Governor's Office for Drug Control Policy FY 2006 Budget Presentation

STATE OF IOWA

THOMAS J. VILSACK
GOVERNOR
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LT. GOVERNOR

OFFICE OF DRUG CONTROL POLICY
MARVIN L. VAN HAAFTEN, DIRECTOR

Budget Presentation by: Marvin Van Haaften, Director **February 16, 2005**

ODCP Background

The Office of the Drug Policy Coordinator, established in Chapter 80E of the Code of Iowa, directs the Governor's Office of Drug Control Policy (ODCP); coordinates and monitors all statewide counter-drug efforts, substance abuse treatment grants and programs, substance abuse prevention and education programs; and engages in other related activities involving the Departments of public safety, corrections, education, public health and human services. The coordinator assists in the development of local and community strategies to fight substance abuse, including local law enforcement, education, and treatment activities.

The Drug Policy Coordinator serves as chairperson to the Drug Policy Advisory Council, which includes 15 members representing a variety of disciplines. The Council and the Coordinator oversee the development and implementation of a comprehensive Statewide Drug Control Strategy (provided in January).

The Office of Drug Control Policy administers federal grant programs to improve the criminal justice system by supporting drug enforcement, substance abuse prevention and offender treatment programs across the state. The ODCP prepares and submits the Iowa Drug and Violent Crime Control Strategy to the U.S. Department of Justice, provides technical assistance to state and local agencies, as well as program evaluation and grants management.

SFY 2006 Budget Request

ODCP's budget request, submitted last year, was a status quo request for $262,800…including funding for a DAS distribution. Subsequently, Governor Vilsack has recommended an additional $395 for DAS distribution, plus $50,000 in one-time funding to fill a void between federal grants for Iowa's new initiative to protect Drug Endangered Children (DEC)…for a total request of $313,195. The additional $50,000 is needed to sustain continuity of DEC operations from July 14, when one federal grant ends, until at least November 1, when a new federal grant will kick in.

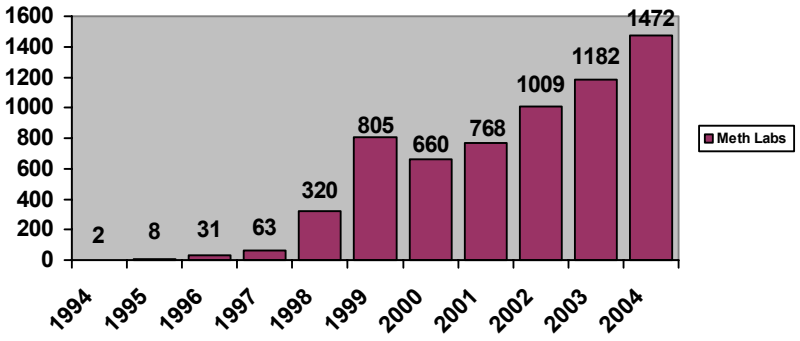
ODCP administers nearly $9 million in federal grant funds, primarily in support of coordinated local and state drug enforcement, treatment and prevention programs. The largest chunk of these funds—$3.1 million as of this year—come to Iowa via one Byrne-Justice Assistance Grant (or JAG) program…formerly the Edward Byrne and Local Law Enforcement Block Grant programs. Congress merged these two programs into the JAG program in FFY 2005, changed the funding

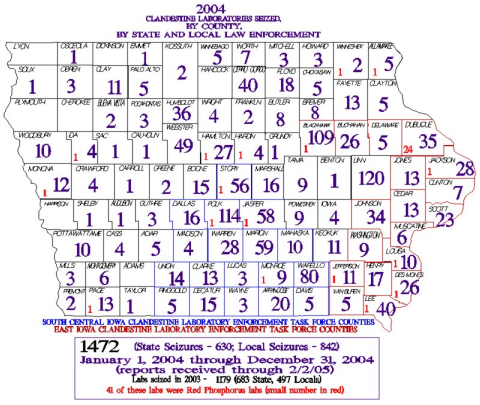
formula, and appropriated less money than before. The net result is an overall 22% (or $1.3 million) reduction in funds to Iowa.

Iowa METH Facts

➔ The DEA's El Paso Intelligence Center (EPIC) reports **1266** Iowa meth lab incidents in 2004, the **3rd** largest number of meth labs of any state in the nation, & **2nd** on a per capita basis. The Iowa Division of Narcotics Enforcement tracked a record high **1,472** lab responses in 2004.

Meth Lab Incident Responses in Iowa, CYs '94–'04 (Iowa DPS)

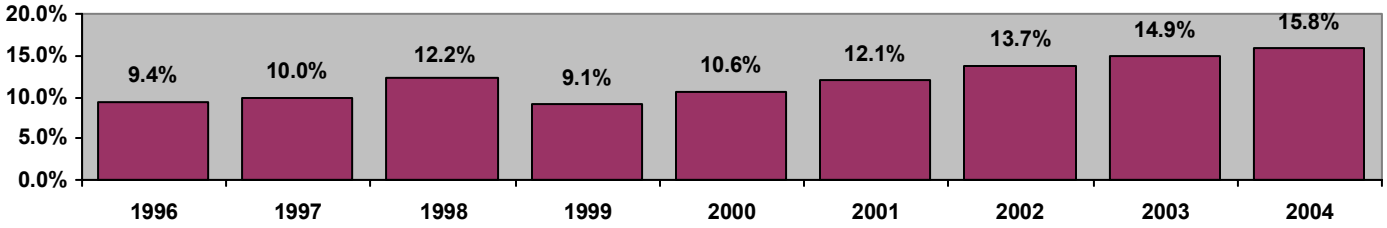




➔ Meth & meth precursor offenses made up **62%** of new drug crime prison admissions in SFY 2004 (Iowa DOC).

➔ The proportion of Iowa drug treatment clients citing meth as their primary substance of abuse rose to an all-time high of **15.8** percent in FY 2004.

% Iowa Adults in Treatment w/Meth as Primary Drug of Abuse FY '96–'04 (Iowa DPH)

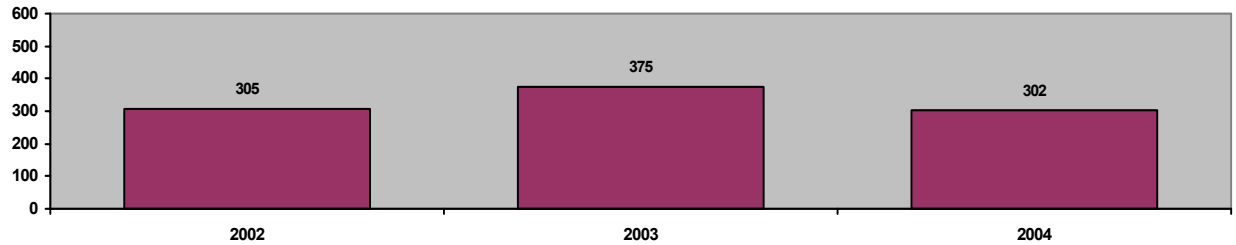


➔ Iowa has the nation's **4th** highest rate of meth use, and the **5th** highest rate of smoked meth (2004 U.S. Dep't. of Health & Human Services).

➔ In SFY 2004, **39%** of new male prisoners & **47%** of new female prisoners had histories of meth use (Iowa DOC).

➔ Over the last three years (CYs 2002-2004), the Iowa Department of Human Services classified **nearly 1,000** children as victims of abuse due to dangerous meth labs and precursors.

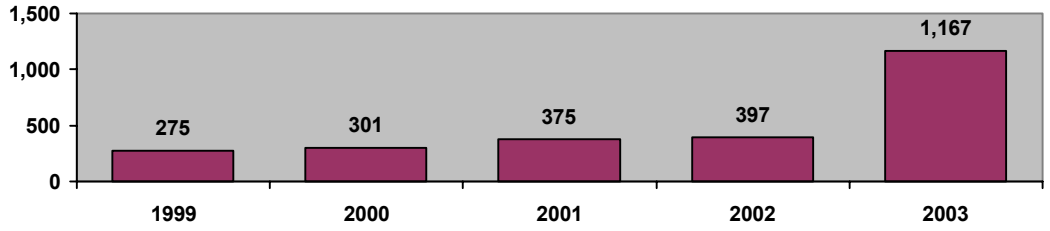
Confirmed Child Abuse Involving Children Exposed to Meth Labs and/or Precursor Chemicals CY 2002-2004 (Iowa DHS)



Other Iowa DRUG Facts

➔ The number of Iowa children testing positive for illegal drugs in their system jumped to **1,167** in 2003, following gradual increases in previous years, according to a Prevent Child Abuse Iowa analysis of Iowa DHS data.

Confirmed Child Abuse Involving the Presence of Illegal Drugs in a Child's Body CY 1999-2003 (Prevent Child Abuse Iowa)



➔ Alcohol remains the substance most abused by Iowans, followed by marijuana, meth and crack…based on admissions & screenings at Iowa's substance abuse treatment centers.

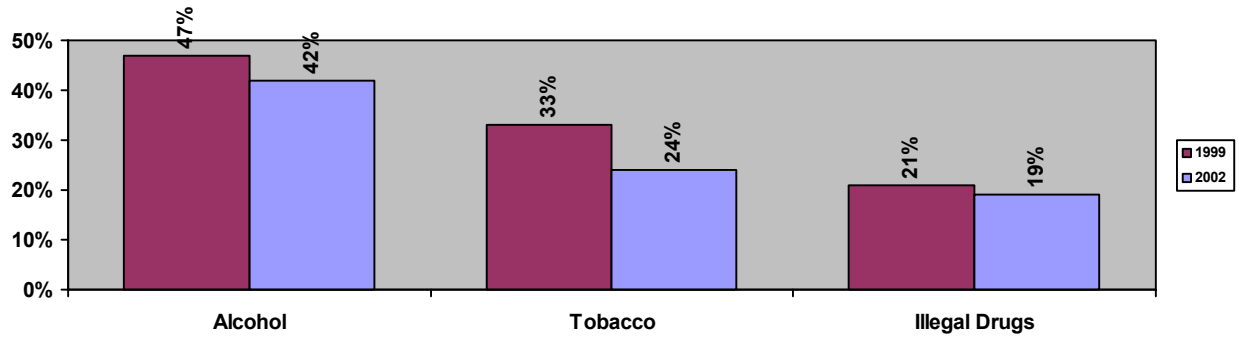
Primary Substance of Abuse Trends (Iowa DPH)

Year	Alcohol	Marijuana	Methamphetamine	Crack	Heroin	Other	Total Clients*
1992	85%	7.0%	1.0%	5%	0.5%	1.5%	22,471
1993	82%	9.0%	1.3%	5%	0.7%	2.0%	22,567
1994	78%	11.0%	2.2%	6%	0.8%	4.0%	25,328
1995	69%	14.3%	7.3%	6%	0.7%	2.7%	29,377
1996	64%	18.1%	9.1%	6%	0.5%	1.8%	33,269
1997	62.5%	19.3%	9.6%	6.3%	0.6%	1.7%	38,297**
1998	60%	20%	12.0%	6%	0.5%	1.5%	38,347**
1999	63%	20%	8.3%	5.6%	0.5%	1.3%	40,424**
2000	62.3%	20.9%	9.4%	5.4%	0.5%	1.5%	43,217**
2001	60.5%	22.2%	10.7%	4.6%	0.5%	1.5%	44,147
2002	58.5%	22.7%	12.3%	4.2%	0.5%	1.8%	42,911
2003	57.5%	21.8%	13.4%	4.6%	0.6%	1.9%	40,925
2004	55.6%	22.7%	14.6%	4.7%	0.6%	1.8%	42,449

➔ Marijuana, many times more potent than the marijuana of 30 years ago, continues to be the most prevalent illegal drug used by Iowans. More than half of Iowa youth—**52.5%**—seeking drug treatment in SFY 2004 cited marijuana as their primary substance of abuse (Iowa DPH).

➔ According to the two most recent triennial Iowa Youth Surveys of 6th, 8th & 11th graders, substance use among younger Iowans has declined.

Iowa Youth Reporting Substance Use in Their Lifetime (1999 & 2002 Iowa Youth Surveys)



Ventilation system

Ventilation systems (heating, air conditioning) tend to collect fumes and dust and redistribute them throughout a home. The vents, ductwork, and filters can become contaminated. It is recommended to replace all of the air filters in the system, remove and clean vents, clean the surfaces (such as walls and ceilings) near system inlets and outlets, and clean the system's ductwork.

Plumbing

Sinks, drains, tubs and toilets are frequently used for the disposal of waste products generated during the meth manufacturing process. These waste products can collect in drains, traps, and septic tanks and give off fumes. If a strong chemical odor is coming from household plumbing or if you suspect the septic tank or yard may be contaminated, do not attempt to address the problem yourself. Contact an environmental clean up contractor or your local health department.

Have questions or need more information?
Contact:

Division of Environmental Health
Iowa Department of Public Health
321 East 12th Street
Des Moines, IA 50319-0075
Tel: (515) 281-7726
Fax: (515) 281-4529
www.idph.state.ia.us

Remember these steps to cleaning a former meth property:

1. ***Consult with a certified environmental clean up contractor, if warranted.***
2. ***Contact your local law enforcement agency to determine what chemicals were present on the property.***
3. ***Thoroughly air out the property before and during cleanup.***
4. ***Remove all unnecessary items and dispose of them.***
5. ***Remove visibly contaminated items or items that have an odor.***
6. ***Clean all surfaces using household cleaning methods and proper personal protection.***
7. ***Clean the ventilation system.***
8. ***Leave plumbing cleaning to the experts.***
9. ***Air out the property for three to five days.***
10. ***If odor or staining remains, have your home evaluated by a professional.***

Guidelines for Cleaning up Former Methamphetamine Labs

Iowa Department of Public Health
Division of Environmental Health
(515) 281-7726

METHAMPHETAMINE

Methamphetamine (meth) drug labs are not a new hazard to Iowa. In 2003, federal, state and local authorities seized more than 1,100 Iowa labs, and the number of labs seized increases each year. These labs are discovered in houses, apartments, motel rooms, motor vehicles, and even an occasional combine.

Currently there is no official federal guidance or regulations on how to clean up a former meth lab. The Iowa Department of Public Health, Division of Environmental Health, has created these basic guidelines to assist public health officials, property owners and the general public in cleaning up former meth lab properties.

WHY THE CONCERN ABOUT CLEANING UP ILLEGAL METH LABS?

After the bulk of any lab-related debris, such as chemicals and containers has been removed, it is possible that a small amount of contamination may accidentally be inadvertently left on surfaces and in absorbent materials (carpets, furniture), sinks, drains and ventilation systems.

Failure to properly clean former meth lab sites may result in continued exposure of occupants to chemicals. This may cause health or safety problems and may affect the value and future use of property.

IDPH advises property owners to exercise caution and use the safest possible methods for cleaning a former meth lab property and any possible remaining contamination.

The Iowa Department of Public Health believes that the safest way to clean up a former meth lab is to hire an environmental company trained in hazardous substance removal and clean up. Owners who decide to clean properties on their own should be aware that household building materials and furniture may have absorbed contaminants and may give off fumes. Use caution and wear clothing to protect your skin, such as gloves, long sleeves, and eye protection during cleaning.

GENERAL GUIDELINES FOR CLEANING FORMER METH LABS:

Air out the property

Be sure the property has been aired out for several days before cleaning. Good ventilation should be continued throughout the property's cleanup.

To promote the volatilization (dissolving into the air) of some chemicals, windows and doors may be closed and the temperature inside the home increased to approximately 90 degrees Fahrenheit for a few days. After cleaning and heating is complete, the property should be aired out for three to five days to allow for any volatiles to disperse from the house. Open all windows and set up exhaust fans to circulate air out of the house. During this time, the property should remain off limits unless it is necessary to make short visits.

After the cleaning and final three to five days of airing-out, the property should be checked for re-staining and odors, which would indicate that the initial cleaning was not successful. Additional, more extensive steps will need to be taken to complete the cleaning process.

Contamination removal and disposal

During the meth "cooking" process, spilled chemicals, supplies and equipment may contaminate household items. Remove, double-bag, and properly dispose of any items that are visibly contaminated. Absorbent materials, such as carpeting, drapes, clothing, and furniture can accumulate dust or splattered chemicals. It is recommended these materials be disposed of if odors or staining are present. These contaminated items, if properly double-bagged, may be disposed along with regular household trash.

If you find suspicious containers or lab equipment at the property, do not handle them yourself. Leave the area and contact your local law enforcement agency or fire department.

Surfaces

Surfaces, such as walls, counters, floors, ceilings, etc., are porous and can hold contamination from the meth cooking process, especially in those areas where the active lab existed. Cleaning these areas is very important because of frequent contact, such as in food preparation, with these surfaces. Where appropriate, painting should be considered after cleaning, especially where contamination was found or suspected.

If a surface has visible contamination, staining, or gives off odors, complete removal and replacement of the surface is recommended. This may include removal and replacement of wallboard, floor coverings, and counters.

PARTNERSHIP FOR A DRUG-FREE IOWA

The Power of a Grandparent

TALK WITH YOUR GRANDCHILDREN ABOUT DRUGS! HERE'S HOW.

The power of a grandparent

Grandparents can be a powerful influence in the lives of their grandchildren. Grandparents are often people that a child respects and admires and does not want to disappoint; they are looked up to and their opinions are valued.

Because of this, you have many opportunities to provide support and guidance on a variety of issues – including the use of alcohol, tobacco and other drugs.

You are not alone. According to an AARP survey, 44 percent of grandparents see a grandchild each week; 45 percent of grandparents talk once weekly (or more often) with their grandchildren; and approximately 54 percent of grandparents want guidance on how to discuss sensitive topics, like drugs, with their grandchildren.

From early childhood on, children are presented with a confusing picture of the world when it comes to drugs: some drugs are legal at certain ages (alcohol and tobacco); some are "medicines"; others are illegal.

A grandparent, among other things, can help reinforce the no-use messages their grandchildren hear from parents and school; they can help support a grandchild's decision not to use drugs; and they can help sort out all the information their grandchildren see and hear about alcohol, tobacco and other drugs.

Once is not enough

Talking with children about illegal drugs is not as difficult as most people think. But it is not as simple as delivering one message ("Don't do drugs."). As kids age, their attitudes about drugs become more and more sophisticated.

While young children tend to view drugs in simple terms ("good" vs. "bad"), pre-teens and teenagers come to understand that not all drugs are the same. Drug-related attitudes and

Simply by being a loving part of a child's life, grandparents provide security, acceptance and care that support and strengthen that child's decision-making abilities about risky behaviors.

a child's perception of the risk of taking a drug have a direct influence on decisions to use drugs, and are influenced by a wide variety of factors: age, gender, peer and family influences, among others. The messages and warnings parents use with children when they're young will not work with children as they grow into adolescents. This is also true of grandparents. It is important that the grandparent's message "grows" with the grandchild.

Ongoing communication with children about drugs is critical. As their attitudes about drugs change, kids need guidance and advice from their parents and grandparents. That's why one-time conversations about drugs will not do the job.

What should I say?

For grandparents who don't know what to say or aren't sure where to start, the ability to listen intently to children as they talk about drugs is a great strategy to employ. Start by asking open-ended questions about the issue of drugs, and listen.

Below are more tips for talking to your grandchildren at different stages in their lives.

Preschool

At this age, children are eager to know and memorize rules. But while they're old enough to understand simple concepts, they're not ready to take in complex facts about tobacco, alcohol and other drugs.

- Present information in simple terms –"Smoking is bad for you."
- Encourage healthy habits.
- Explain that even medicine can be harmful if it's not taken the way it's supposed to be. Illustrate this by reading warning labels. And if you are taking prescription or

over-the-counter medications in the presence of a grandchild, only take the amount directed or prescribed.

- Admonish grandchildren never to put anything into their mouth if they don't know what it is. Kids this age can't tell the difference between candy and medicine.
- Teach them never to take medicine, candy or other things they might put in their mouths from anyone but their parents or someone to whom the parent has given permission – like a grandparent, teacher or doctor.
- Keep medicines, vitamins and other similar products out of reach.

Kindergarten through grade three (5 to 8 years old)

At this age, kids are taking an increased interest in the world beyond home. They may start seeing ads and shows depicting alcohol or tobacco use and hear people talking about drugs.

- Explain what alcohol, tobacco and drugs are. Talk about how some people use them, even though they can be harmful.
- Use "teachable moments" while watching television, overhearing a conversation in a restaurant, or reading a book, to talk about how drugs can be harmful or dangerous.
- Praise your grandkids for taking good care of their bodies and avoiding things that might be harmful.

One of the primary reasons non-using teenagers cite for remaining drug-free is fear of disappointing their parents.

Grades four through six (9 to 11 years old)

At this age, one out of every seven kids has been offered drugs. Now is the time to help children prepare to make the right decision. This is also an age when they are very curious about how the body works, and are ready for more complex information about drugs.

- Talk with your grandchildren about why people may be attracted to drugs, and discuss with them how to say "no" when offered drugs by friends.

Information is available at the Iowa Substance Abuse Information Center web site at www.drugfreeinfo.org or toll-free at 1-866-242-4111.

- Take time to learn about alcohol, tobacco and other drugs so you feel prepared to talk with your grandchildren about them.
- If you feel confident your knowledge is accurate, talk with your grandchildren about specific drugs and how they might affect the user's body and life.
- Don't worry about having all the facts. It's more important that you express how you'd feel if your grandchild used drugs, and the impact it could have on the family.
- Be prepared to answer questions about whether or not you ever used drugs, alcohol or tobacco.

Grades seven through nine (12 to 14 years old)

According to the National Center for Addiction and Substance Abuse at Columbia University, between the ages of 12-16:

- The likelihood that a teen will smoke, drink or use illegal drugs increases almost 500 percent.
- The percent of teens who have close friends who use marijuana increases 1000 percent.

At this age, kids are trying both to fit in and to establish their own sense of identity – and they are increasingly exposed to drugs and drug use. They are more likely to see older kids doing drugs without seeing immediate consequences, so they are less likely to believe a "black-and-white" statement that drugs are bad. Many kids this age overestimate the number of their peers who do drugs, and may think they have to use drugs to fit in.

Studies show that teenagers who learn at home about the risks of drugs are up to 50 percent less likely to use drugs compared to other teens. The "power of grandparents" in helping prevent substance abuse is clear.

- Talk to your grandkids about the immediate distasteful consequences of drugs (i.e., tobacco and marijuana use can cause socially undesirable things like bad breath, discolored teeth, or smelly hair and clothes).
- Talk with grandkids about what their world is like, what they value, and their future goals. Then ask them how engaging in unhealthy or risky behavior, like using drugs, would impact their dreams.
- Talk with them about how drug use might hurt friendships or positive opportunities in their lives.

Grades 10 through 12 (15 to 17 years old)

At this age, teens already have had to make decisions about drugs. They are making distinctions between different drugs and their effects; between occasional use, regular use and addiction. And they are increasingly seeing peers use drugs.

- Youth in this age group are starting to focus on their future, so tell them how drug use can ruin their chances of getting into a good college or landing a good job.
- Be specific about the consequences of using drugs. For example, teens are ready to hear that alcohol use during pregnancy can lead to Fetal Alcohol Syndrome or other alcohol-related birth defects. They also need to know the risks of drinking or taking drugs and driving, or riding with an impaired driver.
- Teens tend to be idealistic, so remind them how avoiding illegal drugs can make the community a better place. Talk about the ways a person's drug use affects others, and that drug use is not a "victimless crime."

For all ages

- If you suspect your grandchildren may be drinking or trying drugs, talk with their parents first. It may be something they are already addressing.
- Tell your grandchildren how much you love them and how disappointed you'd be if they took unhealthy or unsafe risks.
- Express interest in, or if possible get involved in, your grandkids' activities.
- Make your values clear by setting a good example. Reinforce their parents' expectations clearly and consistently.
- Listen to what your grandkids have to say. And listen closely. You'll learn a lot about what they think and already know about drugs, alcohol and tobacco.
- If you don't know all the answers, that's okay. There are places to find facts and figures. It's more important to listen and to express, in a caring way, how you'd feel if your grandchildren made unhealthy or risky choices.

Remember: Talking with your grandkids about drugs is important!

Just by trying, your grandkids will get the message that you care about them.

If you don't know how to start the conversation, try asking questions:

- "What have you heard about kids in your school using drugs?"
- "What have you heard about drugs?"

- "Why do you think kids get involved in drugs?"
- "What's it like being a teenager today?"
- "What are the issues you face?"

Or, let them know that this is a difficult topic for you, by saying:

- "I don't really know how to talk about this, but I'd like to know about …"

Reinforce how much you care about your grandchildren by clearly expressing your expectations and how disappointed you'd be if they made unhealthy choices. You can begin this conversation in a number of ways:

- "You know how much I love you and care about you. I would never want you to do anything – like drinking, taking drugs or smoking – that would be harmful."
- "I know that you can make great decisions, even when they are difficult – like saying 'no' to a friend who's asked you to do something dangerous or illegal."
- "I'd be very disappointed if you made a decision that could be harmful to your health and body, like drinking or smoking."

Take the opportunity – talk to your grandchildren about drugs!

Information adapted from "Growing Up Drug-Free: A Parent's Guide to Prevention," developed by the Partnership for a Drug-Free America for the U.S. Department of Education.

For more information on drugs or a copy of this booklet, visit the Iowa Substance Abuse Information Center web site at www.drugfreeinfo.org, or call toll-free 1-866-242-4111.

If you need to talk with someone, you will be referred to a local substance abuse prevention agency in your area.

Parents, take five on March 5th.

March 5th has been designated Take Five Day, a time for you to **take five minutes to talk with your kids about drugs.** A five-minute conversation now and then can make a huge difference toward keeping your kids away from drugs. So Take Five on March 5th. Or don't wait. Start talking with your kids today.

For help with what to say, call the Iowa Substance Abuse Information Center toll-free Help Line.

1.866.242.4111
www.drugfreeinfo.org

Partnership For
A Drug-Free Iowa

Talking With Your Kids About Drugs

5-8 Years Old

- Now is the time to begin explaining what alcohol, tobacco and drugs are.
- Discuss how anything you put in your body that is not food can be harmful.
- Explain the idea of addiction, that drug use can become a bad habit that's hard to stop.
- Praise your children for taking good care of their bodies and avoiding things that might harm them.

9-11 Years Old

- Children this age can handle more sophisticated discussion; use their curiosity about traumatic events (such as car accidents or divorces) to discuss how drugs could cause these events.
- Friends become extremely important at this time, and older children may expose your child to alcohol, tobacco or drugs. Rehearse scenarios in which friends offer drugs.
- "Upsetting my parents" is one of the top reasons preteens give for why they won't use marijuana; give them permission to use you as an excuse, such as, "My mom will kill me if I drink a beer!"

12-14 Years Old

- Adolescence is often a confusing and stressful time as teens try to figure out who they are and how to fit in. Nearly nine out of ten teens agree that "it seems like marijuana is everywhere these days".
- Take advantage of a teen's concerns about social image and appearance to point out immediate, distasteful consequences of tobacco and marijuana use: bad breath, stained teeth, smelly hair and clothes. Point out that drug use is not only dangerous, but can also lead to broken friendships, even prison.
- Also point out long-term consequences, such as brain damage, cancer, and the potential for accidents, coma or death.

15-17 Years Old

- Older teens have already made decisions about whether or not to use drugs. Now is the time to help them continue to resist peer pressure.
- Use specific reasons to reinforce why drugs are bad: addiction, birth defects, car accidents, prison.
- These students are thinking about their futures; remind them that drug use could ruin their chances of college acceptance or embarking on their career choice.

Partnership For
A Drug-Free Iowa

THE IOWA
CONSORTIUM
FOR SUBSTANCE ABUSE RESEARCH AND EVALUATION

Outcomes Monitoring System
Iowa Project

Year Six Report

Prepared By:
Iowa Consortium for Substance Abuse Research and Evaluation
University of Iowa, Iowa City, Iowa 52242-5000

With Funds Provided By:
Iowa Department of Public Health, Division of Health Promotion, Prevention, and Addictive Behaviors

Outcomes Monitoring System
Iowa Project

Year Six Report

September 2004

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Executive Summary

OMS Background

The Outcomes Monitoring System (OMS) was established to systematically gather data on substance abuse treatment outcomes in Iowa. Randomly selected clients are tracked for follow-up interviews that occur approximately six months after discharge from treatment. In calendar year 2003, 362 follow-up interviews were completed.

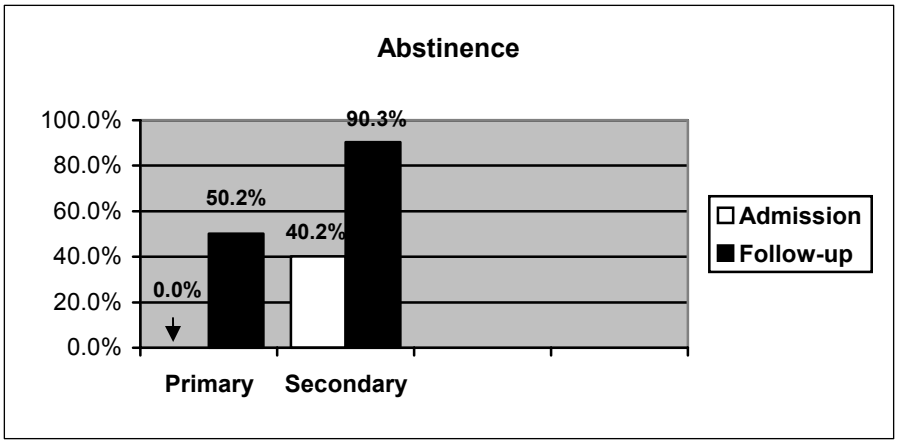
Overview of Findings

Changes between the admission and follow-up data include the following highlights:

Outcomes at Admission and Follow-Up				
	N	% Abstained	% No Arrest	% Employed Full-Time
Admission	832	0.0 (0)	30.9 (257)	36.1 (300)
Follow-Up	362	50.2 (181)	88.7 (319)	52.7 (191)

Primary and Secondary Substance

- Clients responding to "no primary substance" increased from 0.0% at admission to 50.2% at follow-up. For secondary substance use, 40.2% of clients reported no use at admission. This number increased at follow-up to 90.3% of clients reporting no use of a secondary substance.

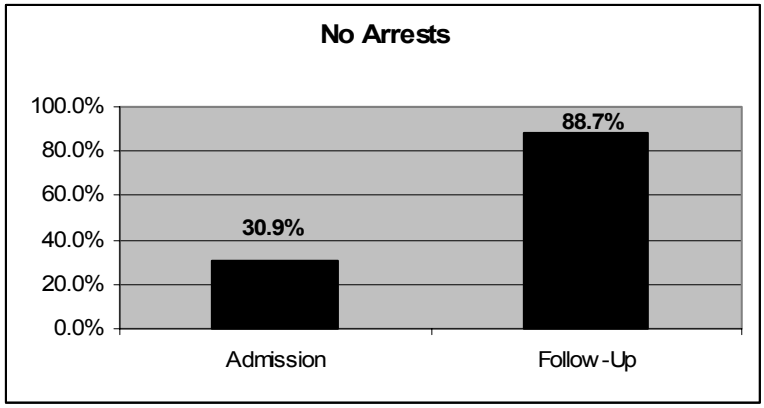


- Of those clients reporting use of a primary substance, alcohol was the most common at both admission (51%) and follow-up (77.3%).

Arrests

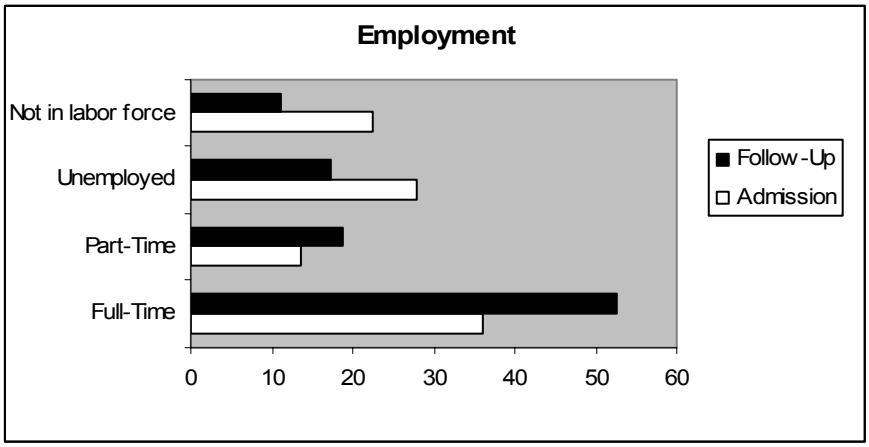
- At admission, 30.9% of clients reported no arrests in the twelve months prior to their admission to treatment.

- At follow-up, 88.7% of clients reported no arrests in the six months since their discharge from treatment.



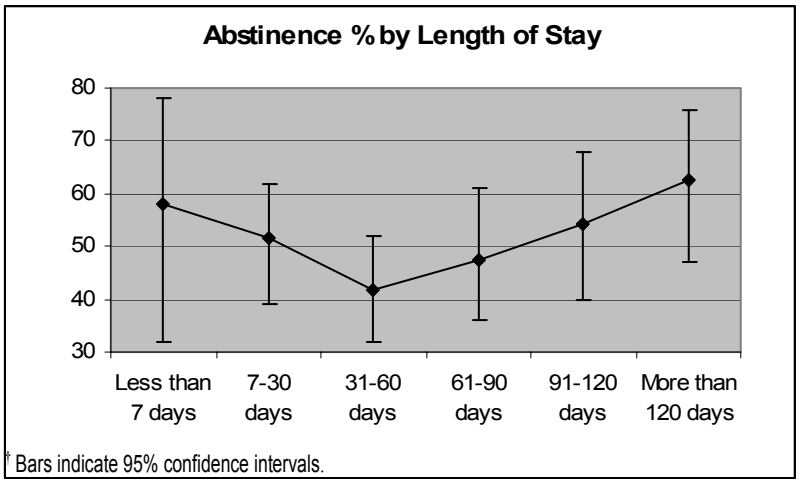
Employment Status

- The percent of clients employed full-time increased from 36.1% at admission to 52.7% at follow-up. Likewise, part-time employment among clients increased from 13.7% at admission to 18.7% at follow-up. Conversely, unemployment dropped from 27.8% at admission to 17.8% at follow-up and clients not in the labor force decreased from 22.4% at admission to 11.2% at follow-up.



Length of Stay

- The abstinence percentage for clients who were in treatment longer than 30 days increased in essentially a straight line as length of stay increased.



- Data on no arrest rate and full-time employment by length of stay also was examined, but are not statistically significant. Clients in all length of stay categories had an arrest-free rate of approximately 90% and approximately 55% of clients in each length of stay category reported full-time employment.

Primary substance use was examined in relation to the key outcome variables of abstinence, number of arrests, employment, and length of stay.

Abstinence

- Clients whose primary substance at admission was methamphetamine had the highest abstinence rate of 65.5%, with the exception of four substance groups with only 1 or 2 clients. The lowest abstinence rate of 43.9% belonged to those clients whose primary substance at admission was alcohol. Clients reporting marijuana as their primary substance at admission had an abstinence rate of 53.3%.

Arrests

- Over 90% of clients whose primary substance was alcohol at admission reported no arrests at follow-up. Marijuana and methamphetamine as primary substances at admission were similar with 86.8% and 86.0% of clients respectively, reporting no arrests at follow-up.

Employment

- Although not statistically significant, full-time employment at follow-up was reported by 58.7% of clients whose primary substance was alcohol at admission. Slightly over half of the clients whose primary substance at admission was methamphetamine were employed full-time at follow-up.

Length of stay

- For clients who reported alcohol as their primary substance at admission, 28.2% had a length of stay of 31-60 days. Almost 25% of clients who reported marijuana as their primary substance also had a length of stay of 31-60 days. While only 18.1% of clients who reported methamphetamine as their primary substance at admission had a length of stay of 31-60 days (the lowest percent for this length of stay), clients who reported methamphetamine were the highest percent (17.1%) of clients who had a length of stay of 120 days or more.

ACKNOWLEDGEMENTS

Several staff members at the Iowa Consortium for Substance Abuse Research and Evaluation made significant contributions to this report. We would like to especially thank Vishal Gupta for delivering numbers for analysis and for presenting those numbers in a desirable format. There would be no data to report if it were not for the dedication and impressive work of research assistants Juanita Richman, Angela Trujillo, and Bethany Moore who tracked the clients and conducted the follow-up interviews. Also, special thanks to Dr. Stephen Arndt and Kristina Barber for their guidance through the process and contributions to the report.

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APPENDIX: Presentation of Tracking Data

Section A. Background

In July 1998, at the request of the Iowa Department of Public Health (IDPH), the Iowa Consortium for Substance Abuse Research and Evaluation (Consortium) designed and tested an Outcomes Monitoring System (OMS) to reflect substance abuse treatment related outcomes in Iowa. Before then, treatment agency staff conducted their own interviews. Implementation of the OMS project relieved the treatment agencies from the responsibility of tracking and interviewing clients, and provided an independent evaluation regarding treatment related client outcomes. OMS client sampling was initiated in January 1999.

In addition to providing treatment related outcomes, OMS was created to examine:

- the costs associated with the tracking, recruiting and interviewing substance users by an independent organization;
- the effects of different levels of care on treatment outcomes for various client groups; and
- the process involved in obtaining and utilizing meaningful client outcomes at the individual agency level.

Section B. OMS Overview

B.1. Sampling Procedures

Since 1982, IDPH has collected client data using the Substance Abuse Reporting System (SARS). Data are collected that relate to various aspects of the treatment provision process including: crisis, screening, admission, discharge, services, and follow-up. OMS follow-up data collection is designed to integrate with SARS data. While the primary focus of OMS is the acquisition of follow-up data, the success of its design is dependent upon complete and accurate SARS admission and discharge data.

OMS data are obtained through random sampling procedures from the population of publicly funded substance abuse treatment clients. This population includes drug clients who receive IDPH-funded treatment in one of the following environments: medically managed inpatient, primary residential treatment, extended residential treatment, halfway house, continuing care, extended outpatient, intensive outpatient, or medically monitored residential. The data set from which the sample is drawn is comprised of the previous month's SARS admission data. Given that the number of admissions varies from month to month, the sample size also varies. The average monthly sample size during calendar year 2003 was 64 with a range of 51 to 93 clients.

In August 2003, the monthly random sample size was increased from approximately 5% to 8% of the adult and adolescent (age 18 and younger) client population. The sampling also was weighted to increase the number of clients from medium and small agencies. Due to the change in the sampling proportions, data have been weighted resulting in minor variations in the N values. The percentages, however, are accurate.

B.2. Recruitment

Immediately after the monthly OMS sample is selected, Consortium staff members contact clients in an effort to secure a verbal agreement to participate in a 15 minute follow-up telephone interview that takes place approximately six months after discharge from treatment. When OMS staff locate a potential participant via the telephone, they explain that they are calling on behalf of the Health Research Network (HRN is a pseudonym for the Consortium.) and that they would like to talk about participation in a public health study. Staff members confirm the identity of the client before describing the project in detail and attempting to recruit the client. The confirmation process involves matching social security number and date of birth records during the phone call. If the information matches, the staff member will read the remaining recruitment script that describes OMS and the risks and benefits associated with participation in the OMS project.

After the script has been read, clients are asked if they would like to participate in OMS. If they agree to participate, client contact information is recorded and participants are told that they will receive periodic update calls or letters from OMS staff until it is time for the follow-up interview. OMS staff explain that the update calls take only a few minutes and are used to keep contact information current. OMS staff also collect collateral contact information for a client, such as a relative's phone number, during the update call. Participants are informed that when an update call is made, OMS staff members identify themselves as a staff member with the Health Research Network, calling to inquire about a public health study.

Clients without phone contact information or those that do not have current telephone service are sent letters asking them to call the Health Research Network's toll-free number in regard to a public health study. Clients frequently call the toll-free number from a pay phone or from a neighbor's phone to contact OMS staff members. It is at this point that recruitment occurs and information is recorded about contacting them in the future.

Clients may refuse participation in OMS at any time. They may refuse during the reading of the recruitment script or they may withdraw their participation after previously indicating that they would like to take part in the follow-up interview. There are no penalties for withdrawing participation in the study. Clients do, however, receive a twenty-five dollar gift certificate upon completion of the follow-up interview.

B.3. Tracking

Client tracking information is recorded on each client until the case is closed. This tracking information consists of the successful contacts and attempted contacts that are made in an effort to communicate with the client. There are two groups of tracking information: 1) the contacts that take place prior to a client's recruitment; and 2) the contacts that take place after a client has been successfully recruited into OMS. Once a client refuses participation, the case is officially closed and tracking of that individual ceases unless the client later contacts the HRN and indicates a desire to participate.

An on-line system for recording tracking information in real time was developed and implemented in 2002. OMS staff members enter tracking events for each client as they occur. This provides a database that contains updated tracking and case status information for each client. This system reduces data entry time and provides more detailed information while reducing the chance for error.

B.4. Follow-up Interview

Four important elements of OMS must be present before a client's follow-up interview can occur. OMS staff must: 1) be able to contact the client via the telephone; 2) have the client's documented agreement to participate in the follow-up interview; 3) have a discharge date from IDPH; and 4) have documented that six months have passed since the discharge date.

The discharge date is critical as it sets the time frame for when the follow-up interview should take place. Since its inception, the OMS design has follow-up interviews occurring six months after the client has been discharged from primary treatment. Without an official SARS discharge date, it is impossible for OMS staff to determine when an interview should take place.

Once OMS staff receives a SARS discharge date, a plan to obtain the client follow-up interview is implemented. Due to the normal complexities of every day living, it is not always possible to obtain the follow-up interview on the exact post discharge date. Given this, the project design allows OMS staff to interview recruited participants anywhere from two weeks prior to eight weeks after the date that indicates six months post discharge.

Section C. Recruitment, Tracking and Follow-Up Efforts

This report describes the group of randomly selected clients who had treatment admission dates from January 1, 2003 through December 31, 2003. During this twelve month period, 832 individuals were selected to take part in the OMS project. Of that number, 582 individuals have consented to participate in the follow-up interview process. To date, 362 of these follow-up interviews have been completed. An additional 142 individuals, who have been recruited, are receiving regular update calls from staff as their interview date nears. Of the OMS clients admitted during the 2003 calendar year, 83 declined to participate in the project.

The total number of clients currently classified as "not able to recruit" is 119. Of this number, 41 individuals are incarcerated. OMS staff is not allowed to recruit or interview individuals that are incarcerated; however, several clients (24) became incarcerated after being successfully recruited into the follow-up study. Seventy-three unrecruited individuals could not be located, even after numerous phone calls, letters, and internet searches. Likewise, 39 clients who were successfully recruited, could not be located when their interview date arrived. Interview due dates already had passed for 4 unrecruited and 4 recruited clients when the Consortium received notification of their discharge dates. Two clients died.

In this report, the recruitment rate was calculated two ways. The first recruitment rate is based on only those individuals OMS staff was able to contact and who then directly told the staff that they either did or did not want to participate in OMS. This calculation results in a recruitment rate of 87.5%. The second recruitment rate is based on all individuals who had a potential opportunity to state whether or not they wanted to participate in the OMS. Therefore, the denominator of the second recruitment rate includes a larger set of individuals consisting of those who were successfully recruited, those who refused, and unrecruited clients whom staff has been unable to locate. This calculation results in a recruitment rate of 78.9%.

Of the clients eligible for a follow-up interview (successfully recruited who are not in prison, and with an interview due date that has arrived), 87.0% received an interview. This includes recruited clients who could not be located when their interview was due and those who decided not to take part in the interview after initially agreeing to do so.

Detailed tracking information regarding the status of the entire OMS sample is displayed in the Appendix, pages 31 through 39.

Section D. Changes from Admission to Follow-Up

Clients undergo many changes after admission to substance abuse treatment. When considering the observed changes, it is important to use caution when ascribing reasons for the changes to particular causes, i.e. good treatment/poor treatment, number of previous treatments/no previous treatment, etc. It is also important to realize that a combination of many factors affect client outcomes. These include such things as readiness to change, mental illness, transportation, child care needs, age, gender, culture, ethnicity, etc.

The tables in Section E reflect the changes in a client's life situation based on a comparison of the SARS admission data and the OMS SARS follow-up interview data collected approximately six months after discharge and, on average, 8 months following admission. Comparisons on individual variables are made between status at admission and status at follow-up on those clients who had a response at *both* admission and follow-up for that variable. Fifteen categories were identified for comparison from the SARS admission and follow-up forms. Some of the more interesting findings between the admission and follow-up data are reported below. For a complete overview of comparisons refer to the tables in Section E on pages 7 through 15.

- **Primary Substance Used**: Clients responding "no primary substance" increased from 0% at admission to 50.2% at follow-up. Thus, at follow-up, half of the clients remained abstinent after treatment. For those clients who were not abstinent at follow-up, alcohol was the most common primary substance with 77.3% of clients reporting use.

- **Frequency of Primary Substance Use**: Nearly twice as many clients reduced the frequency of their primary substance (51.7%) compared to those who increased their use (27.4%). Of the people who used at least daily at admission, 46.6% were abstinent and an additional 13.5% had reduced the frequency of their use.

- **Secondary Substance Use**: Clients responding "no secondary substance" increased from 42.8% to 90.3%. Therefore, only 9.7% of clients reported using more than one substance at follow-up. For those who did indicate use of a secondary substance, marijuana was most common followed by alcohol. Both showed a large decrease between admission and follow-up in the percentage of clients using them (decreases of 22.2 and 17.8 percentage points).

- **Frequency of Secondary Substance Use**: Clients were 10 times more likely to reduce the frequency of their secondary substance use – over 40% reduced their use while only 3.9% increased their use.

- **Arrests**: For the question regarding arrests, the admission response refers to the 12 months prior to admission and the follow-up response refers to the 6 months since discharge. Only 11.3% of the clients had been arrested during the 6 months following treatment. Of those who were arrested, nearly all were arrested 1-3 times.

- **Months Employed**: Clients responding “no months employed” went down 19.6 percentage points while clients responding “4 or more months” for employment went up 16.2 percentage points.

- **Income**: Clients responding “no income” dropped 25.1 percentage points. Clients responding to “$1001 to $2000 for taxable monthly income” increased by 8.1 percentage points. This increase in monthly income corresponds with the previous finding that more clients are employed.

Section E. Comparison of Admission and Follow-up Responses

Tables 1 through 16 show the admission responses from all clients admitted in 2003. The tables also describe the admission and follow-up responses from the clients who completed follow-up interviews (a subset of the first group). The first column describes the responses, or categories of responses, for the SARS question. The second column describes the responses for all clients in the OMS that answered the item at admission. The third and fourth columns describe the responses for clients that answered the particular item both at admission and at follow-up--a group of 368 clients. The number of clients in this group is smaller because it represents only those clients who completed the follow-up interview.

Table 1. Primary Substance Used

At follow-up, 50% indicated no primary substance was used. The success rates for primary substance used are included in the Outcomes section on pages 16, 21 and 25.

	Complete OMS Sample at Admission % N=832 (weighted)	OMS Sample with Follow-Up Interviews Completed N=362 (weighted %)	
		Admission	Follow-Up
None	0.0	0.0	50.2
Alcohol	46.3	51.0	38.5
Marijuana and/or hashish	27.1	26.7	8.3
Methamphetamine	20.9	17.8	2.1
Cocaine	3.7	2.7	0.7
Other Opiates and Synthetics	0.7	0.5	0.0
Heroin	0.6	0.4	0.0
Other Amphetamine	0.3	0.4	0.0
Benzodiazepines	0.2	0.4	0.0
Other Stimulants	0.2	0.4	0.0
PCP	0.1	0.0	0.0
Other	0.0	0.0	0.1
Barbiturates	0.0	0.0	0.0
Inhalants	0.0	0.0	0.0
Other Hallucinogens	0.0	0.0	0.0
Other Sedatives and Hypnotics	0.0	0.0	0.0
Over the Counter	0.0	0.0	0.0
Non-Prescription Methadone	0.0	0.0	0.0
Other Tranquilizers	0.0	0.0	0.0
Steroids	0.0	0.0	0.0
Ecstasy	0.0	0.0	0.0

† Due to rounding, percentages may not add up to exactly 100%.

Table 2. Secondary Substance Used

Clients responding "no secondary substance" increased by 50 percentage points from 40.2% to 90.3% at follow-up. Therefore, only 9.7% of clients reported using more than one substance at follow-up.

	Complete OMS Sample at Admission % N=832 (weighted)	OMS Sample with Follow-Up Interviews Completed N=362 (weighted %)[†]	
		Admission	Follow-Up
None	38.8	40.2	90.3
Alcohol	21.7	20.4	2.6
Marijuana and/or hashish	25.9	26.9	4.7
Methamphetamine	8.2	9.0	1.8
Cocaine	3.9	2.4	0.5
Other Opiates and Synthetics	0.3	0.4	0.0
Heroin	0.2	0.0	0.0
Other Amphetamine	0.0	0.0	0.0
Benzodiazepines	0.0	0.0	0.0
Other Stimulants	0.0	0.0	0.0
PCP	0.0	0.0	0.0
Other	0.4	0.1	0.0
Barbiturates	0.0	0.0	0.0
Inhalants	0.0	0.0	0.0
Other Hallucinogens	0.1	0.1	0.0
Other Sedatives and Hypnotics	0.2	0.0	0.0
Over the Counter	0.0	0.0	0.0
Non-Prescription Methadone	0.0	0.0	0.0
Other Tranquilizers	0.4	0.6	0.0
Steroids	0.0	0.0	0.0
Ecstasy	0.0	0.0	0.1

[†] Due to rounding, percentages may not add up to exactly 100%.

Tables 3 and 4 reflect changes in the frequency of substance use. These tables describe frequency change for the primary and secondary substances that are reported at the time of the interview. At follow-up, the primary substance listed at admission may no longer be their drug of choice. For example, a participant who reports alcohol as their primary substance at admission, and they use it 1-2 times per week, may report at follow-up that they have used their primary substance 1-3 times in the past month. Although this looks like a promising finding, caution

must be used when interpreting it because the participant may have made a change in the type of primary drug. Table 5 shows the percentage of clients who changed primary drugs.

Table 3. Frequency of Primary Substance

At admission, 14.9% of clients reported "no use in the past six months." At follow-up, the percentage increased to 50.5% for this category (an increase of 35.6 percentage points).

	Complete OMS Sample at Admission % N=832 (weighted)	OMS Sample with Follow-Up Interviews Completed N=362 (weighted %)		
		Admission	Follow-Up	Change
No use in past six months	15.8	14.9	50.5	+35.6
No past month use	32.8	34.3	8.4	-25.9
1-3 times in past month	24.4	26.4	13.3	-13.1
1-2 times per week	10.9	11.1	16.2	+5.1
3-6 times per week	5.2	4.7	7.2	+2.5
Once daily	4.6	3.8	3.5	-0.3
2-3 times daily	3.0	2.6	0.3	-2.3
4 + times daily	3.3	2.2	0.6	-1.6

Table 4. Frequency of Secondary Substance

Clients responding "no use in the past six months" increased by 30.0 percentage points from 60.3% to 90.3%. At follow-up, no clients reported using more than 2-3 times daily and less than 1% of clients reported using 3-6 times per week or once daily.

	Complete OMS Sample at Admission % N=832 (weighted)	OMS Sample with Follow-Up Interviews Completed N=362 (weighted %)		
		Admission	Follow-Up	Change
No use in past six months	57.9	60.3	90.3	+30.0
No past month use	17.6	16.1	4.8	-11.3
1-3 times in past month	13.8	15.0	2.1	-12.9
1-2 times per week	4.7	4.0	1.8	-2.2
3-6 times per week	2.4	1.9	0.7	-1.2
Once daily	1.9	2.0	0.4	-1.6
2-3 times daily	0.6	0.1	0.0	-0.1
4 + times daily	1.1	0.6	0.0	-0.6

Table 5. Change in substance use at follow-up

	% of Non-abstinent Clients N=180[†]
Changed primary substance	29.0
Changed secondary substance	55.1
Changed frequency of primary drug	78.7
Changed frequency of secondary drug	47.1

[†] The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the number of clients is approximate.

Table 6. Days per month attended AA, NA or similar meetings
Clients indicating "no meetings" decreased by 28.2 percentage points. Clients indicating "1-10 meetings" increased by 24.3 percentage points. Compared to clients' attendance at AA or NA meetings at the time of admission, attendance increased substantially during the 6 months following discharge from treatment.

	Complete OMS Sample at Admission % N=832 (weighted)	OMS Sample with Follow-Up Interviews Completed N=361 (weighted %)		
		Admission	Follow-Up	Change
None	76.5	81.7	53.5	-28.2
1- 10 meetings	17.4	14.3	38.6	+24.3
11 + meetings	6.1	4.0	7.9	+3.9

Table 7. Arrests
Clients responding "no arrests" increased by 58.1 percentage points from 30.6% at admission to 88.7% at follow-up. This shows that only 11.4% of the clients had been arrested during the 6 months following treatment.

	Complete OMS Sample at Admission % N=832 (weighted)	OMS Sample with Follow-Up Interviews Completed N=359 (weighted %)		
		Admission	Follow-Up	Change
None	30.9	30.6	88.7	+58.1
1-3 times	65.1	66.2	11.0	-55.2
4 times or more	4.0	3.2	0.4	-2.8

Table 8. Hospitalizations
The percent of clients reporting hospitalization at follow-up (1.1%) was six times less than the percent reported at admission (9.0%). Clients indicating "no hospitalizations" increased from 91.0% at admission to 98.6% at follow-up.

	Complete OMS Sample at Admission % N=832 (weighted)	OMS Sample with Follow-Up Interviews Completed N=362 (weighted %)		
		Admission	Follow-Up	Change
None	89.5	91.0	98.6	+7.6
1-3 times	10.5	9.0	1.1	-7.9
4 times or more	0.0	0.0	0.4	+0.4

Table 9. Employment Status

Clients responding "employed full time" increased by 16.7 percentage points. Clients responding "unemployed" decreased by nine percentage points. At follow-up, 71.4% of clients reported being employed full or part-time, an improvement over the 50.8% of clients reporting full or part-time employment at admission. The percentage of those "not in labor force" was reduced by more than one-half (22.9% to 11.2%) between admission and follow-up.

	Complete OMS Sample at Admission % N=832 (weighted)	OMS Sample with Follow-Up Interviews Completed N=362 (weighted %)		
		Admission	Follow-Up	Change
Employed Full Time (>35 hrs/ wk)	36.1	36.0	52.7	+16.7
Employed Part Time (<35 hrs/ wk)	13.7	14.8	18.7	+3.9
Unemployed (looking for work in the past 30 days)	27.8	26.4	17.4	-9.0
Not in labor force	22.4	22.9	11.2	-11.7

Table 10. Months Employed

The percent of clients responding "none" to months employed was five times less at follow-up (4.9%) than at admission (24.5%). Over 70% of clients were employed 4 months or more at follow-up.

	Complete OMS Sample at Admission % N=832 (weighted)	OMS Sample with Follow-Up Interviews Completed N=328 (weighted %)		
		Admission	Follow-Up	Change
None	29.0	24.5	4.9	-19.6
1-3 months	22.0	21.2	24.6	+3.4
4 + months	49.0	54.3	70.5	+16.2

Table 11. Income

Clients responding "none" decreased by 25.1 percentage points. There was an increase in all taxable monthly income categories, supporting the previous finding that more clients are employed.

	Complete OMS Sample at Admission % N = 826 (weighted)	OMS Sample with Follow-Up Interviews Completed N=313 (weighted %)		
		Admission	Follow-Up	Change
None	48.0	43.5	18.4	-25.1
$500 or less	8.5	10.4	15.1	+4.7
$501 to $1000	18.9	16.1	20.3	+4.2
$1001 to $2000	18.3	22.8	30.9	+8.1
Over $2001	6.3	7.1	15.3	+8.2

Table 12. Income Source

Clients responding "none" at follow-up decreased dramatically by 96% for clients completing follow-up interviews (from 17% to 0.7%). Over 45% of clients who responded "none" to income source at admission responded "wages/salary" at follow-up, which corresponds to a 13.3 percentage point increase in clients earning income.

	Complete OMS Sample at Admission % N=832 (weighted)	OMS Sample with Follow-Up Interviews Completed N=362 (weighted %)		
		Admission	Follow-Up	Change
None	20.6	17.7	0.7	-17.0
Wages/ Salary	47.7	46.7	60.0	+13.3
Family/ Friends	24.5	28.1	32.1	+4.0
Public Assistance	1.5	1.9	2.4	+0.5
Retirement/ Pension	0.4	0.4	0.0	-0.4
Disability	2.0	1.7	1.5	-0.2
Other	3.4	3.5	3.4	-0.1

Table 13. Days Missed Work or School

The percent of clients who reported missing work or school "six or more days" due to substance abuse decreased by approximately 83% between admission (6.5%) and follow-up (1.1%).

	Complete OMS Sample at Admission % N=832 (weighted)	OMS Sample with Follow-Up Interviews Completed N=362 (weighted %)		
		Admission	Follow-Up	Change
Five or fewer days	85.4	87.5	89.4	+1.9
Six or more days	7.2	6.5	1.1	-5.4
N/A	7.4	6.0	9.6	+3.6

Table 14. Education

At follow-up, 48.9% of clients had completed high school, a five percentage point increase from admission. The number of clients responding "did not graduate high school" decreased by seven percentage points, indicating that a number of clients completed high school or earned their GED between admission and follow-up.

	Complete OMS Sample at Admission % N=832 (weighted)	OMS Sample with Follow-Up Interviews Completed N=362 (weighted %)		
		Admission	Follow-Up	Change
Did Not Graduate High School	33.5	32.2	25.2	-7.0
High School Only	47.2	43.5	48.9	+5.4
Some College	16.3	20.2	19.4	-0.8
College Grad	3.2	4.2	6.5	+2.3

Table 15. Relationship Status

Clients responding "married" at follow-up decreased slightly, however, the number of clients "cohabiting" increased by over 40% between admission and follow-up. Although the percentage of clients responding "single" decreased by over three percentage points, it is the largest category with 53.5% of clients responding "single" to relationship status at follow-up.

	Complete OMS Sample at Admission % N = 832 (weighted)	OMS Sample with Follow-Up Interviews Completed N=362 (weighted %)		
		Admission	Follow-Up	Change
Single	55.2	57.0	53.5	-3.5
Married	14.3	13.6	12.3	-1.3
Cohabitating	10.4	8.8	15.8	+7.0
Separated	5.6	4.3	4.7	+0.4
Divorced	14.0	15.9	13.7	-2.2
Widowed	0.6	0.4	0.1	-0.3

Table 16. Living Arrangements
The majority of clients lived with parents, although the number decreased more than nine percentage points at follow-up.

	Complete OMS Sample at Admission % N = 832 (weighted)	OMS Sample with Follow-Up Interviews Completed N=362 (weighted %)		
		Admission	Follow-Up	Change
Alone	14.5	11.7	13.0	+1.3
Parents	27.3	35.8	26.3	-9.5
Significant Other Only	10.5	10.6	12.7	+2.1
Significant Other and Child(ren)	14.4	12.1	16.3	+4.2
Child(ren) Only	2.7	3.5	5.0	+1.5
Other Adults	18.2	17.8	16.3	-1.5
Other Adults and Child(ren)	4.8	5.0	6.7	+1.7
Prison or Jail	2.0	0.2	0.0	-0.2
Homeless	1.5	0.6	0.1	-0.5
Half-way House	4.1	2.9	3.8	+0.9
Hospital	0.0	0.0	0.0	0.0

Section F Outcome: Abstinence

Tables 17 through 25 examine abstinence in relation to other variables. Abstinence is defined as responding “none” when asked at follow-up to name a primary substance. The follow-up interview occurred approximately 6 months after the client was discharged from treatment. Mention of the “follow-up period” in this report refers to the 6 months between the client’s discharge from treatment and the follow-up interview.

Although 362 follow-up interviews were completed, individual tables contain data from fewer clients due primarily to missing data. The N for each question response represents the number of abstinent clients and the number of total clients (out of clients who answered the question at follow-up) who indicated that response.

Table 17. Abstinence by Primary Substance

Table 17 shows that clients whose primary substance at admission was alcohol (43.9%) or marijuana (53.3%) abstained at a lower rate during the follow-up period than clients whose primary substance was methamphetamine. Those whose primary substance at admission was methamphetamine had the highest abstinence percentage during the follow-up period (65.5%) with the exception of four substance groups made up of only 1 or 2 clients.

OMS Sample with Follow-Up Interviews Completed (N=362)	
Primary Substance at Admission	Abstinence at follow-up %* (N)†
Alcohol	43.9 (81/185)
Marijuana	53.3 (51/96)
Methamphetamine	65.5 (42/64)
Cocaine	19.7 (2/10)
Other Opiates and Synthetics	71.2 (1/2)
Heroin	0.0 (0/1)
Other Amphetamine	100.0 (1/1)
Benzodiazepines	100.0 (1/1)
Other Stimulants	100.0 (1/1)
PCP	0.0 (0/0)
Other	0.0 (0/0)
Barbiturates	0.0 (0/0)
Inhalants	0.0 (0/0)
Other Hallucinogens	0.0 (0/0)
Other Sedatives and Hypnotics	0.0 (0/0)
Over the Counter	0.0 (0/0)
Non-Prescription Methadone	0.0 (0/0)
Other tranquilizers	0.0 (0/0)
Steroids	0.0 (0/0)
Ecstasy	0.0 (0/0)

* Statistically significant ($p<.05$)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Tables 18 through 25 present one question each and show admission and follow-up responses from clients who completed the follow-up interview. The second column lists the abstinence percentage of clients at follow-up who were asked the question at admission and the third column lists the abstinence percentage of clients when asked the question at follow-up.

Table 18. Abstinence by Employment

Clients who were not in the labor force when they completed their follow-up interview had the highest abstinence rate of 63.0% at follow-up. Clients who reported they were not in the labor force at admission also had a relatively high abstinence rate of 54.7% at follow-up. For clients employed full or part-time at follow-up, an abstinence rate of 48.6% was reported. The number of clients employed full-time had a large increase from 130 at admission to 191 at follow-up. Clients employed part-time also increased from 53 at admission to 68 at follow-up.

	OMS Sample with Follow-Up Interviews Completed N=362	
	Employment asked at Admission Abstinence % (N)†	*Employment asked at Follow-Up* Abstinence % (N)†
Employed Full Time (>35 hrs/ wk)	46.1 (60/130)	46.9 (89/191)
Employed Part Time (<35 hrs/ wk)	47.1 (25/53)	55.3 (37/68)
Unemployed (looking for work in the past 30 days)	53.4 (51/96)	46.1 (29/63)
Not in labor force	54.7 (45/83)	63.0 (26/41)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Table 19. Abstinence by Living Arrangements

The abstinence rate at follow-up for clients living alone at admission was 52.2% whereas clients who lived alone at follow-up had an abstinence rate of 42.5%. The number of clients living with parents decreased from 129 at admission to 95 at follow-up. The abstinence rate for clients living with parents at follow-up was 52.8%, however, the abstinence rate at follow-up for clients living with parents at admission was 44.1%. Clients living with other adults and children had high abstinence rates at admission and follow-up (76.4% and 66.8% respectively).

	OMS Sample with Follow-Up Interviews Completed N=362	
	Living Arrangements asked at Admission Abstinence % (N)†	*Living Arrangements asked at Follow-Up* Abstinence % (N)†
Alone	52.2 (22/42)	42.5 (20/47)
Parents	44.1 (57/129)	52.8 (50/95)
Significant Other Only	60.3 (23/38)	51.0 (23/46)
Significant Other and Children	55.1 (24/44)	48.7 (29/59)
Children Only	44.4 (6/13)	57.9 (10/18)
Other Adults	41.5 (27/64)	40.5 (24/59)
Other Adults and Children	76.4 (14/18)	66.8 (16/24)
Prison or Jail	100.0 (1/1)	0.0 (0)
Homeless	38.8 (1/2)	0.0 (1)
Half-way House	73.3 (8/10)	0.0 (0)
Hospital	0.0 (0)	0.0 (0)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Table 20. Abstinence by Relationship

Divorced clients had the highest abstinence rate of 68.7% at follow-up, followed closely by those clients who were cohabiting at admission with an abstinence rate of 67.7%. People who are in a stable relationship (married, 58.6%) or who have been divorced, 68.7%; separated, 57.4% tend to have higher abstinence rates.

	OMS Sample with Follow-Up Interviews Completed N=362	
	Relationship asked at Admission Abstinence %** (N)†	*Relationship asked at Follow-Up* Abstinence %* (N)†
Single	41.6 (86/206)	44.4 (86/194)
Married	61.5 (30/49)	58.6 (26/44)
Cohabitating	67.7 (22/32)	45.1 (26/57)
Separated	49.0 (8/16)	57.4 (10/17)
Divorced	62.6 (36/57)	68.7 (34/50)
Widowed	12.7 (0/1)	0.0 (0/0)

* *Statistically significant (p<.01) * Statistically significant (p<.05)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Table 21. Abstinence by Income Source

The number of clients with no income decreased substantially at admission (N=64) and follow-up (N=2). Additionally, the number of clients reporting income through salary and wages increased from 169 at admission to 217 at follow-up. This supports the finding in Table 18 that more clients were successful in finding employment after treatment. Six clients reported disability income at admission and follow-up, and had one of the highest abstinence rates (73.9% and 68.3% respectively).

	OMS Sample with Follow-Up Interviews Completed N=362	
	Income Source asked at Admission Abstinence % (N)†	*Income Source asked at Follow-Up* Abstinence % (N)†
None	54.0 (35/64)	56.1 (1/2)
Wages/ Salary	45.1 (76/169)	48.8 (106/217)
Family/ Friends	57.2 (58/102)	51.2 (59/116)
Public Assistance	60.3 (4/7)	71.1 (6/9)
Retirement/ Pension	0.0 (0/1)	0.0 (0)
Disability	73.9 (4/6)	68.3 (4/6)
Other	30.0 (4/13)	40.6 (5/12)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Table 22. Abstinence by Income

Abstinence rates increased from 45.0% at admission to 56.2% at follow-up for clients earning $500 or less. The number of clients reporting no income decreased substantially from 136 at admission to 58 at follow-up.

	OMS Sample with Follow-Up Interviews Completed N=313	
	Income asked at Admission Abstinence % (N)†	*Income asked at Follow-Up* Abstinence % (N)†
None	49.7 (68/136)	45.5 (26/58)
$500 or less	45.0 (15/33)	56.2 (27/47)
$501 to $1000	54.2 (27/50)	53.6 (34/63)
$1001 to $2000	44.3 (32/71)	45.2 (44/97)
Over $2000	43.9 (10/22)	43.1 (21/48)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Table 23. Abstinence by Arrests

At follow-up, 319 clients had not been arrested and slightly over 50% of the clients in this group were abstinent during the follow-up period. The number of clients indicating no arrests increased from 110 at admission to 319 at follow-up. Clients arrested 4 times or more decreased at follow-up.

	OMS Sample with Follow-Up Interviews Completed N=360	
	Arrests asked at Admission Abstinence % (N)†	*Arrests asked at Follow-Up* Abstinence % (N)†
None	55.9 (62/110)	50.6 (161/319)
1-3 times	46.6 (111/238)	47.6 (19/39)
4 times or more	65.5 (8/12)	0.0 (0/1)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Table 24. Behavioral change and abstinence at follow-up

A comparison of clients who were abstinent at follow-up versus clients who were not abstinent on the three variables in Table 24 reveals slight differences. The percentage of abstinent clients whose employment status changed between admission to treatment and follow-up was approximately nine percentage points higher than for clients who were not abstinent. Overall, clients who were abstinent at follow-up experience a higher percentage of behavioral changes than those clients who were not abstinent at follow-up.

	Abstinent N=182†	Not Abstinent N=180†
Percent that changed employment status	57.1	47.7
Percent the changed relationship status	30.3	27.8
Percent that changed income status	57.1	49.6

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the number of clients is approximate.

Table 25. AA/NA meetings attended

Table 25 presents numbers showing that clients who were abstinent at follow-up attended an average of 3.4 AA, NA, or similar type meetings per month. This compares to an average of only 2.4 meetings per month for clients who were not abstinent during the follow-up period.

	Abstinent N=179[†]	Not Abstinent N=181[†]
Average number of NA/AA meetings attended per month since treatment ended	3.4	2.4

[†] The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the number of clients is approximate.

Section G. Outcome: Arrests

Tables 26 through 31 examine arrest status in relation to other variables. For purposes of this report, clients were categorized as having at least one arrest since discharge from treatment or having no arrests since discharge.

Table 26. No Arrests by Primary Substance

Clients whose primary substance at admission was alcohol were arrest-free during the follow-up period at a rate of 90.7%. Clients reporting marijuana as their primary substance at admission were arrest-free at a rate of 86.8%, followed by methamphetamine (86.0%) and cocaine (79.2%).

OMS Sample with Follow-Up Interviews Completed (N=360)	
Primary Substance at Admission	No Arrest at follow-up % (N)[†]
Alcohol	90.7 (166/183)
Marijuana	86.8 (84/96)
Methamphetamine	86.0 (55/64)
Cocaine	79.2 (8/10)
Other Opiates and Synthetics	100.0 (2/2)
Heroin	100.0 (1/1)
Other Amphetamine	100.0 (1/1)
Benzodiazepines	100.0 (1/1)
Other Stimulants	100.0 (1/1)
PCP	0.0 (0/0)
Other	0.0 (0/0)
Barbiturates	0.0 (0/0)
Inhalants	0.0 (0/0)
Other Hallucinogens	0.0 (0/0)
Other Sedatives and Hypnotics	0.0 (0/0)
Over the Counter	0.0 (0/0)
Non-Prescription Methadone	0.0 (0/0)
Other Tranquilizers	0.0 (0/0)
Steroids	0.0 (0/0)
Ecstasy	0.0 (0/0)

[†] The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Table 27. No Arrests by Employment

At follow-up, clients who were employed full-time were the most successful – 91.1% were arrest-free. Clients not in the labor force had the second highest arrest-free rate (88.8%).

	OMS Sample with Follow-Up Interviews Completed N=360	
	Employment asked at Admission No arrests % (N)†	*Employment asked at Follow-Up* No arrests % (N)†
Employed Full Time (>35 hrs/ wk)	89.7 (116/129)	91.1 (172/189)
Employed Part Time (<35 hrs/ wk)	87.5 (46/53)	85.7 (58/68)
Unemployed (looking for work in the past 30 days)	87.7 (83/96)	84.6 (53/63)
Not in labor force	89.9 (74/83)	88.8 (36/41)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Table 28. No Arrests by Living Arrangements

The largest number of clients reported living with "parents" at both admission and follow-up, although there was a slight decrease from 129 clients at admission to 95 at follow-up. All the clients who indicated "other adults and children," "prison or jail," or "homeless" at admission remained arrest-free at follow-up. Clients who are living with "significant other and children" at admission and follow-up remained arrest-free at high rates, 99.6% and 95.7% respectively. Somewhat surprisingly, high no-arrest rates also were found among clients living alone at admission (89.8%) and follow-up (94.5%).

	OMS Sample with Follow-Up Interviews Completed N=360	
	Living Arrangements asked at Admission No arrests %** (N)†	*Living Arrangements asked at Follow-Up* No arrests % (N)†
Alone	89.8 (38/42)	94.5 (44/46)
Parents	87.1 (113/129)	84.3 (80/95)
Significant Other Only	74.3 (28/38)	91.1 (42/46)
Significant Other and Children	99.6 (42/43)	95.7 (55/58)
Children Only	90.0 (11/13)	86.0 (15/18)
Other Adults	92.9 (59/64)	86.0 (51/59)
Other Adults and Children	100.0 (18/18)	94.8 (23/24)
Prison or Jail	100.0 (1/1)	0.0 (0/0)
Homeless	100.0 (2/2)	0.0 (0/0)
Half-way House	62.7 (7/10)	66.7 (9/14)
Hospital	0.0 (0/0)	0.0 (0/0)

** Statistically significant (p<.01)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Table 29. No Arrests by Relationship

Clients who were married at follow-up had the highest no-arrest rate (94.3%), with the exception of one client who was a widow at admission and was arrest-free at follow-up.

	OMS Sample with Follow-Up Interviews Completed N=360	
	Relationship asked at Admission No arrests % (N)†	*Relationship asked at Follow-Up* No arrests % (N)†
Single	88.9 (182/205)	87.7 (169/193)
Married	90.9 (45/49)	94.3 (42/44)
Cohabitating	86.1 (26/31)	88.6 (49/56)
Separated	77.3 (12/16)	88.4 (15/17)
Divorced	91.4 (53/57)	87.4 (43/50)
Widowed	100.0 (1/1)	0.0 (0/0)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Table 30. No Arrests by Income Source

All clients indicating "public assistance," "retirement/pension," or "other" as source of income at admission were arrest-free at follow-up. The number of clients reporting no income decreased substantially from admission (64) to follow-up (2, arrest-free at follow-up).

	OMS Sample with Follow-Up Interviews Completed N=360	
	Income Source asked at Admission No arrests % (N)†	*Income Source asked at Follow-Up* No arrests % (N)†
None	83.1 (53/64)	100.0 (2/2)
Wages/ Salary	88.5 (148/167)	88.6 (191/215)
Family/ Friends	90.7 (92/102)	89.1 (103/116)
Public Assistance	100.0 (7/7)	73.4 (6/9)
Retirement/ Pension	100.0 (1/1)	0.0 (0/0)
Disability	79.1 (5/6)	77.2 (4/6)
Other	100.0 (13/13)	100.0 (12/12)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Table 31. No Arrests by Income

Clients earning over $2000 a month admission (100%) and follow-up (95.9%) had the highest arrest-free rates. The lowest arrest-free rate of 79.8% was found in those clients who reported earning “500 or less” at admission. Clients responding “none” to monthly income at admission had a no-arrest rate of 88.2%. Similarly, clients with no income at follow-up had a no-arrest rate of 88.6% at follow-up. The number of clients with no income decreased from 136 at admission to 58 at follow-up.

	OMS Sample with Follow-Up Interviews Completed N=313	
	Income asked at Admission No arrests % (N)†	*Income asked at Follow-Up* No arrests % (N)†
None	88.2 (120/136)	88.6 (51/58)
$500 or less	79.8 (26/33)	84.3 (40/47)
$501 to $1000	89.2 (45/50)	84.2 (53/63)
$1001 to $2000	88.9 (63/71)	89.7 (87/97)
Over $2000	100.0 (22/22)	95.9 (46/48)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Section H. Outcome: Employment

Tables 32 through 36 examine employment status in relation to other variables. For purposes of this report, clients were categorized as being employed full-time at follow-up or not being employed full-time at follow-up.

Table 32. Full Time Employment by Primary Substance

Table 32 shows that approximately 59% of the clients who reported alcohol as their primary substance at admission were employed full-time at follow-up. Clients whose primary substance was marijuana were working full-time at a rate of 45.7%, however, marijuana tends to be a drug of choice for adolescents, which would help explain the lower full-time employment rate.

OMS Sample with Follow-Up Interviews Completed (N=362)	
Primary Substance at Admission	Employed Full Time at follow-up % (N)†
Alcohol	58.7 (108/185)
Marijuana	45.7 (44/96)
Methamphetamine	50.7 (33/64)
Cocaine	55.5 (5/10)
Other Opiates and Synthetics	0.0 (0/2)
Heroin	0.0 (0/1)
Other Amphetamine	0.0 (0/1)
Benzodiazepines	0.0 (0/1)
Other Stimulants	0.0 (0/1)
PCP	0.0 (0/0)
Other	0.0 (0/0)
Barbiturates	0.0 (0/0)
Inhalants	0.0 (0/0)
Other Hallucinogens	0.0 (0/0)
Other Sedatives and Hypnotics	0.0 (0/0)
Over the Counter	0.0 (0/0)
Non-Prescription Methadone	0.0 (0/0)
Other Tranquilizers	0.0 (0/0)
Steroids	0.0 (0/0)
Ecstasy	0.0 (0/0)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Table 33. Full Time Employment by Living Arrangements

All clients living in halfway houses at admission were employed full-time at follow-up. Clients living alone at admission and follow-up had high full-time employment rates of 75.2% for the admission group and 75.8% for the follow-up group. Full-time employment rates are rather low among those clients who lived with parents at admission and follow-up. This is understandable, however, as many of these clients are adolescents and not in the work force.

	OMS Sample with Follow-Up Interviews Completed N=362	
	Living Arrangements asked at Admission Working full time %*** (N)†	*Living Arrangements asked at Follow-Up* Working full time %*** (N)†
Alone	75.2 (32/42)	75.8 (36/47)
Parents	37.1 (48/129)	32.6 (31/95)
Significant Other Only	42.0 (16/38)	57.7 (26/46)
Significant Other and Children	71.2 (31/44)	64.5 (38/59)
Children Only	56.0 (7/13)	52.0 (9/18)
Other Adults	55.9 (36/64)	53.1 (31/59)
Other Adults and Children	53.6 (10/18)	50.9 (12/24)
Prison or Jail	0.0 (0/1)	0.0 (0/0)
Homeless	27.4 (1/2)	0.0 (0/0)
Half-way House	100.0 (10/10)	49.2 (7/14)
Hospital	0.0 (0/0)	0.0 (0/0)

*** Statistically Significant (p>.001)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Table 34. Full Time Employment by Relationship

At follow-up, clients who reported being single at admission and follow-up were working full-time at rates of 47.0% and 48.3% respectively, the lowest employment rates among the relationship statuses. Of clients who were married at follow-up, 67.4% were working full-time. Similarly, 67.6% of clients who were married at admission were employed full-time at follow-up.

	OMS Sample with Follow-Up Interviews Completed N=362	
	Relationship asked at Admission Working full time % (N)†	*Relationship asked at Follow-Up* Working full time % (N)†
Single	47.0 (97/206)	48.3 (93/194)
Married	67.6 (33/49)	67.4 (30/44)
Cohabitating	48.5 (15/32)	53.8 (31/57)
Separated	62.1 (10/16)	64.1 (11/17)
Divorced	59.3 (34/57)	51.9 (26/50)
Widowed	87.3 (1/1)	0.0 (0/0)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Table 35. Full Time Employment by Income Source

Clients with income from wages at admission had a full-time employment rate at follow-up of 68.3% compared to an 81.4% rate for clients at follow-up. None of the clients who indicated "public assistance," "disability," or "other" at follow-up were employed full-time. Low employment rates were found among those clients whose income source was family and/or friends at admission (31.6%) and follow-up (12.2%). Presumably, these clients are adolescents and are not in the work force.

	OMS Sample with Follow-Up Interviews Completed N=362	
	Income Source asked at Admission Working full time %*** (N)†	*Income Source asked at Follow-Up* Working full time %*** (N)†
None	50.9 (33/64)	0.0 (0/2)
Wages/ Salary	68.3 (115/169)	81.4 (177/217)
Family/ Friends	31.6 (32/102)	12.2 (14/116)
Public Assistance	41.8 (3/7)	0.0 (0/9)
Retirement/ Pension	100.0 (1/1)	0.0 (0/0)
Disability	11.1 (1/6)	0.0 (0/6)
Other	45.2 (6/13)	0.0 (0/12)

*** Statistically significant (p<.001)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Table 36. Full Time Employment by Income

Most clients earned $1001-$2000. Clients in this category at admission had a full-time employment rate of 78.7% while clients in this category at follow-up had a full-time employment rate of 94.5% at follow-up. None of the clients reporting "none" for monthly income at follow-up were employed full-time at follow-up. Conversely, 44.6% of the clients who reported "none" at admission were employed full-time at follow-up.

	OMS Sample with Follow-Up Interviews Completed N=313	
	Income asked at Admission Working full time %*** (N)†	*Income asked at Follow-Up* Working full time %*** (N)†
None	44.6 (61/136)	0.0 (0/58)
$500 or less	21.9 (7/33)	8.1 (4/47)
$501 to $1000	66.8 (34/50)	58.8 (37/63)
$1001 to $2000	78.7 (56/71)	94.5 (91/97)
Over $2000	82.9 (18/22)	91.2 (44/48)

*** Statistically significant (p<.001)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the numbers of clients are approximate but the percentages are accurate.

Section I. Length of Stay

Length of stay is defined as the number of days from client admission through discharge and represents the number of days that the client had an active, open case with the treatment agency. The length of stay for clients in residential treatment is defined as the time they spend physically living at the treatment facility along with the number of days they participate in aftercare as an outpatient.

Percentages in the column titled "abstinence" refer to the percentage of clients that were abstinent during the follow-up period for each length of stay range. Number in parentheses represent the approximate number of clients who were abstinent and the approximate total number of clients who were in that length of stay range. For example, of the 18 clients who were in treatment less than seven days, 10 of them were abstinent at follow-up, equaling a success rate of 58.2%. Numbers in the "no arrests" and "employed full-time" columns are presented the same way as abstinence.

The follow-up interview took place approximately 6 months after the client was discharged from treatment. The follow-up period refers to the period of time between the client's discharge and completion of the follow-up interview.

Table 37. Length of Stay by Outcomes

Clients who were in treatment at least four months (more than 120 days) had the most success and remained abstinent at a rate of 62.4%. The most common length of stay was 31-60 days while the least common was less than 7 days.

This table shows that the longer clients are in treatment, the less they are arrested. Clients who were in treatment 91-120 days had the highest no arrest rate (91.2%). Similarly, clients who remained in treatment 7-30 days had a no arrest rate of 90.8%. Clients who remained in treatment less than 7 days, however, had a no arrest rate of 84.4%, the lowest rate among length of stay categories.

Clients who remained in treatment the longest, more than 120 days, had a full-time employment rate of 58.5%. At follow-up, clients who had the shortest length of stay, less than 7 days, had the highest full-time employment rate of 62.9%.

	OMS Sample with Follow-Up Interviews Completed		
Days of Treatment	Abstinence % (N)† Total N=362	No arrest % (N)† Total N=362	Employed Full Time % (N)† Total N=362
Less than 7 days	58.2 (10/18)	84.4 (15/18)	62.9 (11/18)
7 - 30 days	51.7 (36/71)	90.8 (64/71)	44.8 (32/71)
31 - 60 days	41.8 (43/102)	87.7 (90/102)	51.7 (53/102)
61 - 90 days	47.6 (35/73)	89.4 (65/73)	56.7 (42/73)
91 - 120 days	54.4 (27/50)	91.2 (45/49)	51.1 (26/50)
More than 120 days	62.4 (29/47)	85.6 (40/47)	58.5 (28/47)

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data Therefore, the numbers of clients are approximate but the percentages are accurate.

Admission data revealed four substances that clients repeatedly mentioned as their primary substance: alcohol, marijuana, methamphetamine, and cocaine (see Table 1). Table 38 presents the percent of clients in each length of stay category for these substances. The table also presents the average number of days in treatment when the client listed that substance as their primary substance at admission.

Table 38. Length of Stay by Primary Substance at Admission
Unlike previous tables in this section that include data only from clients who completed follow-up interviews, data in Table 38 are drawn from the entire 832 clients who were admitted during 2003.

The table shows that for clients whose primary substance at admission was marijuana, 4.9% were in treatment less than 7 days. This number was 6.3% for clients whose primary substance at admission was methamphetamine. Clients whose primary substance at admission was marijuana were in treatment an average of 73.4 days. This was the longest average length of stay of the four groups. Clients who listed cocaine as their primary substance had the shortest average length of stay in treatment at 51.3 days.

	Length of Treatment						
Primary Substance at Admission	Less than 7 days %	7-30 days %	31-60 days %	61-90 days %	91-120 days %	More than 120 days %	Average # of days treated
Alcohol N=385†	14.8	16.0	28.2	17.9	9.4	13.7	64.4
Marijuana N=226†	15.1	19.1	20.3	18.1	11.5	15.8	68.3
Methamphetamine N=174†	14.6	24.6	18.1	15.7	10.0	17.1	65.9
Cocaine N=31†	19.2	18.9	30.1	5.1	12.2	14.6	62.0

† The number of clients is rounded to the nearest integer but could contain a decimal point due to weighting of the data. Therefore, the number of clients is approximate.

Section J. Recommendations

- Consortium staff should consider providing a biannual newsletter to participating treatment centers to keep them informed about the OMS project.

- Clients that were not able to be located made up 17.5% of the closed cases. Perhaps Consortium staff could work with the treatment agencies to gather additional contact information at the time of admission to treatment.

STATE OF IOWA

THOMAS J. VILSACK
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OFFICE OF DRUG CONTROL POLICY
MARVIN L. VAN HAAFTEN, DIRECTOR

DRUG ENDANGERED CHILDREN PROGRAM (DEC)

Children who live in, or visit, homes where methamphetamine manufacture or use is taking place face acute health and safety risks including physical, emotional, or sexual abuse; fire and explosions; and medical neglect. Collaboration among providers is critical to ensure the adequate protection and care of children found in these environments.

What is DEC?

A multi-disciplinary partnership involving:

- Law Enforcement – state and local
- Human Services
- Prosecution
- Medical Community
- Substance Abuse Treatment

DEC involves the development of a collaborative, coordinated response to drug affected children, including:

- Joint protocol and procedures
- Training for participating staff

Why do we need DEC?

- Children in these environments are especially at risk due to:
  - Behaviors that lead to increased exposure - crawling & hand to mouth
  - High metabolic rate
  - Immature organ systems
  - Weaker immune system
- In 2002 there were 19,539 reports of child abuse – 9,836 confirmed (77% were 0-11 years old)
- In SFY 2002 there were 520 founded child abuse cases due to parents manufacturing meth or possessing precusors
- High % of child protection cases are drug related – some studies report over 90%
- In a California study, children in a “meth oriented” dwelling were:
  - 30% sexually abused
  - 28% physically abused
  - 35% tested positive for heavy metals
  - 30% tested positive for methamphetamine
  - 90% were already in the system for drugs, truancy, or abuse/neglect

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- 1,009 meth labs reported in Iowa in 2002 and in 2001 there were 606 arrests for methamphetamine manufacture or distribution and 1320 arrests for meth possession and use
- Treatment admissions for illicit drugs continue to increase – large % referred from the criminal justice system to Human Services

Exposure to methamphetamine is often associated with:

- Family violence
- Emotional abuse
- Neglect
- Criminal behavior
- Exposure to toxic chemicals
- Dysfunctional care-giving

Exposure to methamphetamine also poses multiple dangers, including:

- Injury or death from fire or explosions
- Risk of poisoning and intoxication
- Risk of acute health problems
- Risk of long-term health outcomes
- Developmental, emotional, mental health, or behavior problems

How DEC typically works in a community?

- Drug warrant is issued
- DEC law enforcement officer (DEC officer) is assigned to a child welfare role
- DEC officer contacts DHS worker on call
- DEC officer conducts a child endangerment investigation
- In consultation with DHS, the DEC officer makes the decision to remove the child or children from the home
- DHS worker determines the need for medical testing and initiates Child In Need of Assistance (CINA) procedures
- Case is referred to the County Attorney

Expected outcomes of DEC

- Greater understanding of the impact of methamphetamine manufacture and exposure on children
    - Cross training of disciplines involved with drug affected families
    - Media coverage raises awareness of the problem
- Enhancement of efforts resulting from collaboration between DHS and law enforcement
- Incentive for drug involved parents to seek meaningful drug treatment
- Early intervention with drug affected families
- Medical attention for exposed children
- Enforcement sends a powerful message to drug involved parents
- Removal of children from drug environments
- Interruption of the addiction cycle with possible treatment or referral to drug court
- Helps the public and policy makers see the CHILD in the methamphetamine problem