



King County

**Mental Health, Chemical Abuse
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December 9, 2008

TO: Chemical Dependency Prevention and Treatment Adult and Youth Providers

FM: Jim Vollendroff, Assistant Division Director/CD Prevention and Treatment Coordinator,
Mental Health, Chemical Abuse and Dependency Services Division

RE: Chemical Dependency Performance Indicator Report, January-June 2007

Dear Stakeholders:

I am pleased to present the King County Chemical Dependency Performance Indicators Report (CDPIR) for the period of January 1 – June 30, 2007 (see enclosure). This report provides information about components of the chemical dependency prevention and treatment delivery system funded by King County. The system serves adults and adolescents who do not have adequate resources to pay for treatment and support services.

Changes to the format and content to this report occur when we make changes to the system, or identify ways to make the report more meaningful to its readers. The report is prepared on a semi-annual basis and each report includes the most recent six months of data available. Data from current reports is compared to data from previous reports in order to identify trends, successes, and areas of concern.

The CDPIR includes

- Data for a three year period for each program funded by MHCADSD;
- Summary program and demographic data for the most recent calendar year;
- Appendices that provide detail about the data, define terms used, and list the agencies that provide the programs and services included in this report.

As I look back over this report, I am amazed by the growth of the chemical dependency system over the past few years. Growth in and of itself isn't always a good thing, so monitoring system performance through this report and other methods informs us if our services provide the intended impact on the clients we serve. I welcome your feedback about the usefulness of the report, its content, and the format we use to display and discuss the data.

JV:ran

Enclosure



Mental Health, Chemical Abuse and Dependency Services Division

CHEMICAL DEPENDENCY PERFORMANCE INDICATORS REPORT

January – June 2007

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Executive Summary

The following summarizes findings from the current reporting period, and when relevant, compares these findings to those from preceding reporting periods.

Prevention programs: These address risk and protective factors known to reduce the likelihood that youth will abuse alcohol and other drugs. The utilization patterns for many prevention programs show that the highest periods of activity coincide with school calendars because many youth programs are held in schools. For the past three years, an increasing percentage of prevention programs have reflected “best”, “promising”, and “innovative” practice models, which are important factors for increasing the probability of positive long-term outcomes for at-risk youth. For this reporting period in excess of 90% of program participants were provided with best, promising and innovative practices.

For the period January – June 2007, 1,659 individuals participated in multi-session prevention programs, which is nearly 700 more than the number served in the second half of 2006. Since the current report is a six month period when school was in session, greater participation could be expected. In the four most recent reporting periods, programs that target “early initiation of problem behaviors” that can lead to illegal use of drugs and alcohol had by far the greatest number of participants.

Alcohol/Drug 24-Hour Help Line: Calls to the Help-Line often result in the caller being offered several referrals. For the six biennial quarters ending with the first half of 2007, there is a steady increase in the number of referrals made to outpatient treatment and a corresponding decline in referrals made to self-help groups. This shift may reflect the state Division of Alcohol & Substance Abuse (DASA) enhancing access to outpatient treatment by paying for expanded services.

Emergency Services and Sobering Center: In each of the previous five biennial quarters, there was a decline in the number/percent of people transported by the Emergency Services Patrol to the Sobering Center. However, during the first half of 2007, there was approximately a five percent increase in transports to this site and a corresponding decrease in transports to the 1811 Program. This turnaround might reflect capacity issues at the 1811 program. This residential program (a supported living residential program that does not require sobriety for its residents) began in 2006, and during its first year of existence it provided a new alternative to the Sobering Center for certain clients.

For the three biennial quarters preceding the current report, there was a dramatic decline in visits to the Sobering Center. In the first half of 2005, there were 12,262 visits, but only 8,754 in the second half of 2006. However, this trend was reversed in the first half of 2007 when there were 11,235 visits. While it's too soon to predict a trend, it could be that individuals with many repeat visits are impacting the absolute number of visits.

Detoxification Center: There was a slight increase in both the number of admissions and the number of unduplicated people using these services during the first half of 2007, but there is still

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an overall decline since the first half of 2005 when one of the detoxification centers in King County closed. Ever since the first half of 2004, the proportion of those who identify alcohol as their drug of choice has grown, while the proportion of those who choose opiates has declined. When individuals are released from the Detoxification Center, the majority of referrals are made to self-help groups (nearly 60 percent), with outpatient treatment receiving the second highest number of referrals (approximately 20 percent).

Involuntary Commitment Services: The number of referrals has grown steadily since the second half of 2005 (approximately 150) to the first half of 2007 (nearly 200). During the current report period, approximately 40 individuals were placed at Pioneer Center North where intensive inpatient services are provided in a secure setting.

Outpatient Treatment – Youth: While the number of open cases has declined since the second half of 2004 (approximately 900 compared to 780 in the first half of 2007), the number of youth retained in treatment has steadily increased to roughly 470. The net effect is a smaller gap between the number of new admissions and the number of youth in ongoing treatment. While there has been a slight decline, the vast majority of youth admitted to treatment identify marijuana as their drug of choice, followed by a significantly smaller portion who identify alcohol. Completion rates are an outcome of significant importance for King County. For the third consecutive quarter, the percentage of youth completing treatment has declined (from approximately 62 percent to 55 percent). Excluding King County, the statewide completion rate in the first half of 2007 was 42 percent compared to 56 percent for King County.

Outpatient Treatment – Adults: Since the second half of 2004, the number of adults newly admitted and the number of adults in treatment has grown steadily. While alcohol is identified as the drug of choice by the majority of adults, there is a slight increase in those who identify cocaine. Over 60% of youth identify marijuana as their drug of choice while just 12% of adults identify marijuana in the first half of 2007. The proportion of adults who did complete treatment is less than those who did not complete treatment over six consecutive biennial quarters. The statewide completion rate for the first half of 2007 was 46 percent compared to 42 percent in King County.

Opioid Treatment: There has been a slight decline in the number of new admissions to opioid treatment for four consecutive biennial quarters. However, because people often stay in opioid treatment for extended periods of time, the number of those served has grown since the previous quarter.

Chemical Abuse and Dependency Programs

Prevention

The target populations for drug and alcohol prevention programs are children, youth and parents. Programs are designed to prevent or delay first use and abuse of alcohol and other drugs by reducing risk factors and enhancing protective factors.

Through a required public process, four risk and protective factors were targeted for action in King County during the period of July 2003 through June 2005. One of these was dropped and another added for the period of July 2005 through June 2007. The five factors targeted during the three years covered in this report are:

- Favorable attitudes among youth that encourage substance use (risk factor)
- Family management problems due to inconsistent guidelines for behavior and inappropriate rewards and consequences for following and not following guidelines (risk factor)
- Warm, supportive relationships with parents, teachers, other adults and peers (bonding) who reinforce competence, expect success and support not using alcohol, tobacco or other drugs (protective factor)
- Healthy beliefs and clear standards that oppose teenage use of illegal drugs and alcohol (protective factor)
- Early initiation of the problem behavior (risk factor)

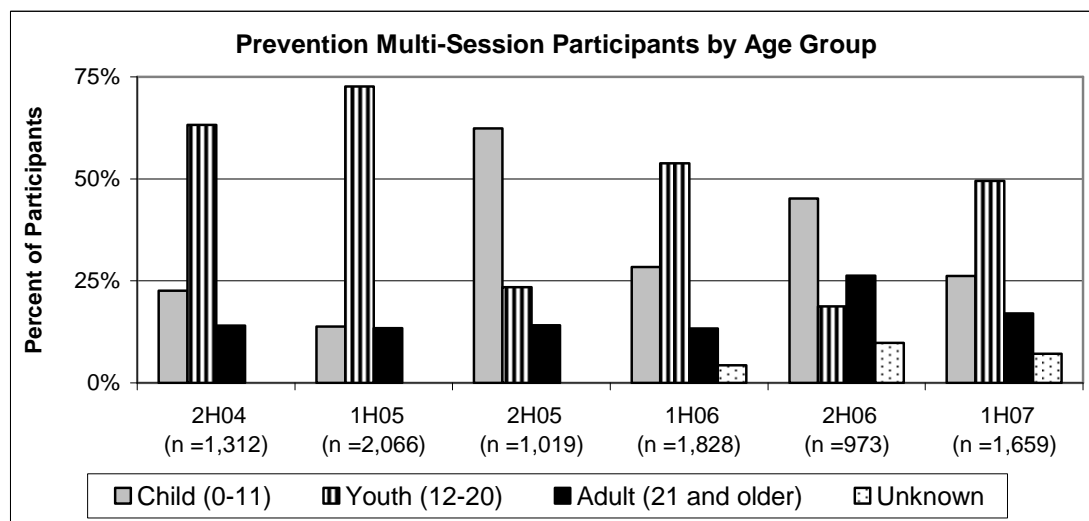
Risk and protective factors are addressed through single event or multiple session programs.

Single event programs during January through June 2007 were:

- Mentoring and school/community-based events developed and sponsored by youth targeting bonding reached 22,386 youth.
- A community prevention coalition targeting early initiation of the problem behavior reached 248 youth and adults.

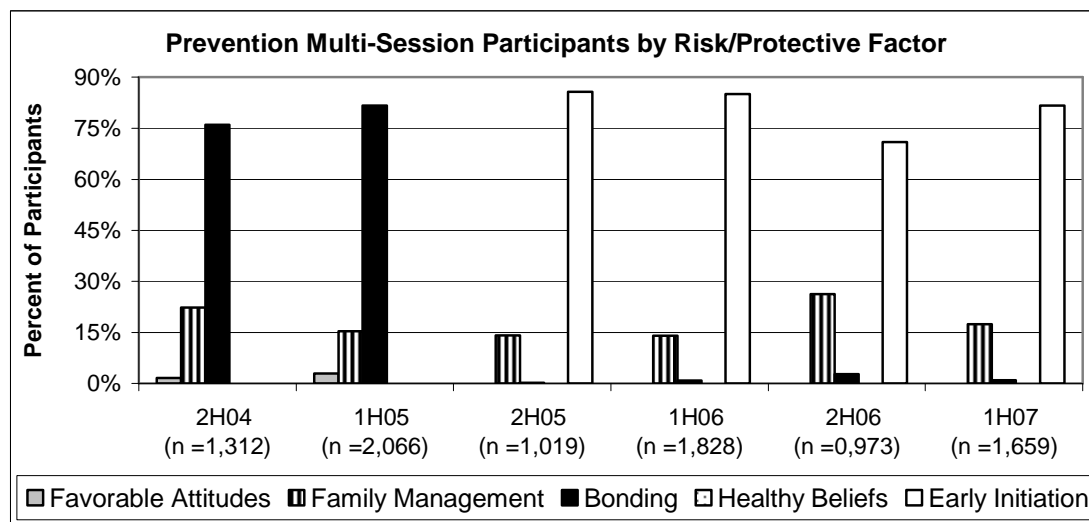
Prevention programs that have a multiple session format, such as skills training classes or support groups, collect demographic data about participants. Only multi-session programs are included in the following graphs.

The following graph shows the number of participants by biennial quarter and age group.



The large changes above in the relative proportions of the Child and Youth age groups reflect programs based on the school calendar as well as biennial changes in the targeted factors.

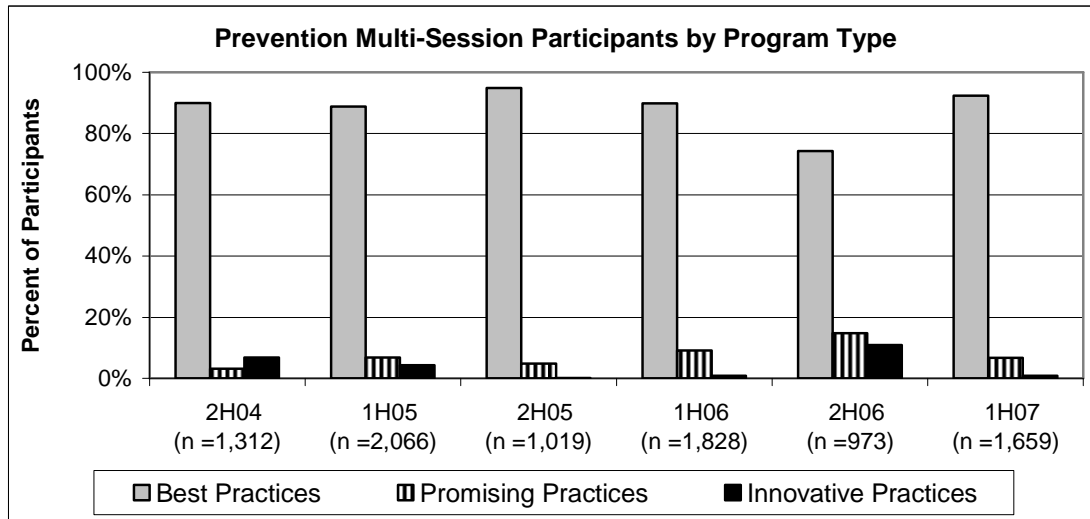
The following graph shows the number of participants by the risk or protective factor that is targeted by the program.



As with age groups, the changes above in the percentages of risk factors result from biennial changes in the targeted factors and the fact that many prevention programs are scheduled in conjunction with the school calendar.

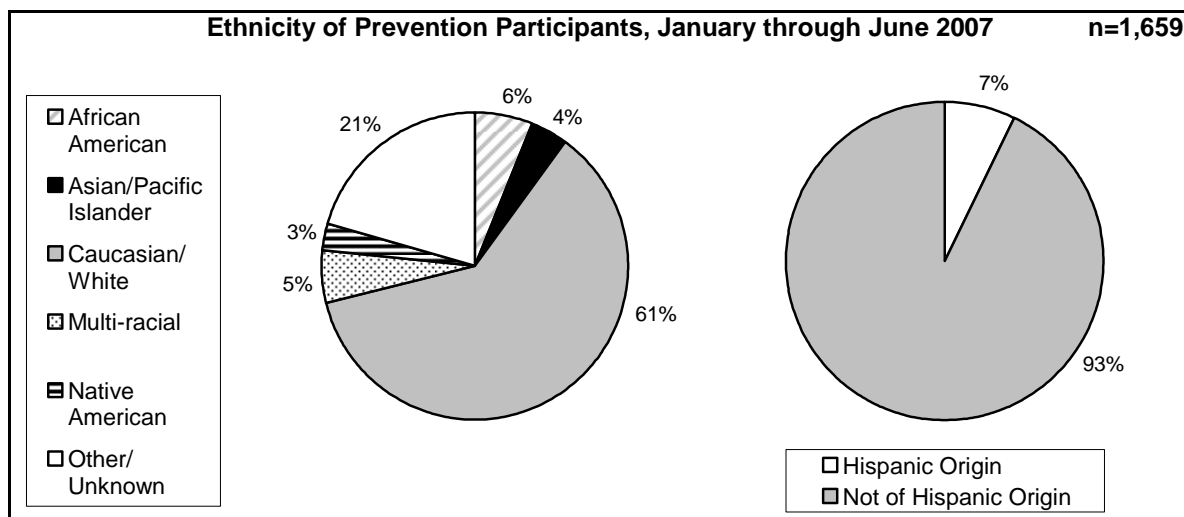
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Research has validated the effectiveness of some prevention efforts while others have not been evaluated yet. Applying this research, programs funded in King County are categorized as “best practices”, “promising practices” or “innovative practices”. The following graph shows the number of participants by biennial quarter and program type.



The results above show continued focus on prevention methods that have been demonstrated to be effective. The modest reduction in the number of participants reflects programs based on the school calendar as well as differences in the mix of services during the time period.

The charts below show the ethnicity of people who participated in multi-session prevention programs from January through June 2007.

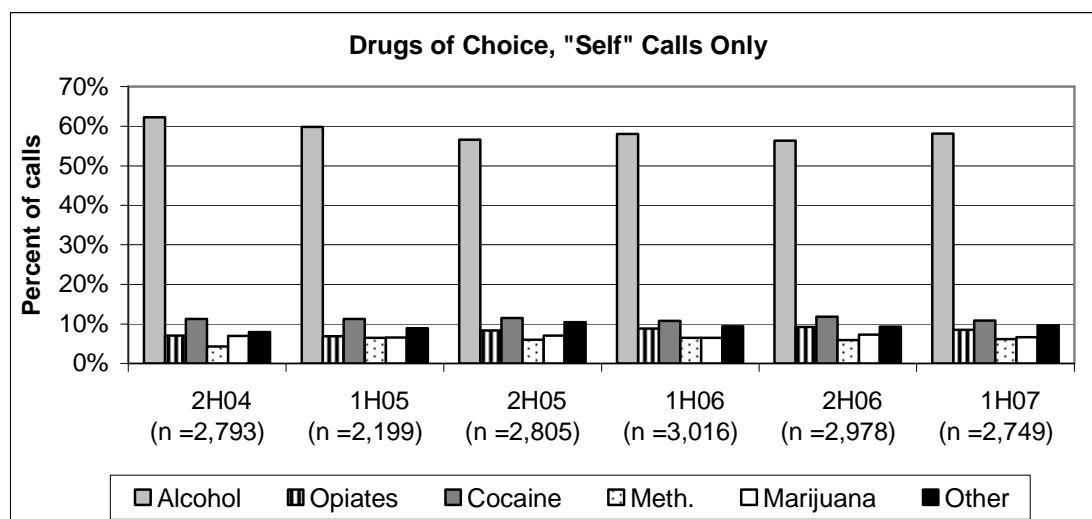


Alcohol/Drug 24-Hour Help Line

The Alcohol/Drug 24-Hour Help Line provides telephone crisis intervention and information and referral services.

Although the Help Line is a statewide service, data presented are limited to callers from King County. The Help Line responds to all calls for information about drug and alcohol use, regardless of caller eligibility for publicly funded treatment.

In the chart and table below, “Self” refers to persons who are calling about themselves, “Other” reports persons calling on behalf of another person. Because of concerns about accuracy with “Other” calls, “Drugs of Choice” data are presented for self calls only. More than one substance may be reported per call.



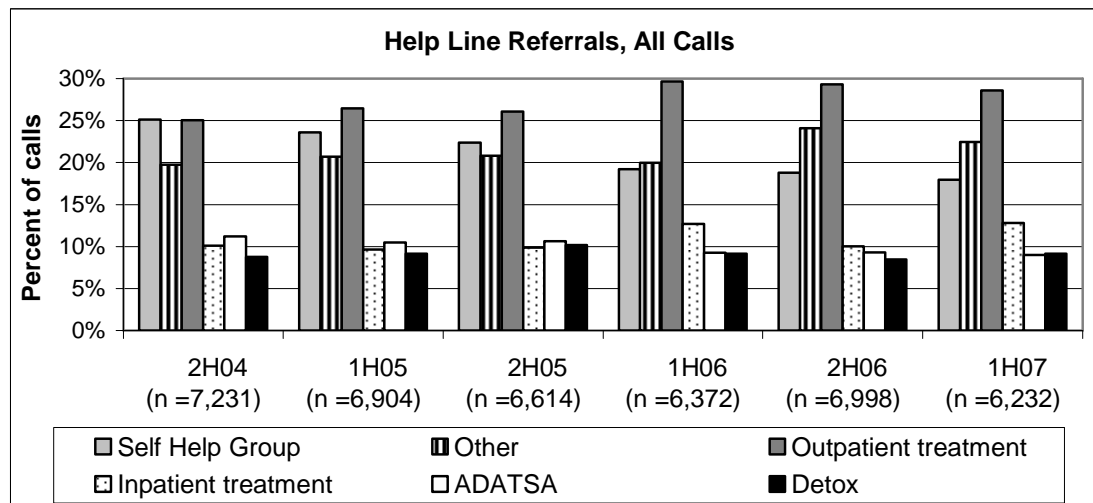
For the last five biennial quarters, prescribed pain pills have been 4-5% of drugs reported; those are included in “Other”. This is a small increase from previous biennial quarters and is consistent with recent drug trend reports for King County that indicate an increase in the use of Oxycontin and prescription methadone.

Although limiting the data to “Self” calls provides better information about substances being used by callers, 96% of those calls are about adult use (as shown in the table below). This means that the predominance of alcohol as the drug of choice primarily reflects adult use. Other data (see the Outpatient Youth and Adult drug of choice charts) suggest a significant difference between adult and teen drugs of choice.

Age of subject of call	Number of Calls Made By:			Percentage of Calls Made By:		
	Self	Other	All	Self	Other	All
Teens & younger	117	305	422	4%	19%	9%
Adults (20 - 60)	2,935	1,256	4,191	92%	78%	87%
Older adults (over 60)	146	46	192	5%	3%	4%
All ages	3,198	1,607	4,805	100%	100%	100%

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Referrals made by the Help Line are shown in the chart below. More than one referral may be made per call. "Other" includes referrals to medical, housing, domestic violence, legal, mental health, involuntary CD treatment, emergency and police resources. Referrals made to providers of outpatient chemical dependency treatment include both privately and publicly funded services.



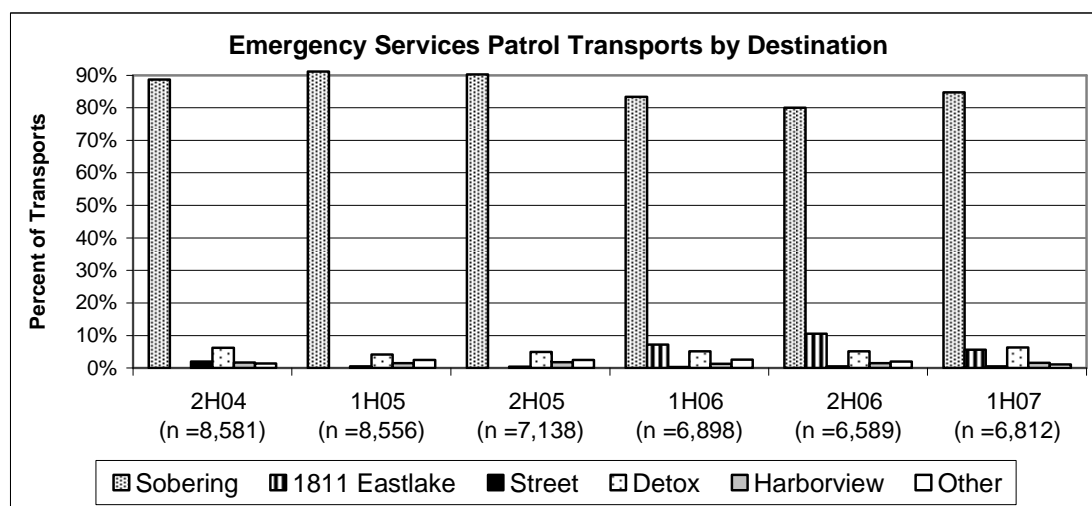
Through 2003, Self Help Group was the resource most frequently suggested. Since January 2005, more referrals have been made to CD outpatient treatment than to self help groups.

Although the total percentage for "Other" referrals is large, no single area represents more than 3% of all referrals.

Emergency Services Patrol

The Emergency Services Patrol (ESP) provides direct assistance and transport of intoxicated/incapacitated individuals to appropriate services and treatment from designated areas within the City of Seattle, 24 hours a day, seven days a week.

The chart below shows the number of individuals transported and the destination of each transport by biennial quarter.



Since 2004, there has been a notable decrease in the number of transports that reflects two significant changes.

From 2004 to 2005, total ESP transports decreased by 12% following reductions to the service hours and service area that were made to absorb a budget decrease in January 2005. Because continuing development in the downtown area has pushed people out of the reduced service area since 2005, this change may have continued to reduce transports in 2006.

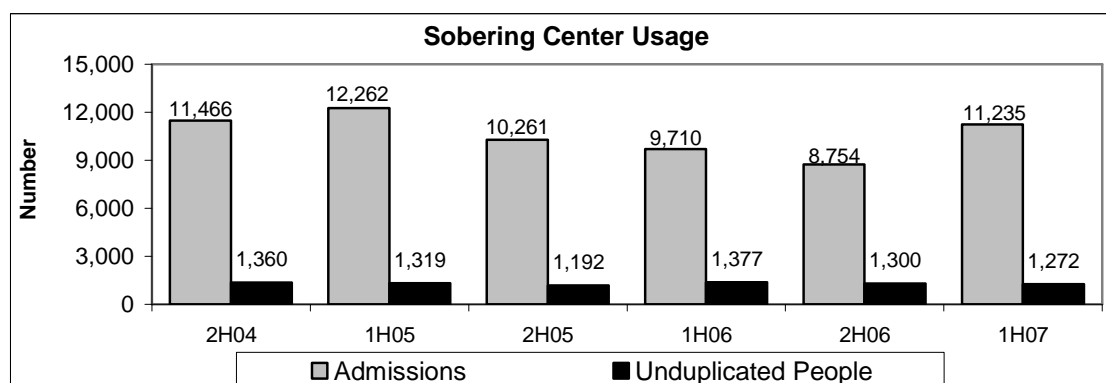
In 2006, a pilot housing program (1811 Eastlake) started that provides intensive case management and housing for chronic inebriates who may continue to drink, and many of the highest users of the ESP entered this program. Since then, 1811 Eastlake residents are transported to their home rather than the Dutch Shisler Sobering Center. This change is reflected in the graph in two areas: total transports, which decreased by 14% from 2005 to 2006, and transport destination with those to the Sobering Center decreasing from 91% to 82% while 9% of all transports were to the new 1811 Eastlake destination.

It is not possible to collect reliable demographic data about ESP clients. However, because a majority of transports are to the Dutch Shisler Sobering Center (Sobering Center), the demographic data from the Sobering Center provide a good approximation of ESP client demographics.

Dutch Shisler Sobering Center

The Dutch Shisler Sobering Center provides adults a safe and secure place to recover from the effects of acute intoxication by alcohol and/or other drugs. Clients receive a medical screening and are referred to treatment and other appropriate services.

The chart below shows the number of admissions to the Sobering Center and the number of unduplicated people who were admitted.

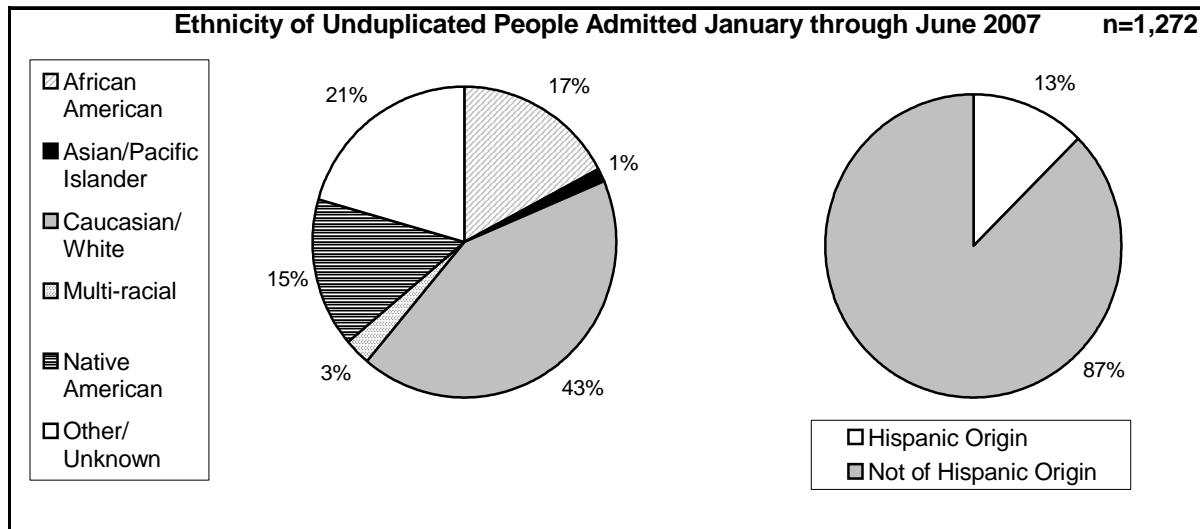


The decline in Sobering Center admissions between 2004 and 2006 reflects the decreases from budget reductions and the 1811 Eastlake project that were noted for ESP transports in the previous section. However, the large increase in admissions for January through June 2007 compared to the same period in 2006 cannot be explained as easily. It appears that as Sobering Center resources became more available, individuals appeared more frequently to use them.

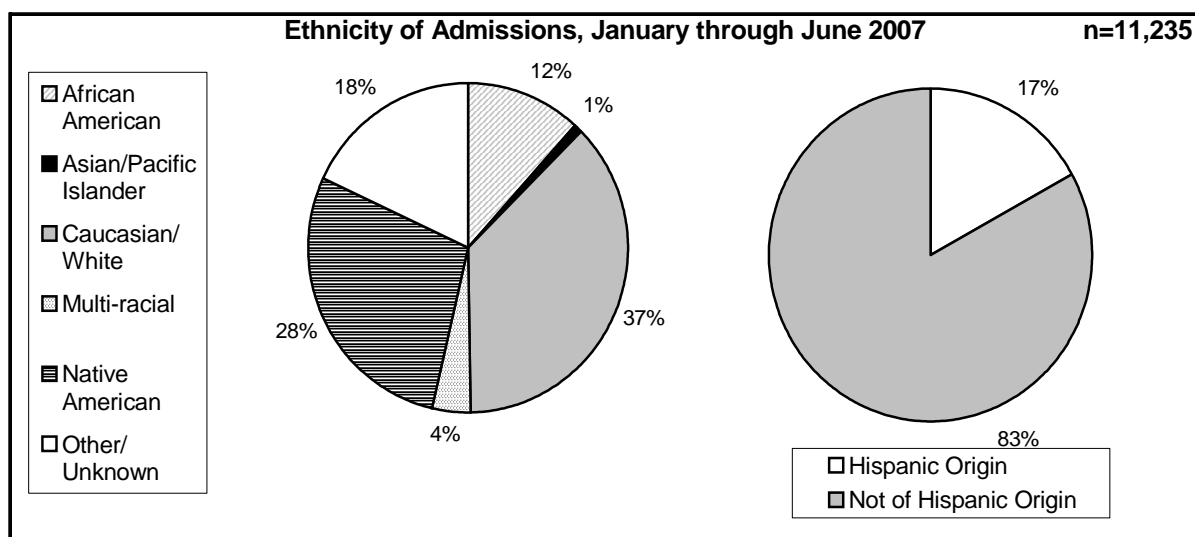
The data above show that some individuals are multiple users of the Sobering Center. In the last biennial quarter, 10% (125) of the 1,273 people admitted accounted for 64% of the total admissions. These 125 individuals averaged 58 admissions each during the six-month period, with a range from 25 to 162 admissions. After progress was made from 2005 to 2006 in getting high utilizers into supportive housing and treatment, new high utilizers are absorbing the excess capacity.

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The following charts show the ethnicity of unduplicated people served by the Sobering Center from January through June 2007. See Appendix A for additional details.



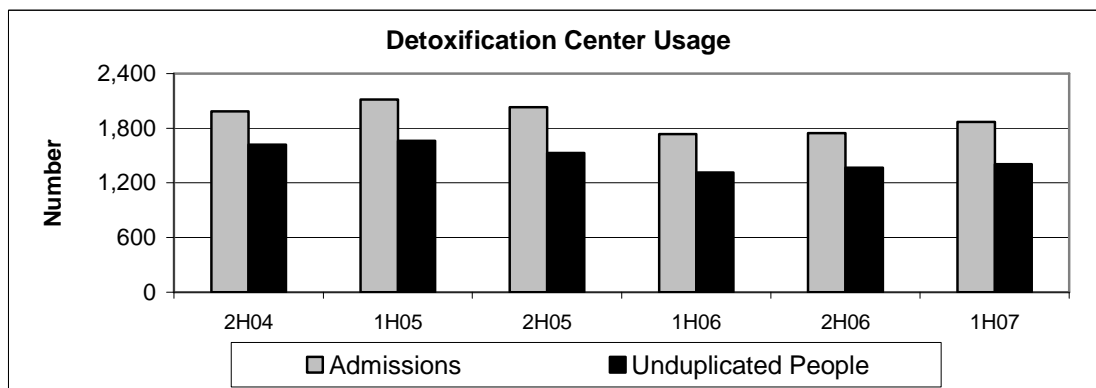
Among those admitted to the Sobering Center, the percentage who are Native American (15%) is much higher than the percentage in either the general population (2%) or in any other drug/alcohol program area (see Summary Data, Demographic Detail). In addition, a disproportionate number of the multiple users of the Sobering Center are Native American. Among those admitted more than five times in the last biennial quarter, 25% were Native American. As shown in the left charts below and above, 28% of all admissions to the Sobering Center are for Native Americans although they are only 15% of the individuals served.



Detoxification Center

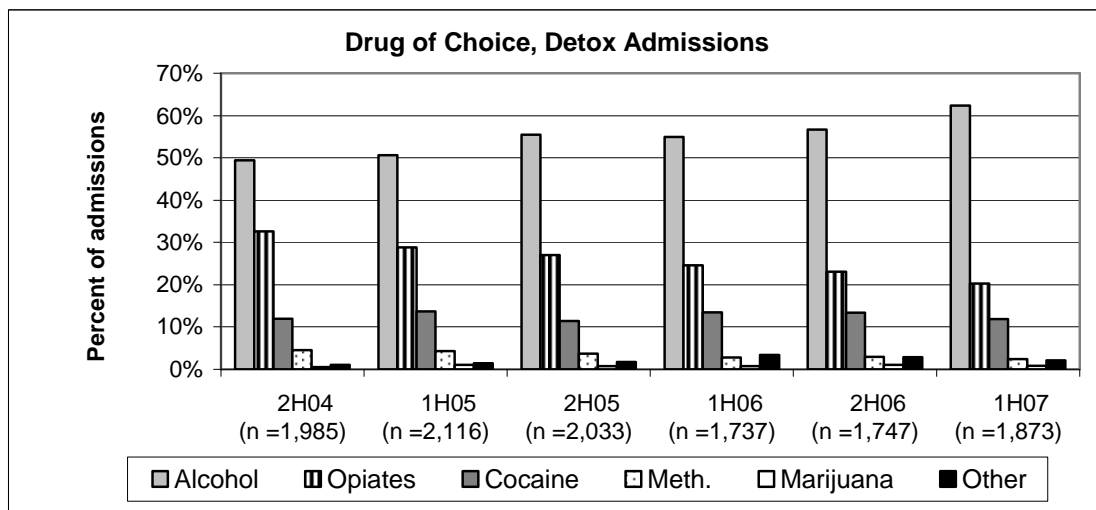
Detoxification services are provided to indigent clients who are recovering from the effects of acute or chronic intoxication or are withdrawing from alcohol or other drugs. Upon successful completion of detoxification services, clients are referred for ongoing treatment and support.

The chart below shows the number of new admissions to the Detoxification Center during each biennial quarter and the number of unduplicated people admitted.



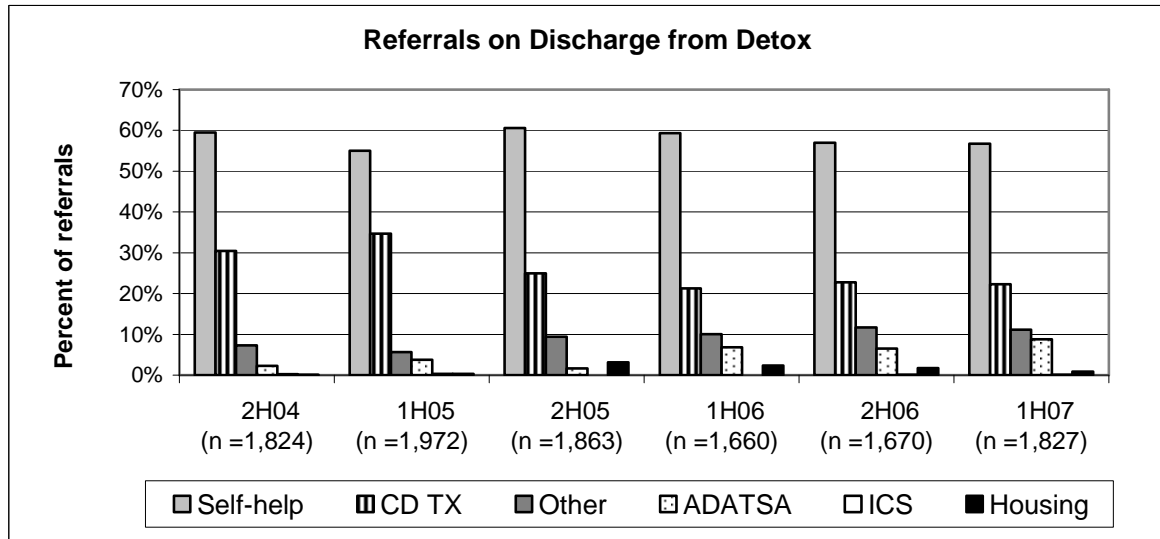
During 2004 and 2005, there were two detoxification facilities open. One was closed at the end of 2005, which resulted in the 2006 decrease in admissions and people served.

The following chart shows the primary substance used by people admitted to the Detoxification Center; this isn't always the substance for which detoxification is needed (see Appendix A for more information).

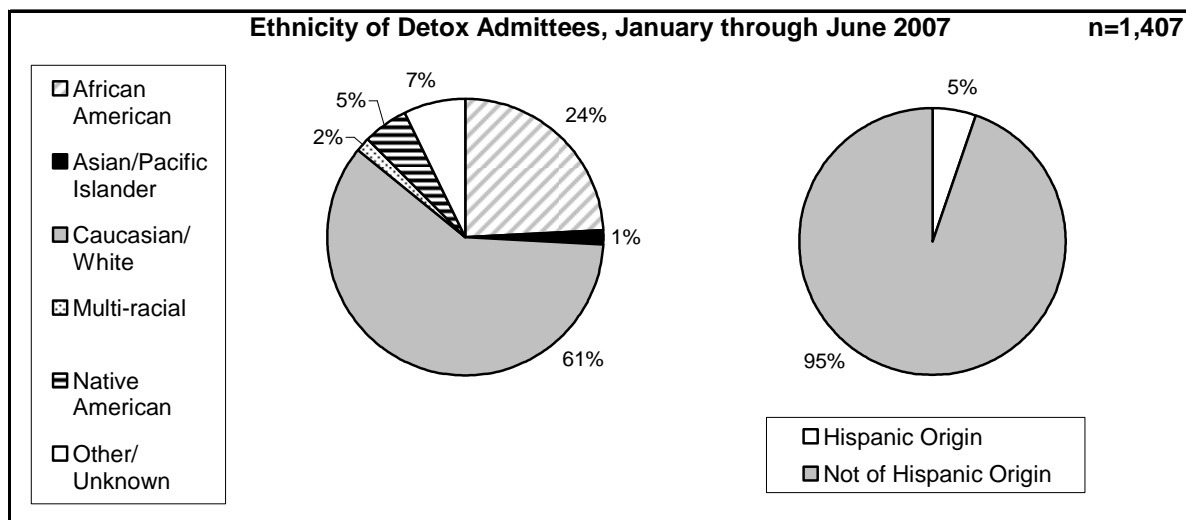


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The chart below shows the resources to which people were referred when discharged from the Detoxification Center, based on the biennial quarter of the discharge.



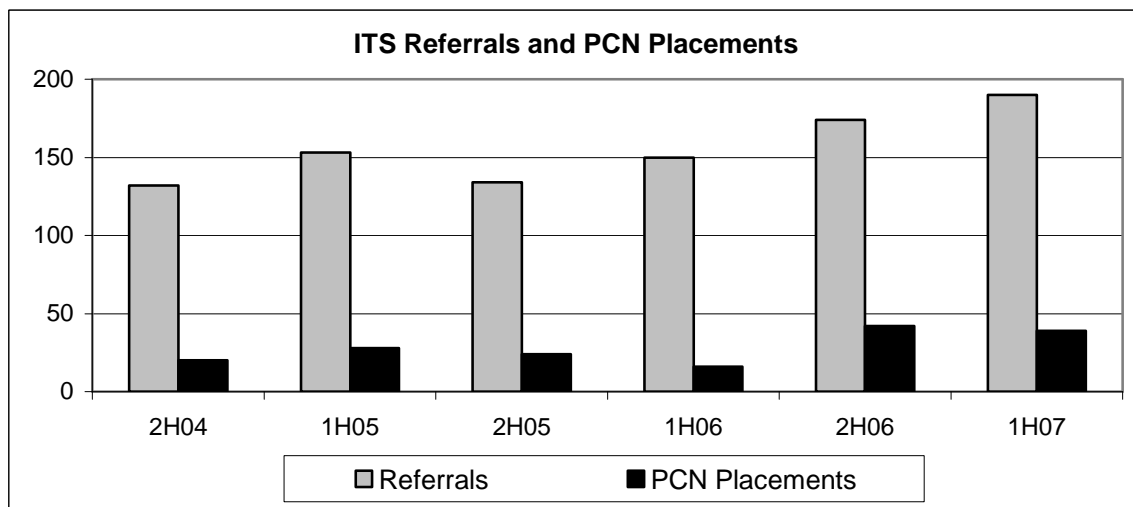
The charts below show the ethnicity of unduplicated people admitted to the Detoxification Center from January through June 2007. See Appendix A for additional details.



Involuntary Commitment Services

Involuntary Commitment Services (ICS) include investigation and evaluation of facts to determine whether a person is incapacitated as a result of chemical dependency. If a chemical dependency specialist determines there is reliable evidence to support a finding of incapacity, a petition for commitment can be filed on behalf of the incapacitated person. Courts can then commit a person to a locked treatment facility for intensive treatment.

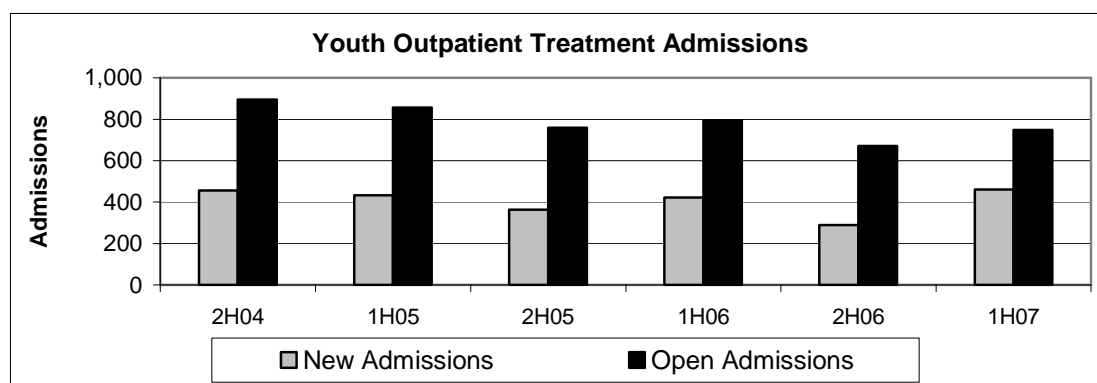
The following chart shows the referrals received by ICS for investigation and the number of commitments that resulted in a placement at Pioneer Center North (PCN) for inpatient treatment.



Outpatient Treatment – Youth

Outpatient treatment services for youth and young adults are targeted for low-income and indigent youth. Services include development of sobriety maintenance skills, family therapy or support, case management and relapse prevention. Services are expected to improve school performance and peer and family relationships and to decrease risk factors associated with substance use and abuse.

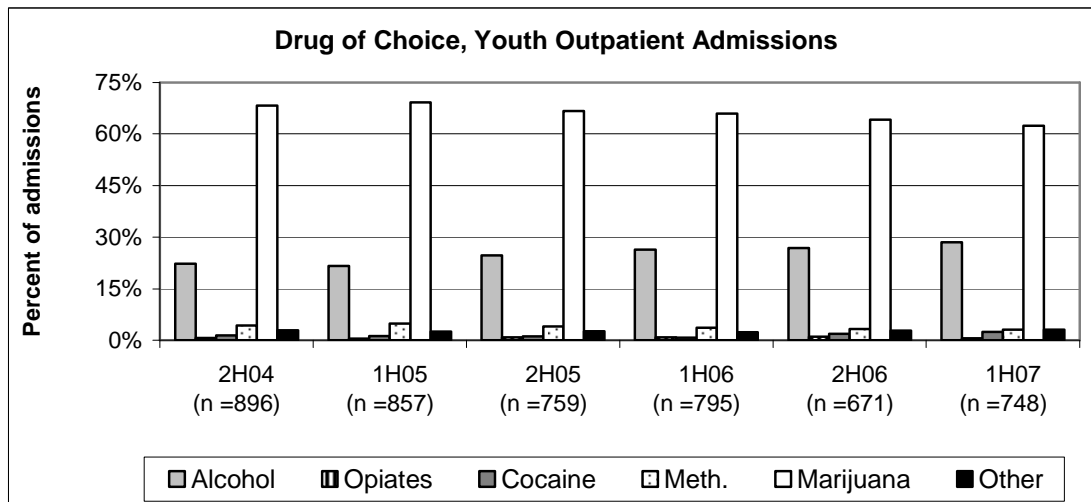
The following chart shows admissions to outpatient treatment for youth under 18. Both “new admissions”, which started during the biennial quarter, and “open admissions”, which include people who started treatment prior to the start of the quarter and were not yet discharged, are shown.



Historically, youth treatment admissions have fluctuated in relation to the school calendar because schools are a major source of referrals. Referrals, assessments and admissions have been lower in July, August and December and have been higher from January through June. However, a longer term decrease in admissions that emerged in 2005 continued through 2006. MHCADSD has identified several issues that have contributed to this trend including inadequate reimbursement rates, reductions in funding that supports school prevention/intervention specialists and a shortage of qualified youth Chemical Dependency Counselors. Working with providers, schools and DASA, we implemented several strategies to improve referral networks, review school drug and alcohol policies, address the shortage of qualified treatment staff, and increase vendor rates. There has been a small increase in admissions in the first half of 2007.

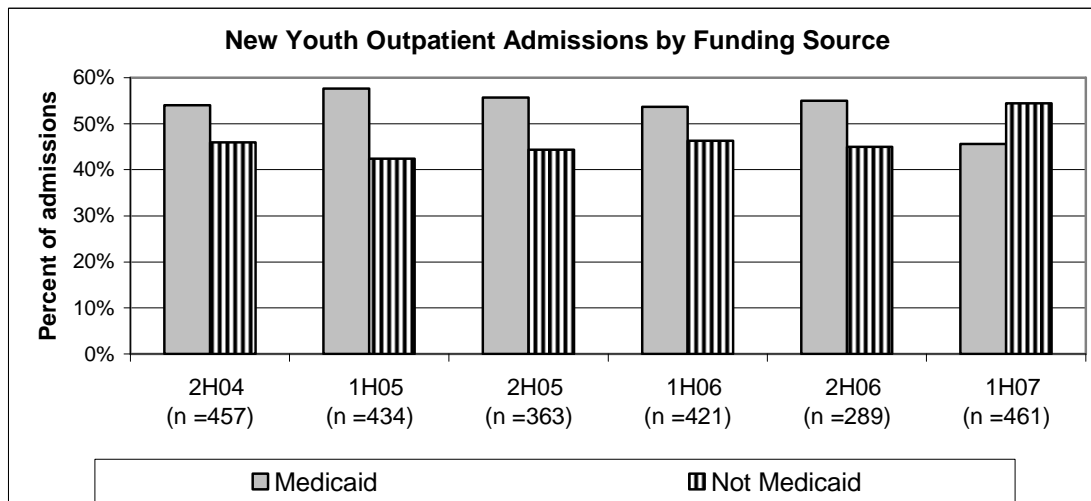
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The chart below shows the primary substance used by youth admitted to outpatient treatment.



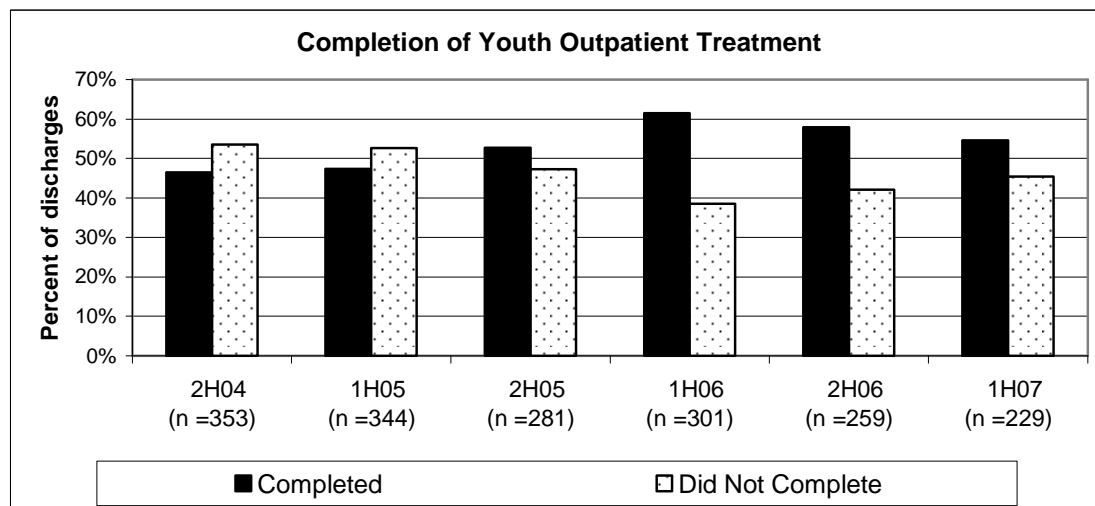
While the most frequently used drug among youth in treatment is marijuana, a significant—and increasing—percentage of youth are using alcohol.

The chart below shows the proportion of newly admitted youth each biennial quarter whose treatment is funded by Medicaid vs. other public funding.



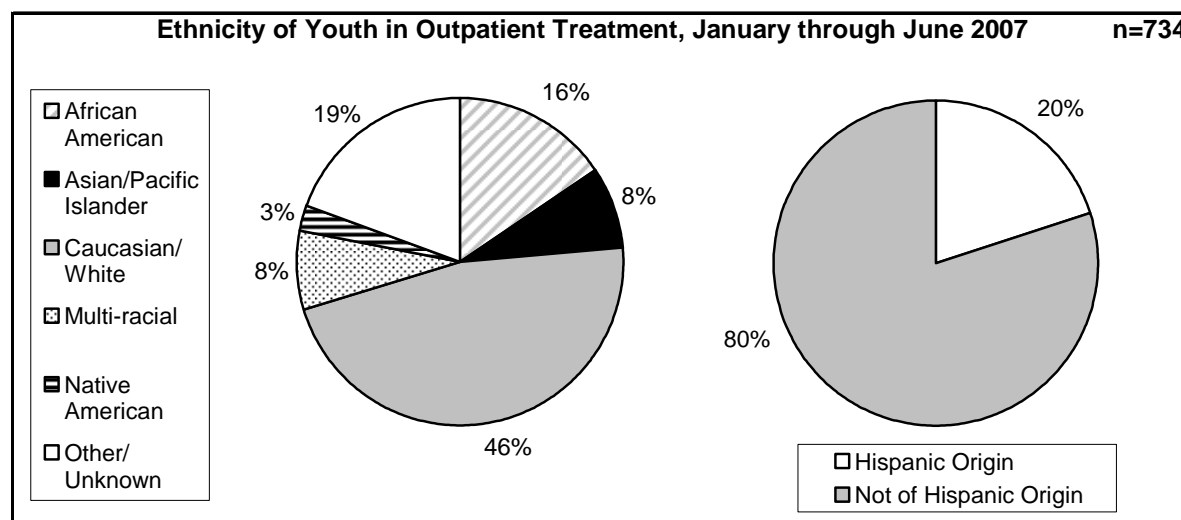
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The following chart shows rates for successfully completing treatment for youth who were discharged during the quarter. (See Appendix A for details on how the rate is determined.)



The statewide completion rate, excluding King County, for youth outpatient treatment for the first half of 2007 was 42% compared to 56% for King County.

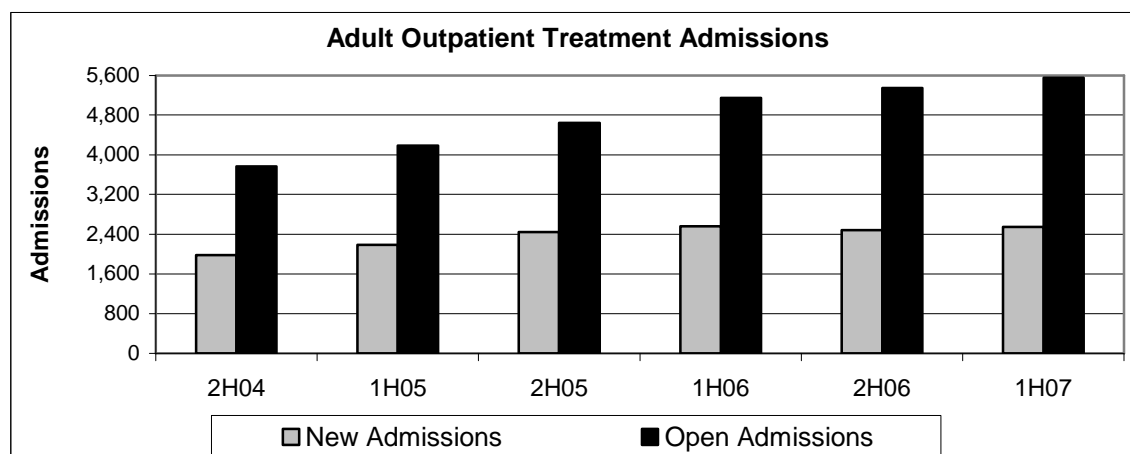
The charts below show the ethnicity of unduplicated youth receiving outpatient treatment from January through June 2007. See Appendix A for additional details.



Outpatient Treatment - Adult

Outpatient treatment services provide treatment to low-income and indigent adults who need treatment to recover from addiction to drugs and/or alcohol. Services are designed to assist clients to achieve and maintain sobriety, and can include individual face-to-face treatment sessions, group treatment, case management, job-seeking motivation and assistance, or other services, including referrals to appropriate service agencies.

The following chart shows admissions to outpatient treatment for adults, 18 and over. Both “new admissions”, which started during the biennial quarter, and “open admissions”, which include people who started treatment prior to the start of the quarter and were not yet discharged, are shown.

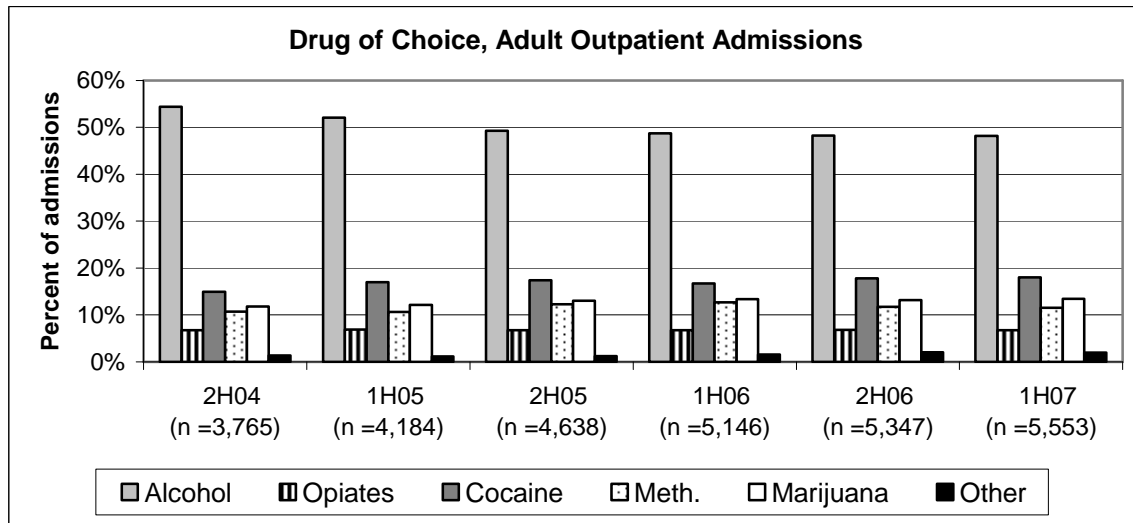


Additional funding to support treatment for more adults was allocated by the Legislature starting in July 2005 with an increase in July 2006. Federal funding for other services that support recovery also became available in 2005. As a result of these additional funds and of efforts by mental health providers to address the chemical dependency treatment needs of people who are receiving publicly funded mental health treatment, the numbers of people who are newly served increased steadily between July 2004 and early 2006 before leveling off at a higher number.

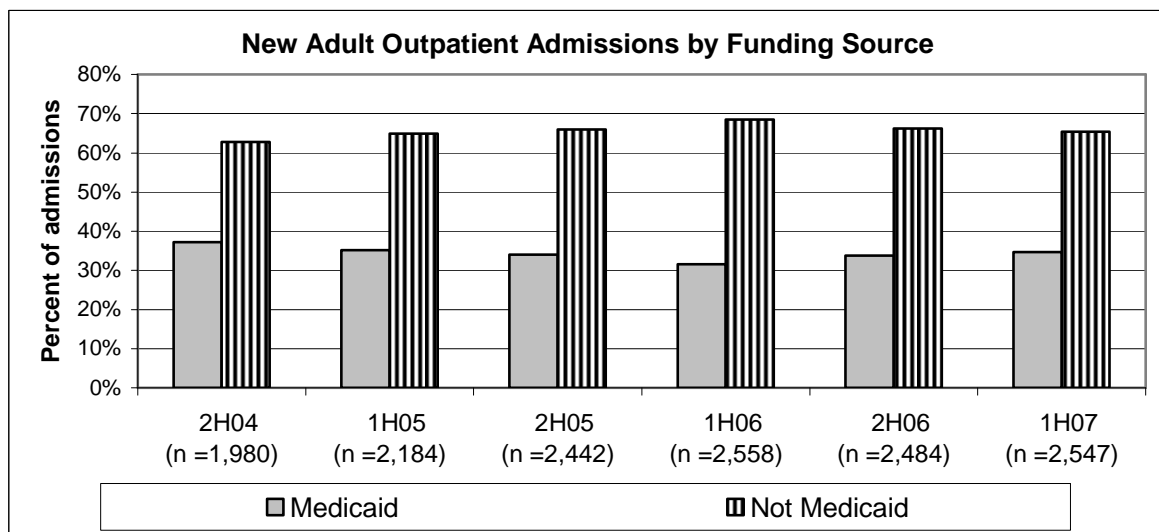
The total number of people in treatment has continued to increase since early 2006 because people are remaining in treatment longer. This longer treatment duration reflects the increased funding to pay for treatment and to meet other needs that can interfere with engagement in treatment, as well as the often longer-term treatment needs of people who receive chemical dependency services in addition to mental health services.

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The chart below shows the primary substance used by adults admitted to outpatient treatment.

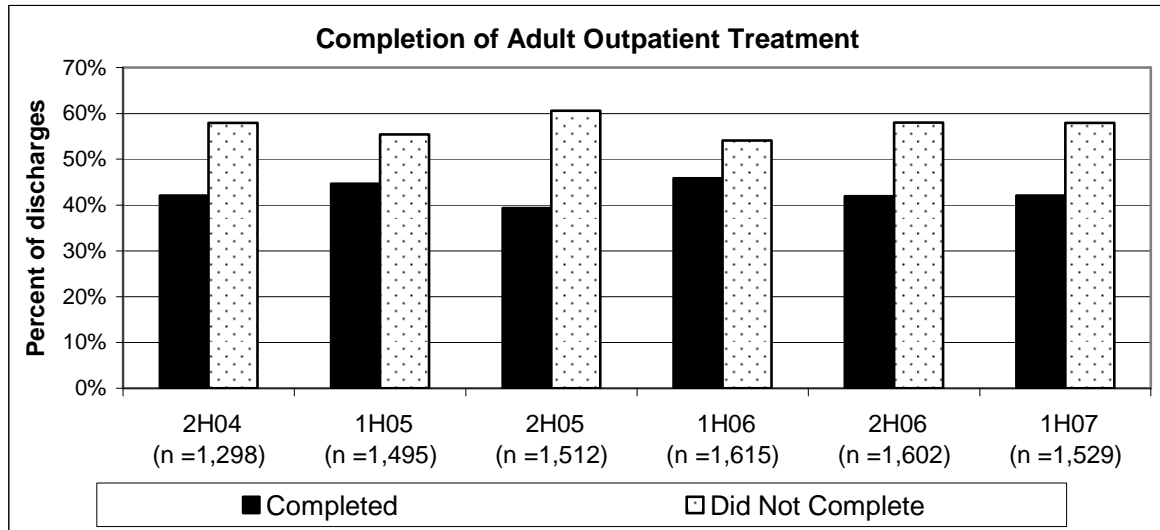


The following chart shows the proportion of newly admitted adults each biennial quarter whose treatment is funded by Medicaid vs. other public funding.



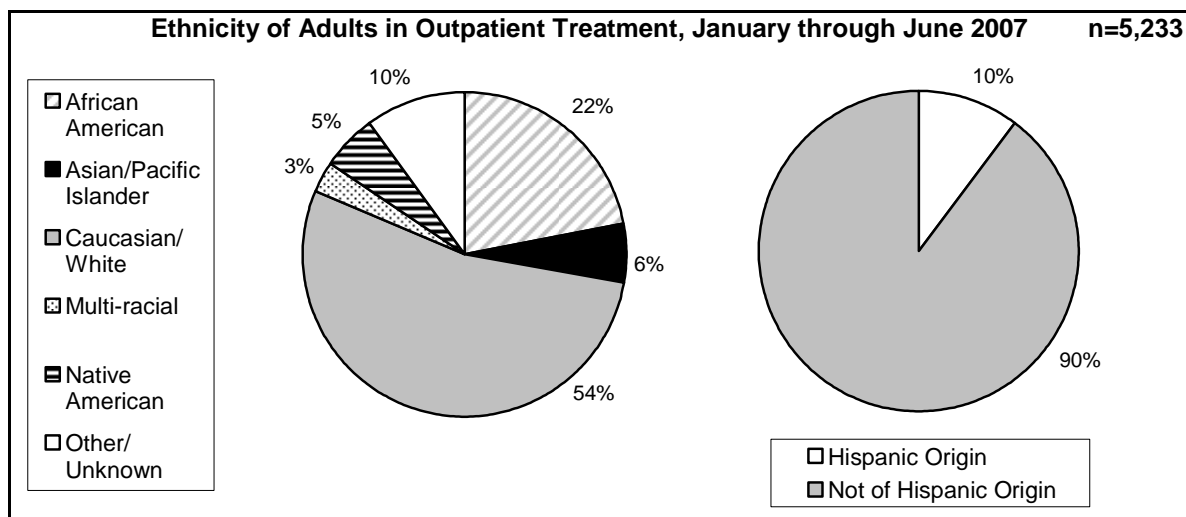
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The chart below shows rates for successfully completing treatment for adults who were discharged during the quarter. (See Appendix A for details on how the rate is determined.)



The statewide completion rate, excluding King County, for adult outpatient treatment for the first half of 2007 was 46% compared to 42% for King County.

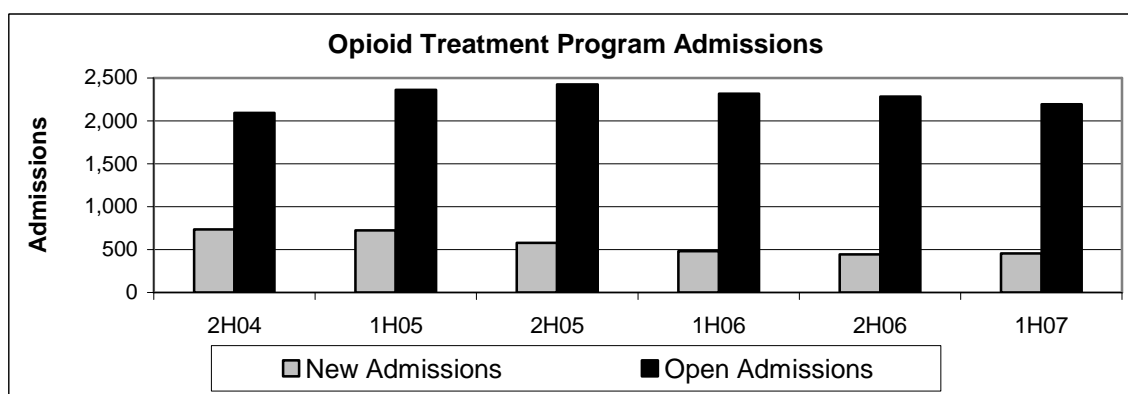
The charts below show the ethnicity of unduplicated adults receiving outpatient treatment from January through June 2007. See Appendix A for additional details.



Opioid Treatment Programs

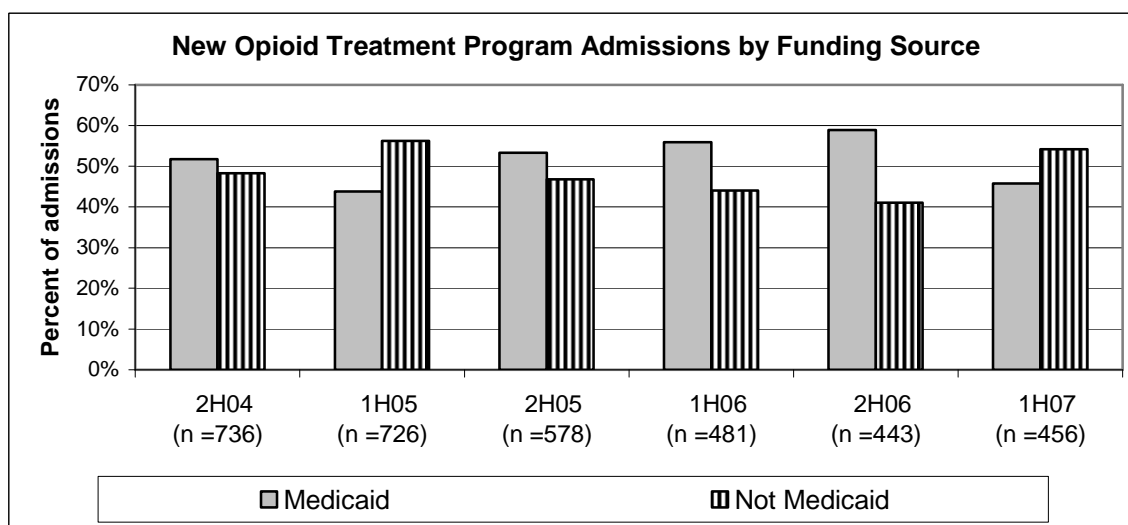
Opioid treatment programs provide medically supervised treatment services to persons with chronic opiate addictions. In addition to physical exams and medical monitoring, clinics provide individual and group counseling, medications, urinalysis screening, referral to other health and social services, and patient monitoring.

The chart below shows admissions to opioid treatment programs. Both “new admissions”, which started during the biennial quarter, and “open admissions”, which include people who started treatment prior to the start of the quarter and were not yet discharged, are shown.



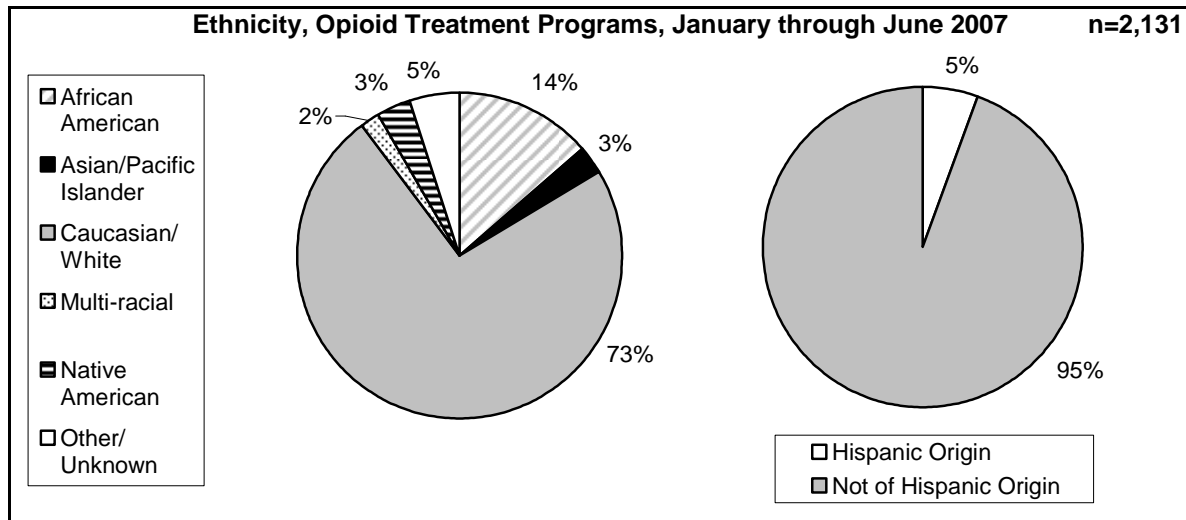
New admissions for opioid treatment programs increased in 2004 and 2005 as a result of additional Medicaid and criminal justice funding, as well as a new federal grant. Because of the long-term nature of successful opioid treatment, those admissions resulted in a lasting increase in the number of people in opioid treatment programs (open admissions) from 2004 through 2006 that is gradually declining as new admissions have decreased.

The following chart shows the proportion of newly admitted people each biennial quarter whose opioid treatment is funded by Medicaid vs. other public funding.



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The following charts show unduplicated people receiving opioid treatment from January through June 2007. See Appendix A for additional details.



Summary Data

Overview

This section provides summary data for the current calendar year in two areas: services and dispositions, and demographics of individuals served.

The services data are for the same program areas and measures that were presented graphically in the Programs section. The time period that the data describe is different. Data in this section are for the most recent calendar year to date, which is the same time period as the last biennial quarter shown in the charts. Both numbers and percentages are shown. See Appendix A for additional details.

The demographic data are broader than the data in the Programs section. For each area where data on unduplicated individuals are available (that is, all areas except the Alcohol/Drug 24-Hour Help Line and Emergency Services Patrol), the gender, race or ethnic group and Hispanic origin status of all individuals served during the most recent calendar year is reported. Both numbers and percentages are included. For Prevention, demographic data are shown only for participants in multiple episode programs.

To provide additional context, census data for gender and ethnicity in the youth and adult populations in King County that are below the federal poverty level are shown beside the program demographic data. Although many people with somewhat higher incomes also qualify for public funding, these data approximate the gender and ethnic mixtures among King County residents who are eligible for publicly funded services. Data for the “Youth Outpatient” programs should only be compared to the “Youth” population. All other programs except Prevention serve only adults. (Data provided by: Public Health- Seattle & King County, Epidemiology, Planning and Evaluation Unit. Data Source: 2000 Census, SF3 tables.)

Chemical Dependency Performance Indicators Report January-June 2007

Services and Dispositions, January – June 2007

	<u>Number</u>	<u>Percent</u>
Prevention Participants	1,659	100%
Age Group		
Child	435	26%
Youth	822	50%
Adult	283	17%
Unknown	119	7%
Risk/Protective Factor		
Favorable Attitudes	0	0%
Family Management	288	17%
Bonding	16	1%
Healthy Beliefs	0	0%
Early Initiation	1,355	82%
Program Type		
Best Practices	1,532	92%
Promising Practices	111	7%
Innovative Practices	16	1%
Alcohol/Drug Help Line Calls		
Drug of Choice (about self only)	2,749	100%
Alcohol	1,599	58%
Opiates	234	9%
Cocaine	300	11%
Methamphetamines	169	6%
Marijuana	182	7%
Other	265	10%
Referrals (all calls)	6,232	100%
Self help group	1,120	18%
Other	1,399	22%
Outpatient treatment	1,781	29%
Inpatient treatment	799	13%
ADATSA	561	9%
Detox	572	9%
ESP Transports		
All Destinations	6,734	100%
Sobering	5,770	86%
1811 Eastlake	386	6%
Street	38	1%
Detox	432	6%
Harborview	108	2%
Other	78	1%
Sobering Center		
Admissions	11,235	
Unduplicated People	1,272	
Detoxification Center		
Admissions	1,873	
Unduplicated People	1,407	
Admissions by drug of choice	1,873	100%
Alcohol	1,169	62%
Opiates	380	20%
Cocaine	223	12%
Methamphetamines	46	2%
Marijuana	15	1%
Other	40	2%

	<u>Number</u>	<u>Percent</u>
Referrals on discharge, all d/c	1,827	100%
Self-help	1,036	57%
CD TX	409	22%
Other	204	11%
ADATSA	160	9%
ICS	2	0%
Housing	16	1%
Involuntary Commitment Services		
Referrals	190	
Unduplicated people	172	
PCN Placements	42	
Outpatient Treatment		
Youth		
New admissions	461	
Open admissions	748	
Unduplicated people (open)	734	
Open admissions by drug of choice		
Alcohol	213	28%
Opiates	4	1%
Cocaine	18	2%
Methamphetamines	23	3%
Marijuana	467	62%
Other	23	3%
New admissions by Medicaid status		
Medicaid	210	46%
Not Medicaid	251	54%
Discharges (during year)	349	
Completed treatment	125	55%
Did not complete	104	45%
Excluded from calc.	120	34%
Adult		
New admissions	2,547	
Open admissions	5,553	
Unduplicated people (open)	5,233	
Open admissions by drug of choice		
Alcohol	2,677	48%
Opiates	376	7%
Cocaine	1,001	18%
Methamphetamines	640	12%
Marijuana	749	13%
Other	110	2%
New admissions by Medicaid status		
Medicaid	882	35%
Not Medicaid	1,665	65%
Discharges (during year)	2,323	
Completed treatment	643	42%
Did not complete	886	58%
Excluded from calc.	794	34%
Opioid Treatment Programs		
New admissions	456	
Open admissions	2,192	
Unduplicated people (open)	2,131	
New admissions by Medicaid status		
Medicaid	209	46%
Not Medicaid	247	54%

Program Comparisons

The table below shows the drug of choice data for different program areas and highlights differences among substances used.

Drug of Choice Comparison, January - June 2007				
	<u>Alcohol/Drug Help Line Calls</u>	<u>Detoxification Center Admissions*</u>	<u>Outpatient Youth Admissions</u>	<u>Outpatient Adult Admissions</u>
Total Number	2,749	1,873	748	5,553
Drug of Choice Percentage				
Alcohol	58%	62%	28%	48%
Opiates	9%	20%	1%	7%
Cocaine	11%	12%	2%	18%
Methamphetamines	6%	2%	3%	12%
Marijuana	7%	1%	62%	13%
Other	10%	2%	3%	2%

Although not all the Alcohol/Drug Help Line (ADHL) calls are about adult use of drugs or alcohol, the fact that the majority is about adult use is consistent with the similarity in pattern between ADHL and Outpatient Adult. There is a dramatic difference between the Youth and Adult Outpatient use of marijuana.

Chemical Dependency Performance Indicators Report January-June 2007

Demographic Detail, January – June 2007

	Prevent.	Sobering	Detox	ICS	Outpatient			King County Residents Below Fed. Pov. Level	
					Youth	Adult	Opioid Tx.	Youth (12 - 17)	Adult (over 17)
Unduplicated people served	1,659	1,272	1,407	172	734	5,233	2,131	11,836	104,592
Gender									
<u>Number of people</u>									
Male	617	1,104	1,050	136	508	3,344	1,148	5,744	46,617
Female	923	144	357	36	226	1,889	983	6,092	57,975
<u>Percent of all served</u>									
Male	37%	87%	75%	79%	69%	64%	54%	49%	45%
Female	56%	11%	25%	21%	31%	36%	46%	51%	55%
("Unknown gender" counts are not included)									
Race/ethnic group:									
<u>Number of people</u>									
African American	100	219	341	21	115	1,143	293	1,856	10,791
Asian/Pacific Islander	66	19	21	1	58	315	56	2,306	16,594
Caucasian/ White	1,016	541	846	127	342	2,807	1,563	5,185	63,711
Multi-racial	91	35	24	7	58	161	40	1,200	6,081
Native American	45	196	73	11	19	280	73	277	2,125
Other/ Unknown	341	262	102	6	142	527	106	1,012	5,290
<u>Percent of all served</u>									
African American	6%	17%	24%	12%	16%	22%	14%	16%	10%
Asian/Pacific Islander	4%	1%	1%	1%	8%	6%	3%	19%	16%
Caucasian/ White	61%	43%	60%	74%	47%	54%	73%	44%	61%
Multi-racial	5%	3%	2%	4%	8%	3%	2%	10%	6%
Native American	3%	15%	5%	6%	3%	5%	3%	2%	2%
Other/ Unknown	21%	21%	7%	3%	19%	10%	5%	9%	5%
	100%	100%	100%	101%	100%	100%	100%	100%	100%
Hispanic origin:									
<u>Number of people</u>									
Hispanic origin	120	163	75	3	147	539	116	1,567	10,482
Not Hispanic origin/Unknown	1,539	1,109	1,332	170	587	4,694	2,015	10,269	94,110
<u>Percent of all served</u>									
Hispanic origin	7%	13%	5%	2%	20%	10%	5%	13%	10%
Not Hispanic origin/Unknown	93%	87%	95%	99%	80%	90%	95%	87%	90%
	100%	100%	100%	101%	100%	100%	100%	100%	100%

(Percentages may not add up to 100% because of rounding)

Chemical Dependency Performance Indicators Report, Appendix A – Data Notes

This appendix describes the data sources used for the Chemical Dependency Performance Indicators Report (CDPIR) and issues around the quality, meaning and availability of the data. It also includes specific notes about the data presented for different program areas.

Data Sources and Data Quality Issues

Data Sources

The data included in this report come from four broad types of sources:

- Summary data furnished by service providers. Such data are used for Alcohol/Drug 24-Hour Help Line and Emergency Services Patrol.
- A database developed by MHCADSD that is used by the Dutch Shisler Sobering Center and Involuntary Commitment Services to collect data for those programs. Until early 2004, each program used a separate Access database. Those were replaced with an integrated chemical dependency services information system that stores data from each program in a single database accessed by separate applications for each program.
- The State DASA Prevention database that contains data from contracted providers about individuals who participate in multiple episode prevention programs.
- The State TARGET database that contains data from contracted providers about individuals and their treatment services. TARGET data are used for the Detoxification Center and Youth, Adult and Opioid Treatment Program outpatient treatment portions of the CDPIR. (Although the Sobering Center also submits data to the TARGET system, those data are not used in this report because only minimal TARGET data are collected.)

Race/Ethnicity/Hispanic Origin Data Issues:

Among the programs that are included in this report, there are a number of differences in how data about race, ethnicity and Hispanic origin are collected and/or reported. To combine the data into a single consistent format, the following decisions were made:

- The “race/ethnicity” data reported for all program areas is presented using a single set of categories.
- The categories chosen are four commonly identified broad “race/ethnicity” groups (Black/African American, White/Caucasian/European American/Middle Eastern, Asian/Pacific Islander and Native American/Alaska Native) and two other groups (Multi-racial and Other/Unknown).
- In those areas where the data collection system allowed more than one choice per person, any individual with data that “rolled up” into two or more different broad groups is counted as “Multi-racial” (White and Chinese, which rolled up to White and Asian-Pacific Islander, is counted as “Multi-racial”; Korean and Chinese as “Asian-Pacific Islander”).

The new MHCADSD integrated CD database allows reporting multiple ethnicities,

Chemical Dependency Performance Indicators Report, Appendix A – Data Notes

unlike the earlier separate databases. As these were put into use, there has been a shift in the data from a single race/ethnicity to the “Multi-racial” category.

- “Other” is grouped with “Unknown” into “Other/Unknown”.

Program Specific Data Notes

Prevention

Prevention data shown in the report were provided in summary form by the Alcohol, Tobacco and Other Drug Prevention (ATODP) Division of the Seattle-King County Public Health Department. Since July 2003, providers have reported data about individuals who participated in multiple session prevention programs while reporting only the total number of participants at single event prevention activities. Data about individuals include gender, age group, ethnicity and hispanic origin.

Each multiple session program has a defined curriculum that is implemented with a registered group of participants who attend a prescribed number of sessions. Examples are Life Skills or the Nurturing Program. A single event is not an ongoing program but a prevention event that occurs once. Examples include a specific media campaign for graduation or prom time or a Health Fair.

Alcohol Drug 24-Hour Help Line

Help Line staff enter data for each call into a database. Data shown in this report are summary data for calls received during the three years in this report.

Emergency Services Patrol

The nature of this service does not support identifying individuals sufficiently to collect data on unduplicated persons.

Sobering Center

Data for services are entered into the integrated chemical dependency database by Sobering Center staff using the Sobering Center application.

Detoxification Center

Data for services at the Detoxification Center are entered into the TARGET data system by Detoxification Center staff. This report is based on downloaded data from that system.

Chemical Dependency Performance Indicators Report, Appendix A – Data Notes

Since February 2003, a separate TARGET admission has been reported for each level of care. To represent the true volume of admissions regardless of changes in level of care, only one admission is counted when a person had a prior TARGET detoxification admission that ended the day before the new TARGET admission date.

TARGET requires that data about the person's self-identified drugs of choice be reported. The Detoxification Center is not required to report data about the drug(s) for which the person is receiving detoxification services.

TARGET allows multiple referrals to be reported; however, the CDPIR uses only one referral for each discharge. Discharge referrals were counted based on the following hierarchy that generally orders the choices according to the intensity of response that the referral represents: ADATSA, ITS, CD TX, Self-help, Housing and Other. ("Other" includes referrals for medical/dental, mental health and miscellaneous other resources.) Those discharges with multiple referrals are reported based on whichever of those referrals is the highest in this hierarchy. (Discharges that represent a transfer to a different level of care are excluded to remain consistent with the admission data reported.)

Involuntary Commitment Services

Data for ICS referrals are entered into the integrated chemical dependency database by ICS staff using the ICS application. Data included are for referrals received and the disposition of each of those referrals.

Outpatient Treatment: Youth, Adult and Opioid Treatment Programs

Data for all Outpatient programs are entered into the TARGET system by service providers and the CDPIR is based on those data.

The data used in this report are limited as follows:

- Only admissions where the TARGET "Fund Source" is "County Community Services" or there was a King County "Special Project Code" at some time during the admission are included. Those data indicate that the services are provided under contracts with King County.
- Data included for Youth and Adult are for the TARGET modalities of intensive outpatient, outpatient and MICA outpatient. Data for Youth are for all admissions where the client was under 18 on the admission date (for Adult, 18 or over).
- Data for Opioid Treatment Programs are for all admissions where the TARGET modality is "Methadone/Opiate Substitution Treatment".
- To remove Youth and Adult admissions that are missing discharge data, any admissions that started before 2000 and have no discharge data were excluded as probable errors.

Chemical Dependency Performance Indicators Report, Appendix A – Data Notes

(This was not done with Opioid Treatment Programs because admissions longer than three years are common for that treatment modality.)

- Opioid Treatment Program admissions that were essentially transfers to another treatment location (often with the same provider) were combined. Such continuous treatment episodes were counted as a new admission only for the period when the first admission started and were counted as only one admission for any period in which the combined admissions were open.

The treatment completion rate is computed using the following algorithm:

$$\frac{\text{\# of discharges with treatment completed}}{\text{number of discharges}}$$

Note that the denominator used to compute treatment completion rate includes only discharges for the following reasons: completed treatment, no contact/aborted treatment, not amenable to treatment, rule violation and withdrew against program advice.

Discharges for the following reasons are excluded from the calculation of treatment completion rate: client died, funds exhausted, inappropriate admission, incarcerated, moved, transferred to different facility, withdrew with program advice, administrative closure and other.

The statewide rates for treatment completion that are cited for Youth and Adult Outpatient Treatment are based on reports from the DASA Treatment Analyzer, which contains TARGET data although it is different from the TARGET system. Those reports use the treatment completion algorithm described above. The reported results were calculated in each area (Youth and Adult) by running a statewide report and a King County report, then subtracting the numbers for King County from the statewide numbers for both the “number of discharges with treatment completed” and the “number of discharges”. The rate was then calculated as shown above.

Chemical Dependency Performance Indicators Report, Appendix B – Glossary

ADATSA	The Alcohol and Drug Addiction Treatment and Support Act, which provides state-financed treatment and support to indigent people who are chemically dependent. ADATSA provides eligible people with inpatient and outpatient chemical dependency treatment and with limited financial support for housing and other needs.
ADHL	Alcohol/Drug 24-Hour Help Line (see program description).
Biennial	Washington State’s fiscal year is organized on a two-year basis, referred to as a biennium. Biennial quarters are one fourth of that period, or six months long. The current biennium began July 1, 2005 and will end June 30, 2007.
CD TX	Chemical dependency treatment.
DASA	The Washington State Division of Alcohol and Substance Abuse, a division of the Department of Social and Health Services.
ESP	Emergency Services Patrol (see program description).
ICS	Involuntary Commitment Services (see program description).
MHCADSD	The Mental Health, Chemical Abuse and Dependency Services Division of the King County Department of Community and Human Services.
TARGET	Treatment Assessment and Report Generation Tool is a data collection and reporting system that is maintained by DASA and contains data about publicly funded chemical dependency treatment that are submitted by contracted treatment providers.

**Chemical Dependency Performance Indicators Report, Appendix C -
Program Providers for January - June 2007**

Provider	Prev.	ADHL	ESP	Sober . Ctr	Detox	ICS	Outpatient		OTP
							Youth	Adult	
Alcohol & Drug 24-Hour Helpline		x							
Asian Counseling Referral Service							x	x	
Auburn Youth Resources	x						x		
Avalon Center								x	
Boys & Girls Clubs of King County	x								
Catholic Community Services								x	
Center for Career Alternatives	x								
Center for Human Services	x						x	x	
Encompass	x								
Community Psychiatric Clinic							x	x	
Consejo Counseling & Referral Svcs							x	x	
Downtown Emergency Service Center								x	
Evergreen Treatment Services									x
Friends of Youth	x						x		
Girl Scouts-Totem Council	x								
Greater Maple Valley Community Center	x								
Harborview Medical Center Addictions Program								x	
Highline-West Seattle Mental Health								x	
Intercept Associates								x	
Kent Youth and Family Services							x		
King County Emergency Services Patrol			x						
King County Involuntary Commitment Services						x			
Lifelong AIDS Alliance	x								
Mercer Island Youth & Family Services	x								
Muckleshoot Indian Tribe								x	
Neighborhood House	x								
Perinatal Treatment Services								x	
Pioneer Human Services								x	
Recovery Centers of King County				x	x			x	
Reel Grrls	x								
Renton Area Youth and Family Services	x						x		
Ruth Dykeman Youth and Family Services							x		
SafeFutures Youth Center	x								
Seattle Counseling Services							x	x	
Seattle Indian Health Board								x	
Snoqualmie Indian Tribe								x	
Sound Mental Health (formerly Seattle Mental Health)							x	x	
Therapeutic Health Services							x	x	x
United Indians of All Tribes							x		
Valley Cities Counseling and Consultation	x						x	x	
Vashon Youth & Family Services	x								
Washington Asian/Pacific Islander Families Against Substance Abuse							x		
Youth Eastside Services							x		