clients discharged between July and October 1997, 6 to 11 months post-discharge. Findings included:
 - 67% reported full or part time employment at admission, compared to 81% at time of follow-up
 - 77% reported prior arrests of any kind at admission, but only 18% reported any arrests at time of follow-up
 - 78% reported no use of their primary drug at follow-up, and 51% reported complete abstinence from alcohol and/or drugs at time of follow-up
 - Mean monthly income rose by \$496
 - 80% felt they were coping with life situations better at follow-up than before they entered treatment
 - 50% rated their overall treatment experience as very good or excellent

- **DUI Demographics**

ADAD, in accordance with a legislative audit recommendation, completed the second year of phasing in a requirement that DUI providers submit DACODS information on each of their DUI clients. During FY05 ADAD identified those DUI providers not yet submitting DACODS and invited them to another series of statewide trainings. These sessions reviewed in detail how to complete a DACODS data collection instrument and how to submit data electronically using ADAD's Treatment Management System (TMS). Overwhelmingly the provider response to these trainings was positive and supportive. DUI client demographic data is now available and has been included in this report for the first time.

This phase-in process has expanded the percent of DUI providers submitting client data from 37% to 65%. This additional information has enhanced ADAD's view of statewide substance abuse issues, services and gaps as well as provided for a comparison population for those in non-DUI treatment programs.

In FY06, ADAD will focus training efforts on those ADAD-licensed, community-based providers who have not yet submitted DACODS information. Staff will also offer periodic trainings as DACODS or TMS updates or provider staff turnover occur.

15. STRENGTHENING THE OPERATION: PLANS FOR THE FUTURE

- **Division of Prevention and Intervention**

ADAD works closely with the Division of Prevention and Intervention at the Colorado Department of Public Health and Environment (CDPHE) to provide input into a state plan for prevention and intervention services. The Department of Human Services has entered into a formal memorandum of understanding with the CDPHE to coordinate the implementation of the plan.

- **ADAD's Data Infrastructure**

ADAD continues to improve and expand the Treatment Management System (TMS), the web-based client server system for ADAD's primary data collection instruments: DACODS and the Discharge Referral Summary (DRS). The Persistent Drunk Driver Project (PDD) is one such expansion.

In the present DUI system, court evaluators assess DUI offenders for treatment needs and refer them to DUI education and therapy providers licensed by ADAD. These DUI providers rendered services and submit data to ADAD and to probation only at the time of the offender's discharge from services. Some individuals may take years to complete their education and/or therapy, during which time there is no feedback about clients to the court evaluators, probation, ADAD or the providers.

In an effort to improve the safety of Colorado's highways, ADAD, in collaboration with Judicial, created the PDD project. This project will enable court evaluators, probation, DUI providers and ADAD to query TMS for real-time data about the status and compliance level of their clientele as they progress through the DUI remediation system. This data will promote better coordination between these interdepartmental entities, including the Department of Revenue Division of Motor Vehicles, which queries TMS DUI records to assure offenders completed the recommended treatment before reinstatement of their vehicular license. ADAD plans to develop and implement the PPD Project in FY06.

Two other major enhancements to TMS are planned for FY06. The first relates to NOMS. The federal funding agency will be requiring states submit new outcome measures that will promote consistent data collection on substance abuse treatment services nationwide. CSAT is in the process of defining these measures. ADAD will need to revise DACODS and TMS to comply with NOMS requirements.

The second major enhancement relates to the Medicaid substance abuse treatment benefits. ADAD will be responsible for collecting DACODS data on these Medicaid clients and reporting this information to Health Care Policy and Financing, the state entity managing the Medicaid program. ADAD data staff anticipate revising DACODS and TMS to interface with the Medicaid Information Management System to track client demographics and service authorization and utilization.

- **Medicaid**

- Medicaid Waiver

- House Bill 1075 allows for an extension of Medicaid eligibility from 60 days post-partum to one year for women who began their substance abuse treatment during their pregnancies. This bill extends the amount of time a woman can receive outpatient and residential substance abuse treatment after delivery, and provides additional recovery support during the critical first year of an infant's life. Health Care Policy and Financing (HCPF) has submitted the waiver and ADAD awaits notice of its approval. This benefit is planned to become effective January 1, 2006.
- An additional benefit will cover detox, residential and outpatient substance abuse treatment services for Native Americans treated by a Tribal "638" provider-based facility. ("638" is defined as a facility owned and operated by Native Americans and located on the reservation.)

- Outpatient Substance Abuse Treatment Benefit

The Legislature created an outpatient Medicaid substance abuse treatment benefit for certain identified high-risk populations in Colorado. This benefit is planned to go into effect July 1, 2006. HCPF will administer the benefit and ADAD will lend its expertise in substance abuse treatment to assist in its implementation and ongoing monitoring. The eligibility categories are: low income pregnant women; foster or adopted children placed by Child Welfare; persons receiving SSI or Colorado Old Age Pension; the elderly, blind and disabled in long-term care and persons with Traumatic Brain Injury or HIV/AIDS.

- **Evidence-based Practices**

ADAD is working closely with providers and researchers to incorporate evidence-based practices in the substance abuse prevention and treatment settings. This shift in approach has been shown to positively impact client outcomes, facilitate clinical monitoring, promote increased accountability and improve the effectiveness of services rendered.

- **Strategic Plan**

ADAD developed a 5 year strategic plan to position the division to meet current and future challenges with limited resources, to improve the division's effectiveness, incorporate lessons learned, refocus priorities on evidence-based practices and strengthen collaborations. During the development process ADAD management reassessed and clarified values, examined the organizational culture and core business tenets, reaffirmed the division's commitment to its target populations and redefined its collaborative structure. Work proceeds on integrating evidence-based practice into all aspects of substance abuse prevention and treatment. Plan development is expected to continue throughout the next fiscal year.

16. RECOMMENDED LEGISLATION IN THE FIELD OF ALCOHOL AND DRUG ABUSE

Create a Parity Law for Substance Abuse Treatment in Colorado

Under parity substance abuse treatment would be subject to the same benefit levels and limitations as other chronic relapsing disorders.

- o Treatment and management of addiction is essentially similar to that for any chronic and relapsing disorder, such as diabetes or hypertension; yet the insurance industry continues to impose restrictions on treatment. These restrictions cannot be justified as sound health care or drug control policy. Parity will help close the treatment gap by utilizing private health insurance coverage.
- o Parity will help bring drug treatment more fully into the mainstream health care system, and will encourage the development of more pharmaceuticals to treat addiction.
- o Research indicates that the effect of substance abuse parity on insurance premiums would be minimal. A study by the National Institute of Mental Health found that in states where parity was introduced, the actual costs were even lower than was expected from actuarial estimates.
- o Parity will reduce the overall burden of substance abuse to society. The costs associated with the abuse of alcohol and drugs are avoidable. Data from several major studies have demonstrated that abusers in treatment programs have shown decreased drug use, lower crime rates, better social functioning and reduced likelihood of transmitting serious disease through needle sharing.

17. DIVISION CONTACTS

The Alcohol and Drug Abuse Division
Colorado Department of Human Services
4055 South Lowell Blvd.
Denver, CO 80236-3120
(303) 866-7480
Fax: (303) 866-7481

<u>Title</u>	<u>Name</u>	<u>Phone</u>	<u>E-mail</u>
Division Director	Janet Wood	(303) 866-7486	janet.wood@state.co.us
Chief Financial Officer	Laurel Healey	(303) 866-7509	laurel.healey@state.co.us
Director of Clinical Services	Mary McCann	(303) 866-7488	mary.mccann@state.co.us
Director of Prevention	Mary VanderWall	(303) 866-7503	mary.vanderwall@state.co.us
Director of Evaluation & Info	Nancy Brace	(303) 866-7502	nancy.brace@state.co.us
Director of Treatment Licensing	Rich Keil	(303) 866-7487	richard.keil@state.co.us

APPENDIX A: Detailed Tables and Graphs of Client Demographics

Table 1: Generational Drug Habits, FY2005 (See page 14)

Age Ranges	Sedatives Tranquilizers*	Stimulants	Opiates	Marijuana	Hallucino- gens	Club Drugs	Other	Total
Y Generation	1,089 26%	804 19%	71 2%	2,157 52%	10 <1%	20 1%	20 <1%	4,171 100%
Generation X	2,839 39%	2,605 36%	522 7%	1,196 17%	6 <1%	19 <1%	14 <1%	7,201 100%
Baby Boomers	2,162 54%	1,065 27%	449 11%	280 7%	2 <1%	3 <1%	9 <1%	3,970 100%
Seniors	176 79%	16 7%	22 10%	9 4%	0	0	0	224 100%
Total	6,266 40%	4,490 29%	1,064 7%	3,642 24%	18 <1%	43 <1%	43 <1%	15,566 100%

* Sedatives/Tranquilizers include Alcohol

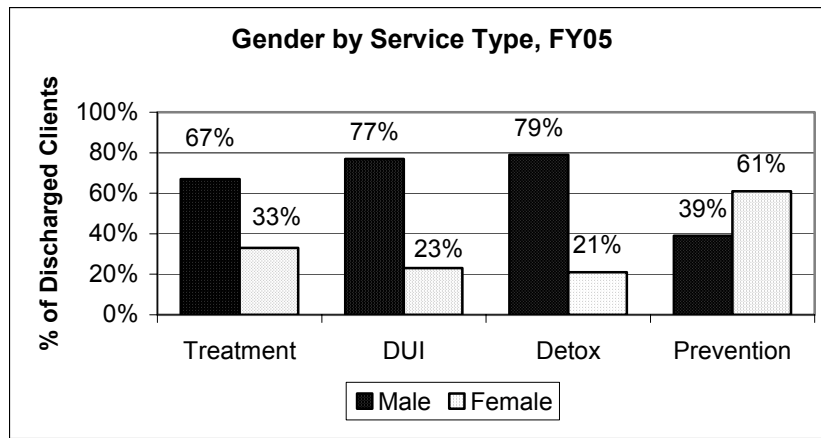
Baby Boomers include anyone born between 1946-1964

Y Generation includes anyone born after 1981

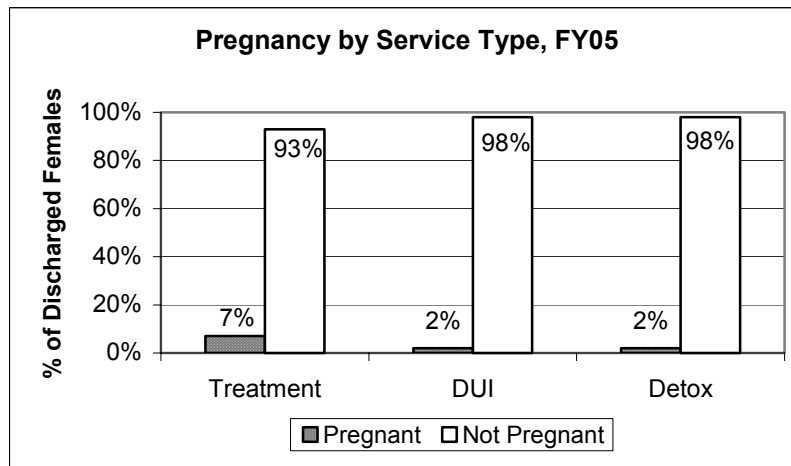
Seniors include anyone born before 1946

Generation X includes anyone born between 1965-1981

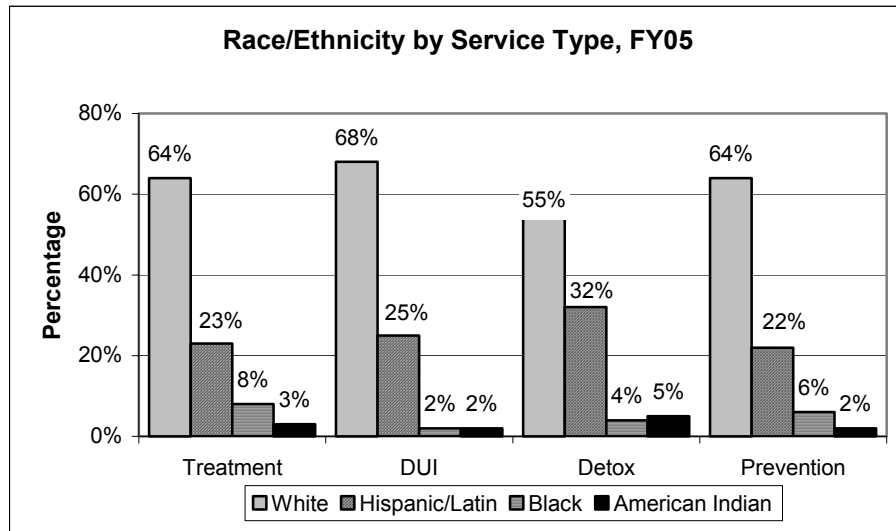
Graph 1: Gender by Service Type, FY05 (See page 14)



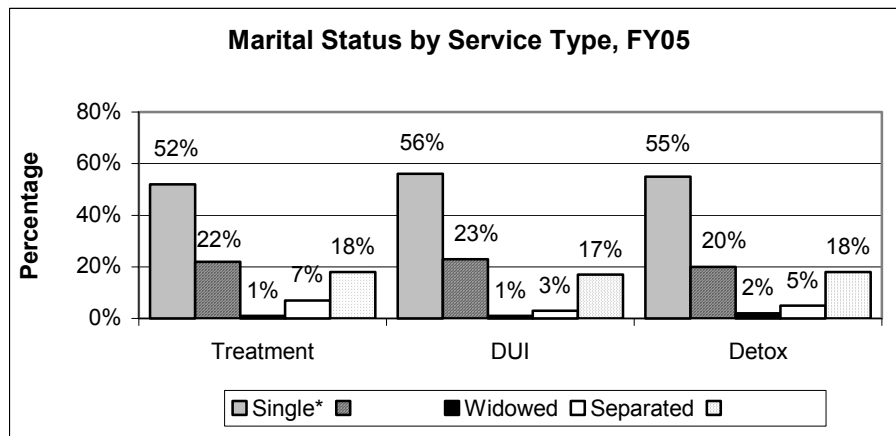
Graph 2: Pregnancy by Service Type, FY05 (See page 14)



Graph 3: Race/Ethnicity by Service Type, FY05 (See page 15)

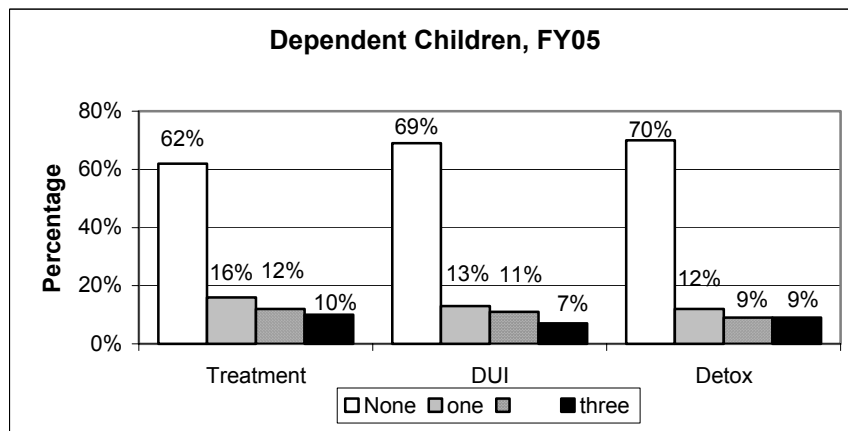


Graph 4: Marital Status by Service Type, FY05 (See page 15)

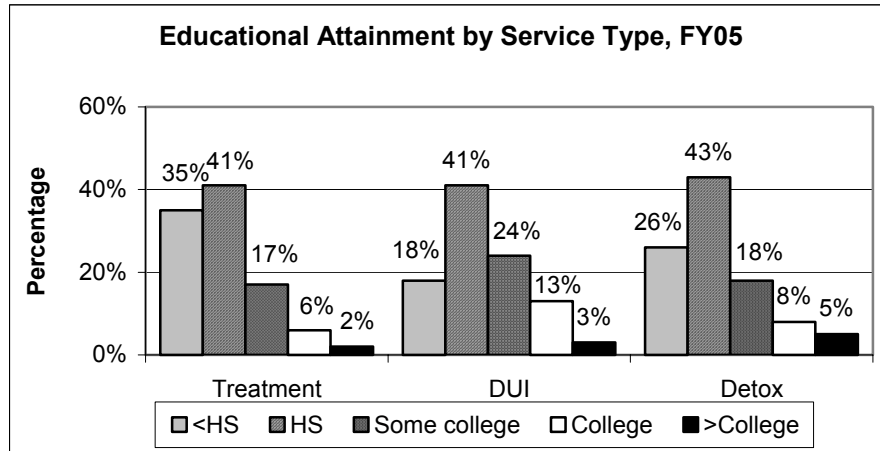


* Single is defined as never married

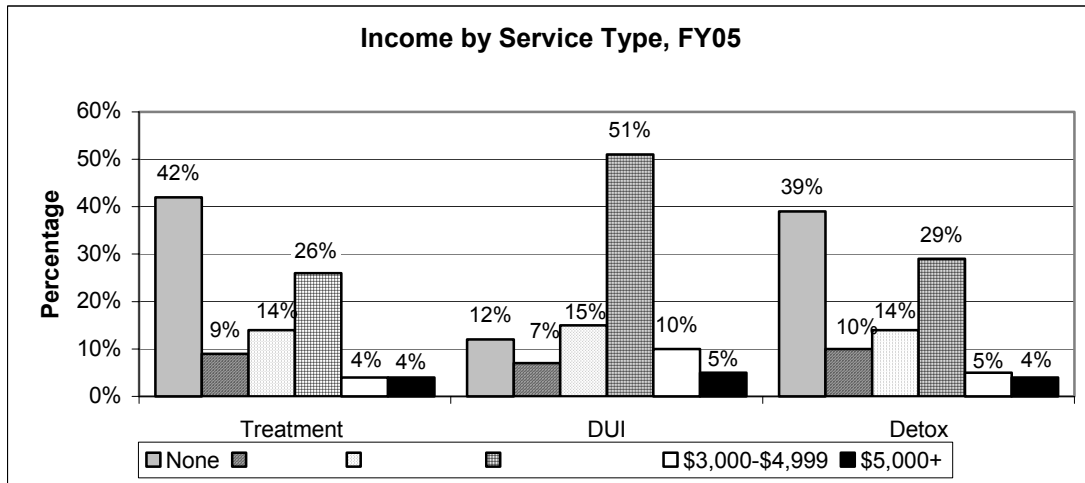
Graph 5: Dependent Children, FY05 (See page 15)



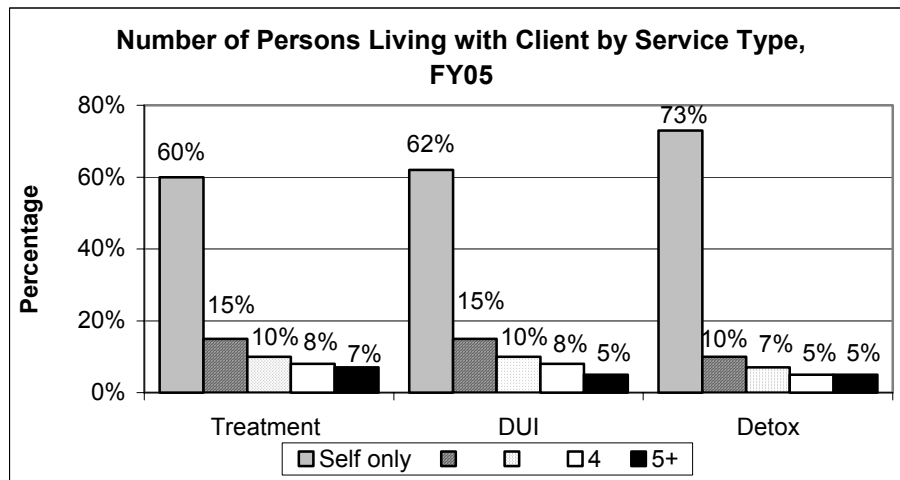
Graph 6: Educational Attainment by Service Type, FY05 (See page 16)



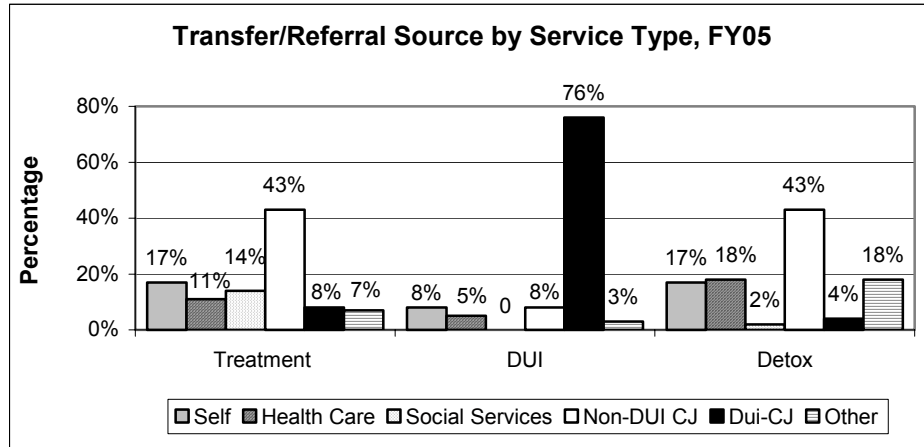
Graph 7: Income by Service Type, FY05 (See page 16)



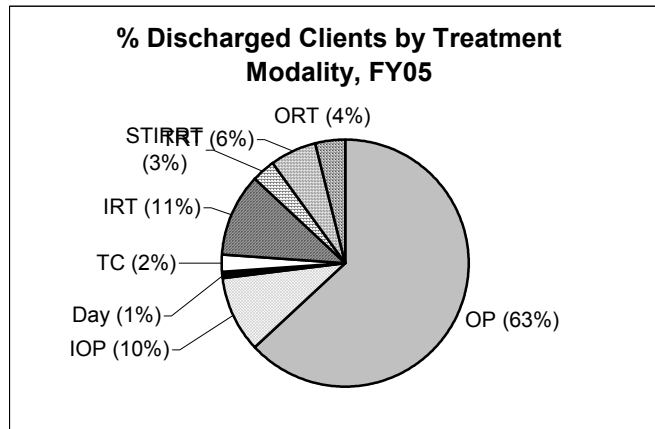
Graph 8: Number of Persons Living with Client by Service Type, FY05 (See page 16)



Graph 9: Transfer/Referral Source by Service Type, FY05 (See page 16)

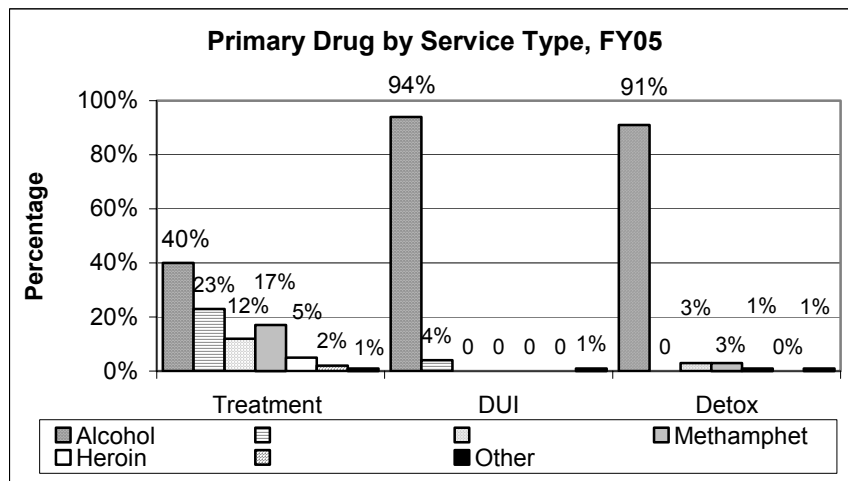


Graph 10: Percent of Discharged Clients by Treatment Modality, FY05 (See page 17)



OP=Traditional Outpatient; IOP=Intensive Outpatient; TC=Therapeutic Community
 IRT=Intensive Residential; STIRRT=Short-Term Intensive Residential Treatment;
 TRT=Transitional Residential; ORT=Opioid Replacement Therapy

Graph 11: Primary Drug by Service Type, FY05 (See page 17)



APPENDIX B: SERVICE UTILIZATION

Table 1: Numbers of Clients in and Discharges from Treatment Services, FY05 and Percent Change from FY04 (See page 17)

Service Type	# of Clients FY05	% Change from FY04	# of DACODS, FY05	% Change from FY04	# of Discharges, FY05	% Change from FY04
Treatment	15,572	+40%**	18,540	+24%	18,540	+24%
DUI	24,187	+11%	13,314	***	25,183	+20%
Detox	26,190	+14%	46,721	+5%	46,721	+5%
Eval & Assess (ADDSCODS)	Data unavailable	Data unavailable	Not applicable	Not applicable	26,799	-13%
Total	65,949		78,575		117,243	

*Total populations of 4,516,847 (FY04) and 4,691,258 (FY05) are based on the forecasted state population

developed by the Demography Section of the Colorado Department of Local Affairs

** A plus sign (+) = increase; a minus sign (-) = decrease

Table 2: Discharge Rate per Client and per 1000 Population, FY05 and FY04 (See page 17)

Service Type	# Discharges per Client, FY 05	# Discharges per Client FY04	# Discharges per 1000 pop, FY05	# Discharges per 1000 pop, FY04
Treatment	1.2	1.3	4	3
DUI	1.1	1.0	5	3
Detox	1.9	1.9	10.0	9.8

*Total populations of 4,516,847 (FY04) and 4,691,258 (FY05) are based on the forecasted state population developed by the Demography Section of the Colorado Department of Local Affairs

Table 3: Number and Percent of Discharges from Treatment by Modality, FY05 compared to FY04 (excluding "Differential Assessment Only") (See page 17)

Treatment Modality	Number FY05	Percent FY05	Percent Change from FY04	Number FY04	Percent FY04
Therapeutic Community	318	2	10% decrease	352	2
Intensive Residential	2,021	12	36% increase	1,482	10
Transitional Residential	1,439	8	19% increase	1,207	8
Opioid Replacement Therapy	685	4	3% decrease	705	5
STIRRT*	679	4	5% increase	649	4
Traditional Outpatient	10,363	59	14% increase	9,071	61
Intensive Outpatient	1,818	10	42% increase	1,279	9
Day	185	1	0.5% increase	184	1
Total	17,508	99	17% increase	14,929	100

*STIRRT=Short-Term Intensive Residential Treatment

Table 4: Number and Percent of Discharges from Detox Modalities, FY05 compared to FY04 (See page 17)

Detoxification Modality	Number FY05	Percent FY05	Percent Change from FY04	Number FY04	Percent FY04
Ambulatory Medical	9	1	89% decrease	82	0.2
Residential non-Hospital	46,668	99	5% increase	44,432	99.8
Medically Managed Inpatient	0	0	0	0	0
Total	46,677	100	5% increase	44,514	100

Table 5: Number and Percent of DUI Discharges, FY05 compared to FY04 (See page 17)

DUI DISCHARGES	Number FY05	Percent of DUI Discharges FY05	Percent Change from FY04	Number FY04	Percent of DUI Discharges FY04
DUI Level 1 Education	3,272	4	14% decrease	3,817	10
DUI Level 2 Education only	19,485	55	6% decrease	20,820	55
DUI Level 2 Education & Therapy	12,515	36	4% decrease	13,068	35
Total	35,272		6% decrease	37,705	

"Other" category was excluded from this table.

Note: Clients may have enrolled in and been discharged from more than one service.

Table 6: Number and Percent of DACODS Submitted by DUI Providers, FY05 Compared to FY04 (See page 17)

DUI DACODS	Number FY05	Percent of Total DACODS received FY05	Percent Change from FY04	Number FY04	Percent of Total DACODS received FY04
DUI Level 1 Education	2,207	3	63% increase	1,354	2
DUI Level 2 Education only	4,241	5	87% increase	2,272	3
DUI Level 2 Education & Therapy	6,866	9	114% increase	3,213	5
Total	13,314		94% increase	6,839	

Table 7: Length of Stay, Treatment and Detox FY05, Comparison with FY04 (in Days) and TEDS**
(See page 18)

Modality	Average Colorado #Days, FY05	Change in Avg. # Days from FY04	Median Colorado # Days, FY05	Change in Median # Days from FY04	Median TEDS** # Days 2002 (national)
Residential	57	1 less	32	3 less	78
Opioid Replacement Therapy	212	27 more	105	4 more	79
STIRRT****	14	1 more	13	Same	24
Day Treatment	100	26 more	80	24 more	-
Detox	1	Same	1	Same	3

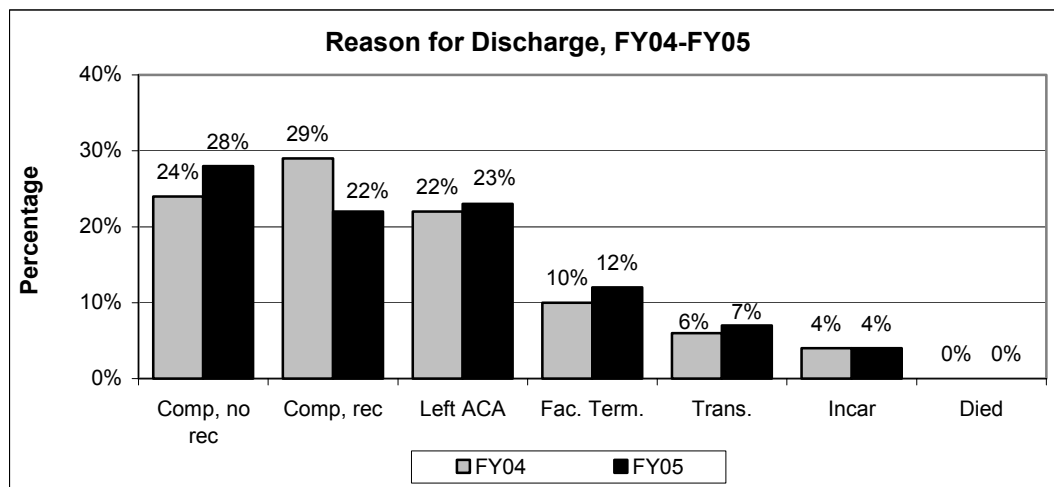
* Median is defined as the midpoint in a distribution of scores, or the point above and below which exactly 50 percent of the measures fall.

** Treatment Episode Data Set (TEDS) for 2002 was national composite data from 22 states.

****STIRRT=Short-term Intensive Residential Treatment

Average length of stay was calculated using date of admission and date of last contact for clients in treatment. Excluded from these calculations are: discharges coded as "Differential Assessments Only" on either Progress Towards Treatment or Reason for Discharge DACODS fields; discharges from both Detox and DUI services, and discharges from Outpatient. DUI and Outpatient treatment services were excluded from the calculations for Length of Stay because the length of time from admission to discharge may not accurately reflect active service, such as when a client takes a year or more to complete the several weeks of DUI education and/or therapy, or the client is enrolled in Outpatient treatment but only attends 3 hours per week.

Graph 1: Reason for Discharge, FY05 Compared with FY04 (See page 18)



Comp, no rec = Treatment completed, no further treatment recommended

Comp, rec = Treatment completed at this facility, additional treatment recommended

Left ACA= Left against counselor advice/dropped out

Fac Term=Terminated by facility

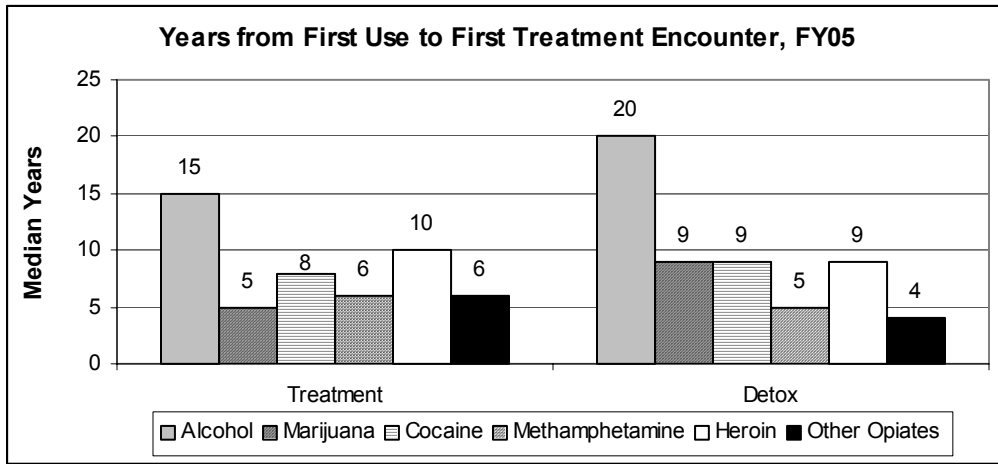
Trans = Transferred

Incar= Incarcerated

Discharges coded as Differential Assessment Only were excluded from these calculations.

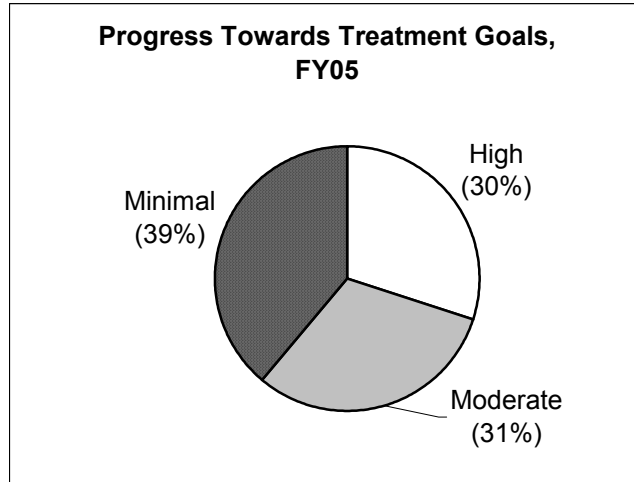
APPENDIX C: BARRIERS TO TREATMENT

Graph 1: Years from First Use to First Treatment Encounter, FY05 (See page 18)

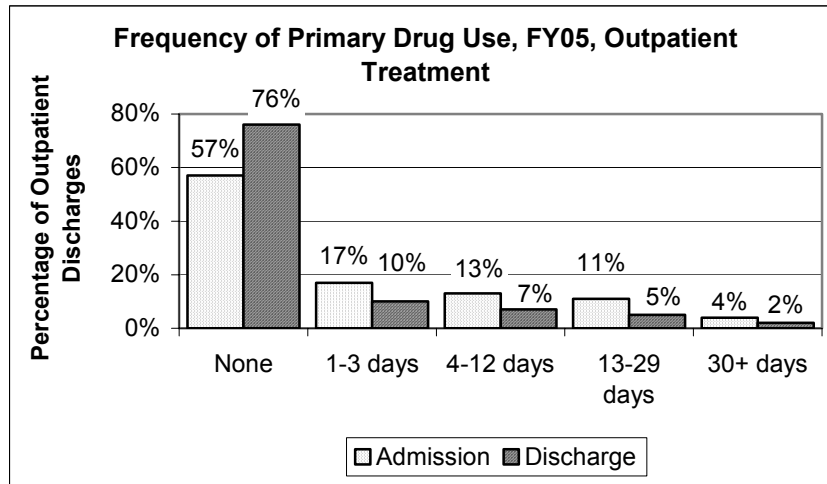


APPENDIX D: PREVENTION AND TREATMENT OUTCOMES

Graph 1: Progress Towards Treatment Goals, FY05 (See page 22)



Graph 2: Frequency of Primary Drug Use, FY05, for Outpatient Treatment (See page 22)

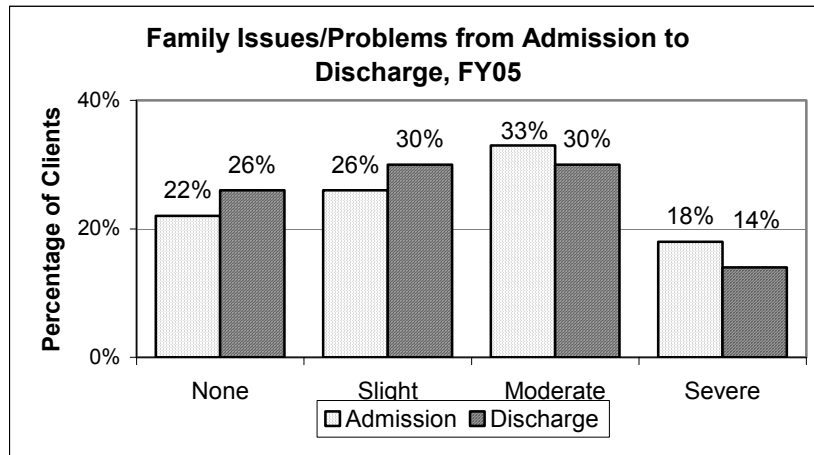


(The 57% of respondents who indicated they had no use of their primary drug within 30 days of admission were placed in treatment because their counselors, upon differential assessment at intake, determined these respondents do have current substance abuse problems requiring treatment.)

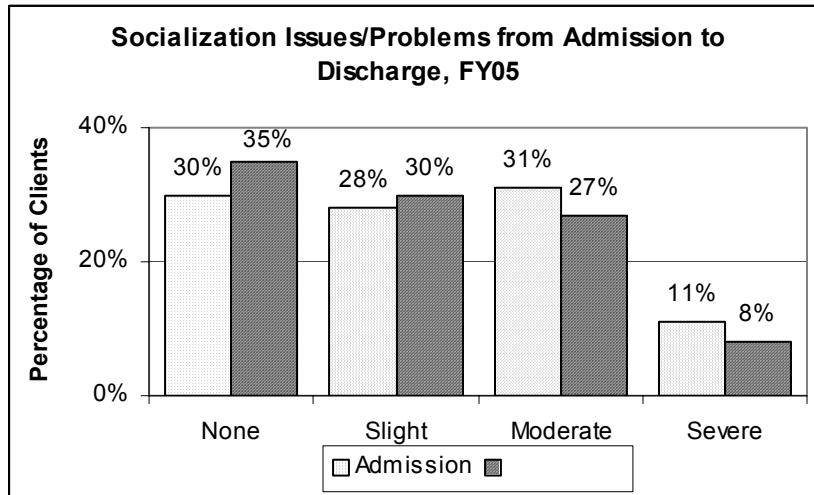
Table 1: A Comparison of Percentage Point Change in Frequency of Use of Primary Drug from Admission to Discharge between FY05 and FY04 (See page 22)

Frequency of Use	Percentage Point Change, FY05	Percentage Point Change, FY04
No use	19% increase in abstinence	25% increase in abstinence
1-3 days in last 30 days	7% decrease in use	8% decrease in use
4-12 days in last 30 days	6% decrease in use	6% decrease in use
13-29 days in last 30 days	6% decrease in use	8% decrease in use
Daily	2% decrease in use	3% decrease in use

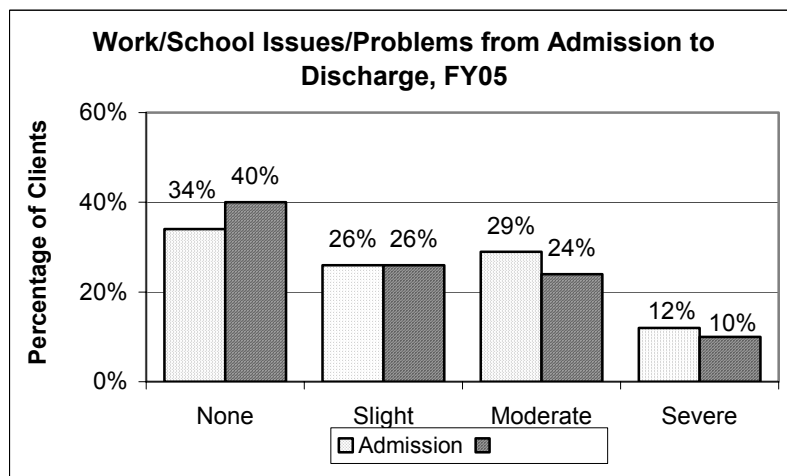
Graph 3: Family Issues/Problems from Admission to Discharge, FY05 (See page 23)



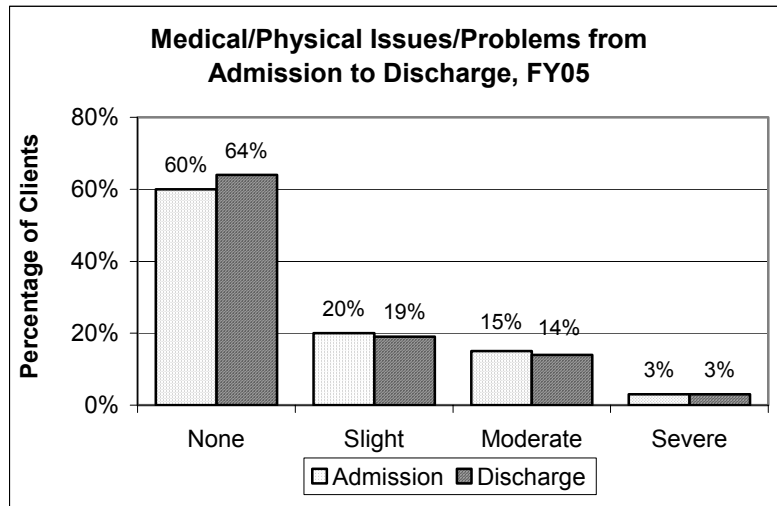
Graph 4: Socialization Issues/Problems from Admission to Discharge, FY05 (See page 23)



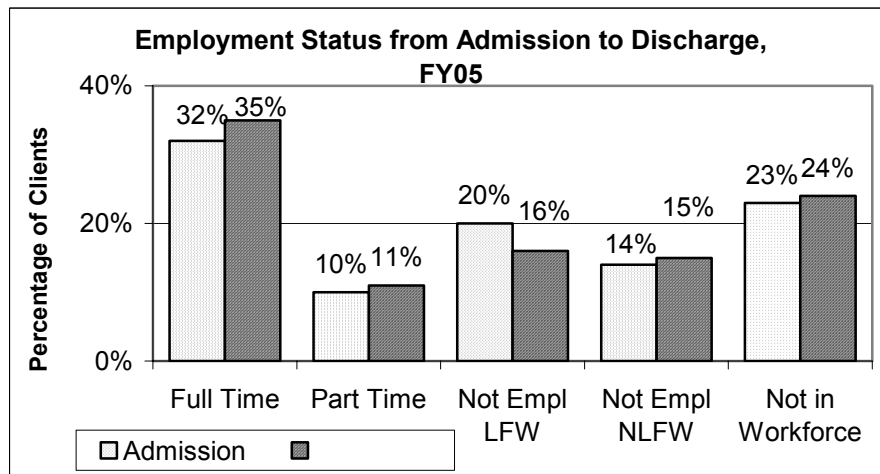
Graph 5: Work/School Issues/Problems from Admission to Discharge, FY05 (See page 23)



Graph 6: Medical/Physical Issues/Problems from Admission to Discharge, FY05 (See page 23)



Graph 7: Employment Status from Admission to Discharge, FY05 (See page 23)



Not Empl LFW = Not Employed, Looking for Work
 Not Empl NLFW = Not Employed, Not Looking for Work

Graph 8: Living Situation from Admission to Discharge, FY05 (See page 23)

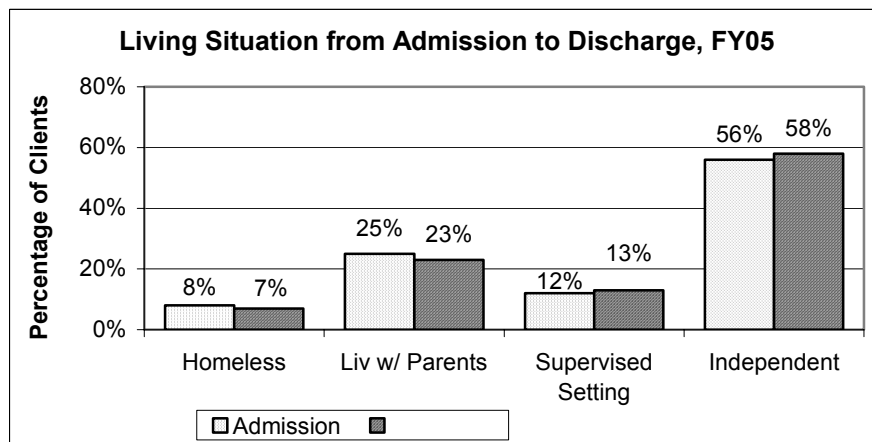


Table 2: Proportions of Clients at Admission and Discharge with Arrests, Emergency Room (ER) Visits or Hospital Admissions (See page 23)

Outcome Measure	Admission (%)	Discharge (%)
DUI/DWAI Arrests during 24 months prior to admission and at discharge		
None	82	95
1-2	17	4
3+	1	0.5
Other Arrests 24 months prior to admission and at discharge		
None	56	84
1-2	36	13
3+	8	3
Medical ER visits during 6 months prior to admission and at discharge		
None	81	91
1-2	16	7
3+	3	2
Medical Hospital Admissions during 6 months prior to admission and at disch.		
None	91	94
1-2	8	5
3+	1	1
Psychiatric ER visits during 6 months prior to admission and at discharge		
None	96	97
1-2	4	2
3+	0.3	1
Psychiatric Hospital Admission 6 months prior to admission and at discharge		
None	95	97
1-2	4	3
3+	1	0.2

APPENDIX E: Factors Relating to Achievement of Treatment Goals

Demographics

Of 17,508 discharges from treatment, 30% were assessed as having high progress toward their treatment goals, 31% with moderate progress, and 39% with minimal progress. Clients assessed with high progress were more likely to have been in treatment for more than 90 days (43% vs. 22% of those in treatment for less than 90 days), more likely to be either married or divorced (32% and 31% respectively vs. 28% to 31% for those separated, never married or widowed), and slightly more likely to have children (32% vs. 30%). High achievers were less likely to be black (22%) than any other ethnic group (ranging from 31% to 37%).

Age

For adults, the older the age group the higher the achievement of goals. Those 17 years and under were more likely than all other age-groups except those 65 and over to be high achievers (36.6% vs. 39.7% respectively).

Primary Drug Type

Clients who reported alcohol as their primary drug had the highest proportion of achievers (33%) and those who reported heroin had the lowest proportion of achievers (15%). This finding may be skewed by the fact that most heroin users remain in treatment for years or even decades. Those discharged from an agency after only a short span of treatment are usually discharged because of poor performance or compliance.

Primary Drug Route

Clients who used their primary drug orally were the most likely to be high achievers (33%). Those who injected their drug had the lowest proportion of high achievers (22%). The drug type, however, may confound these findings. Alcohol is usually ingested orally. Heroin is frequently injected.

Geographic Area

The group of facilities in the southeast region of Colorado reported the highest proportion of clients with high achievement (48%), followed by facilities in the southwest (44%). The areas with the lowest proportions of high-achieving clients were Denver (20%) and Boulder (26%). The remaining regions had proportions of clients with high achievement ranging from 32% (northeast) to 36% (Colorado Springs and the northwest).

APPENDIX F: METHAMPHETAMINE IN COLORADO

In recent years, methamphetamine (meth) abuse has become an increasingly serious problem. To explore the issue in Colorado, ADAD examined clients who reported meth as their primary drug of use, and compared them to users of other substances. During FY05 there were 78,575 discharges from treatment, DUI and detoxification services combined. Of these, 5% (4,246) of all discharges identified meth as their primary drug of use. When breaking down service types into treatment, DUI and detox, 73% (3,122) of meth-related discharges occurred in treatment modalities. This analysis was restricted to discharges from treatment only (no DUI or Detox).

During FY05, there were 18,540 discharges from treatment. When examining treatment outcomes, we looked at all discharges, excluding 1,032 cases coded as “differential assessment only.” This left 17,508 treatment discharges on which to examine outcomes, 3003 (17%) of which were for meth using clients.

Since some clients had multiple treatment episodes and thus, multiple discharges, the analysis of demographic, treatment and substance use indicators was restricted to unique clients only (n=15,572). Of 15,572 unique clients discharged from treatment modalities during FY05, 2,587 (17%) reported meth to be their primary drug of use.

Table 1 below presents demographic distributions and table 2 presents information on treatment and substance use for meth and non-meth users. Tables 3 and 4 show information on treatment outcomes.

As shown in Table 1, compared to clients who do not use meth, meth users are more likely to be female (44% vs. 30%), between the ages of 18 and 34 (67% vs. 45%), White (82% vs. 61%), separated or divorced (32% vs. 23%), and to have dependent children (44% vs. 37%). Meth users are less likely than those who do not use meth to be younger than 18 years (4% vs. 14%) or over 34 years (28% vs. 40%). They are also less likely to be Black (1% vs. 10%) or Hispanic (13% vs. 25%), or have any education beyond high school (17% vs. 25%).

Regarding employment and living situation, meth users are less likely to be working (37% vs. 45%) and living independently (51% vs. 57%). They were also less likely to have referred themselves into treatment (11% vs. 18%) and were more likely to be referred by social services (18% vs. 13%) or non-DUI criminal justice (56% vs. 40%).

Table 2 shows that meth-using clients had prior treatment episodes (61% vs. 56%), and were in more intensive treatment modalities, like intensive residential treatment (16% vs. 10%). Regarding drug use, meth users were more likely to have used tobacco products (83% vs. 66%) and multiple substances (70% vs. 55%), and more to have been assessed with drug dependency upon admission (69% vs. 52%). Despite these findings, meth users were less likely to report using their primary drug in the 30 days before admission (38% vs. 51%).

Table 1: Non-Meth Users vs. Meth Users - Demographics

	Non-Meth Users						Meth Users					
	Males		Females		Total		Males		Females		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Total	9,047	70	3938	30	12,985	83	1,440	56	1,147	44	2,587	17
Preg. Women	--	--	247	6	247	6	--	--	91	8	91	8
Age												
<18	1,295	14	561	14	1,856	14	51	3	56	5	107	4
18-24	1,857	20	735	19	2,592	20	375	26	379	33	754	29
25-34	2,259	25	1,016	26	3,275	25	539	37	448	39	987	38
35-44	2,098	23	1,013	26	3,111	24	356	25	216	19	572	22
45-54	1,205	13	514	13	1,719	13	115	8	45	4	160	6
55-64	285	3	90	2	375	3	4	0.3	3	0.3	7	0.3
65+	48	0.5	9	0.2	57	0.4	0	0	0	0	0	0

Race												
White	5,377	59	2,497	63	7,874	61	1,195	83	932	81	2,127	82
Black	941	10	308	8	1,249	10	24	2	11	1	35	1
American Indian	246	3	124	3	370	3	20	1	16	1	36	1
Asian/Pac Islander	143	2	37	1	180	1	14	1	8	1	22	1
Hispanic	2,269	25	943	24	3,212	25	183	13	165	14	348	13
Other	71	1	29	1	100	1	4	0.3	4	1	19	1
Education												
<HS	3,167	35	1,406	36	4,573	35	428	30	396	34	824	32
HS Diploma	3,769	41	1,344	34	5,093	39	751	52	542	47	1,293	50
Some College	1,412	16	772	20	2,184	17	222	15	197	17	419	16
College Degree	539	6	296	7	835	6	31	2	9	1	40	1
Beyond College	180	2	120	3	300	2	8	1	3	0.3	11	0.4
Marital Status												
Never Married	5,012	55	1,858	47	6,870	53	765	53	503	44	1,268	49
Married	2,032	22	890	23	2,922	22	266	18	210	18	476	18
Widowed	93	1	83	2	176	1	6	0.4	11	1	17	1
Separated	430	5	356	9	786	6	107	7	175	15	282	11
Divorced	1,480	16	751	19	2,231	17	296	21	248	22	544	21
Has Children	2,922	32	1,877	48	4,799	37	505	35	642	56	1,145	44
Job Status												
Full-time	3,668	40	888	22	4,556	35	524	36	207	18	731	28
Part-time	859	9	472	12	1,331	10	129	9	117	10	246	9
Unemploy, Looking	1,522	17	818	21	2,340	18	328	23	342	30	670	26
Unemploy, Not Look	796	9	649	16	1,445	11	171	12	285	25	456	18
Not in Work Force	2,202	24	1,111	28	3,313	25	288	20	196	17	484	19
Living Situation												
Homeless	506	6	197	5	703	5	104	7	77	7	181	7
Depend, Liv w/ parents	2,377	26	959	24	3,336	26	330	23	288	25	618	24
Depend, Supervised	1,201	13	279	7	1,480	11	342	24	121	10	463	18
Living Independ	4,963	55	2,503	64	7,466	57	664	46	661	58	1,325	51
Referral Source												
Self	1,530	17	806	20	2,336	18	150	10	131	11	281	11
SA Provider	647	7	324	8	972	7	95	7	96	8	191	7
Health Care Prov	301	3	246	6	547	4	27	2	22	2	49	2
School	187	2	106	3	293	2	1	0.01	2	0.02	3	0.01

Employer	138	1	22	1	160	1	8	1	3	0.03	11	0.4
Soc. Serv.	769	8	918	23	1,687	13	99	7	369	32	468	18
Non-DUI CJ	4,192	46	1,026	26	5,218	40	980	68	480	42	1,460	56
DUI CJ	969	11	283	7	1,252	10	27	2	8	1	35	1
Other	275	3	186	5	461	4	44	3	35	3	79	3

Table 2: Non-Meth Users vs. Meth Users – Treatment and Substance Use Indicators

	Non-Meth Users						Meth Users					
	Males		Females		Total		Males		Females		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Total	9,047	70	3,938	30	12,985	83	1,440	56	1,147	44	2,587	17
Modality												
TC	147	2	62	2	209	2	45	3	31	3	76	3
IRT	872	10	456	12	1,328	10	231	16	175	15	406	16
TRT	541	6	147	4	688	5	119	8	64	6	183	7
ORT	416	5	254	6	670	5	0	0	0	0	0	0
Tradition Outpt	5,817	64	2,509	64	8,326	64	740	51	702	61	1,442	56
STIRRRT	333	4	54	1	387	3	131	9	26	2	157	6
Intensive Outpt	826	9	419	11	1,245	10	160	11	136	12	296	11
Day	95	1	37	1	37	1	14	1	13	1	27	1
Prior Tx Episodes	5,068	57	2,174	55	7,242	56	890	62	676	59	1,566	61
MH Issues	2,559	28	1,595	40	4,154	32	399	28	445	39	844	33
Poly-Sub Use	5,037	56	2,158	55	7,195	55	1,068	74	754	66	1,822	70
Tobacco Use	5,954	66	2,656	68	8,610	66	1,203	83	948	83	2,151	83
Use Freq												
None	4,486	50	1,825	46	6,311	49	904	63	704	61	1,608	62
1-4 days	1,751	19	730	18	2,481	19	247	17	189	16	436	17
5-9 days	566	6	291	7	857	7	73	5	41	4	114	4
10-19	818	9	397	10	1,215	9	107	7	79	7	186	7
20-29	749	8	361	9	1,110	8	79	5	81	7	160	6
30+	677	7	334	8	1,011	8	30	2	52	4	82	3
Dx Impress												
Unknown	167	2	54	1	221	2	18	1	38	1	34	1
Use	818	9	398	10	1,216	9	31	2	332	3	69	3
Abuse	3,416	38	1,371	35	4,787	37	370	26	760	29	702	27
Dependency	4,637	51	2,111	54	6,748	52	1,021	71	1,146	66	1,781	69

Outcomes-Clinical Impressions

Table 3 presents treatment outcomes determined by the impression of the SA counselor as well as employment status and living situation. It can be seen that while meth using clients were less likely to be discharged successfully with no further treatment recommendations (23% vs. 29%), they were more likely to be discharged successfully with recommendations for further treatment (26% vs. 21%). There were no differences between the two groups in proportions of drop-outs or terminations, or in progress toward treatment goals.

Upon admission, meth using clients were more likely than non-meth users to have moderate to severe family issues (61% vs. 49%), socialization issues (50% vs. 40%), and work/school issues (49% vs. 40%). Both groups of clients improved at discharge, and showed similar degrees of change. However, since meth-using clients generally began treatment with more severe issues, they were still, at discharge, more likely to be assessed with those issues. One exception is with employment status. The proportion of meth users employed full-time increased from 37% at admission to 43% at discharge compared to non-meth users who rose from 43% to 45%.

Table 3: Changes from Admission to Discharge – Clinical Impressions, Employment Status & Living Situation

DACODS Data Item	Non-Meth Users				Meth Users			
	Admission		Discharge		Admission		Discharge	
	#	%	#	%	#	%	#	%
Reason for discharge								
Tx completed, no further formal tx recommended	NA	NA	4,417	29	NA	NA	694	23
Tx completed, additional formal tx recommended	NA	NA	3,081	21	NA	NA	772	26
Left against professional advice	NA	NA	3,374	23	NA	NA	664	22
Terminated by facility	NA	NA	1,689	12	NA	NA	371	12
Transferred to another agency	NA	NA	981	7	NA	NA	238	8
Other	NA	NA	1,233	8	NA	NA	264	9
Progress towards tx goal								
High	NA	NA	4,419	30	NA	NA	892	30
Moderate	NA	NA	4,479	31	NA	NA	881	29
Minimal	NA	NA	5,607	39	NA	NA	1,230	41
Family Issues/Problems								
None	3,367	23	4,039	28	457	15	594	20
Minimal	4,001	28	4,404	30	710	24	913	30
Moderate	4,608	32	4,189	29	1,107	37	926	31
Severe	2,529	17	1,873	13	729	24	570	19
Socialization Issues/Problems								
None	4,633	32	5,313	37	651	22	877	29
Minimal	4,071	28	4,254	29	845	28	956	32
Moderate	4,394	30	3,816	26	1,072	36	865	29
Severe	1,407	10	1,122	8	435	14	305	10
Work/School Issues/Problems								
None	5,055	35	5,899	41	814	27	1,049	35
Minimal	3,738	26	3,727	26	720	24	819	27
Moderate	4,012	28	3,456	24	1,015	34	793	26
Severe	1,700	12	1,423	10	454	15	342	11
Medical/Physical Issues/Problems								
None	8,773	60	9,275	64	1,774	59	1,911	64
Minimal	2,915	20	2,634	18	646	21	616	20
Moderate	2,224	15	2,092	14	471	16	376	12
Severe	593	4	504	3	112	4	100	3
Employment Status								
Full time	4,819	33	5,128	35	815	27	977	32
Part time	1,485	10	1,527	10	292	10	324	11
Unemployed, looking	2,742	19	2,155	15	781	26	605	20
Unemployed, not looking	1,907	13	1,921	13	597	20	626	21
Not in workforce	3,552	24	3,774	26	518	17	471	16
Living Situation								
Homeless	1,078	7	1,022	7	252	8	220	7
Dependent, living w/ parents	3,629	25	3,291	23	735	24	648	22
Dependent, supervised setting	1,534	11	1,680	12	494	16	500	17

Living independently	8,264	57	8,511	59	1,522	51	1,635	54
----------------------	-------	----	-------	----	-------	----	-------	----

Outcomes-Behaviors

Table 4 shows that meth-using clients less likely to have used their primary drug within 30 days of admission (39% vs. 53%) and have used that drug during their treatment (19% vs. 25%). This finding held up when restricting the analysis to outpatient discharges only.

Regarding arrests, meth-using clients were less likely to have DUI-related arrests at both admission (7% vs. 19%) and discharge (3% vs. 5%). Meth users were more likely to have non-DUI arrests at admission (54% vs. 42%), but both groups were similar at discharge. When restricted to outpatient discharges only, meth users were more likely to have non-DUI arrests at both admission (53% vs. 42%) and discharge (19% vs. 15%).

Meth using clients were less likely than non-meth users to visit a medical ER at both the time of admission (19% vs. 24%) and discharge (9% vs. 11%) and this held up when examining outpatient discharges only.

Both groups were similar at admission and discharge in visits to psychiatric ERs and admissions to psychiatric hospitals.

Table 4: Changes from Admission to Discharge – Reported Behaviors

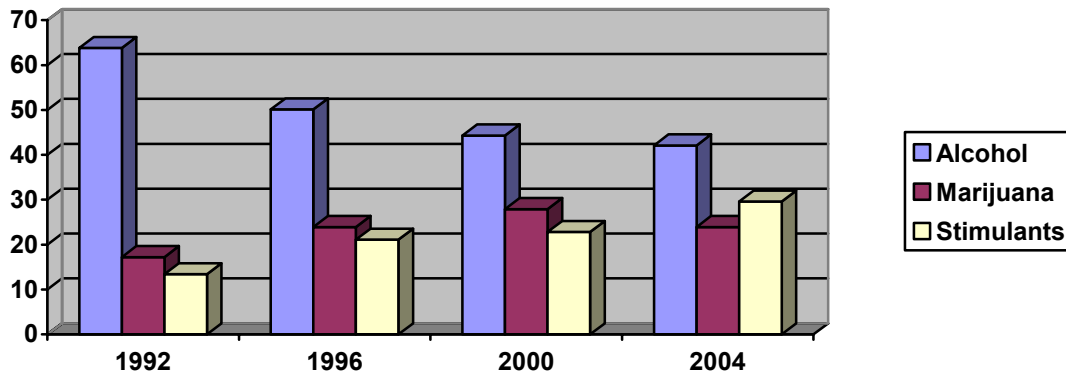
DACODS Data Item	All Treatment Modalities				Outpatient Only			
	Non-Meth Users		Meth Users		Non-Meth Users		Meth Users	
	Admission	Discharge	Admission	Discharge	Admission	Discharge	Admission	Discharge
	%	%	%	%	%	%	%	%
Frequency of Use, Primary Drug								
None	47	75	61	81	54	75	68	78
1 or more days	53	25	39	19	46	25	32	22
DUI/DWAI Arrests								
None	81	95	93	97	80	95	93	97
1 or more	19	5	7	3	20	5	7	3
Other Arrests								
None	58	85	46	84	58	85	47	81
1 or more	42	15	54	16	42	15	53	19
Medical Emergency Room Visits								
None	76	89	81	91	81	90	83	93
1 or more	24	11	19	9	19	10	17	7
Medical Hospital Admissions								
None	88	93	92	96	90	94	92	95
1 or more	12	7	8	4	10	6	8	5
Psychiatric Emergency Room Visits								
None	95	97	95	98	96	97	95	98
1 or more	5	3	5	2	4	3	5	2
Psychiatric Hospital Admissions								
None	95	97	95	98	95	97	95	97
1 or more	5	3	5	2	5	3	5	3

*COD=Co-occurring disorders

Methamphetamine Trend Analysis (1992-2004)

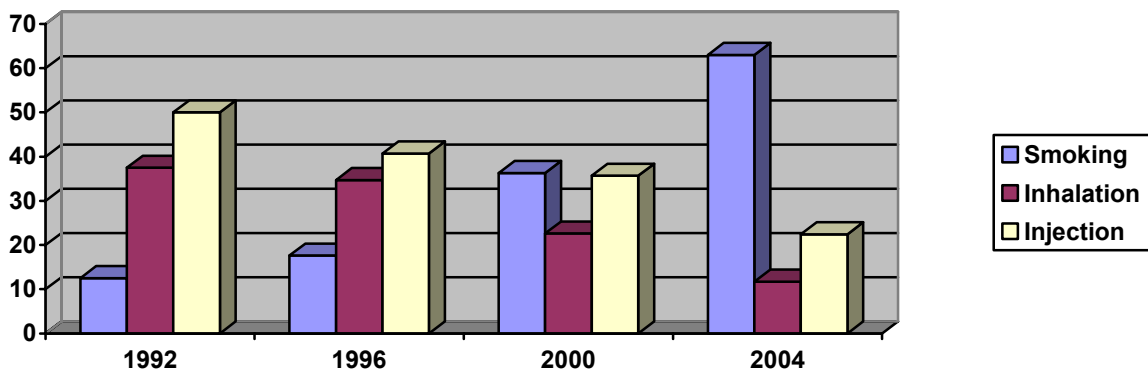
Amphetamines and methamphetamines are stimulants that affect the central nervous system. Stimulants are the primary substance of abuse in almost 30% of Colorado treatment admissions in 2004, up from 13% in 1992. When combining methamphetamines and cocaine into one category, their combined treatment admissions now surpass marijuana by nearly 6% (29.6% vs. 23.9%).

Graph 1: Treatment Admissions, by Primary Drug Type: 1992-2004



Methamphetamines can be consumed in many different methods, but smoking is the primary route. Smoking is not only the preferred method, but continues to increase in popularity among methamphetamine users. In 1992, the percentage of methamphetamine admissions that indicated smoking as the primary route was at 12%. In 2004, that number had skyrocketed to 63%. This upward trend for smoking methamphetamines was also reflected in the national figures, where smoking went from 12% in 1992 to 50% in 2002 according to data provided by SAMHSA.

Graph 2: Methamphetamine Treatment Admissions, by Route of Administration: 1992-2004



The demographic analysis of methamphetamine treatment admissions also shows some clear trends.

Race

Methamphetamine use has increased among all races but is increasing faster in the White community than other populations. In analyzing all treatment admissions by Whites, those who identify methamphetamine as their primary drug of choice have gone from 2% in 1992 to 20% in 2004. In that same time frame, cocaine has stayed steady among Whites as drug of choice with 9.1% of treatment admissions in 1992 and 8.7% of treatment admissions in 2004.

Blacks (3.3%), Hispanic Mexicans (8%) and Native Americans (9%) who enter treatment all have under 10% of their population identifying methamphetamine as their primary substance and each of them identify cocaine as their drug of choice more often.

Of all the methamphetamine treatment admissions in 2004, 84% of the clients were White.

Gender

Methamphetamine use has also increased among both male and female clients. The percentage of males admitted into treatment who identify methamphetamine as their primary drug has increased from 1.6% in 1992 to 11.6% in 2004. Cocaine use over that same time has only increased slightly from 9% to 11.7%. Female admissions that identify methamphetamine as their primary drug have increased at an even higher percentage going from 1.9% in 1992 to 18.4% in 2004. Cocaine use among women has also increased from 10% in 1992 to 17.7% in 2004.

Age

Young adults are much more likely to identify methamphetamine as their primary drug than more mature adults. Methamphetamine is identified as the primary drug among 18-25 year olds (32.5%) and 26-35 year olds (35%) in 2004, outpacing cocaine in both these age groups. The percentage of clients admitted with cocaine as their primary drug peaks with the 36-45 year olds at 37% while methamphetamines begin to trail off at just 22%. Methamphetamine use is a much lower percentage of the admissions for the 46-55 year olds (4.2%) and 56-65 year olds (0.2%).

Location*

Methamphetamine use in both rural and urban Colorado continues to rise. Methamphetamines have surpassed cocaine as the primary drug of choice among treatment admissions in rural clients for the past 4 years. In 2004, for all admissions in rural areas that identified stimulants as their primary drug, methamphetamine outpaced cocaine (63% vs. 37%). In 2004, we saw methamphetamines surpass cocaine for the second straight year with urban clients (52.8% vs. 47.2%).

*urban clients are those whose county of residence include Adams, Arapahoe, Boulder, Denver, Douglas, El Paso, Jefferson or Larimer counties. Clients who identified any other county of residence were categorized as rural clients.

APPENDIX G: CO-OCCURRING CLIENTS

Individuals with co-occurring psychiatric and substance use disorders represent a challenging population associated with poorer outcomes and higher costs in multiple domains. Prevalence of comorbidity is sufficiently high so that it is an expectation, not an exception throughout the system of care.⁴⁶

Prevalence of Co-occurring Clients

During FY05 in Colorado, there were 17,508 discharges from treatment (DUI and detoxification services were excluded from this analysis). These 17,508 discharges were based on 15,572 unique clients. Thirty two percent (n=4,998) of these individuals met the criteria for co-occurring disorders. Criteria were based on the following DACODS responses. Clients had to have at least one of these to be considered co-occurring:

- the client reported or was assessed as having a current mental health condition;
- the client had a disability based on a psychiatric disorder;
- the client had one or more visits to a psychiatric emergency department within six months before admission to substance abuse services; or
- the client had one or more admissions to a psychiatric hospital within six months before admission.

Demographics and Service Utilization of Co-occurring Clients

Only slight variations in demographic patterns were noted between the co-occurring population of 4,998 and those clients without co-occurring disorders (n=10,574). Clients with co-occurring disorders were composed of higher proportions of: females (41% vs. 29%); persons under 18 years of age (17% vs. 11%); Whites (71% vs. 61%); persons with dependent children (44% vs. 40%); and persons with an educational level beyond high school (29% vs. 23%). Individuals with co-occurring disorders were less likely to be: married (20% vs. 23%); employed (36% vs. 47%); or referred by the criminal justice system (38% vs. 57%).

Table 1: Demographics for Treatment Clients With Co-occurring Disorders Compared to Clients Without Co-occurring Disorders

	Co-occurring Clients						Clients without Co-occurring Disorders*					
	Males		Females		Total		Males		Female		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Total	2,958	59	2,040	41	4,998	100	7,529	71	3,045	29	10,574	100
Pregnant Women	--	--	116	6	116	100	--	--	222	7	222	100
Age												
<18	565	19	260	13	825	17	781	10	357	12	1,138	11
18-24	569	19	386	19	955	19	1,663	22	728	24	2,391	23
25-34	704	24	572	28	1,276	26	2,094	28	892	29	2,986	28
35-44	664	22	519	25	1,183	24	1,790	24	710	23	2,500	24
45-54	350	12	251	12	601	12	970	13	308	10	1,278	12
55-64	93	3	49	2	142	3	196	3	44	1	240	2
65+	13	0	3	0	16	<0.1	35	0.5	6	0.2	41	0.4
Race/Ethnicity												
White	2,067	70	1,486	73	3,553	71	4,505	60	1,943	64	6,448	61
Hispanic	524	18	357	17	881	18	1,928	26	751	25	2,679	25
Black	216	7	112	5	328	7	749	10	207	7	956	9
American Indian	101	3	55	3	156	3	165	2	85	3	250	2
Asian/Pacific Islander	28	1	9	0	37	1	129	1	18	1	165	2
Other	22	1	21	1	43	1	53	1	23	1	76	1
Marital Status												
Never Married	1,754	59	887	45	2,641	53	4,023	53	1,474	48	5,497	52

Married	538	18	454	23	992	20	1,760	23	646	21	2,406	23
Divorced	467	16	440	22	907	18	1,309	17	440	18	1,868	18
Separated	166	6	166	8	393	8	371	5	304	10	675	6
Widowed	33	1	32	2	65	1	66	1	62	2	128	1
Has Dependent Children												
	778	26	922	45	1,700	44	2,647	35	1,597	52	4,244	40
Educational Status												
<HS	1,089	37	701	34	1,790	36	2,506	33	1,101	36	3,607	34
HS Diploma	1,082	37	694	34	1,776	35	3,418	45	1,192	39	4,610	44
Some College	515	17	50	21	936	19	1,119	15	548	18	1,667	16
College Degree	195	7	164	8	359	7	375	5	141	5	516	5
Beyond College	77	2	60	3	137	3	111	15	63	2	174	2
Employment Status												
Full Time	970	33	403	20	1,373	27	3,222	43	692	23	3,914	37
Part Time	262	9	211	10	473	9	726	10	378	12	1,104	10
Unemployed, Looking	533	18	437	21	970	19	1,317	17	723	24	2,040	19
Unemployed, Not Looking	296	10	401	20	697	14	671	9	533	17	1,204	11
Not in Work Force	897	30	588	29	1,485	30	1,593	21	719	24	2,312	22
Referral Source												
Self	546	18	420	21	966	19	1,134	6	517	17	1,651	16
SA Provider	327	11	244	12	571	11	415	2	177	6	592	6
Health Care Provider	209	7	182	9	391	8	119	2	86	3	205	2
School/Employer	71	2	38	2	109	2	263	1	95	3	458	3
Social Services	312	10	488	24	800	16	556	7	799	26	1,355	13
Non-DUI CJ**	1,206	41	504	25	1,710	34	3,966	53	1002	33	4,968	47
DUI CJ	139	5	56	3	195	4	857	11	235	8	1092	10

* Both groups are mutually exclusive.

** Criminal Justice

Co-occurring clients were more likely to have: had prior treatment episodes (62% vs. 55%); and used tobacco products daily (73% vs. 68%). Co-occurring clients were less likely to be employed (37% vs. 44%).

Table 2: Treatment Modality, Prior Treatment & Tobacco Use for Clients with Co-occurring Disorders Compared to Clients without Co-occurring Disorders

	Co-occurring Clients						Clients without Co-occurring Disorders					
	Males		Females		Total		Males		Female		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Treatment Modality												
Therapeutic Community	74	2	11	1	85	2	118	2	82	3	200	2
Intensive Residential	352	12	359	18	711	14	751	10	272	9	1,023	10
STIRRT*	74	2	22	1	96	2	390	5	58	2	448	4
Transitional Residential	137	5	94	5	231	5	523	7	117	4	640	6
Intensive Outpatient	417	14	276	13	693	14	569	8	279	9	848	8
Traditional Outpatient	1,723	58	1,157	57	2,880	58	4384	65	2054	67	6,888	65
Day Treatment	82	3	37	2	119	2	27	0.4	13	0.4	40	0.4
Opioid Replacement Therapy	99	3	84	4	183	4	317	4	170	6	487	5

Prior Treatment Episodes												
	1,781	61	1,254	62	3,035	61	4,177	56	1,596	53	5,773	55
Daily Tobacco Use												
	2,093	71	1,534	75	3,627	73	5,064	67	2,070	68	7,134	68

*STIRRT Short-term Intensive Remedial Residential Treatment

Outcomes for Treatment Clients With Co-occurring Disorders

This analysis was based on the number of treatment discharges, not the number of unique treatment clients. Outcomes of the 5,556 discharges of co-occurring clients from treatment were compared to outcomes of those clients without co-occurring disorders for FY05. Differential assessments, derived from DACODS codes for discharge modality, reason for discharge and progress towards goals, were excluded from this analysis.

Clients with co-occurring disorders were less likely to complete treatment with no further treatment recommended (22% vs. 30%), and less likely to have high progress toward their treatment goals (25% vs. 33%).

Upon admission, clients with co-occurring disorders were more likely to have moderate to severe family issues (66% vs. 44%), socialization issues (57% vs. 34%), work/school issues (48% vs. 34%), and medical physical issues (29% vs. 15%). They were more likely to have used their primary drug within 30 days of admission (55% vs. 48%) and less likely to use that drug during their treatment (73% vs. 69%). Since visits to psychiatric ERs and admissions to psychiatric hospitals were part of the definition of co-occurring disorders, a higher frequency of these behaviors may be artifact of the definition. Within 30 days of admission clients with co-occurring disorders were more likely than clients without co-occurring disorders to have visited a medical ER (31% vs. 25%) and to have been admitted to a medical hospital (17% vs. 14%). There was little difference noted on admission between clients with and without co-occurring disorders in living situation and homeless status.

Treatment resulted in improved outcomes for both clients with and without co-occurring disorders at time of discharge. However, since those with co-occurring disorders generally began treatment with a higher level of severity, they were still, at discharge, more likely to be assessed with a higher level at discharge. Notable changes at discharge specific to clients with co-occurring disorders included: a reduction in family issues/problems (66% at admission; 57% at discharge); and an overall reduction in socialization issues/problems from 57% to 48%. Medical/physical issues/problems, employment status and living situation remained relatively stable for clients with co-occurring disorders from admission to discharge. Almost ¼ of clients with and without co-occurring disorders left treatment against professional advice. Slightly fewer co-occurring clients completed treatment with or without further treatment recommended (46% vs. 51%).

Table 3: Changes from Admission to Discharge – Clinical Impressions

N = 5,556 discharges

DACODS Data Item	Discharges of Co-occurring Clients				Discharges of Clients without Co-occurring Disorders			
	Admission		Discharge		Admission		Discharge	
	#	%	#	%	#	%	#	%
Reason for discharge								
Tx completed, no further formal tx recommended	--*	--	1,209	22	--	--	3,632	30
Tx completed, additional formal tx recommended	--	--	1,329	24	--	--	2,524	21
Left against professional advice	--	--	1,288	23	--	--	2,750	23
Terminated by facility	--	--	679	12	--	--	1,381	12
Transferred to another substance abuse tx agency	--	--	508	9	--	--	711	6
Other	--	--	543	10	--	--	954	8

Progress towards Treatment Goal								
Minimal	--	--	2,324	42	--	--	4,513	38
Moderate	--	--	1,829	33	--	--	3,531	29
High	--	--	1,403	25	--	--	3,908	33
Mental Health Issues								
	5,206	94	3,474	62	--**	--**	721	6
Family Issues/Problems								
None	653	12	830	15	3,171	27	3,803	32
Minimal	1,226	22	1,559	28	3,485	29	3,758	31
Moderate	2,361	42	2,114	38	3,354	28	3,001	25
Severe	1,316	24	1,053	19	1,942	16	1,390	12
Socialization Issues/Problems								
None	981	18	1,257	23	4,303	36	4,933	41
Minimal	1,419	25	1,637	29	3,497	29	3,573	30
Moderate	2,431	44	2,061	37	3,035	25	2,620	22
Severe	725	13	601	11	1,117	9	826	7
Work/School Issues/Problems								
None	1,279	23	1,601	29	4,590	38	5,347	45
Minimal	1,214	29	1,386	25	3,244	27	3,160	26
Moderate	2,096	37	1,759	32	2,931	24	2,490	21
Severe	967	11	810	15	1,187	10	955	8
Medical/Physical Issues/Problems								
None	2,622	47	2,891	52	7,925	66	8,295	69
Minimal	1,326	24	1,235	22	2,235	19	2,015	17
Moderate	1,293	23	1,148	21	1,402	12	1,320	11
Severe	315	6	282	5	390	3	322	3
Employment Status								
Full time	1,399	25	1,592	29	4,235	35	4,513	38
Part time	517	9	563	10	1,260	11	1,288	11
Unemployed, looking	1,086	20	869	16	2,437	20	1,891	16
Unemployed, not looking	928	17	869	16	1,576	13	1,678	14
Not in workforce	1,626	29	1,663	29	2,444	21	2,582	22
Living Situation								
Living independently	3,065	55	3,175	57	6,721	56	6,971	58
Homeless	427	8	387	7	903	8	855	7
Dependent, living w/ parents	1,481	27	1,337	24	2,883	24	2,602	22
Dependent, living in supervised setting	583	10	656	12	1,445	12	1,524	13

* Discharge items only

**Incorporated into the definition of "co-occurring"

Table 4: Changes from Admission to Discharge - Behaviors

DACODS Data Item	Discharges, Co-occurring				Discharges, No Co-occurring			
	All Modalities		Outpatient Only		All Modalities		Outpatient Only	
	Admission	Discharge	Admission	Discharge	Admission	Discharge	Admission	Discharge
	%	%	%	%	%	%	%	%
Frequency of Use, Primary Drug								
None	45	73	52	69	52	69	59	79
1 or more days	55	27	48	31	48	31	41	21
DUI/DWAI Arrests								
None	84	96	83	94	83	94	82	96
1 or more	16	4	17	6	17	6	18	4
Other Arrests								
None	54	85	54	82	54	82	57	85
1 or more	46	15	46	18	46	18	43	15
Medical Emergency Room Visits								
None	69	85	75	86	75	86	84	92
1 or more	31	15	25	14	25	14	16	8
Medical Hospital Admissions								

None	83	91	86	91	86	91	92	95
1 or more	17	9	14	9	14	9	8	5

The table below shows the degree of change from admission to discharge for clients with and without co-occurring disorders. Co-occurring clients showed greater change from admission to discharge than those without co-occurring disorders. More co-occurring clients: abstained from use their primary drug during treatment; and decreased the number of DUI/DWAI, other arrests, medical ER visits and medical hospitalizations.

Table 5: Percent Change from Admission to Discharge, All Modalities, Clients with vs. without Co-occurring Disorders

	Clients with Co-occurring Disorders	Clients without Co-occurring Disorders
Frequency of Primary Drug Use		
None	1.6	0.7
1 or more days	2.3	1.5
DUI/DWAI Arrests		
None	0.9	0.9
1 or more days	4.0	2.8
Other Arrests		
None	0.6	0.7
1 or more days	3.0	2.6
Medical ER Visits		
None	0.8	0.8
1 or more days	2.0	1.8
Medical Hospital Admissions		
None	0.9	0.9
1 or more days	1.9	1.6

- 1 = no change
- >1 = positive change
- <1 = negative change

23. ENDNOTES

¹ U.S. Apparent Consumption of Alcoholic Beverages Based on State Sales, Taxation or Receipt Data, U.S. Alcohol Epidemiologic Data Reference Manual Volume 1, 4th Edition, June 2004, U.S. Department of Health and Human Services.

² State Estimates of Substance Use From the 2004 National Survey on Drug Use and Health. Wright, D. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, September, 2005.

³ Alcohol and Drug-related mentions on death certificates for Colorado residents, 2003. Colorado Department of Public Health and Environment (personal communication) 10/4/04.

⁴ Overview of Substance Abuse Treatment Services Fiscal Year 2002. O'Keefe, M. and Fisher, E. Colorado Department of Corrections, May 2003.

⁵ Urban Peak Public Health Survey Report, 2004: A Multi-City Collaborative, by Jamie Van Leeuwen, December 2004.

⁶ Youth Risk Behavior Survey, 2003 in Health Watch. Colorado Department of Public Health and Environment, July 2004, No. 57.

⁷ 2004 Partnership Attitude Tracking Study by The Partnership for a Drug-Free America, April 2005, Washington DC.

⁸ Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the U.S by the National Center on Addiction and Substance Abuse at Columbia University July 2005.

⁹ A Drug & Alcohol Indicator Chart Book for Colorado. William E. McAuliffe, et.al., National Technical Center for Substance Abuse Needs Assessment, North Charles Research and Planning Group, Harvard Medical School, March 2001.

¹⁰ Shoveling Up: The Impact of Substance Abuse on State Budgets, January 2001. The National Center on Addiction and Substance Abuse at Columbia University.

¹¹ 1979, 1985 and 1995 National Household Survey(s) on Drug Abuse. Office of Applied Studies, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

¹² State Snapshots of Substance Abuse Prevention and Treatment Programs, Performance Management Technical Assistance Coordinating Center, U.S. Department of Health and Human Services, SAMHSA, Center for Substance Abuse Treatment, 2005.

¹³ Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers, Feb 2005, by S. Belenko, N. Patapis and M. French, Treatment Research Institute, University of Pennsylvania.

¹⁴ See Endnote #13.

¹⁵ Overview of Substance Abuse Treatment Services, The Colorado Department of Corrections, Fiscal Year 2004.

¹⁶ 2003 Colorado Department of Corrections Statistical Report by K. Rosten.

¹⁷ The George Washington University Medical Center, "Ensuring Solution to Alcohol Problems: Primer 3; A Sound Investment: Identifying and Treating Alcohol Problems. Pew Charitable Trust, January 2003.

-
- ¹⁸ The National Institute on Alcohol Abuse and Alcoholism Strategic Plan, 2001-2005, The National Investment in Alcohol Research, www.niaaa.nih.gov.
- ¹⁹ See endnote #3.
- ²⁰ Crime and Justice in Colorado, 2004. Office of Research and Statistics, Division of Criminal Justice, March 2005.
- ²¹ The White House Office of National Drug Control Policy, 2002 Final Report on the 1998 National Drug Control Strategy. February 2002.
- ²² See endnote #11.
- ²³ Colorado 2000 Census, Demography Office.
- ²⁴ Treatment Episode Data Set (TEDS), Drug and Alcohol Services Information System, Office of Applied Studies, SAMHSA. www.icpsr.umich.edu/SAMDA Quick Tables.
- ²⁵ Monitoring the Future: National Results on Adolescent Drug Use 2004, National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services, April 2005.
- ²⁶ Tobacco Use in Colorado: Results from the Behavioral Risk Factor Surveillance System. Rosenblatt, R. Health Watch, July 2004, No. 56.
- ²⁷ Patterns and Trends in Drug Abuse: Denver and Colorado, June 2005. Colorado Department of Human Services, Alcohol and Drug Abuse Division.
- ²⁸ See endnote #13.
- ²⁹ California Drug Treatment and Alcohol Treatment Assessment (CALDATA). 1994, Department of Alcohol and Drug Programs, State of California.
- ³⁰ Footnote 86 - A Monograph prepared by Department of Human Services, Office of Mental Health and Drug Abuse Services, Alcohol and Drug Abuse Division, Community Programs, November 2003.
- ³¹ Annual Report. Rand Corporation, Los Angeles, California, 2002.
- ³² National Institute on Drug Abuse News Release. May 1, 2002.
- ³³ Cost Savings in Medicaid Medical Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State. Washington State Department of Social and Health Services, June 1997.
- ³⁴ Social Outcomes and Cost Savings of Drug and Alcohol Treatment in the State of Oregon. Oregon Department of Human Resources, Office of Alcohol and Drug Abuse Programs, February 1996.
- ³⁵ Follow-up Study by the Evaluation and Program Monitoring (section), the New York State Office of Alcoholism and Substance Abuse Services, conducted between January 1997 and December 1998.
- ³⁶ The National Treatment Improvement Evaluation Study. The Center for Substance Abuse Treatment, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 1992-1997.

³⁷ Follow-up Study of Substance Abuse Treatment Clients. Colorado Department of Human Services, Alcohol and Drug Abuse Division, November 1998.

³⁸ Four Year Cost-Effectiveness Study of Alcohol and Other Drug Treatment Programs. The Ohio Department of Alcohol and Drug Addiction Services, 1995.

³⁹ An Analysis of Substance Abuse Prevalence, Treatment Resources and Treatment Gaps in Colorado. Mendelson, B. Colorado Department of Human Services, Alcohol and Drug Abuse Division, December 2002.

⁴⁰ See endnote #39.

⁴¹ Special Connections Annual Report, July 1-2003 – June 30, 2004, by K. Mooney, Alcohol and Drug Abuse Division, Colorado Department of Human Services, March 2005.

⁴² See endnote #2.

⁴³ Methamphetamine Use, Abuse and Dependence: 2002, 2003 and 2004, The NSDUH Report, September 16, 2005.

⁴⁴ Medical Consequences of Drug Abuse 2004, a monograph posted on the NIDA web site, www.nida.nih.gov/consequences/prenatal.

⁴⁵ Prenatal Plus Annual Report, FY01.

⁴⁶ Comprehensive Continuous Integrated System of Care (CCISC): Psychopharmacology Practice Guidelines for Individuals with Co-Occurring Psychiatric and Substance Use Disorders, Kenneth Minkoff, MD, January 2005.