Process Improvement (PI) Project Storyboard
Increasing AB 109 Postrelease Supervised Persons (PSP) Access to Substance Use Disorder (SUD) Assessment and Treatment (DRAFT)

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PLAN: Identify an opportunity for a Process Improvement Plan

Background:

1. California Assembly Bills 109 and 117 (AB 109/117) took effect October 1, 2011, and realigned three major areas of the criminal justice system. On a prospective basis, the legislation:
   - Established local jail custody for specified non-violent, non-serious, non-sex offenders (N3s) who were previously subject to prison sentences;
   - Modified parole statutes and created local Post release Community Supervision (PCS) for criminal offenders released from prison after having served a sentence for a non-violent, non-serious, and non-sex offense;
   - Shifted the revocation process for parolees to the county court system over a two-phase, two-year process.;
2. Los Angeles County Board of Supervisors tasked the local Community Corrections Partnership (CCP*), led by the Department of Probation, to recommend a plan to the County Board of Supervisors for supervised low-level inmates/parolees;
3. In Year 1 of the Realignment, only 60% of AB 109 PSPs presented to their first day SUD treatment after they were assessed and referred to the Department of Public Health-Substance Abuse Prevention and Control (DPH-SAPC) treatment services in Los Angeles County (LAC);
4. SUD addiction is a chronic brain condition; therefore, identifying and reducing SUD Assessment and Treatment Referral System barriers can help meet AB 109 PSP SUD treatment needs. This in turn can have a positive impact on both short-term AB 109 PSP SUD recovery and on long-term public safety outcomes (i.e., reduced recidivism).

DPH-SAPC/UCLA-ISAP Process Improvement (PI) Project Team:

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9. Desiree Crevecour-MacPhail, Ph.D., UCLA Integrated Substance Abuse Programs (ISAP);

Assess the Current Process:

1. There is an expectation that clients with positive SUD should present to treatment within five business days of referral, however, this is not happening;
2. Treatment providers have reported that it is challenging to engage and retain the AB 109 PSP population, primarily because of their criminogenic risk levels.

Planning Phase/Identify Potential Solutions:

1. Met with Criminal Justice Programs Manager and other staff to identify logical AB 109 PSP pathway through assessment and treatment (see Figure 1);
2. Conducted focus groups and individual interviews with PSPs, CASC staff, and treatment providers to learn about their perspectives on the assessment process and how it could improve;
3. Consulted with contracted DPH-SAPC agencies that work with the PSP population;
4. Conducted literature review to determine best practices for assessment and treatment engagement for criminal justice populations;
5. Identified and recommended validated client experience surveys and criminogenic needs screening tools.

Develop an Improvement Theory:

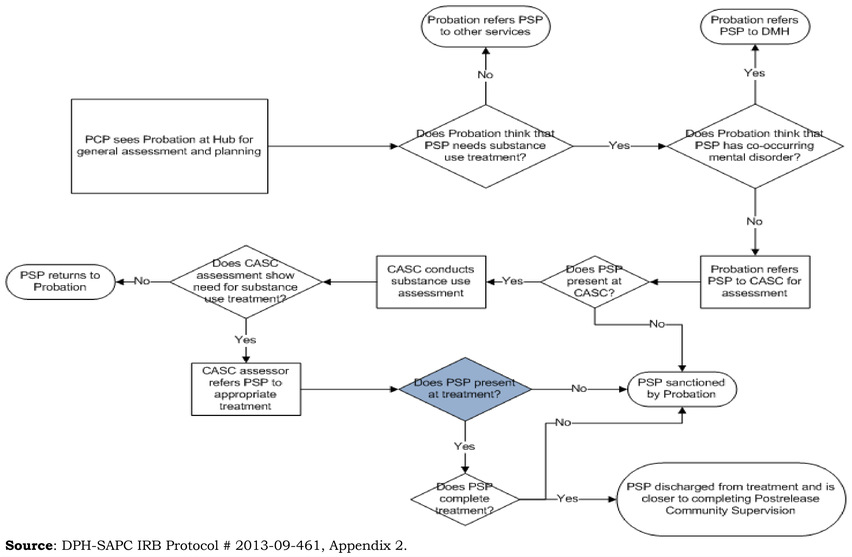
1. It is hypothesized that an assessment pathway at the CASCs that takes into account PSP client experience, criminogenic needs, and case management will increase presentation to and retainment in treatment:
   a. The design of a new assessment pathway at the CASC and other gaps within the system;
   b. Future use of a criminogenic needs screening tool and a client experience survey;
   c. Promote process improvement changes by applying the Network for the Improvement of Addiction Treatment (NIATx) four aims:
      i) Reduce waiting time between first request for service and first treatment session,
      ii) Reduce no-shows by reducing the number of patients who do not keep an appointment,
      iii) Increase admissions to treatment,
      iv) Increase continuation from the first through the fourth treatment session.

Theory Aims:

1. To increase the percentage of PSPs presenting to treatment;
2. To measure PSP satisfaction with the assessment and treatment referral pathway.

*CCP includes the following:
1) Alternate Public Defender, 2) Chief Executive Office, Countywide Criminal Justice Coordination Committee (CCJCC), 3) Department of Mental Health, 4) Department of Pubic Social Services, 5) Department of Public Health-SAPC, 6) Local Law Enforcement, 7) Los Angeles County District Attorney,
8) Los Angeles County Probation Department, 9) Los Angeles County Public Defender, 10) Los Angeles County Sheriff's Department and 11) Los Angeles County Superior Court.

Figure 1. Basic Schematic of PSP pathway through SUD assessment and treatment. Please note shaded blue area represents logical step for project intervention.



Source: DPH-SAPC IRB Protocol # 2013-09-461, Appendix 2.

DO: Test the Theory for Improvement

Test the Theory: The PI Pilot project has helped inform SAPC's CASC and Criminal Justice Programs on qualitative findings obtained by conducting AB 109 No-show to treatment client surveys, and AB 109 treatment completer, CASC assessor and Treatment Provider line staff focus groups. The following are quality improvement recommendations recommended to CASC since this project's inception:

CASC Issues and Recommendations		
	Issue	Recommendation for addressing issue
1	Reliability of phone answering (e.g., answered during business hours; client able to leave message)	DPH-SAPC Bulletin 15-03 instructs CASC to have a live person answer the helpline at all times during business hours. Requires in-treatment standards that messages be returned within one hour. Unless the message is left on a Saturday or Sunday then the message should be returned first thing on Monday morning.
2	Clear, easy to understand phone manner, including how to answer the phone (e.g., Identify full name of agency first)	CASC to answer incoming helpline calls with a standard greeting such as: "Good morning (or afternoon), Substance abuse treatment services."
3	Standardize questions that are asked over the phone (e.g., refrain from asking about funding when giving an appointment)	CASC to schedule the assessment appointment first. At appointment time, CASC staff can ask if client has Medi-Cal, or other funding. Services should not be refused because of the inability to pay.
4	Training for staff on how to speak to public, especially people who are not familiar with the CASC or SUD treatment	DPH-SAPC to coordinate quarterly training sessions on Motivational Interview, NIATx principles, and other quality assurance topics.
5	Train staff and implement motivational interviewing to try to increase show to assessment numbers	DPH-SAPC to develop a plan that focuses on projects such as the AB109 Performance Improvement that can work to engage and retain clients.

STUDY: Use Data to Study Findings/Results

Data Collection Methodology for Focus Groups and No-Show to Treatment Client Phone Survey.

Focus Groups.

The PI Pilot project team conducted a total of eight focus groups with AB 109 treatment completers, CASC assessors and treatment provider staff, including managerial and line staff with focus group facilitation assistance from UCLA-ISAP staff.

1. Convenience sample approach was used for both focus group and the No-Show-To-Treatment survey participants;
2. Due to CASC and treatment provider program staffing limitations, and the limited availability of AB 109 treatment completers to alumni treatment groups, both focus group and No-Show-To-Treatment survey data collection efforts were carried out over a three month-period;
3. Per IRB rules, verbal consent was obtained of all focus group and No-Show-To-Treatment survey participants.

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No-Show to Treatment Client Survey (N=109)

The PI Pilot project team visited eight leading CASC agencies to conduct No-Show-to-Treatment, client phone surveys. Team reviewed clients' charts/notes on-site going back from six to twelve months before the date of the No-Show-To-Treatment phone survey. Client demographic factors are based on review of 109 client charts. Inconsistent documentation was observed during chart review. The team attempted calling a total of 134 No-Show-To-Treatment AB 109 client phone numbers. Of those, we reviewed 109 client charts (81.3 %) and successfully reached and talked with 13 clients (9.7% of total sample).

No-Show to Treatment Client Demographics:

1. Mean age was 38.1 years, with a minimum of 18 and a maximum of 65 years of age;
   - Mean male age (n=99) was 37.9 years, with a minimum of 18 and a maximum of 65 years of age,
   - Mean female age (n=10) was 39.6 years, with a minimum of 30 and a maximum of 57 years of age.
   - Race/Ethnicity: Latino/Hispanic clients (n=57, 20%), White clients' (n=25, 23%);
   - Gender: Males (n=99, 90.6%), Females (n=10, 9%);
   - Primary drug of choice: Methamphetamines (n=29, 35%), alcohol (n=23, 28%) and heroin (n=14, 17%).

No-Show to Treatment Client Survey Interviews:

The Main Barriers to Treatment

1. Access to treatment (e.g., lack of transportation, limited resources, geographical distance and wait time);
2. Limited after-hour assessments;
3. Perception of being stigmatized;
4. Competing priorities:
   - Having to find a job,
   - Finding housing,
   - Needing to address prior probation violations.
5. Self-denial about underlying reasons for being referred to SUD treatment.

Focus Groups

AB 109 PSP Treatment Completers:

1. Gaining client trust and engagement is key to positive treatment compliance and transitioning back to society;
2. Support PSPs in efforts to transition back to society by providing the following:
   - Helping them obtain a driver license or California ID,
   - Supporting them with career planning for future employment,
   - Providing them with life skills such as developing responsibility with oneself and others.

CASC Assessors:

1. Legal constraints limit PSP background information available during assessment;
2. Some PSPs are inappropriately referred to CASC for assessment, thus depleting their limited funds (e.g., time, money) and further demotivating PSPs to present to treatment in the future;
3. PSPs who are wait-listed for either outpatient or residential treatment are less likely to follow-through and present to treatment.

Treatment Providers:

1. Some PSPs do not perceive any incentive from Probation to follow through with treatment requirements;
2. PSPs are sent to a minimum of three different places to initiate treatment, without resources or self-motivation, which often results in no-show to treatment;
3. Treatment providers need criminogenic needs thinking** and cultural differences training to improve understanding of high-risk clients who have difficulty re-entering society again;
4. Some PSPs need services beyond what SUD treatment providers can provide (e.g., stable housing after treatment discharge, on-going health care, on-going legal counseling, etc.)

ACT: Standardize Improvements and Establish Future Plans

The DPH-SAPC AB 109 PI Pilot project has helped inform the DPH-SAPC contracted Criminal Justice Programs and CASC about a number of referral to treatment system-level issues that can be improved. Recommendations are provided below.

Recommendations:

1. Assess viability of incorporating Care Coordinators to reduce client barriers to assessment, referral and placement to treatment;
2. Explore extending assessment hours for CASC and Treatment Service centers;
3. Increase capacity of CASC staff in the following areas:
   - Setting best practices for documentation/follow-up and other standards of care (i.e., the usage of Urine Analysis testing as a way to validate negative ASI test scores),
   - Enhancing collaboration and communication between CASC and treatment providers,
   - Targeting SUD interventions to reduce PSPs' high criminogenic needs thinking and stigmatization among PSP clientele.

Anticipated Risks or Barriers:

1. DPH-SAPC is currently undergoing a system delivery redesign due to implementation of Affordable Care Act:
   - May delay future redesign of DPH-SAPC CASC Pathway.

** According to Guevara and Solomon (2009), criminogenic (correlated to crime) needs thinking includes the following:
1. Having an antisocial peer group;
2. Having a drug and alcohol dependency;
3. Displaying lack of self-control;
4. Having an antisocial belief system

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