CHAPTER 5

SPECIAL POPULATIONS: WOMEN, HOMELESS, CO-OCCURRING DISORDERS, GENERAL RELIEF, and CalWORKs

Introduction

Historically, various groups have been either excluded from treatment or received far fewer services than the dominant population. According to the National Institute on Drug Abuse (NIDA), there is a definite need to examine health disparities within the substance abuse treatment system because "…despite the fact that we know unequivocally that addiction is a disease…it remains a stigmatized disease…" (NIDA, 2001). NIDA identified a number of groups (or special populations) who may experience disparities within the AOD treatment system, including women, the homeless, and individuals with co-occurring disorders. All of these groups are examined in this chapter. In addition, those individuals receiving General Relief and California Work Opportunity and Responsibility to Kids (CalWORKs) funding are considered special populations. For each special population, comparisons will be made to the remaining study population as a whole in order to ascertain if the short-term outcomes (admission-to-discharge changes in substance use, needle use, medical days, etc. – see Appendix III, for the complete list of questions) are significantly different. In other words, women will be compared to men; homeless individuals will be compared to those who did not report being homeless at admission to treatment, etc. Furthermore, only outcome measures showing noteworthy changes are reported here. Comparisons are made to illustrate differences in treatment outcomes, which may or may not indicate the presence of disparities in people's ability to access and remain in AOD treatment (a "*" indicates that additional analyses are not shown).

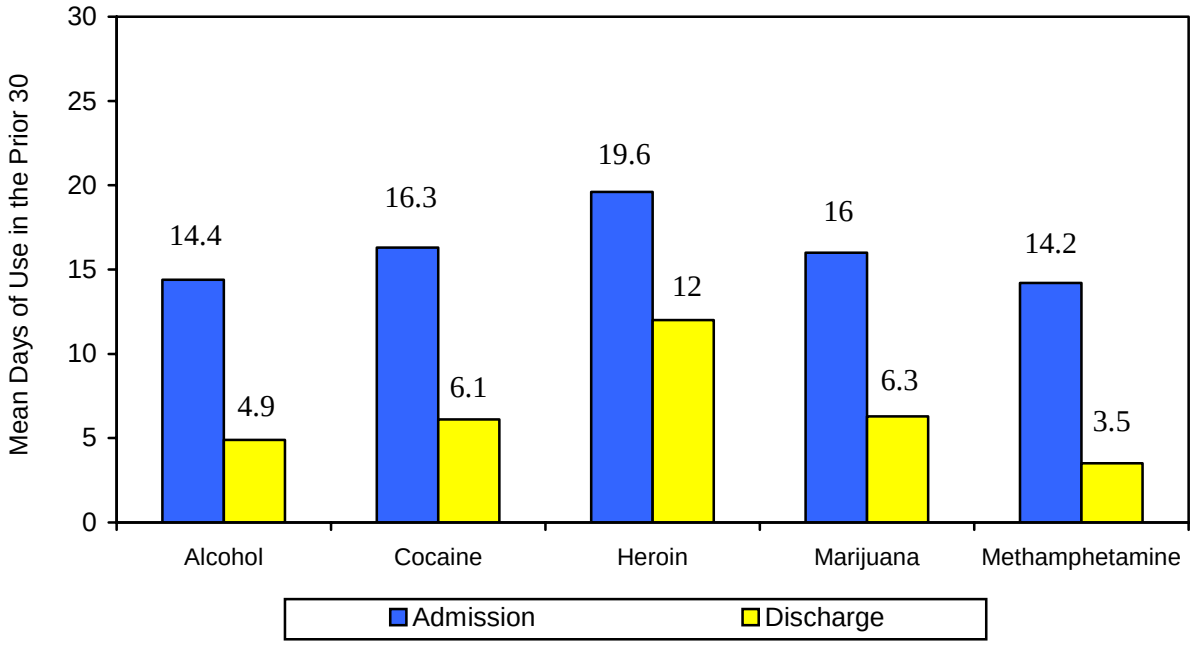
Women in Treatment

The National Institute on Drug Abuse (NIDA, 2001) has recognized that health disparities based on gender still exist. Women, especially those who are pregnant or have children, face persistent barriers in seeking and remaining in AOD treatment. Women with children may mistakenly believe that if they sign up for drug/alcohol abuse treatment they will lose custody of their children. Additional barriers to treatment for women include their lack of money for treatment, the limited availability of services for pregnant women, and a lack of childcare. These are on top of the barriers that may be experienced by all who need treatment, such as lack of transportation and waiting lists for available treatment slots.

LACES found that 43.7% of the sample was female (n = 4,135). Of that group, the majority was between the ages of 35 and 44, with a mean age of 36.1 years. The primary program type for this group was outpatient counseling (OC; 34.8%); however, significant proportions were also found in the residential services (RS; 26.8%) and day care habilitative (DCH; 23.7%). None of the women in this sample received treatment in a narcotic treatment program (NTP).

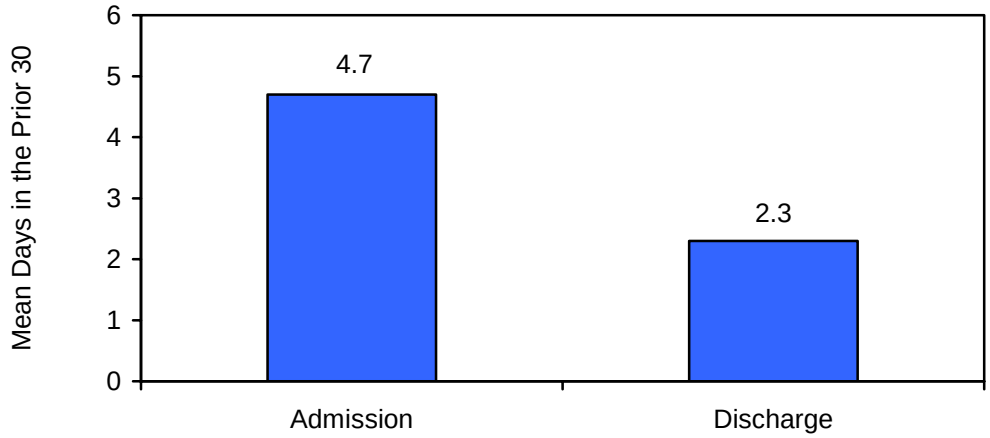
This first figure shows the substance use histories for the 30 days prior to treatment admission and the 30 days prior to discharge (or the period during treatment) for women.

Figure 5.1
Reductions in the Mean Days of Alcohol and Drug Use for Women



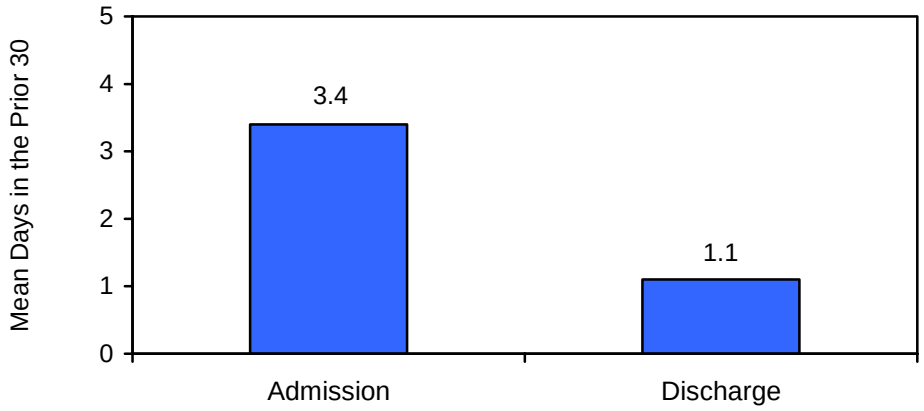
As demonstrated by the figure above, there were significant declines in all drug categories. The number of days (in the previous 30 days) of reported use of alcohol, cocaine, marijuana, and methamphetamine decreased 60%-75% (8-10 days). Heroin use decreased by 39% (7.6 days). Additional analyses* indicate that these results were comparable to those found for men, with the exception that women reported more use of methamphetamine and greater decreases in use of methamphetamine at discharge than did the males.

Figure 5.2
Reduction in Mean Days of Injected Drug Use for Women



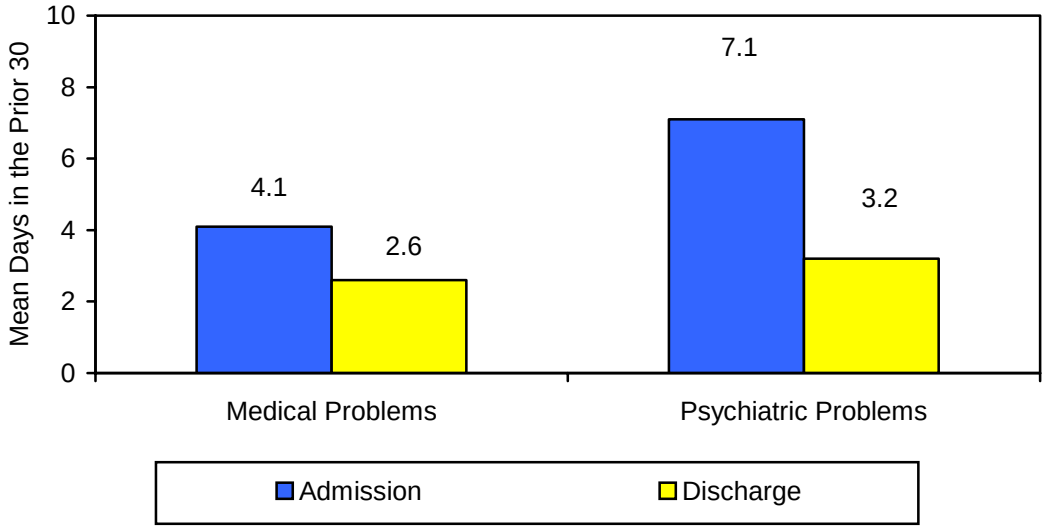
As shown above, there also was a significant decrease (50%, or 2.4 days) in the mean number of reported days of injected drug use. This finding also was comparable to what was found for the males.*

Figure 5.3
Reduction in Days of Family Conflict for Women



The number of days of family conflict in the prior 30 decreased by 67% (2.3 days). Males* reported fewer days of family conflict (1 day) in the 30 days prior to discharge, but the decrease was similar to that found for females (67%).

Figure 5.4
Reductions in Medical and Psychiatric Problems for Women



Days of reported medical problems declined by 36% after treatment (1.5 days). Males reported fewer days of medical problems at admission.* Days of reported psychiatric problems declined by 55% (3.9 days). This decrease was substantially greater than that found for males, who reported a decrease of less than one day.*

As discussed earlier, the comparisons between men and women were made in order to ascertain the possible presence of AOD treatment disparities. The findings show that the

patterns of drug and alcohol use for women were comparable to what was reported by men, with the exception of methamphetamine use. Women, when compared to men, reported a higher mean number of days of methamphetamine use in the 30 days prior to admission (14.2 days and 11.5 days, respectively) and a slightly higher proportionate decrease in the mean number of days of use of methamphetamine in the 30 days prior to discharge (10.7 days reduction for women vs. 8.2 days for men).*

In the cases where women reported a higher mean number of days of problems (medical problems and days of family conflict), they also reported a greater decrease in these problems at discharge when compared to the males.* This signifies that although some research indicates that women may have a more difficult time finding and remaining in AOD treatment (Colletti, 1998), they are just as likely as men to report positive outcomes in the areas of drug addiction and family problems at discharge. In addition, women reported greater decreases from admission to discharge than did men* in the area of methamphetamine abuse and psychiatric problems.

The Homeless in Treatment

A “homeless person” is defined as someone who is living on the street or in an emergency shelter, or who would be living on the street or in an emergency shelter without supportive housing assistance. There are approximately 84,000 homeless people on a given night in the County of Los Angeles (Weingart Center, 2000).

This group of people is considered a “special population” for a number of reasons. Enrolling homeless persons into treatment for substance abuse is more difficult than for the general substance abusing population (Orwin, Garrison-Mogren, Jacobs, & Sonnefelde, 1999). First, they are generally transient and as such, may not have access to many of the services available to those with a stable address. Prior research studies on the homeless have found that their rate of substance use and abuse is higher than that found for the general public and as many as 24% of those who seek AOD treatment in Los Angeles County are homeless (ADPA, 2003). Treatment for this group is also difficult and more expensive given their lack of knowledge of available treatments, their lack of tools to seek out treatment, and, for those who do access treatment, their lack of motivation to stay in treatment (Orwin, et. al, 1999 & Velasquez, Crouch, von Sternberg, Grosdanis, 2000).

LACES found that 18.2% of the study population examined for this report was homeless[1] (n = 1,720). The ratio of males to females among homeless individuals was higher than that of the overall study population. The mean age of the sample was 36.8 years. See Figure 5.6 for the age distribution of the sample. As was expected, the primary program type for this group was RS (64.2%), a rate that is 3 times higher than the overall study population. This higher rate of RS use by the homeless is appropriate and warranted to meet their clinical needs. A significant proportion of participants were also found in OC (26.7%).

Figure 5.5
Gender Breakdown for the Homeless

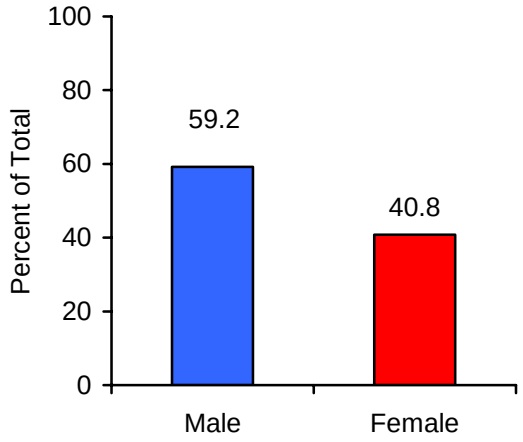
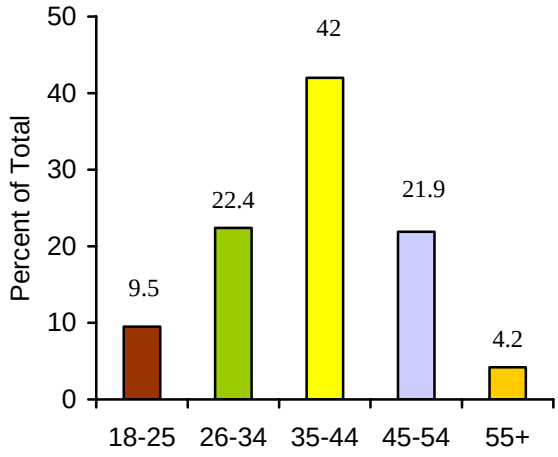
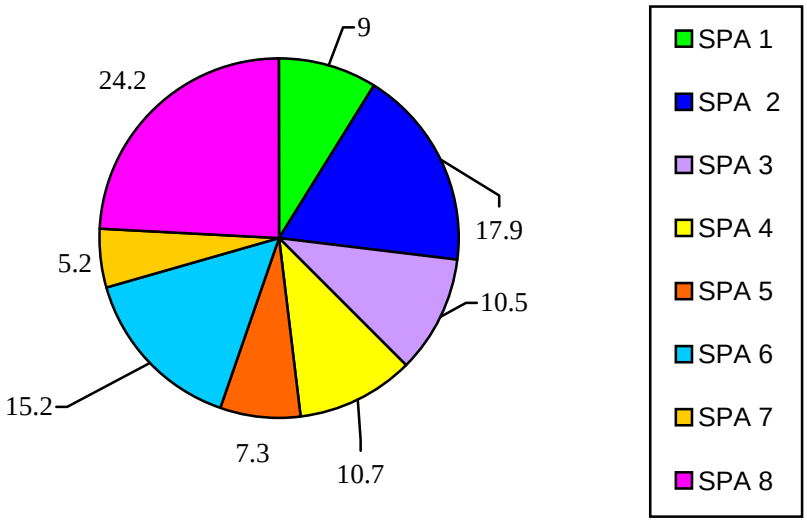


Figure 5.6
Age Categories for the Homeless



[1] Homeless status here was determined by a “yes” response to the LACPRS question, “Are you homeless?”

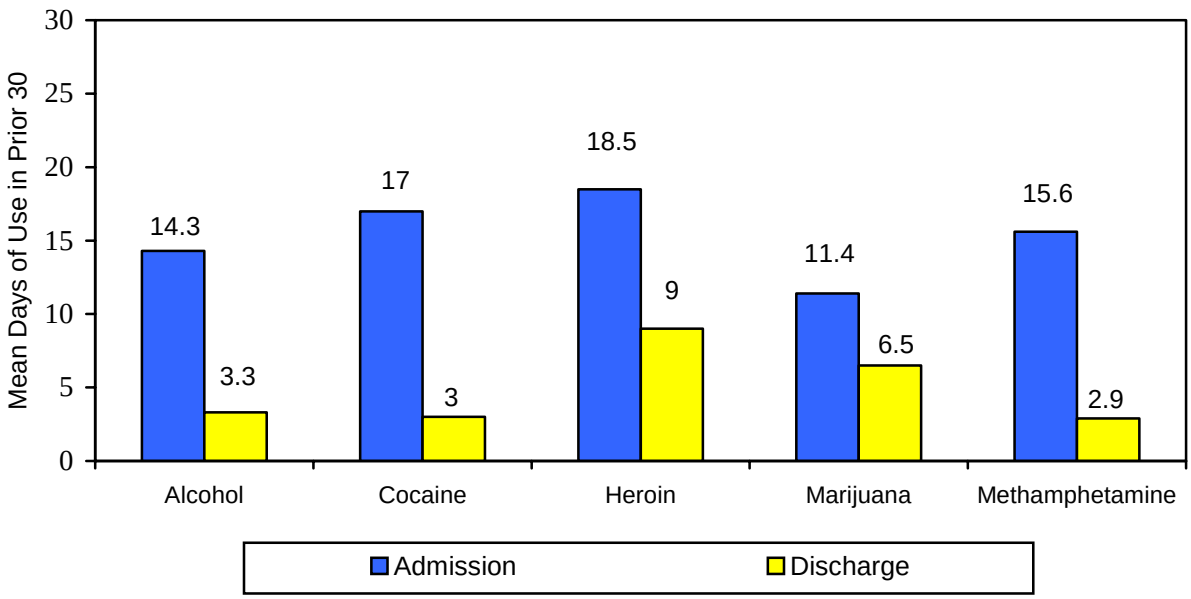
Figure 5.7
Homeless AOD Treatment Participants Across Los Angeles County by Service Planning Area (SPA)



As shown in Figure 5.7, representation across the SPAs was varied (see Appendix VIII for a map of the SPAs), with the majority of the homeless individuals seeking treatment in SPAs 8, 2, and 6. This finding may be explained by the selection of the sentinel site programs from which the admission and discharge information was collected. It may not be the case that there are more homeless individuals in SPAs 8, 2, and 6, but rather, the programs chosen to represent those SPAs may serve a high proportion of homeless participants.

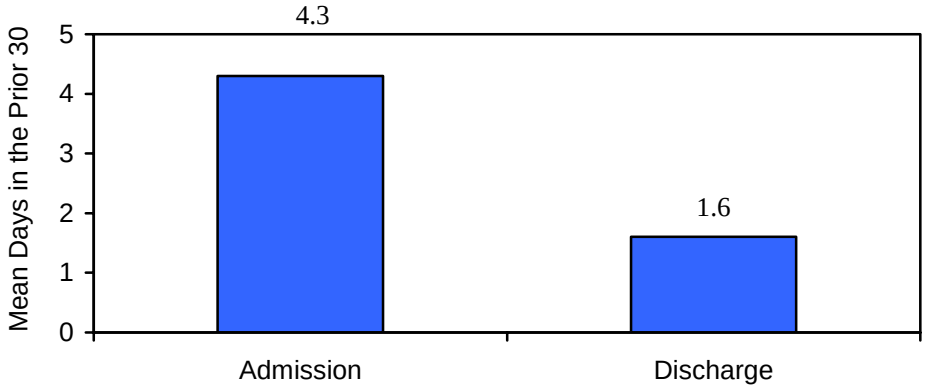
The figure below shows substance use histories for the 30 days prior to treatment admission and the 30 days prior to discharge (or the period during treatment).

Figure 5.8
Reductions in Mean Days of Alcohol and Drug Use for the Homeless



As demonstrated by Figure 5.8 above, there were significant declines in mean days of use for all drug categories, with the following drugs showing the greatest decreases: cocaine, 82% (a 14-day reduction), methamphetamine, 81% (12.7 days), and alcohol, 77% (11 days). For "alcohol use to intoxication," the results are similar to those found for those who reported that they were not homeless at admission.* Use of cocaine and methamphetamine was higher for the homeless group at admission, but the proportion of decrease in use after treatment was also higher for homeless participants than that found for participants who reported that they were not homeless.* Use of heroin and marijuana was lower, but the decrease in use from admission to discharge was greater for the homeless group.

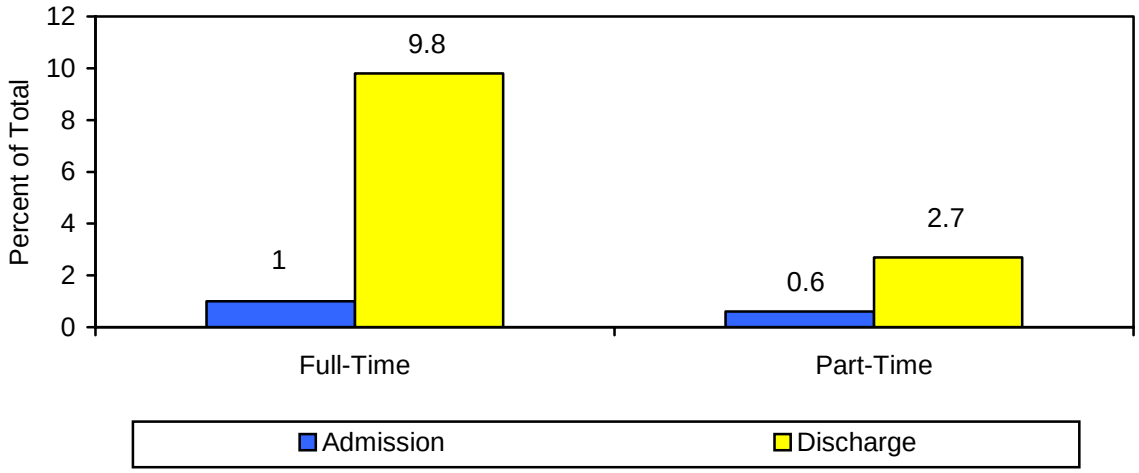
Figure 5.9
Reduction in the Mean Days of Injected Drug Use for the Homeless



There was a 63% decrease in the number of days the homeless participants reported injecting drugs.

One area that requires particular attention for this group is employment. The following figure (5.10) illustrates progress in this area over the course of treatment.

Figure 5.10
Improvements in Employment for the Homeless



Homeless participants showed great improvement in the area of employment: full-time employment increased 9 times and part-time employment increased over 4 times. Not surprisingly, the percentage of employment at admission was much lower for the homeless participants compared to those individuals who reported that they were not homeless.* After treatment, the increases in employment for the homeless surpassed what was found for those reporting that they were not homeless* – a 26% increase in full time employment and a 5% increase in part-time employment. This indicates that treatment for those who are homeless appears to increase employment at discharge.

As indicated by the information above, homeless individuals reported decreases in their mean number of days of drug use and an increase in employment.

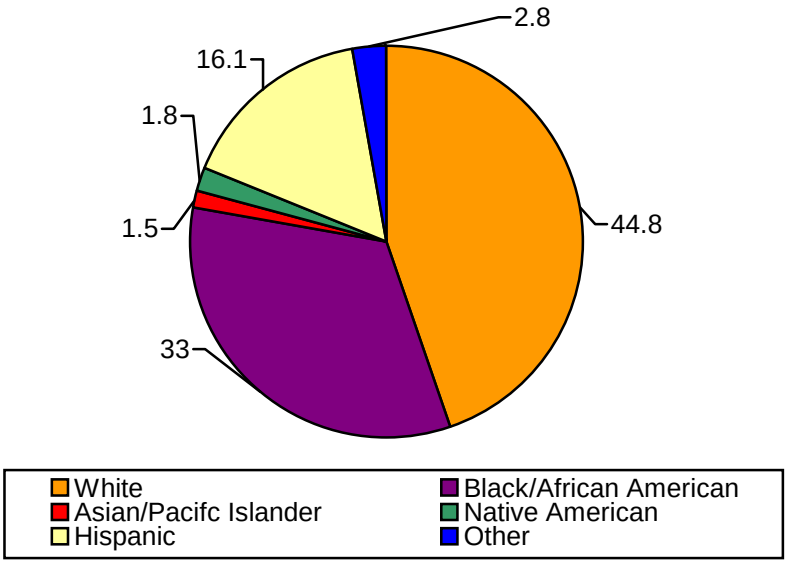
An additional piece of information that would have been beneficial in this study is a measure of participants who reported that they were no longer homeless at discharge, or some other measure of a reduction in homelessness. Regardless, individuals who report being homeless at admission have outcomes that are as good as (AOD use decreases), and in some cases better than (employment), those who report that they are not homeless at admission.

Participants with Co-Occurring Disorders (Mental Illness and Substance Use/Abuse Problems) in Treatment

Participants with co-occurring disorders are those individuals who have received a mental illness diagnosis and reported this fact at their intake to AOD treatment.[2] This method of identification presents problems in obtaining an accurate count of those with co-occurring disorders in ADPA-funded AOD treatment in Los Angeles County because it does not allow for the inclusion of individuals who have a diagnosis but do not report it or for those who would likely have a diagnosis of a mental illness if they received mental health treatment. And like the homeless population, participants with co-occurring disorders present challenges in AOD treatment due to a number of factors, including their noncompliance with treatment (Tsuang, Fong, & Ho, 2003), and their increased risk of homelessness and criminal justice system involvement (Schoppelrey, 2002), as well as AOD treatment staff being poorly trained to meet their mental health needs (Grella & Gilmore, 2002; Rosenthal & Westreich, 1999). Research indicates, however, that individuals with co-occurring disorders in extensive substance abuse treatment showed improvement comparable to participants without co-occurring disorders (Gonzalez et al., 2002).

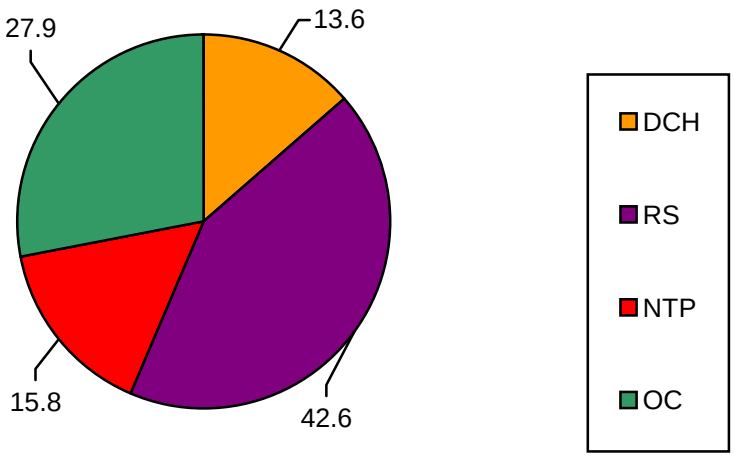
LACES found that 13.2% of the study population was diagnosed as having a mental illness (n = 1,253) at some point in their lives. The proportion of females (47.5%) in the co-occurring disorder group was only slightly higher than that found for the entire study population (43.7%). The mean age for the individuals in this group was 41.2 years. Among the participants with co-occurring disorders, a greater proportion of individuals identified themselves as White (44.8%) and a smaller proportion self-identified as Hispanic (16.1%), when compared to the rest of the study population (see Figure 5.11). An additional 33% identified themselves as Black/African American, 1.8% identified as American Indian, 1.5% identified as Asian/Pacific Islander, and 2.8% identified as “other.”

Figure 5.11
Ethnic/Racial Categories for Participants with Co-Occurring Disorders



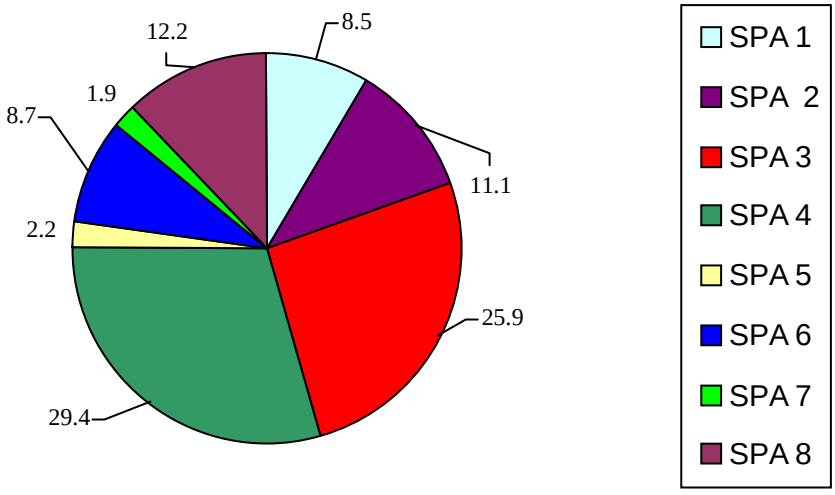
[2] Mental illness was determined by a “yes” response to the LACPRS question, “Have you ever received the diagnosis of mental illness?” The proportion of mentally ill in this group may be greater because it is assumed that there may be individuals who have a mental illness but have not been diagnosed.

Figure 5.12
Program Type Breakdown for Participants with Co-Occurring Disorders



The majority of the participants with co-occurring disorders were treated with RS (42.6%). However, a significant proportion was treated in OC (27.9%).

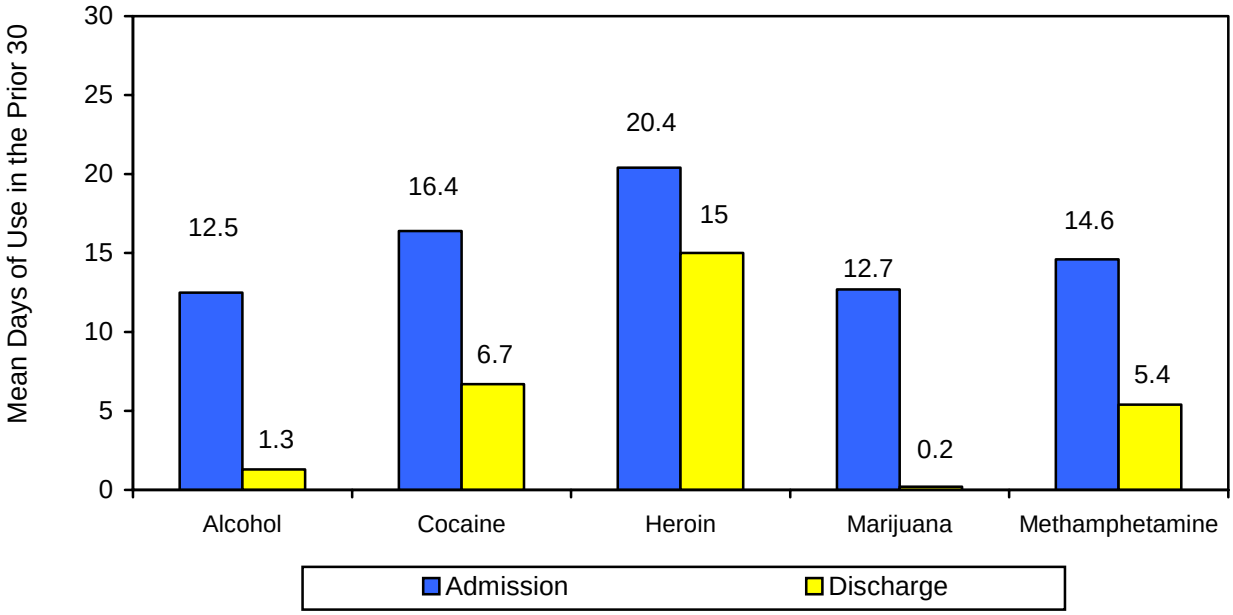
Figure 5.13
Participants with Co-Occurring Disorders Across Los Angeles County by SPA



As shown above, the majority of the participants with co-occurring disorders received treatment in SPAs 3 and 4. This distribution most likely occurred due to the sampling of the Sentinel Site programs (two of the programs in SPAs 3 and 4 dealt specifically with co-occurring disorders). The above distribution of participants does not indicate that there were a greater number of participants with co-occurring disorders in SPAs 3 and 4.

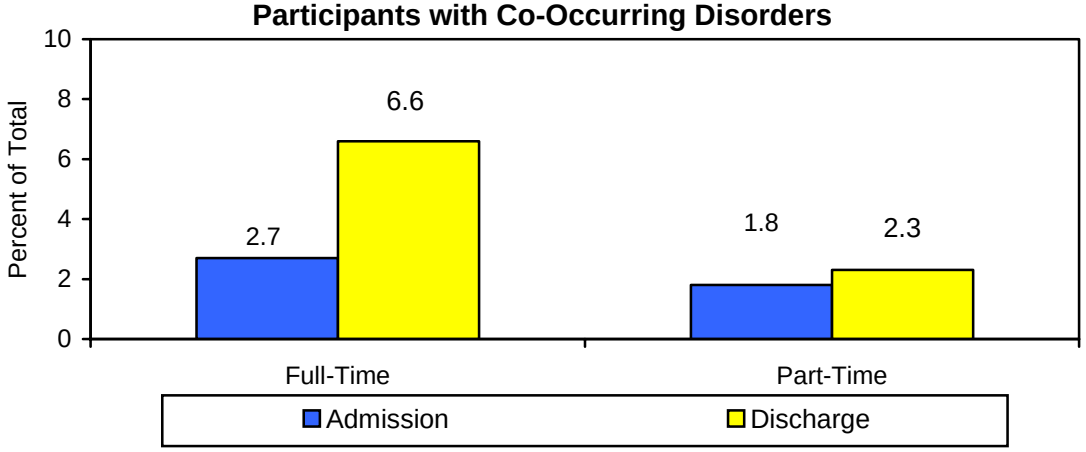
The figure below shows AOD use histories for the 30 days prior to treatment admission and the 30 days prior to discharge (or the period during treatment) for those with co-occurring disorders.

Figure 5.14
Reductions in the Mean Days of Drug and Alcohol Use for Participants with Co-Occurring Disorders



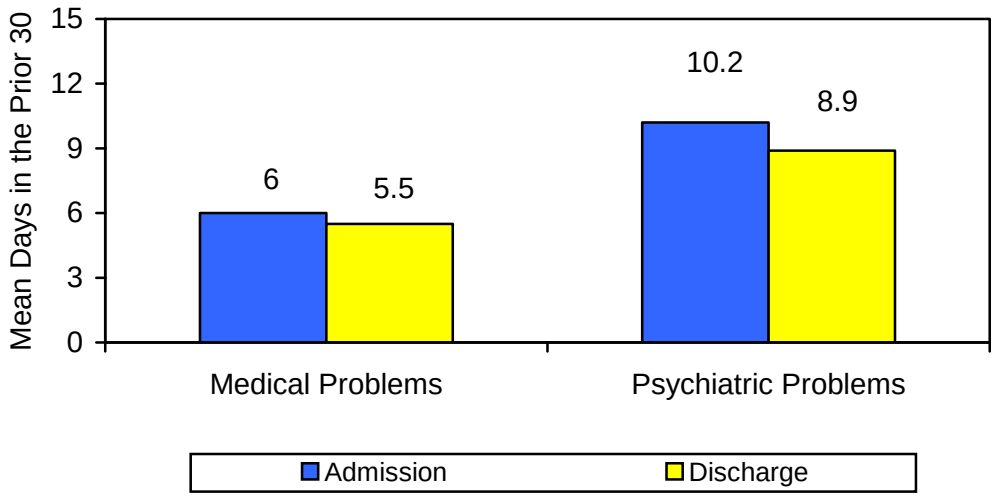
As demonstrated by Figure 5.14 above, there was a significant decline in the number of days (in the prior 30 days) of use in all drug categories, with the greatest declines being in the use of marijuana (98%, or 12.5 days), alcohol (90%, or 11.2 days), and methamphetamine (63%, or 9.2 days). The reduction in the days of use for alcohol, cocaine, and marijuana were greater than the reductions found for those who had not been diagnosed with a co-occurring disorder.*

Figure 5.15
Employment Improvements for Participants with Co-Occurring Disorders



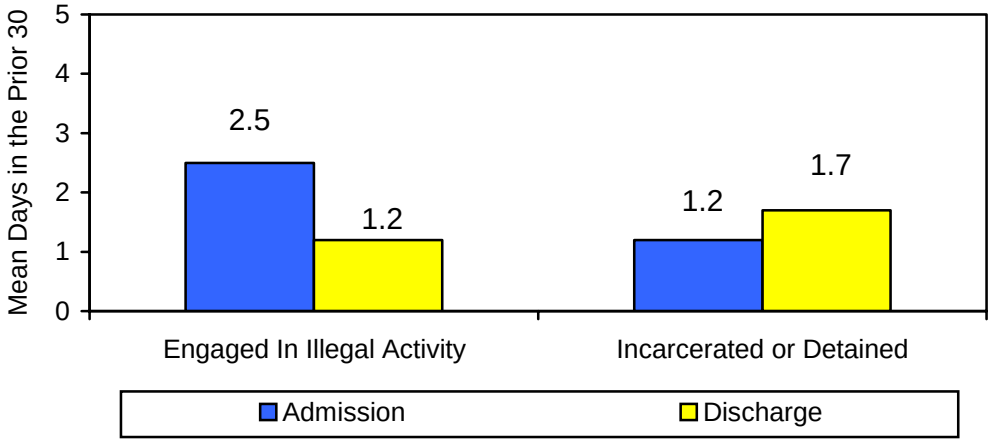
This group reported improvements in the area of employment (Figure 5.15); nevertheless, these improvements were only one third of what was found for the group that *did not* report co-occurring disorders.* The improvements in employment, however small, do still indicate that there are opportunities for increased employment for this population. Additional resources, training, and funding will be needed as well as an examination of the possible reasons for the improvement (job training, better compliance with medication, etc.) in order to increase these benefits and expand them to other treatment programs.

Figure 5.16
Reduction in Mean Days of Medical and Psychiatric Problems for Participants with Co-Occurring Disorders



The mean number of days of reported medical problems did not decrease significantly after treatment for this group (Figure 5.16). Participants with co-occurring disorders reported twice as many days (in the previous 30) of medical problems at admission than those who were not diagnosed with a co-occurring disorder.* Although the mean number of days of psychiatric problems decreased slightly, the participants with co-occurring disorders experienced 3 times as many problem days when compared to those without a diagnosed mental illness. This finding may illustrate the point made above concerning the difficulty in treating this population, and although there were decreases in substance use and abuse as well as increases in employment, the improvements may be greater if, in addition to the AOD treatment, this group has greater access to medical and psychiatric care.

Figure 5.17
Reductions in Criminal Justice Issues for Participants with Co-Occurring Disorders



Days engaged in illegal activity for participants with co-occurring disorders decreased (Figure 5.17) and were similar to that found for the group that *did not* report a co-occurring disorder.* However, this was the only group that showed an increase in the mean number of days spent detained or incarcerated from admission to discharge. This finding supports the literature that implies that those with co-occuring disorders have increased contact with the criminal justice system.

In conclusion, as indicated by the literature reviewed at the beginning of this section, participants with co-occurring disorders present challenges in treatment that require additional training, more intense treatment, and possibly closer monitoring than what may be available in most treatment programs. Nevertheless, as the analyses show, improvements for this group are not impossible to obtain and may even be within the reach of more treatment programs.

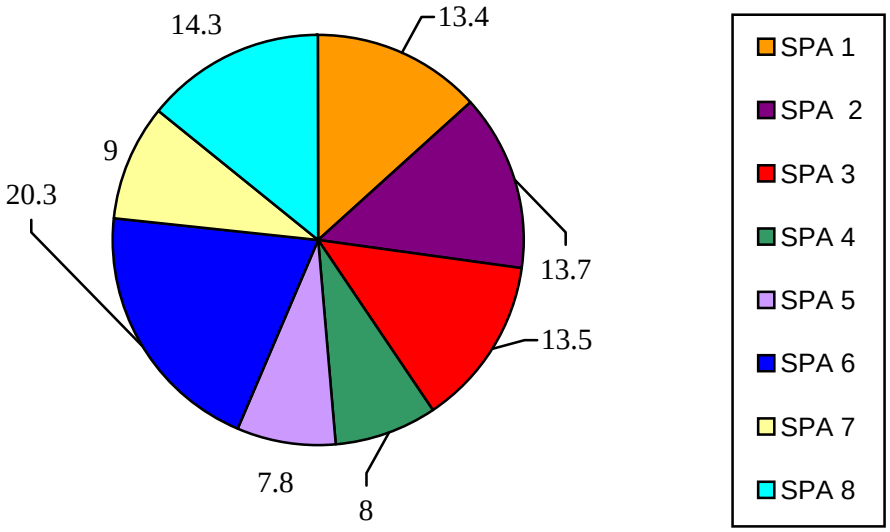
Please note that of the 32 treatment programs included in this report, at least four specialize in the treatment of those with co-occurring disorders. Future reports will have the opportunity to examine, on a program-by-program basis, the results of treatment for this and other special populations. When these additional reports are completed and the treatment strategies of those programs that show the best outcomes for those with co-occurring disorders are analyzed, information will be shared with other programs in the expectation that similar improvements will be found in other programs.

General Relief Participants in Treatment

The law requires counties to maintain a general assistance program for indigent persons, here defined as adults over 18 who have no source of income or means of providing for their basic needs (food, shelter, clothing). In Los Angeles County, this program is termed "General Relief." General Relief (GR) participants suspected of chemical dependency are referred to the Department of Health Services Community Assessment and Service Centers (CASC) for evaluations and urinalysis, if appropriate. Those identified as chemically dependent are required to participate in substance abuse treatment/recovery services as a condition of their continued receipt of GR services and funding (ADPA, 2001).

LACES found that 13.3% of the sample population was receiving GR (n = 1,255).[3] As expected, the majority were males between the ages of 35 and 44. The ethnic/racial breakdown for this group was similar to that found for the entire sample, with the majority of the group identifying themselves as either Black/African American (35.7%), White (31.2%), or Hispanic (29.3%). The majority of individuals receiving general relief were referred to OC (70.1%) and RS (29.1%).

Figure 5.18
General Relief AOD Treatment Participants Across Los Angeles County by SPA

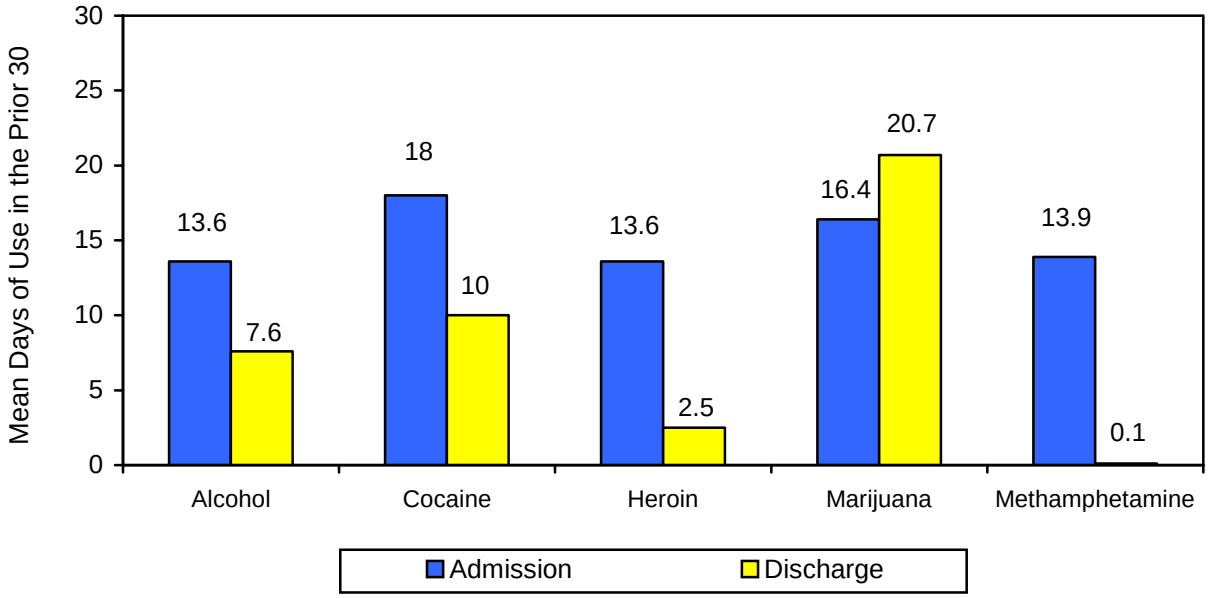


Individuals in the GR category were relatively uniformly distributed across the county.

The figure below shows the substance use histories for the 30 days prior to treatment admission and the 30 days prior to discharge (or the period during treatment) for GR participants.

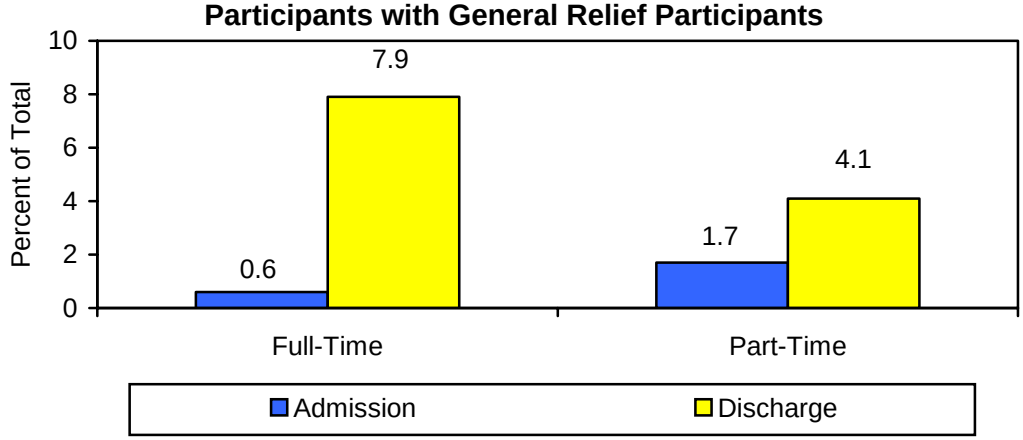
[3] The General Relief and CalWORKs information used in this report were obtained from the LACPRS admission and discharge forms.

Figure 5.19
Reductions in Mean Days of Alcohol and Drug Use for General Relief Participants



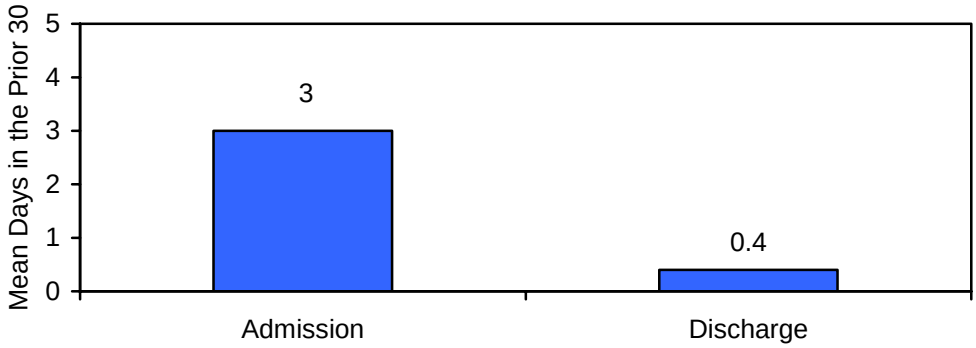
There were significant declines in the mean number of days of reported use (in the prior 30 days) for most drug categories, with methamphetamine (99%, or 13.8 days), heroin (82%, or 11.1 days), and cocaine (44%, or 8 days) showing the greatest decreases. One interesting finding in this group is the increase in the number of days of reported marijuana use from admission to discharge. The exact reason for this finding is unknown at this time. When GR recipients are suspected of drug use, they are referred for assessment to a CASC, as described above. If the assessment determines that they have an AOD problem, they must go to treatment, but they are not, at that time, considered ineligible for services. However, relapse does occur, and there is the possibility that GR participants consider the use of marijuana as less severe than the use of other "more dangerous" drugs. Or, use of marijuana may substitute for their primary addiction. At this time, additional information is needed in order to best explain this finding.

Figure 5.20
Employment Improvements for Participants with General Relief Participants



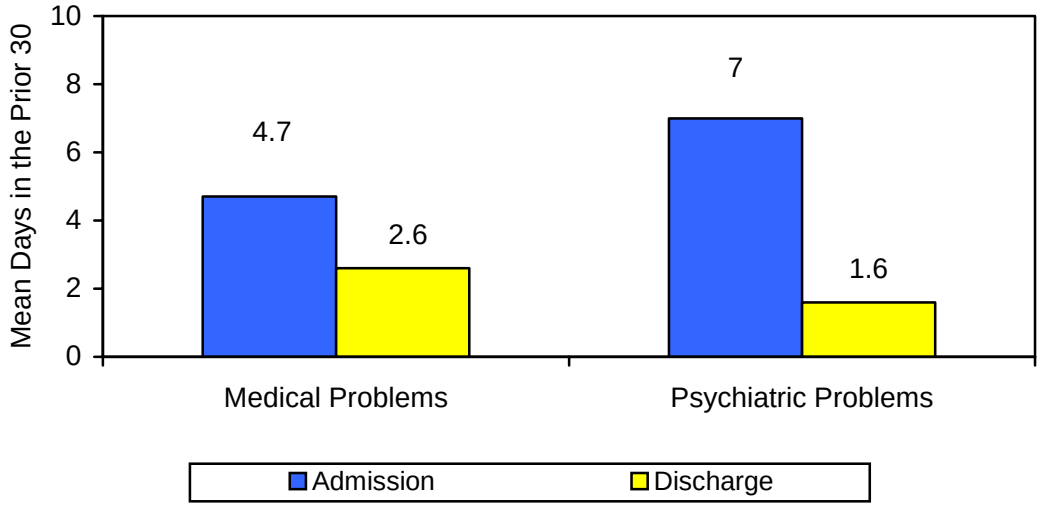
In regard to the short-term outcome for employment (Figure 5.20), GR participants showed considerable improvement: Full-time employment increased 7.5 times and part-time increased 2.5 times.

Figure 5.21
Reduction in Mean Days of Injected Drug Use for General Relief Participants



There was a decrease of 87% (2.6 days) in the mean number of reported days of injected drug use by the GR participants after treatment.

Figure 5.22
Reductions in Mean Days of Medical and Psychiatric Problems for General Relief Participants



The mean number of days for which the GR participants reported medical problems declined by 45% (1.9 days) and there was also a decline of 77% in the mean number of days (5.4 days) of psychiatric problems for this group. The reduction in days of psychiatric

problems may be attributed to the similar reduction in the number of days of methamphetamine use. Research indicates that high use of methamphetamine (methamphetamine intoxication) produces adverse, but usually temporary, effects on one's mental health (Tetesu, S., 1970) resulting in paranoia and hallucinations. It is therefore conceivable that the reduction in methamphetamine use would coincide with a reduction in mental health problems.

In conclusion, GR participants showed reductions in AOD use and in the mean number of days of problems in areas other than substance use. There was an interesting, and at this time, unexplained finding with this group (e.g., increased marijuana use) which will have to be examined in future reports to ascertain its meaning.

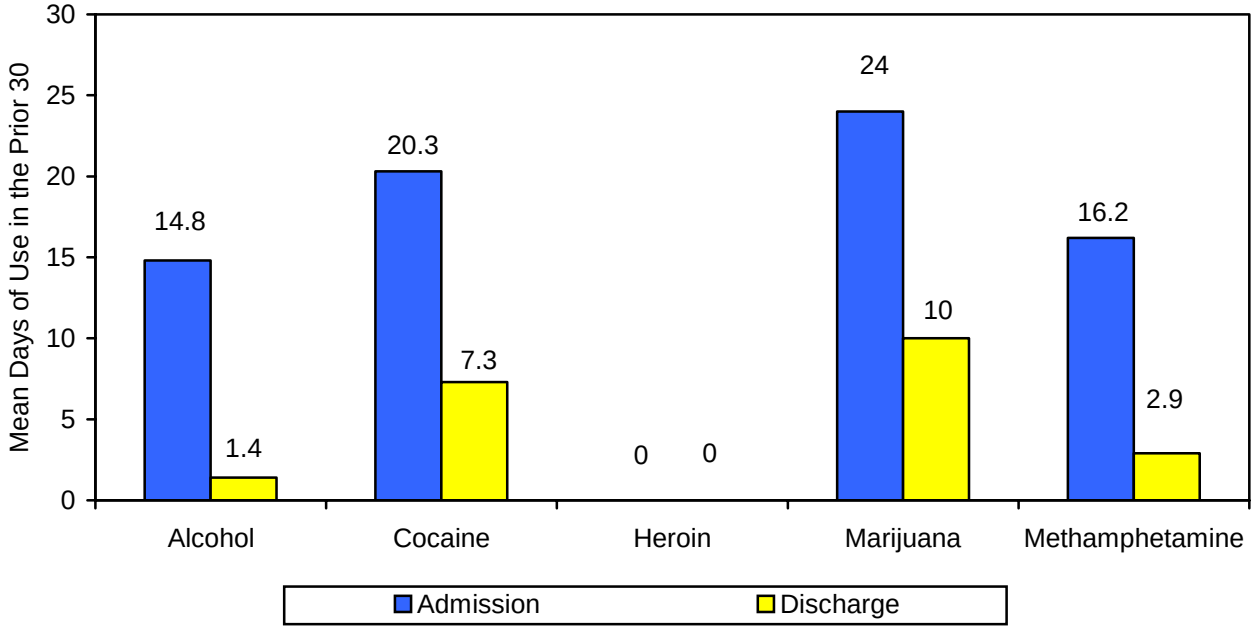
CalWORKs Participants in Treatment

The national welfare reform program, Temporary Assistance to Needy Families (TANF), was adopted in California and renamed the California Work Opportunity and Responsibility to Kids (CalWORKs) program. This program provides funding to counties for supportive services, such as mental health care, assistance to victims of domestic violence, and AOD treatment. The main goal of these services is to remove barriers to those trying to obtain and retain employment. During intake, orientation, and employment assessment, CalWORKs recipients are pre-screened for AOD problems. Participants who report or are found to have an AOD problem are referred for assessment, and are required to participate in AOD treatment as a condition of their continued receipt of CalWORKs benefits (ADPA, 2001).

Of the study population examined for this report, 9.3% were CalWORKs recipients (n = 883). Of that group, the majority (90.3%) was female; the mean age was 32.7 years, which is younger than the mean age found for the entire study population (39 years). This may be due to the fact that this group had dependent children. The racial breakdown was similar to that found for the entire study population (see Page 12). The primary program type for this group was DCH (49.9%); however, a significant proportion was also found in OC (35.6%). The distribution of CalWORKs participants across Los Angeles County was varied. The majority was found in SPA 1 (49.3%), with approximately equal distributions found in SPAs 2, 3, and 6-8. The fact that there were no CalWORKs participants found in SPAs 4 and 5 is a reflection of the distribution of DCH programs. The DCH programs in SPA 1 are well established, which would explain the high numbers. There are few DCH programs in SPA 4 and no DCH programs in SPA 5.

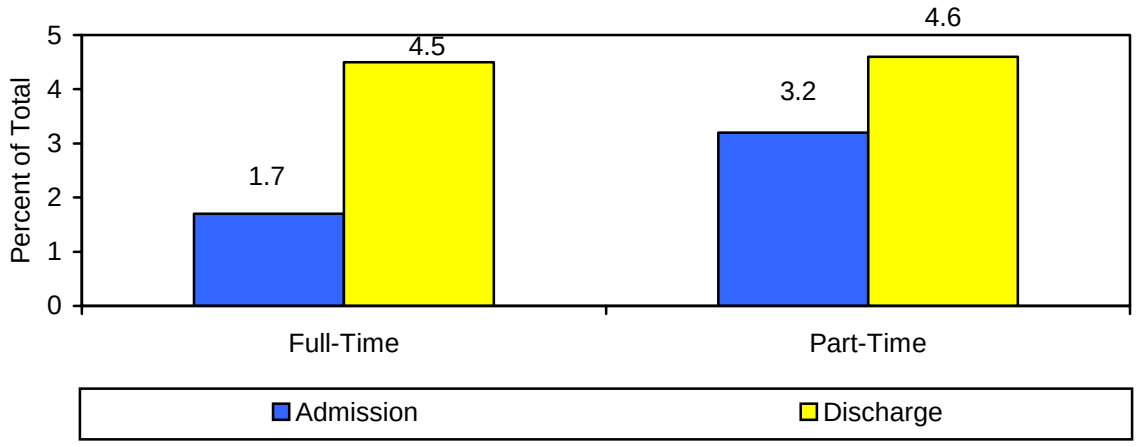
This first figure shows the participants' substance use histories for the 30 days prior to treatment admission and the 30 days prior to discharge (or the period during treatment).

Figure 5.23
Reductions in Mean Days of Alcohol and Drug Use for CalWORKs Participants



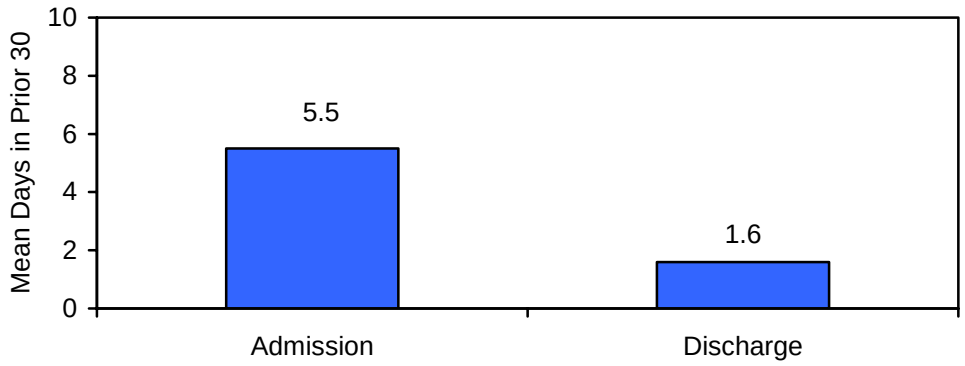
As demonstrated by the figure above (5.23), there were significant declines (58%-90% or 13 to 14 days) in all drug categories in the number of days of reported AOD use in the prior 30. This group did not report the use of any heroin either at admission or at the time of discharge.

Figure 5.24
Improvements in Employment for CalWORKs Participants



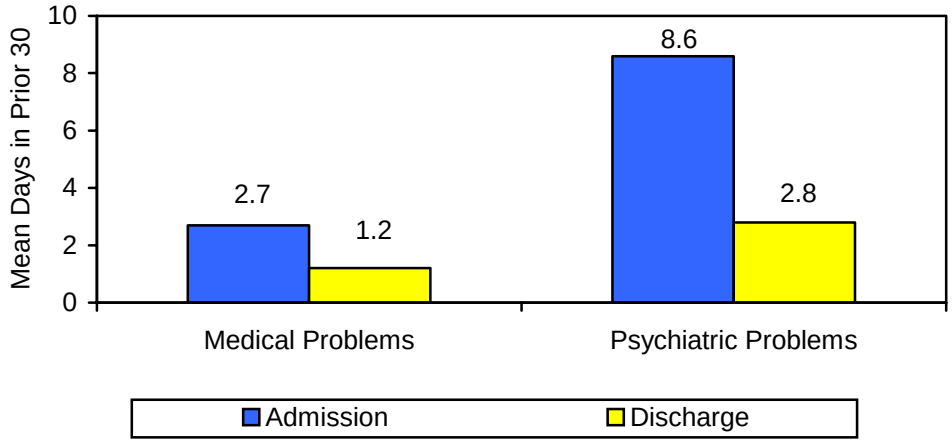
In regard to the short-term outcomes, this group had improvement in the area of employment: full-time employment increased 2.5 times and part-time employment increased 44%.

Figure 5.25
Reduction in Mean Days of Family Conflict for CalWORKS Participants



Mean days of family conflict (Figure 5.25) were reduced by 71% (3.9 days).

Figure 5.26
Reductions in Medical and Psychiatric Problems for CalWORKs Participants



The number of days for which the participants reported medical problems declined by 55% (1.5 days) and the number of reported days of psychiatric problems decreased by 67% (5.8 days).

CalWORKs participants, like the GR participants, produced very positive outcomes. In some cases, the outcomes for these groups were better than those found for the other special populations.* For example, the GR participants' reduction in heroin and methamphetamine abuse and the reduction in the use of alcohol and methamphetamine for CalWORKs participants were greater than what was found for the other special populations. This may be due to the fact that receipt of their respective assistance is contingent upon their continued participation in substance abuse treatment.[4] Furthermore, CalWORKs participants also showed improvements in other areas such as employment, family conflict, and psychiatric problems. And although the increase in employment for the CalWORKs group was not as large as was found for some of the other groups, there was an increase.

[4] Neither GR nor CalWORKs recipients are in danger of losing their assistance if they are found to be or admit to be under the influence of alcohol or other drugs; nor are CalWORKs participants in danger of losing custody of their children, unless the use of drugs or alcohol produces an imminent danger for the child or there is a report of neglect or abuse made against the substance abusing parent; thus, the use of drugs or alcohol, in and of itself, is not sufficient cause for the removal of the child from the home.

CHAPTER SUMMARY

Overall, all of the special population groups showed improvements (i.e., reductions) at discharge from treatment in the number of days of drug use (with one exception, GR participants and their reported use of marijuana) that were comparable (within 1-2 days) to or better than the reductions found for the overall study group. Findings for the other outcome areas (employment, reductions in the mean days of problems) also showed improvements, in some cases more improvement than that found for the study population. This indicates that the ADPA-funded AOD treatment system in Los Angeles County is doing a good job at treating the AOD use behaviors and other problem areas of these special populations. Furthermore, with a few (explainable) exceptions, the representation of these special populations across the SPAs and treatment program types was as expected (i.e., homeless were found mainly in RS, CalWORKs participants were found mainly in DCH) indicating that the data used in this report is accurate and representative of those groups.

There are two major points regarding the information presented on the special populations. First, although NIDA (2001) indicated many areas where there was evidence of health disparities concerning AOD treatment, the current report does not find significant differences in many areas that would indicate the presence of treatment disparities. And second, while there are apparent and marked reductions in the problem areas covered by the outcome measures included in this report, these findings do not completely represent the entire county. Additional information must be gathered from the treatment programs and from the participants to ascertain which aspects of treatment worked best for their given problem areas. This information would also allow for the evaluators to ascertain what worked in the treatment of the special populations in order to pass this information along to other AOD programs that treat these groups.

The Los Angeles County ADPA-funded AOD treatment system has a difficult and demanding task in addressing the needs of the diverse individuals who seek treatment. As indicated by this chapter, the treatment providers are doing a remarkable job at addressing not only the AOD-use treatment problems, but also many of the additional medical and psychological needs evidenced by these special populations.