

National Council

M A G A Z I N E

A quarterly publication from the National Council for Community Behavioral Healthcare

Improving Clinical Practice

The Intersection of Policy and Practice

Linda Rosenberg discusses how new landmark community mental health legislation can support practice excellence • page 1

Process Improvement in Addictions Treatment

Dave Gustafson, Director of NIATx, highlights how addictions treatment organizations are improving access and retention for better outcomes. • page 11

A Signature Approach to Outcomes Measurement

Dr. Carl Clark and his team explain how a “360-degree” outcomes measurement process is promoting consumer successes at the Mental Health Center of Denver. • page 26



NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

Healthy Minds. Strong Communities.

Performance Measurement

A Signature Approach to Outcomes Measurement Improves Recovery

Carl Clark, MD, Chief Executive Officer and P. Antonio Olmos-Gallo, PhD, Director of Evaluation & Research — Mental Health Center of Denver

“As clinicians, we have historically used anecdotal data to inform clinical practice to promote recovery outcomes for consumers. With Recovery Markers, we now have longitudinal, empirical data to support our clinical judgment and decisions.”

Measuring our success in recovery requires those of us in mental health service delivery to be more accountable to our communities and to demonstrate the difference we make in the lives of the people we serve.

The Mental Health Center of Denver received the Community Provider of Excellence Award from the National Council for Community Behavioral Healthcare in 2005 for implementing integrated, evidence-based approaches to recovery.

The “Denver Approach,” which encompasses training, education, social, and arts programs, as well as employment and other rehabilita-

tive services, aligns with MHCD’s operational definition of recovery: “Recovery is a non-linear process of growth by which people move from lower to higher levels of fulfillment in the areas of sense of safety, hope, symptom management, satisfaction with social networks, and active/growth orientation.” (1)

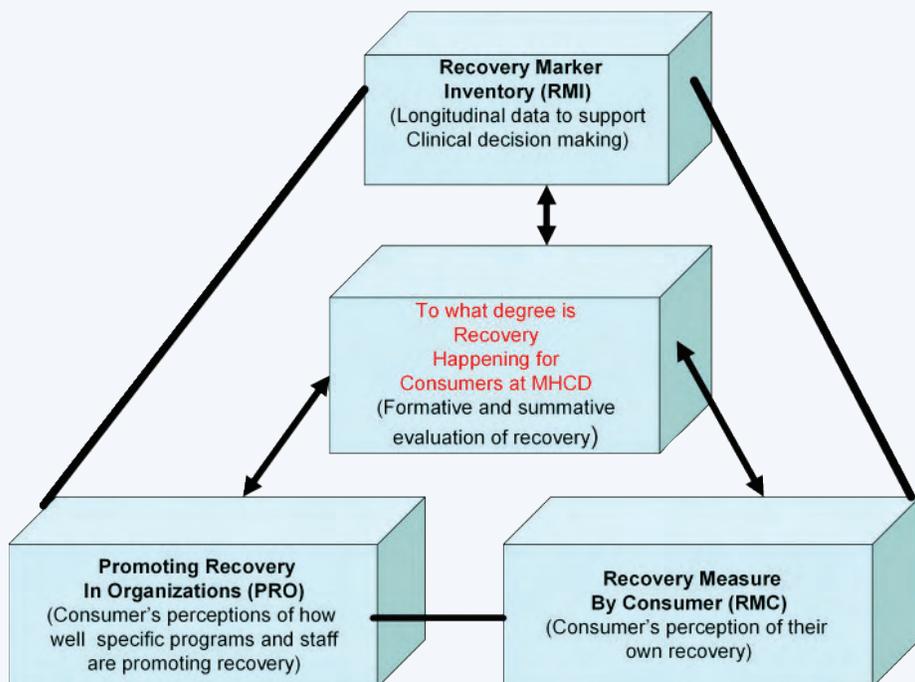
In keeping with its progressive recovery-focused philosophy, MHCD has developed a “360-degree” process of recovery measurement, using environmental, clinical, and client-specific individual indicators. The outcomes measurement process is proving to be a critical component in

instituting system change and promoting consumer recovery successes for MHCD.

Using Data to Inform System Change

The intent of MHCD’s measurement process is to improve clinical practices, rather than to evaluate performance. Measurement is based on a formative and summative process that creates a constant loop of client recovery information while providing empirical feedback to

Holistic Measurement of Recovery



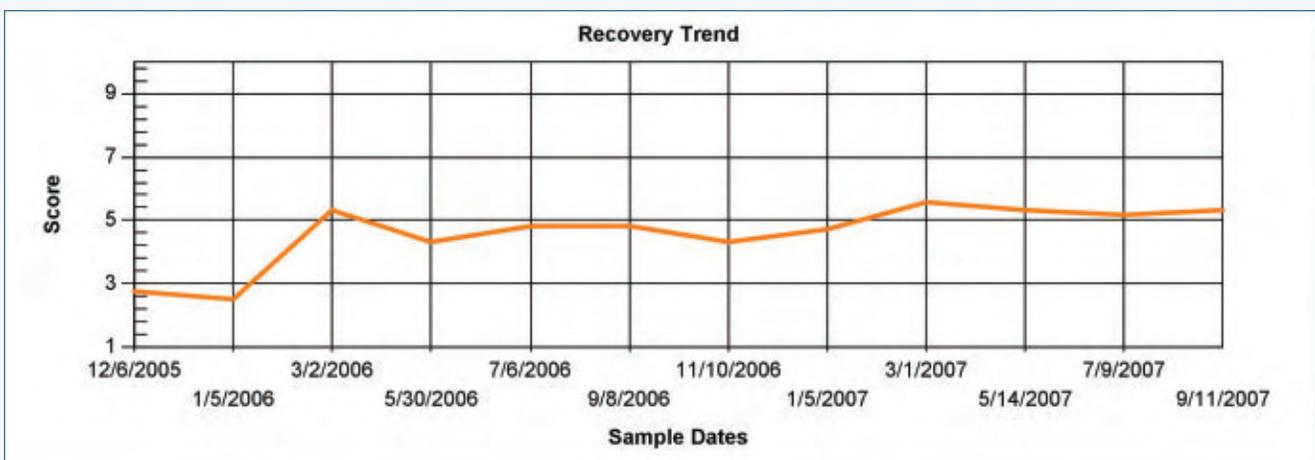
Sample Outcomes from the MHCD Recovery Markers Inventory (RMI)

(Based on 44 new intakes)

Compared to their situation at intake:

- 36.6% of the consumers had an improvement in their employment situation 1 year later
- Almost half of the consumers (47.6%) had an improvement in their active/growth orientation 1 year later
- 37% of the consumers had an improvement in their symptoms 1 year later

Empl	Education		Active/ Growth	Symp Interf	Participation in Services			House	Subst Abuse	Stg of Change	Number of days spent				Report Date	Score
		Max Attmnt				27-10	Probr Parole				click for version 2	Jail	Psy	Phy		
3	5		4	3	4	N	Y	4			0	0	0	1	9/11/2007	5.33
3	5		4	3	3	N	Y	4			0	0	0	0	7/9/2007	5.19
3	4		4	3	5	N	N	4			0	0	0	0	5/14/2007	5.33
2	4		4	4	3			1			0	0	0		3/1/2007	5.55 *
2	4		4	4	1			1			0	0	0		1/5/2007	4.72 *
1	2		4	4	1						0	0	0		11/10/2006	4.33 *
1	2		4	4	2			8			0	0	0		9/8/2006	4.83 *
1	2		4	3	2			8			0	0	0		7/6/2006	4.83 *
1	2		4	3	1			8			0	0	0		5/30/2006	4.33 *
1			4	3	3			2			0	0	0		3/2/2006	5.33 *
								1			0	0	0		1/5/2006	2.50 *
1	1		1	5	2			1			0	20	0		12/6/2005	2.78 *



assist in system transformation. The process promotes recovery at multiple levels within the mental health system (consumers, clinicians, managers, and directors) and from multiple view points (consumers and clinicians).

Tools for Holistic Measurement of Recovery and Provider Effectiveness

To gather a holistic view of mental health recovery, MHCD developed state-of-the-art tools to assess recovery from the perspective of both the clinician and the consumer. Psychometrics of these four recovery tools were established using Item Response Theory (IRT) techniques and have proven to be highly reliable. (2)

Initially, new consumers are administered a **Recovery Needs Level (RNL)** assessment, which rates them on a variety of clinical criteria. The RNL assesses a consumer's current status and progress in achieving his or her recovery goals. It then assigns the consumer to

one of four levels of service corresponding to where their need is the greatest. For instance, a consumer may have high needs in symptom management but have low need in housing. MHCD administers the assessment at three and six months after admission, and every six months thereafter to match the consumer's needs and keep him/her moving forward in recovery.

Every two months, case managers complete a **Recovery Markers Inventory (RMI)**, which rates each consumer's progress based on his or her own goals in six survey areas: employment, education/learning, active/growth orientation, symptom interference, engagement, and housing. This tool is effective in identifying consumers who are having more difficulty than others and in determining in which areas they need more help. (3)

Approximately every six months, consumers rate their own perceptions of their mental

health recovery using a **Consumer Recovery Measure (CRM)**. The CRM is a 15-item survey which includes questions regarding active/growth orientation, hope, symptom interference, sense of safety, and social networks. Likert-type responses are measured on a 0 (strongly disagree) to 3 (strongly agree) scale. Clinicians receive regular reports of consumer perceptions of progress in the various domains to help them to be more responsive to consumer needs. (4)

The **Promoting Recovery in Mental Health Organizations (PRO)** tool is utilized once a year to provide consumer evaluation of how the overall MHCD environment supports his or her recovery. Consumers interview peers to assess MHCD staff, including case managers, therapists, psychiatrists, front desk staff, rehabilitation staff, and residential staff. In addition to serving as a general needs assessment, the PRO survey was designed to help gain an understanding of what staff

Continued on page 28



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A Signature Approach, continued from page 27

characteristics best support consumer recovery.⁽⁵⁾

Recovery data reporting

Data regarding consumers' recovery outcomes is made user-friendly and accessible through online reports developed by MHCD for use in clinical decision-making by clinicians, managers, and directors. MHCD's progressive, recovery-oriented outcomes measures are pivotal in providing the opportunity to look at clinical performance over time. In addition, the reports have allowed MHCD to make system changes that advance recovery for consumers.

The Reaching Recovery Initiative at MHCD is currently working with other mental health centers to pilot the use of this data reporting system to increase understanding of data interpretation and to determine the type of training required for successful recovery outcomes for consumers. For more information about research on mental health recovery at MHCD, go to www.outcomesmhcd.com. For more information about the Reaching Recovery Initiative at MHCD, contact Roy Starks at 303.504.1721 or at Reachingrecovery@mhcd.org.

The Mental Health Center of Denver is a private, not-for-profit, community mental health care organization providing comprehensive, recovery-focused services to more than 6,500 residents in the Denver metro area each year. The CEO, Dr. Carl Clark, was formerly the Medical Director of MHCD. In 1993, Dr. Clark was chosen as NAMI's Exemplary Psychiatrist of the Year and in 2000, he was elected Professional Man of the Year by the Colorado Business Council. Dr. Clark is also Assistant Clinical Professor at the Department of Psychiatry at the University of Colorado School of Medicine and the Second Vice-Chair of the National Council for Community Behavioral Healthcare's Board. P. Antonio Olmos-Gallo, PhD is the Director of Evaluation and Research at MHCD. He is also an adjunct professor at the Department of Psychology, University of Denver, where he teaches graduate level statistics and research design.

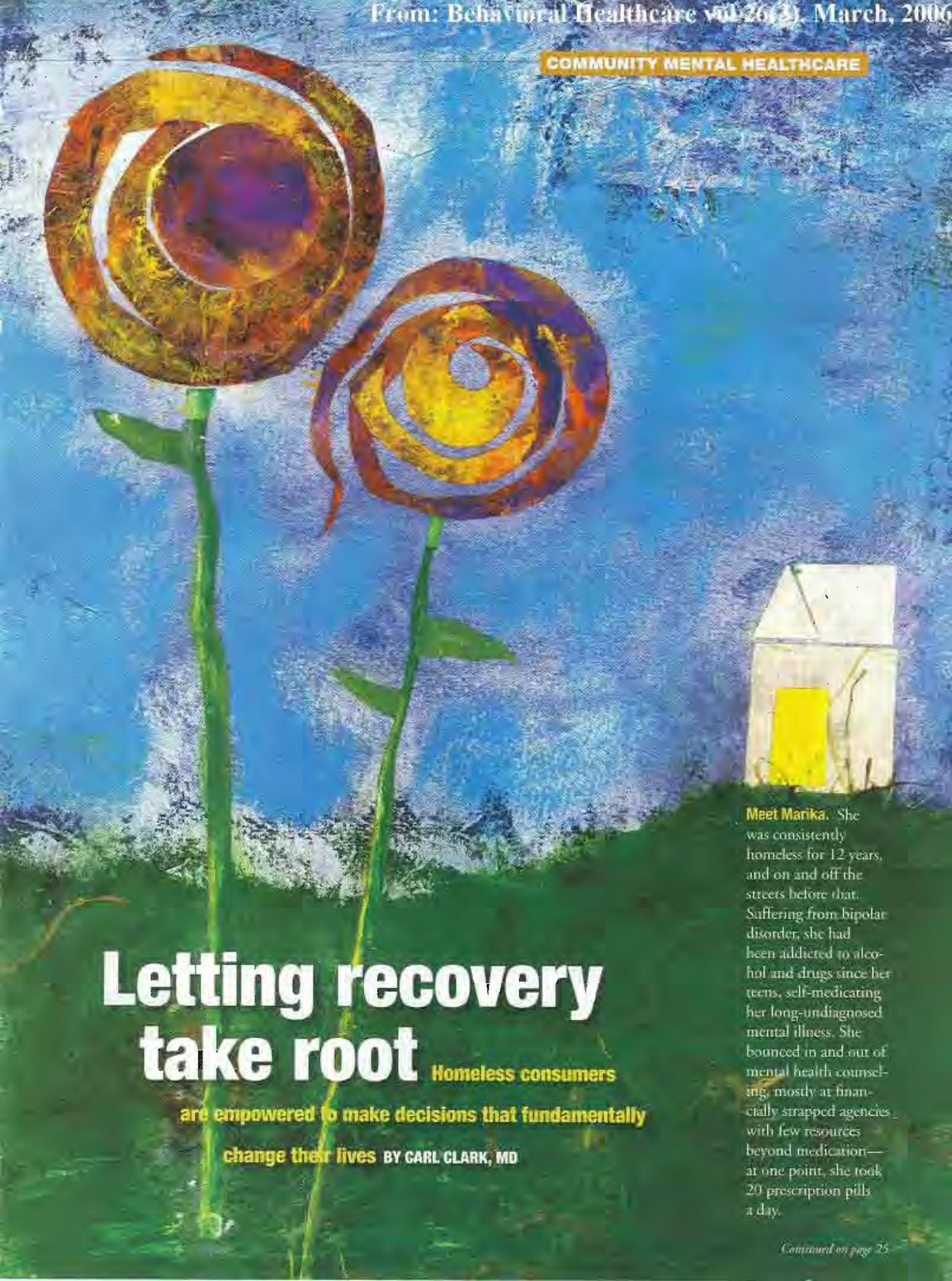
¹ MHCD Recovery Committee (2004)

² Hambleton, R.K., Swaminathan, H., Rogers, H.J. (1991). *Fundamentals of Item Response Theory*, Newbury Park, CA: Sage.

³ A partial credit Rasch model was applied, suggesting good model fit (N = 2,108), including: Individual Response Theory (IRT): person reliability = .75, item reliability = 1.00; Classical Test Theory (CTT): reliability = .78

⁴ A Rasch Rating Scale model was applied, suggesting good model fit (N = 525), including: IRT: person reliability = .83, item reliability = .96; CTT: reliability = .86

⁵ The PRO survey is in its pilot phase, where a trained consumer survey team is currently collecting data. Expected completion March 2008



Letting recovery take root

**Homeless consumers
are empowered to make decisions that fundamentally
change their lives** BY CARL CLARK, MD

Meet Marika. She was consistently homeless for 12 years, and on and off the streets before that. Suffering from bipolar disorder, she had been addicted to alcohol and drugs since her teens, self-medicating her long-undiagnosed mental illness. She bounced in and out of mental health counseling, mostly at financially strapped agencies with few resources beyond medication—at one point, she took 20 prescription pills a day.

Continued on page 25

Continued from page 21

In 2003, she wound up on the streets of Denver. Through a partnership between the Colorado Coalition for the Homeless (CCH) and the Mental Health Center of Denver (MHCD), she found housing and mental healthcare. MHCD began by asking her to make choices about her life and her care. This was a radical concept for Marika—no one had ever asked her what goals she wanted to accomplish.

Recovery was not a straight path for Marika. At one point, she stopped taking all her medications, had a psychotic episode, and landed in the hospital for 21 days. Upon her discharge, CCH took her back into its transitional housing and MHCD continued working with her.

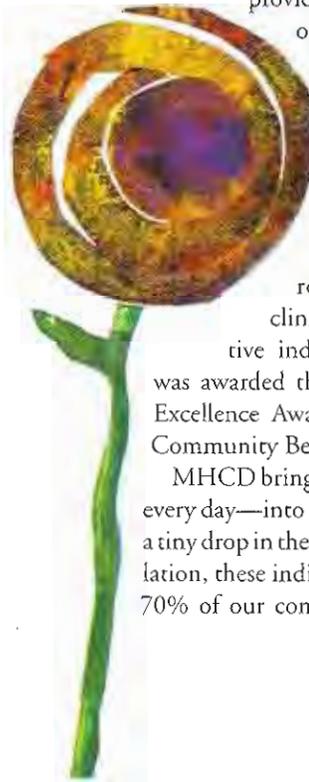
In the ensuing months, Marika turned her life around. Through MHCD's "2Succeed in Education and Employment" program, she obtained a competitive job at Denny's, working 40 hours per week. She also worked on her GED and took a computer course through 2Succeed. After completing these educational programs, she found an administrative job at a Fortune 100 company in early 2005, where she works today.

Marika has her own apartment—not government-subsidized housing—and is engaged. She has rebuilt relationships with her family, and rejoiced in getting paid time off from work when her granddaughter was born. She still sees a counselor and takes medications (down to a much more manageable three pills a day). She understands her disease, knows better how to manage it and the warning signs to look for, and is self-sufficient.

All of us in the mental health field have stories like Marika's that we recall with a great sense of accomplishment, stories we turn to for hope and inspiration and evidence that we can make a difference. Marika's story illustrates how MHCD helps homeless consumers—one of the most difficult populations for any provider—to recover. MHCD's system

of care emphasizes and facilitates consumer strengths and recovery by providing wide-ranging, yet thoroughly integrated, services in an atmosphere of consumer choice. Perhaps MHCD's most important innovation is a "360-degree" approach to measuring recovery, using environmental, clinical, and client-specified subjective indicators. Our signature approach was awarded the 2005 Community Provider of Excellence Award by the National Council for Community Behavioral Healthcare.

MHCD brings one homeless person off the street every day—into housing and into treatment. While a tiny drop in the bucket of Denver's homeless population, these individuals account for approximately 70% of our consumers. It seems fitting, then, to



explain MHCD's approach through the lens of serving the homeless mentally ill.

A Foundation of Funding

MHCD is fortunate to have access to unique funding created by the so-called "Goebel settlement," a landmark resolution to a long-running class-action lawsuit. The Goebel lawsuit is named after Ruth Goebel, a homeless woman with mental illness who died on the streets of Denver because of a lack of housing and access to mental health care. The class-action suit was brought forth on behalf of homeless people with mental illness and provides services/funding for 1,600 people at any given time to receive the evidence-based treatment services that make a difference in people's lives. The settlement created a pool of funds for treating Denver's homeless mentally ill and fostered an impressive (and unfortunately all too rare) basis for collaboration between MHCD and local shelters.

TABLE 1. Consumers' housing status at admission and discharge

Selected housing status	Admission (n = 92) %	Discharge (n = 92) %
Shelter	50.0	26.1
Street	34.8	13.0
Supported housing	3.3	16.3
Other independent housing*	7.6	38.0

*Independent housing includes consumer-owned or rented units and living with family or friends.

Even with the Goebel settlement, MHCD struggles with fragmented funding sources just as every provider does. As our colleagues who employ a recovery-based approach know, many funding and reimbursement rules are not recovery-oriented. It is a constant challenge to determine how to make available funding fit our model and receive sufficient support to continue our work.

A Network of Partnerships

MHCD works closely with CCH, shelters, and other providers to identify needs and develop services, and we support each other in seeking funding. Such close coordination enhances each organization's ability to meet homeless consumers' needs. Two cornerstones of this collaboration are:

Shelter outreach. MHCD case managers are housed full time at three local homeless shelters. Being on-site enables them to identify individuals in need of services and bring them into MHCD's program. In 2003-2004, one shelter case manager identified 63 people who became MHCD consumers.

Housing first. Because the lack of stable housing magnifies every other problem, MHCD's shelter case managers focus first on finding housing for the potential consumers they identify—whether or not those consumers ultimately choose to participate in treatment. The hope is to eventually engage them in needed care by first addressing this most pressing need. We can prioritize MHCD housing resources for homeless consumers who meet Goebel need requirements.

From 2003 to 2005, MHCD provided intensive case management and vocational

rehabilitation services for a subpopulation of homeless people with severe mental illness through a collaborative program with CCH called Recovery Connection. This program was funded by a federal grant and incorporated the service elements described elsewhere in this article. Table 1 shows housing status for Recovery Connection consumers at admission and discharge. Note that five times more consumers were in supported housing at discharge than at admission. The data for this table come from the Colorado Client Assessment Record (CCAR), which is used by the state of Colorado to track outcomes in consumers of mental health services. The CCAR does not differentiate between individuals housed in stable housing and those housed more precariously, for example, staying with friends or relatives (doubled up). We know that a good portion of those listed as living independently in fact do fall into the latter category, but we have no way to identify these individuals. The important point, however, is that these individuals are off the streets.

Guidance Toward Recovery

While we provide a wide array of services to the homeless mentally ill, certain hallmarks distinguish MHCD's approach.

Multiple assessment tools to gauge consumer recovery and provider effectiveness. We start by administering a "Recovery Needs Level Assessment" to new consumers, to help them define "recovery" and help us provide the services they need (see sidebar). Homeless consumers may start by noting basic needs—food, housing, etc. We also ask them to identify their hopes, dreams, and aspirations (e.g., re-creating a relation-

ship with family or not being dependent on others for support).

We administer the assessment at intake, three and six months after admission, and every six months thereafter to gauge progress and match our level of service intensity to each consumer's needs. Every two months, case managers complete a "Recovery Markers Report," rating each consumer's progress in areas such as housing, employment, substance abuse, etc. Again, consumers set their own goals, and the report helps to assess their progress toward these goals. This tool enables us to identify consumers who are having more difficulty than others, allowing us to adapt our methods of engaging them. Not surprisingly, the most dramatic change tends to occur in the first six months of treatment.

Consumers rate their own recovery using our "Consumer Recovery Measure." Administered every six months, this powerful tool enables consumers to explain the extent to which, for example, they feel more hopeful and more in charge of their own lives.

Finally, every year a team of consumers interviews their peers using the "Recovery Enhancing Environment Survey." Consumers rate us, telling us the extent to which the overall MHCD environment supports their recovery.

The figure displays consumer responses from Recovery Connection for 45 consumers for whom initial and follow-up data were available and illustrates the level of difficulty they experienced in nine areas of their lives at each time period (the time frame was from admission to discharge in Recovery Connection, and as a result was variable dependent on how long the individual was in the project). Data were measured with the Government Performance and Results Act (GPRA) tool. At baseline, consumers reported having the most difficulty with work, followed by satisfaction with life, and autonomy. Consumers reported significant improvement in five areas: work, leisure, autonomy, confusion, and satisfaction with life. Of the remaining four areas, two—managing day-to-day life and managing household responsibilities—shifted in the desired direction, apathy appeared to be unchanged, and difficulty with school showed an

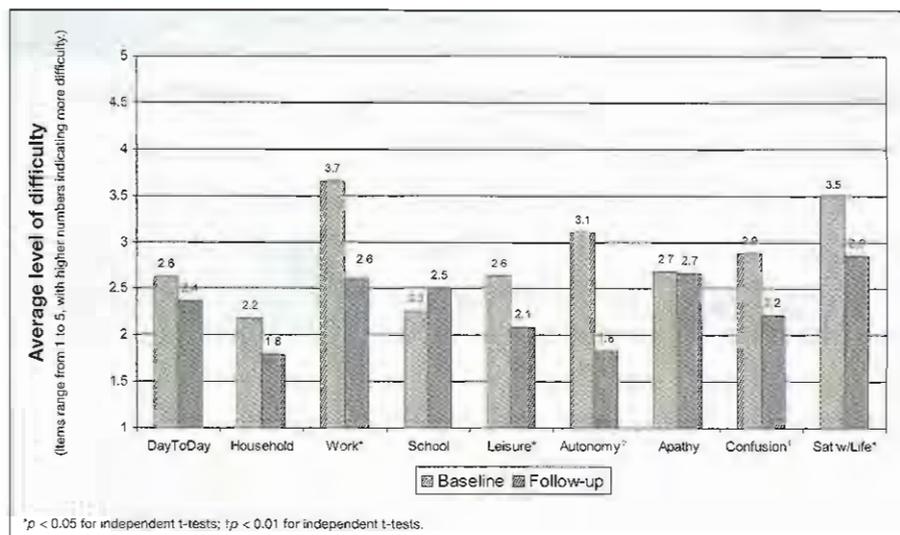


Figure. Recovery Connection consumer-reported level of difficulty in nine domains at baseline and follow-up (n = 45).

upward trend. The school area, however, had a substantial number of missing data, and analyses were not performed.

Intensive Case Management Services (ICM) based on the Assertive Community Treatment (ACT) model. Just one of

TABLE 2. Consumer-reported educational and employment attainment

Attainment	Time 1 (n = 45) %	Time 2 (n = 45) %
Enrolled in school/job training	4.4	22.7
Have a GED	24.4	37.8
Employed	4.4	15.5
Unemployed—looking	24.2	24.4

the evidence-based approaches we employ, this graduated system of case management supports the recovery-oriented model. It is based on the expectation that people with serious mental illness who receive the right level of services can, and do, get better.

The Recovery Needs Level Assessment helps us determine the type of case management team to assign the consumer. For example, a homeless, dually diagnosed person with no acknowledgment of his/her mental health needs requires a very different level of care than a similar person who understands he/she has a problem. We would assign the former consumer to a caseworker with a relatively low caseload. Then, as that consumer gets better and needs less frequent intensive treatment, he would “graduate” to a caseworker with a bigger caseload. The lowest intensity of case management services at MHCD is a 40:1 client/staff ratio.

The “Denver Approach” to psychosocial rehabilitation. As consumers progress through our case management system, they may be offered the opportunity to participate in our signature program, 2Succeed. We provide:

- Vocational counseling
- Educational support
- Transitional employment experiences
- Job skills development
- Job placement services
- Ongoing support to help consumers find and keep jobs
- Social and recreational opportunities

2Succeed provides courses designed to prepare consumers to apply for jobs or simply to function better in society. Offerings

include basic literacy, GED preparation, training for working in food service, and computer training. Approximately 1,000 people enroll in our education courses each year.

2Succeed represents a move away from the traditional, sheltered clubhouse model to full community integration. Indeed, MHCD’s very definition of “supported” employment differs from that of many providers. Rather than “sheltered” employment at an MHCD-managed enterprise, our supported employment is actually a competitive job with ongoing programmatic support from MHCD staff. In 2003, we placed 375 of 550 consumers who entered the program in outside jobs; 47% of consumers in 2Succeed competitive employment continue to receive MHCD services.

Table 2 shows changes in education participation and employment status in Recovery Connection consumers. Education and employment status were measured for a subpopulation of 45 consumers for whom we collected initial and follow-up data using the GPRA tool. The data show a substantial increase in school enrollment/job training and receipt of a GED. We also documented an increase in employment (either full or part time).

Of course, we face challenges with “mental health illiteracy” among prospective employers and their workers. Our Business Advisory Board, composed of businesses that have employed MHCD consumers, gives us a window into the business community’s concerns, and its members act as our ambassadors to their peers. Sometimes we’ll help a prospective employer test the waters with a consumer by covering that consumer’s pay for a couple of months. If things work out,

the employer then assumes responsibility for pay and benefits.

Authentic consumer engagement. As noted throughout this article, we require consumers to take responsibility for their own care by setting their own goals. We broaden this concept by involving consumers in service delivery and governance. For example, consumers helped to develop our Recovery Needs Level Assessment, the Recovery Markers, and the Consumer Recovery Measure, and conduct our annual survey.

In fact, a homeless consumer shaped many of our current mechanisms for consumer involvement. Mike came to us with severe depression and difficulty interacting with others. Through 2Succeed, he completed a community college degree. Soon thereafter, while he continued to receive services through MHCD, we asked Mike to participate on our consumer survey team. He became team leader, and we later hired him full time to run our Office of Consumer and Family Affairs. Mike also oversaw our Consumer/Staff Partnership Council and served as our Consumer & Family Advocate. Mike was able to go off disability benefits entirely and purchase his own home.

The challenge to this level of engagement is finding the right consumers to participate and lead. Mike was, quite simply, a star. Unfortunately, he recently passed away, and we are assessing how to structure the Office of Consumer and Family Affairs for the future.

Conclusion

Applying a recovery model to homeless consumers can seem challenging. Yet this treatment mind-set is perhaps most crucial for the homeless population. Almost more than any other group, the homeless mentally ill population is in a position to truly change their lives if given an opportunity to access more than simply short-term stabilization. ■

Carl Clark, MD, is CEO of the Mental Health Center of Denver. To send comments to the author and editors, e-mail clark0306@behavioral.net.

The Recovery Needs Level Assessment

The Recovery Needs Level Assessment is an instrument developed jointly by clinical staff, management, and consumers of MHCD that evaluates a variety of areas in the consumer's recovery path. These domains include:

- clinical (e.g., Global Assessment of Functioning scores and visits to the hospital or ER for psychiatric reasons)
- engagement (e.g., level of engagement in services and level of case management needed)
- symptoms (e.g., level of symptom interference and harmful behavior toward self or others)
- environment (e.g., community support around the consumer and level of stress in the environment where the consumer currently lives)

The Recovery Needs Level Assessment is scored automatically according to an algorithm based on MHCD's experience of how these areas may affect recovery. The results correspond to proposed levels of treatment that can be accepted or overridden by MHCD's clinical staff, based on further assessment or analysis of other events not necessarily captured by the instrument. MHCD's Recovery Needs Level Assessment and the associated algorithm are available upon request from MHCD. Contact CEO Carl Clark, MD, at (303)

Progress Report:

Court to Community Treatment Program



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MHCD Case Manager Michael Prejean, B.S. CACII works with C2C consumers at MHCD's Capitol Hill Clinic at Humboldt. He credits the direct collaboration with Denver's criminal justice system and flexibility in treating consumers as individuals for the program's success.

When you first meet Matt, a soft-spoken young man in his mid-twenties with a gentle demeanor, it is hard to believe that he has been arrested close to 100 times for violations like trespassing and being uncoopera-

tive with police. Once he entered MHCD's Court to Community Program (C2C), Matt's life started down a different path.

MHCD and the Colorado Coalition for the Homeless partnered 18 months ago with the Denver Crime Prevention and Control Commission and the Denver court system to create Court to Community, targeted at individuals with mental illness and a history of repeated violations of city ordinances, like trespassing. The initial goal of the grant-funded program was to decrease jail time and court appearances by 25 percent. **Remarkably, in just a year-and-a-half, the program has been so successful that results show a reduction in jail recidivism by 80 percent.**

Matt, who has Bipolar Disorder and a

history of substance abuse, was living on the streets when he first became involved with MHCD eight years ago, according to his case manager Michael Prejean. Prejean, one of two MHCD clinicians who work with the 24 C2C consumers at MHCD's Capitol Hill Clinic at Humboldt, entered Matt into the program in the hopes of helping him break his cycle of arrests. A little more than a year later, Matt has not been arrested or jailed, and he now lives in an apartment and manages his own finances.

By court order, C2C connects consumers to mental health treatment and medication, substance abuse services, and housing and social support assistance, leading to significant progress for the majority of the program's 41 total participants, according to MHCD Program Manager J. Eric Smith. "It's the immediate connection to needed services that makes the difference," he says.

C2C's unique approach closes treatment gaps and provides the most appropriate services for consumers, according to James Ginsburg, Director of Substance Treatment Services/ Housing First, who heads up the program for the Coalition. "This program is ultimately about providing the proper care for people who are not really criminals," explains Ginsburg. "They are people who are caught up in the expensive cycle of jail and court."

For consumers like Matt, who calls C2C "a step in the lifelong road to recovery," C2C requires personal effort and commitment. "Court to Community is a program that builds

Total of 41 Court to Community Consumers:

- 70% Male
- 30% Female
- Ages 19 to 69 Years Old

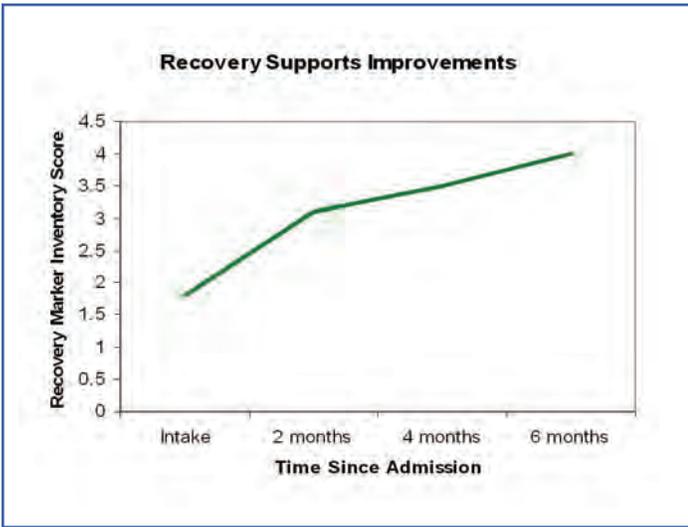
After 18 months:

- 2/3 Have Not Been Re-Arrested
- 80% Reduction in Jail Time
- \$104,790 Savings to Taxpayers

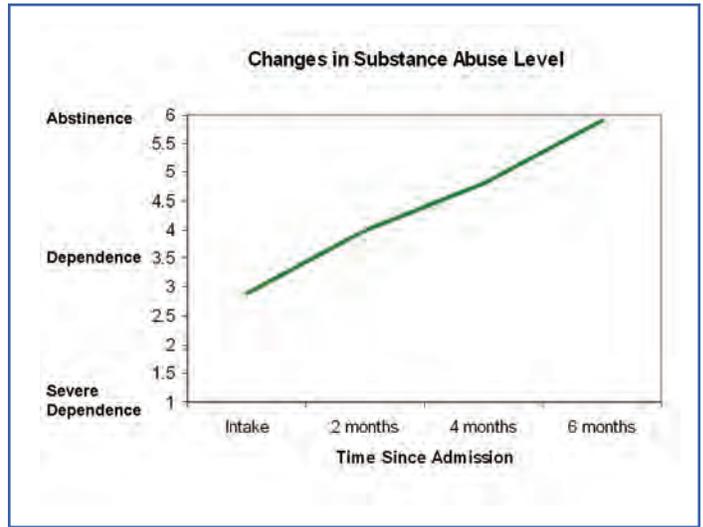
on people's strengths," says Matt, "but you have to contribute. No one is entitled. You have to understand what you can do with your strengths."

There is definitely no sense of entitlement for Matt, a young man who has worked hard to take advantage of the opportunities C2C offers him. "I am grateful for this program and for all of the people who have helped and contributed to MHCD to make this program happen," he says. "I can now look at the different directions in life available to me."

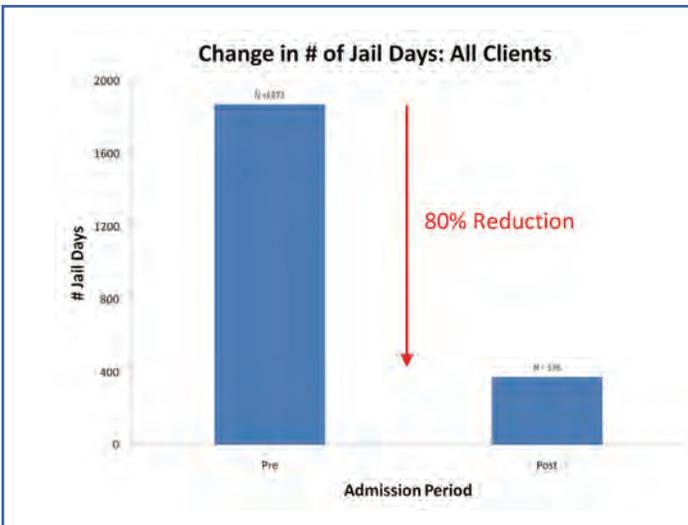
Court to Community is partially funded through grants from the Colorado Health Foundation and Denver's Crime Prevention and Control Commission.



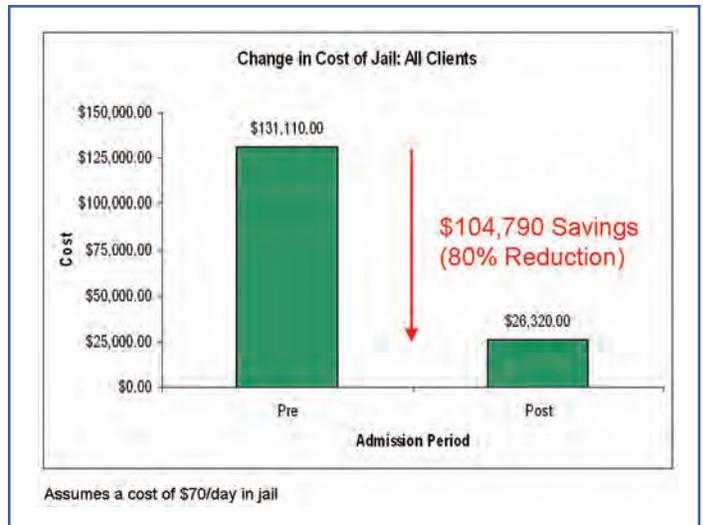
Average change in the Recovery Marker Inventory (RMI) score over the 6 months after admission to the C2C program. Increases in the RMI score indicate improvement in the consumers Recovery Supports.



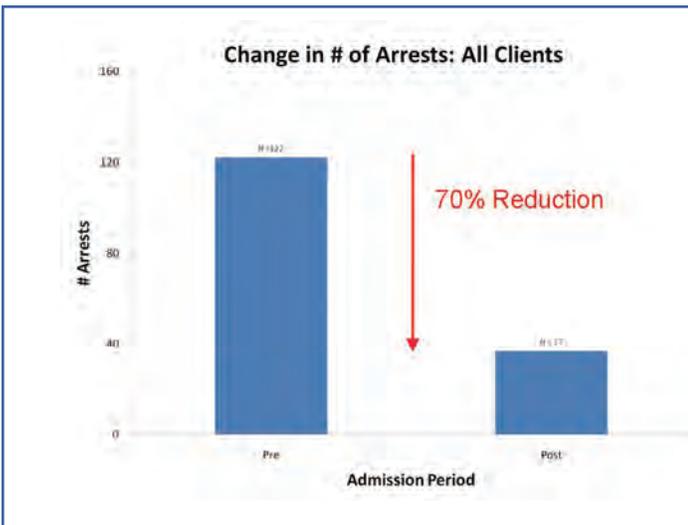
Average change in the level of substance abuse over the 6 months after admission to the C2C program. Increases in the score indicates decreasing dependence on commonly abused substances.



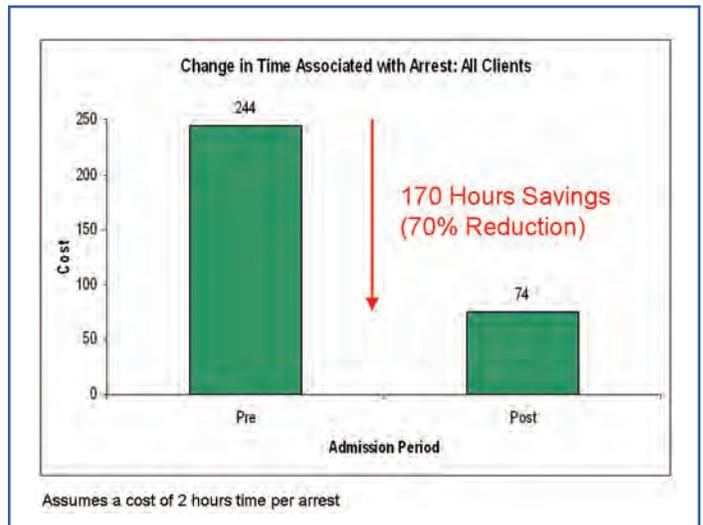
Total number of days served in jail among all consumers during the year prior to admission to the C2C program versus one year after admission.



Estimated cost of days served in jail among all consumers during the year prior to admission to the C2C program versus one year after admission. Cost was based upon estimate of \$70/jail day.



Total number of arrests among all consumers during the year prior to admission to the C2C program versus one year after admission.



Estimated cost of arrests, in terms of officer hours consumed, among all consumers during the year prior to admission to the C2C program versus one year after admission. Cost was based upon estimate of 2 hours/arrest.