King County

Mental Health, Chemical Abuse and Dependency Services Division
Department of
Community and Human Services

The Chinook Building
401 Fifth Avenue, Suite 400
Seattle, WA 98104

CNK-HS-0400

206.263.9000
206.296.0583 Fax
206.205.1634 Fax – Clinical Services
206.205.0569 TTY/TDD

July 28, 2010

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-December 2009

I am pleased to present the King County Chemical Dependency Performance Indicators Report (CDPIR) for the period of January 1 – December 31, 2009 (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 presents data by half-year periods covering the last three years. Subsequent versions of the CDPIR will be issued each spring for the previous calendar year. Data from different periods in this report and previous reports are compared 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.

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:bb

Enclosure

King County

Mental Health, Chemical Abuse and Dependency Services Division

CHEMICAL DEPENDENCY PERFORMANCE INDICATORS REPORT

January – December 2009

TABLE OF CONTENTS

Title	Page
Executive Summary	1
Chemical Abuse and Dependency Programs	3
Prevention	3
Emergency Services Patrol	7
Dutch Shisler Sobering Center	8
Detoxification Center	10
Involuntary Commitment Services	12
Outpatient Treatment – Youth	13
Outpatient Treatment– Adult	16
Opioid Treatment Programs	19
Summary Data	21
Services and Dispositions, January – December 2009	22
Demographic Detail, January – December 2009	24
Financial Summary, 2007 – 2009	25
Appendix A. Data Sources	A-1
Appendix B. Glossary	B-1
Appendix C. Program Providers	C-1

Executive Summary

The following summarizes findings from the current reporting period, January – December 2009, and when relevant, compares these findings to those from preceding reporting periods.

Prevention: In King County, prevention of abuse of drugs and alcohol is addressed through two approaches, both of which target risk and protective factors that are selected through a needs assessment that is updated every two years:

> *Community organizing* activities that facilitate community-based efforts to identify and implement community-based solutions to youth violence and substance abuse. As such, programs reflect the communities from which they are developed.
>
> *Prevention programs* through which contracted agencies offer programs that address the risk and protective factors known to affect the likelihood that youth will abuse alcohol and other drugs. For the past four years, prevention programs represent "best", "promising", or "innovative" practices, thus assuring that programs for at-risk youth have the greatest likelihood for achieving long-term positive outcomes.

In 2009, Community Organizing worked with a total of 120 community coalitions with about 1,400 members to develop prevention programs that subsequently engaged approximately 4,300 youth and 3,800 adults. Program outcomes indicate:

- 86 percent of youth increased their understanding of the harmful effects of substance use and violence.
- 94 percent of parents say they are better able to deal with their young people regarding substance use and violence.
- 96 percent of adult and youth participants say they are better able to see the community as a resource in assisting friends and families to deal with substance abuse and violence.

For the period January – December 2009, 3,985 individuals participated in multi-session prevention programs. Throughout 2009, programs that target the risk factor "favorable attitudes among youth that encourage substance use" had the highest attendance among those offered, and the vast majority of all programs were defined as "best practices".

Emergency Services Patrol: The total number of transports provided by the Emergency Services Patrol (ESP) in 2009 decreased to 13,939, almost 1,500 fewer transports than in 2008. While the majority of transports continue to be to the Dutch Shisler Sobering Support Center, increases in transports to other locations reflect the recently emphasized practice of transporting clients to treatment sites and other locations when they complete their stay.

Dutch Shisler Sobering Support Center (DSSSC): The number of admissions to the DSSSC decreased from 25,858 in 2008 to 23,803 in 2009 – an eight percent reduction. New initiatives designed to encourage users of this facility, who also tend to be high utilizers of other systems, to access treatment may be impacting admission rates.

The demographics of Sobering Center clients continue to be skewed toward certain population groups, for instance: 15 percent of all admissions in the second half of 2009 were of Native Americans, while Native Americans represent only two percent of King County's population; 23

percent of those admitted five times or more during the second half of 2009 were Native American; and 86 percent of unduplicated people admitted in 2009 were male.

Detoxification Center: The number of admissions (episodes) and unduplicated people admitted to the Detoxification Center has been relatively stable since the first half of 2007. During 2009, the percentage of those receiving detoxification services who identify alcohol as their drug of choice declined, while the percentage who choose opiates or cocaine or methamphetamine increased. The percentage of individuals referred to self-help groups on discharge from the Detoxification Center grew to 75 percent by the second half of 2009, while the percent referred to chemical dependency treatment declined to 15 percent, from nearly 30 percent during the second half of 2008.

Involuntary Commitment Services: While the number of referrals has declined since the first half of 2007, the number of placements at Pioneer Center North[1] has remained relatively constant. As a result, the percentage of referrals that lead to placement has grown from 25 percent in 2007 to 70 percent in 2009.

Outpatient Treatment – Youth: The vast majority of youth admitted to treatment identify marijuana as their drug of choice, followed by a smaller portion who identify alcohol as their primary drug. MHCADSD implemented several initiatives in 2006 and 2007 in order to improve access for youth in need of treatment. In calendar year 2009, 1,176 youth were admitted to outpatient treatment. While the number of youth admissions has grown slightly since 2007, the number of youth in treatment (carried on caseloads) has grown more than 40 percent in the same time period, suggesting youth are staying in treatment longer. Completion rates are an important outcome for King County, and the youth outpatient completion rates increased by more than 20 percentage points from the first half of 2007 to the second half of 2009. During the second half of 2009, the statewide outpatient treatment completion rate for youth was 54 percent (excluding King County), while the rate for King County was 71 percent.

Outpatient Treatment – Adults: Unlike youth, the most common drug of choice for adults in treatment was alcohol, followed by cocaine, then marijuana. In calendar year 2009, 6,661 adults were admitted to outpatient treatment. The number of adults in treatment increased approximately 35 percent since the first half of 2007, again reflecting the trend for remaining in treatment for a longer period of time. When looking at the outcome “completion rate”, the statewide adult outpatient treatment completion rate (less King County) was 53 percent for the second half of 2009, which King County exceeded at 58 percent.

Opioid Treatment: New admissions declined to 904 during 2009 from 1,265 in 2008. Retention is an important outcome for opioid treatment, and the number of individuals remaining in treatment grew slightly during 2009 despite declining admission numbers. Declining admissions were more related to funding limitation than to need, as the waiting list for treatment grew during this same period.

[1] Pioneer Center North is a locked treatment facility that provides intensive inpatient services to people who qualify for involuntary commitment services.

Chemical Abuse and Dependency Programs

Prevention

King County programs address prevention of drug and alcohol abuse through two approaches. One approach is contracting with organizations to provide drug and alcohol prevention programs that is facilitated by the Alcohol and Other Drug Prevention Program. The other approach, facilitated by the Community Organizing Program, is supporting the development of community efforts to address substance abuse and violence.

Research has shown that risk factors and protective factors affect youth involvement with substance use. King County conducts a planning process with community involvement to identify which factors to target with our programming. Because this planning process results in changes to which factors are prioritized, the factors addressed by prevention programs vary over time. During the three years covered in this report, the seven factors addressed were:

- 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)
- Early initiation of the problem behavior (risk factor)
- Availability of drugs (risk factor)
- Friends who engage in the problem behavior (risk factor)
- Low neighborhood attachment and community disorganization (risk factor)

This section describes the King County Community Organizing Program (KCCOP) and presents 2009 data on KCCOP activities. It also describes the Alcohol and Other Drug Prevention Program (AODPP) and presents data on AODPP programs in half-year periods.

The goal of the KCCOP is to involve every citizen of King County in the prevention of youth substance abuse and violence through community based solutions. Through a community organizing model, KCCOP works with coalitions that form to address the substance abuse or violence concerns within an identified community. Such communities are defined by the common identity or interests of their members, such as where they live or attend school, ethnicity, sexual orientation, or particular prevention goals and strategies.

In 2009, KCCOP worked with a total of 120 community coalitions, with 1,400 members, to implement strategies for the prevention of substance abuse and violence. Seventy of those coalitions received KCCOP mini-grants to provide prevention strategies that engaged 4,300 youth and 3,800 adults.

Outcomes from these community organizing prevention strategies were:

- 86 percent of youth reported an increase in their understanding of the harmful effects of substance use and violence.

- 95 percent of parents said they are better able to deal with their young people regarding substance use and violence.
- 96 percent of adult and youth participants said they are better able to see the community as a resource in helping friends and families deal with issues of substance abuse and violence.

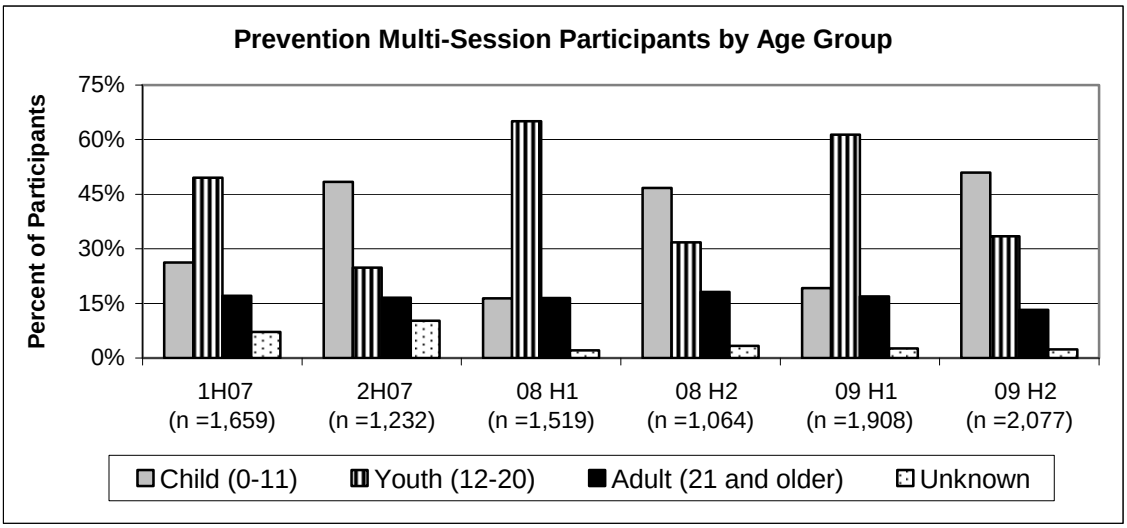
For AODP prevention programs, the target populations are children, youth and parents. Programs are designed to prevent or delay first use and abuse of alcohol and other drugs by reducing risk factors and enhancing protective factors.

Risk and protective factors are addressed through single event or multiple session programs. Single event programs during 2009 were:

- School/community-based events developed and sponsored by youth that targeted bonding and reached 31,393 youth.
- A community-based event sponsored by specific cultural and immigrant communities that targeted favorable attitudes among youth that encourage underage drinking. This event reached 808 youth, their parents and other adults.

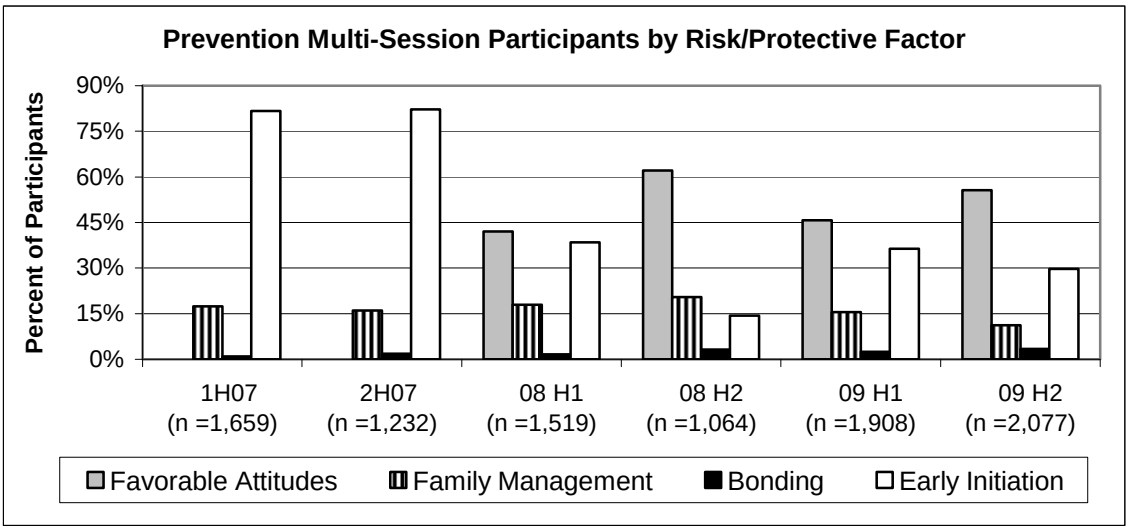
Prevention programs that have a multiple session format, such as skills training classes or support groups, collect demographic data about participants. Only multi-session programs are included in the following graphs.

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



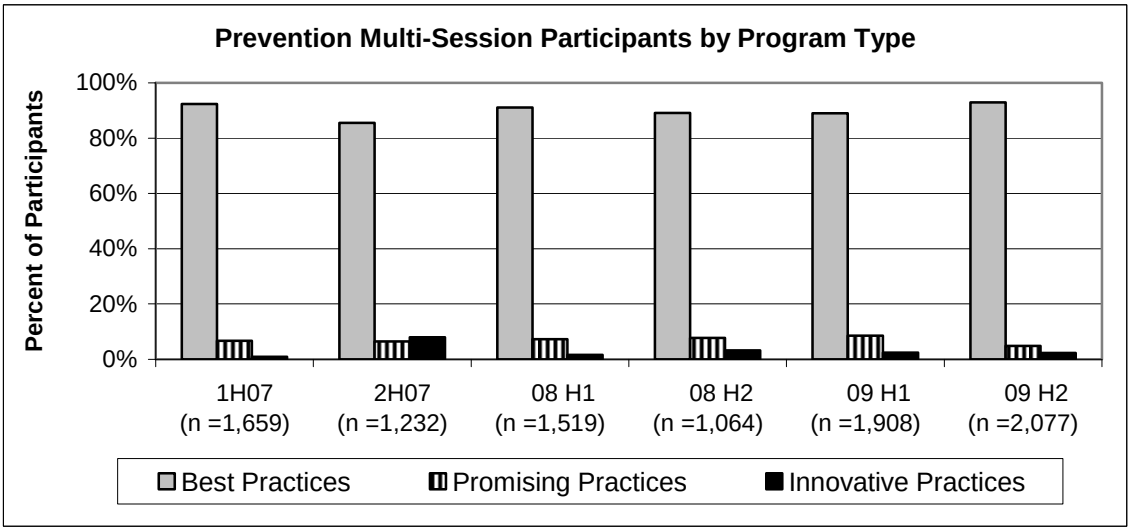
The large changes above in the relative proportions of the Child and Youth age groups reflect programs based on the school calendar as well as biennial changes in the targeted factors.

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



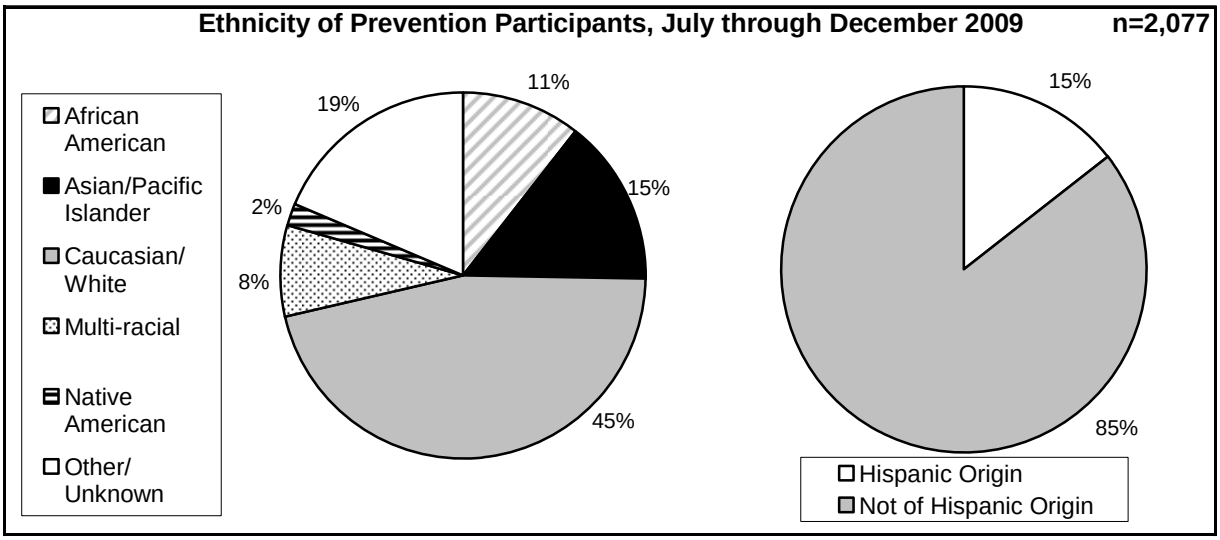
As with age groups, the changes above in the percentages of risk factors result from biennial changes in the targeted factors and the fact that many prevention programs are scheduled in conjunction with the school calendar.

Research has validated the effectiveness of some prevention programs 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.

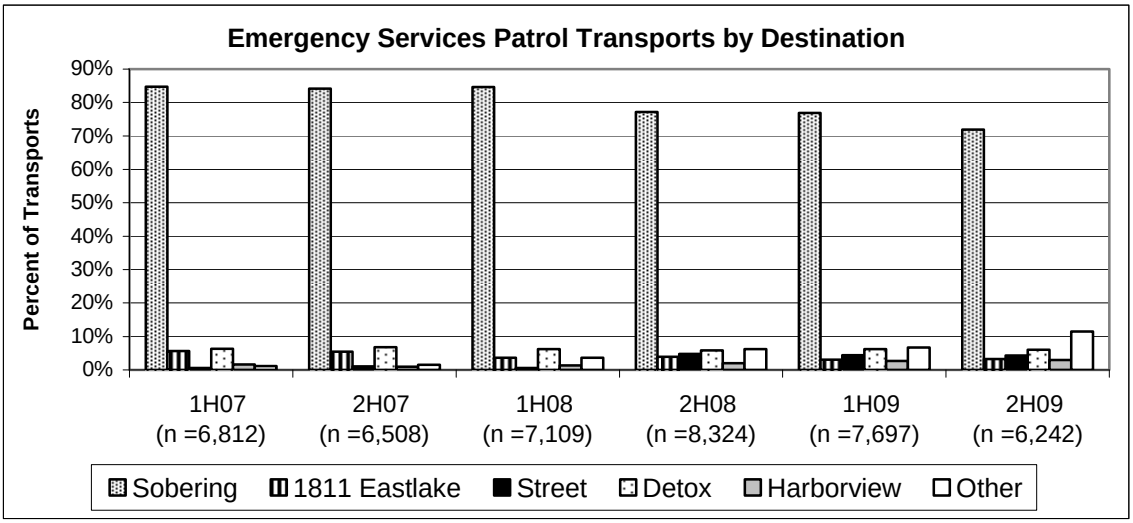
The charts below show the ethnicity of people who participated in multi-session prevention programs from July through December 2009.



Emergency Services Patrol

The main duty of the ESP screeners is to relieve fire, police, and medics in caring for chronic users. The screeners also patrol the downtown core seeking out clients in need of service. In addition, they transport clients away from sobering to other service providers. The service operates 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.



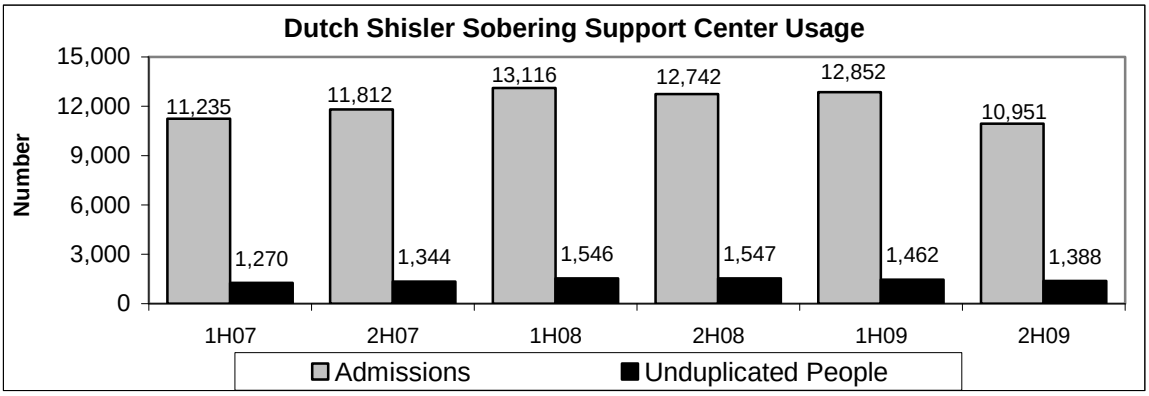
The large increase in the percentage of transports to the Street during July through December 2008, as well as smaller percentage increases in transports to Harborview and Other reflects an increased focus by ESP staff on transporting people away from the Dutch Shisler Sobering Support Center neighborhood when they finish their stay. The further increase in the percentage of transports to Other that occurred in July through December 2009 is the result of increased programming at the Sobering Support Center designed to engage clients in supportive programs that are pathways to treatment.

Client specific demographic data about ESP services are not currently available; however, ESP will implement a new database system during 2010 to collect reliable demographic data about ESP clients. Until those data are available, the demographic data from the Sobering Support Center provide a good approximation of ESP client demographics because a majority of transports are to the Sobering Center.

Dutch Shisler Sobering Support Center

The Dutch Shisler Sobering Support Center serves as a safe and secure place for persons to sleep off the acute effects of intoxication. It also serves as a center for clients to access case management services, outpatient chemical dependency treatment, and assistance to move towards greater self-determination.

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

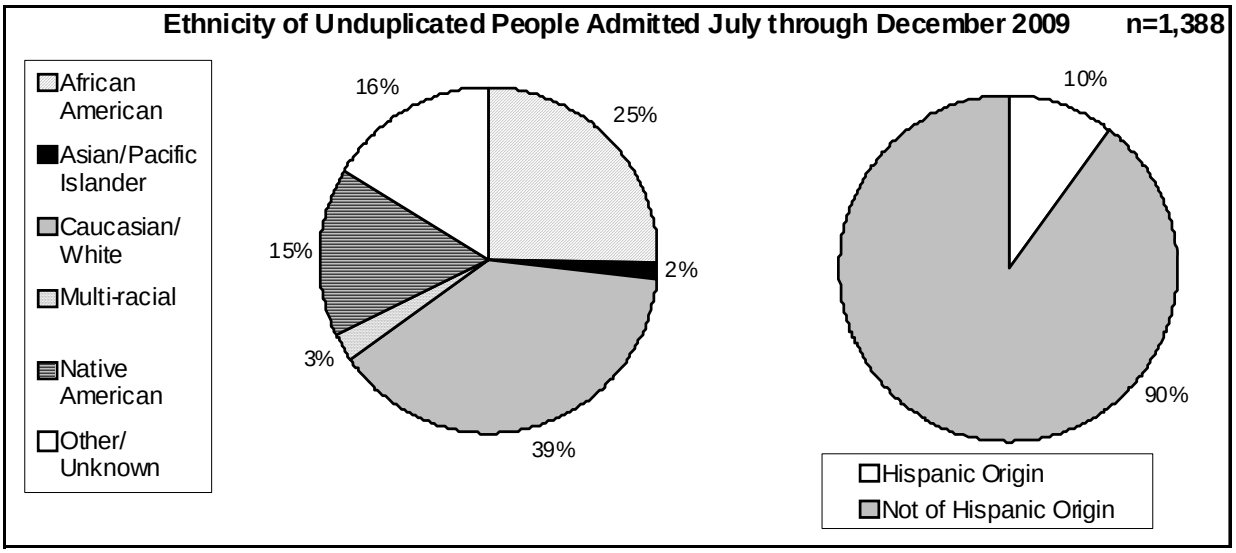


The data above show that some individuals are frequent users of the Sobering Center. In the last biennial quarter, 7.9 percent (110) of the 1,388 people admitted accounted for 53 percent of the total admissions. These 110 individuals averaged 53 admissions each during the six-month period, with a range from 25 to 141 admissions.

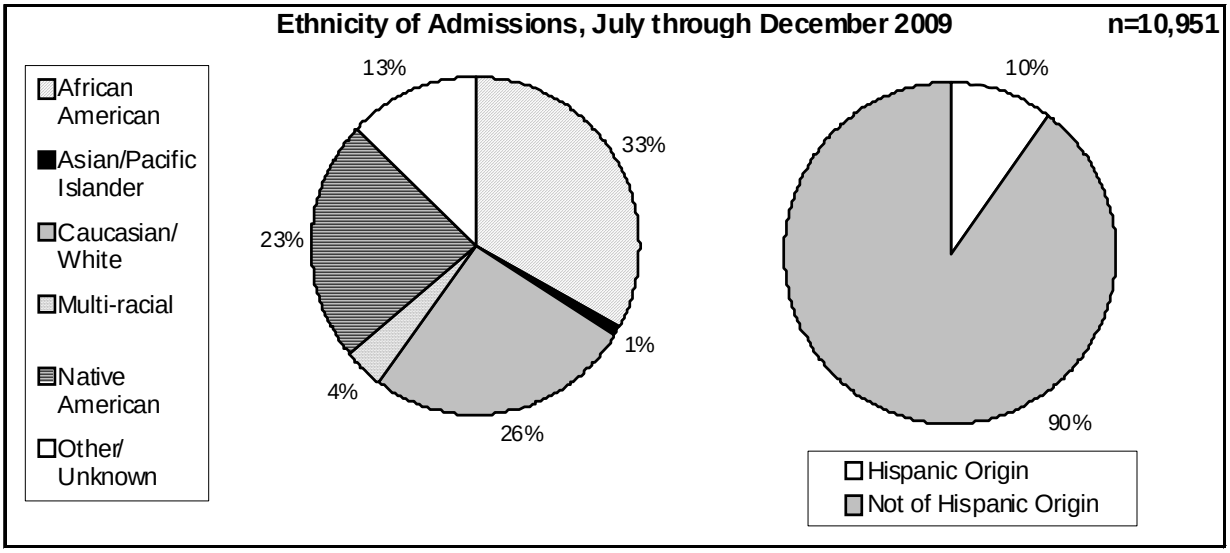
Sobering Center admissions declined between 2005 and 2006 because of the opening of the 1811 Eastlake project that placed many of the highest users in a special housing project. Admissions increased again from 2007 through 2008. In the second half of 2009, there was another marked decrease in admissions that reflects new, proactive programming to engage frequent users in case management, supportive housing and treatment.

Frequent users are often involved in several systems of care (primary and behavioral health, social services, criminal justice, and housing systems). The complex and chronic needs of these persons cannot be met effectively or efficiently in these high-cost settings. Client cases are staffed at a twice-monthly collaboration of service providers and local government staff that focuses on persons with chronic use disorders who appear frequently for services at hospitals, jail and sobering services. In addition to this regular collaboration across service systems, staff at the Sobering Center meet weekly to discuss challenging cases and opportunities for clients at the Sobering Center.

The following charts show the ethnicity of unduplicated people served by the Sobering Center from July through December 2009. See Appendix A for additional details.



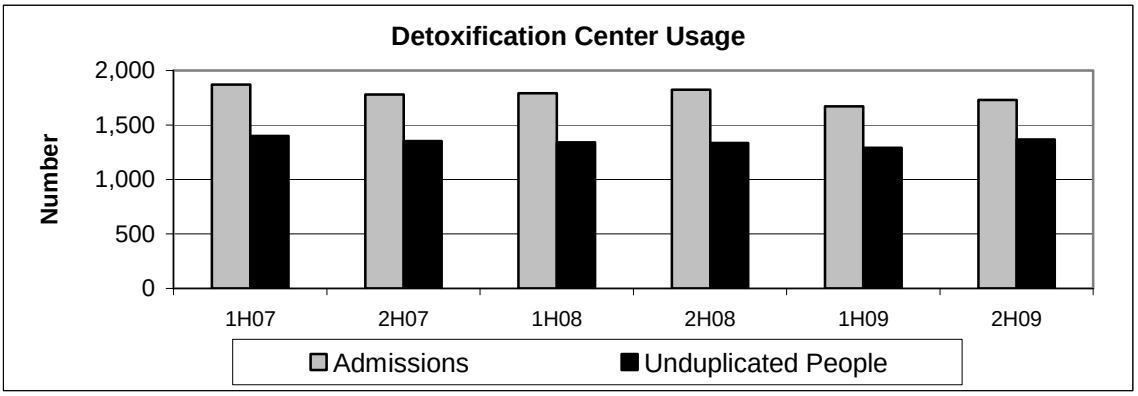
Among those admitted to the Sobering Center during July through December 2009, the percentage who are Native American (15 percent) is much higher than the percentage of Native Americans in either the general population (2 percent) or in any other drug/alcohol program area (see Summary Data, Demographic Detail). In addition, a disproportionate number of the frequent users of the Sobering Center are Native American: 23 percent of those admitted five times or more in the last biennial quarter were Native American. As shown in the chart on the left below, 23 percent of all admissions to the Sobering Center in the last biennial quarter are for Native Americans although Native Americans are only 15 percent of the unduplicated individuals served, as shown in the chart on the left above.



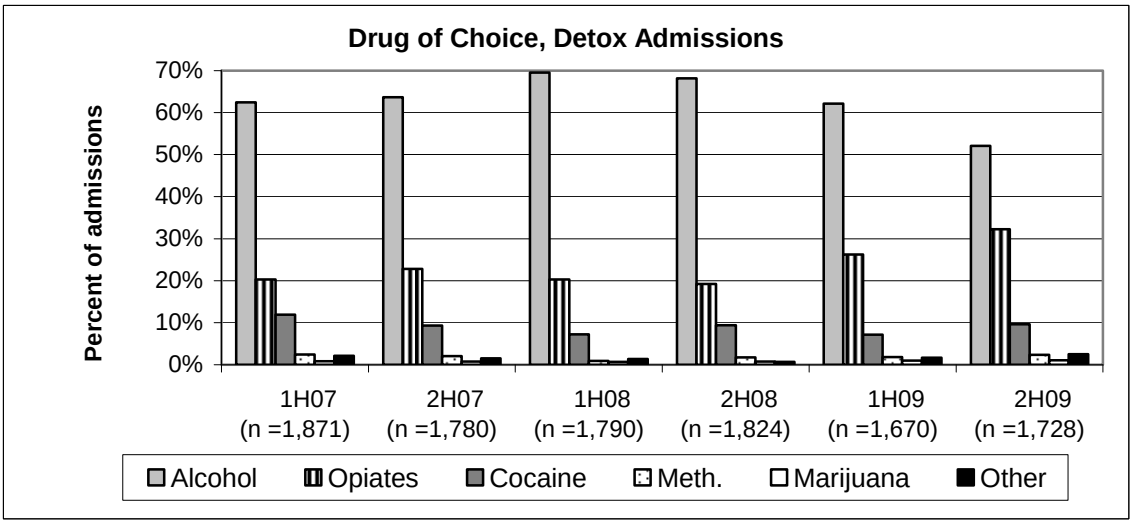
Detoxification Center

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

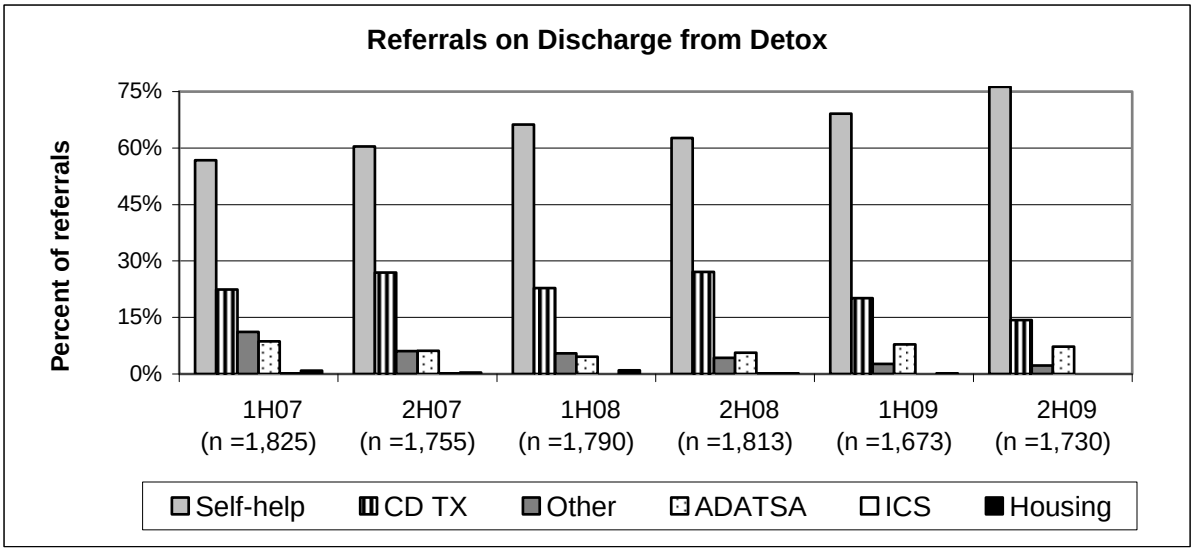
The chart below shows the number of new admissions to the Detoxification Center during each biennial quarter and the number of unduplicated people admitted.



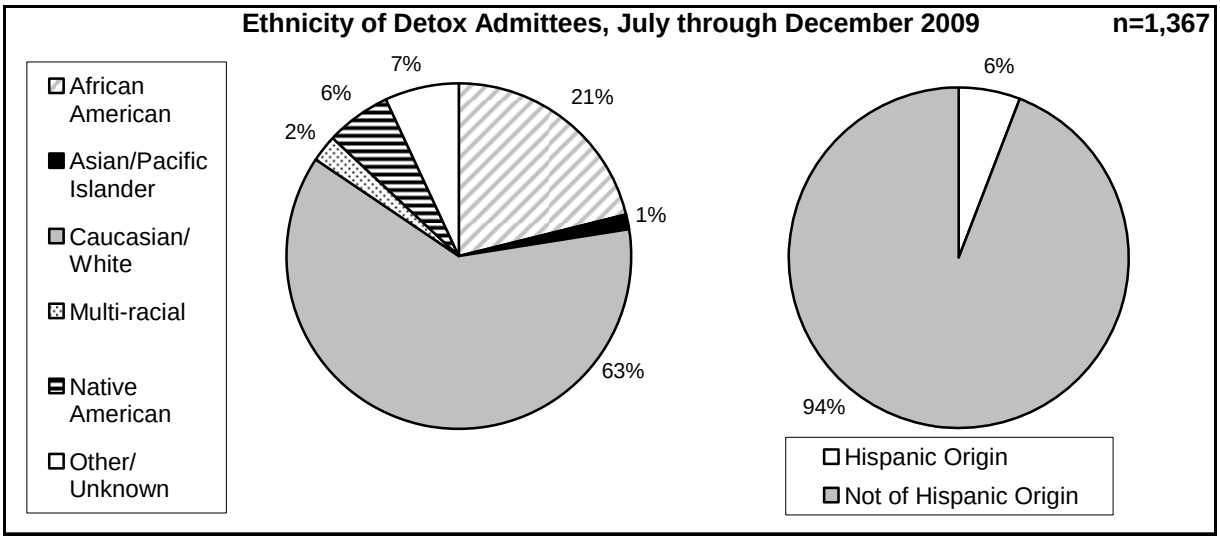
The following chart shows the primary substance used by people admitted to the Detoxification Center. This is usually, but not always, the substance for which detoxification is needed (see Appendix A for more information).



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.



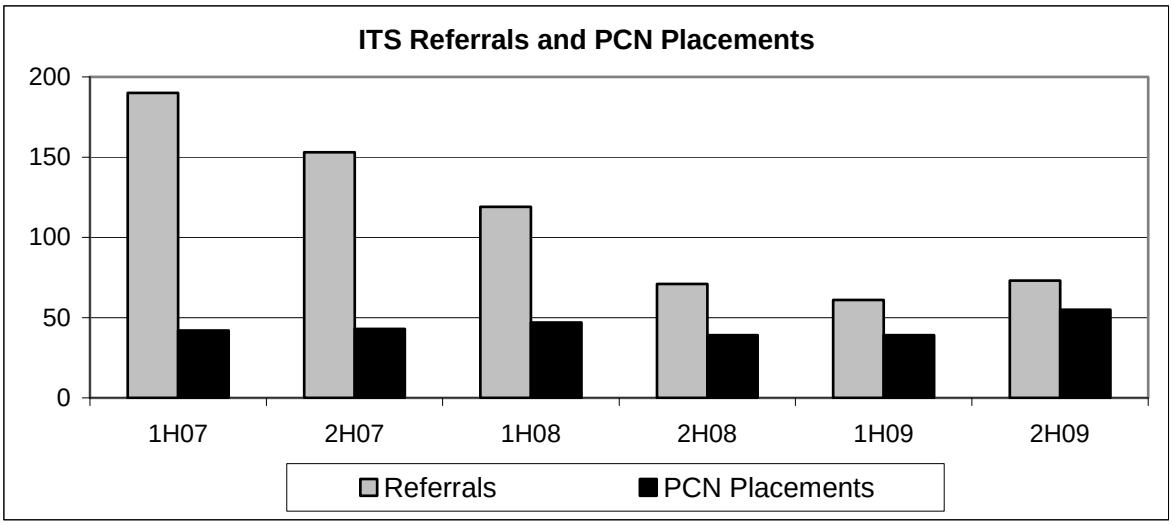
The charts below show the ethnicity of unduplicated people admitted to the Detoxification Center from July through December 2009. See Appendix A for additional details.



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.

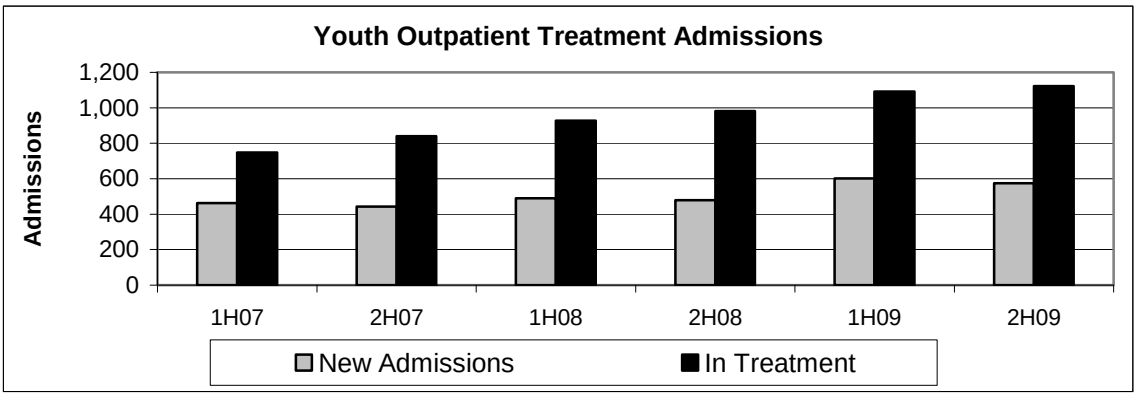


Although the number of referrals has declined steadily from the first half of 2007 through the first half of 2009, the number of PCN placements has remained about the same. Despite reduced staff resources, a focus on working with gravely disabled adults who are willing to enter treatment has led to this continued success at getting incapacitated individuals into treatment at PCN.

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.

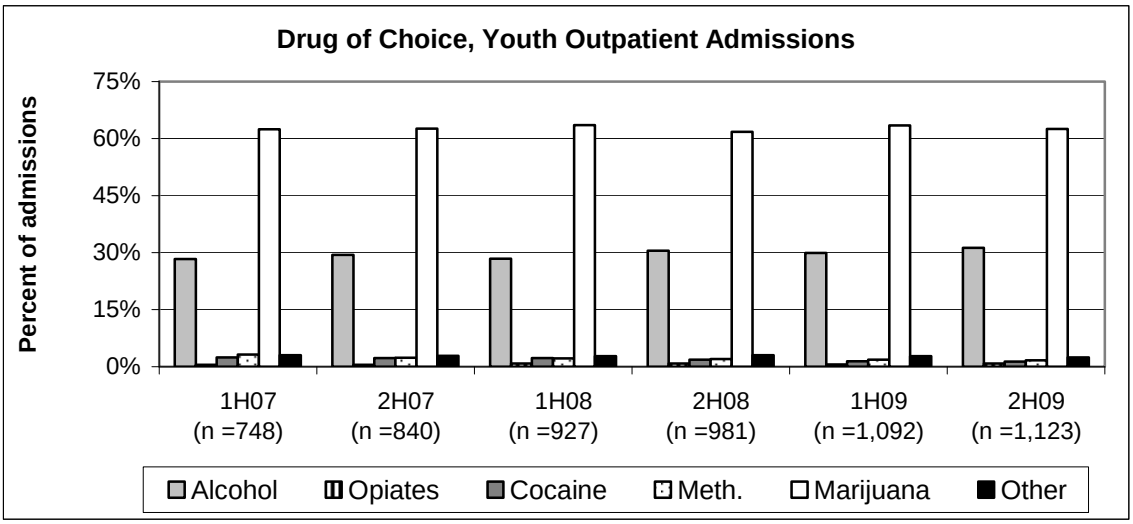
The following chart shows admissions to outpatient treatment for youth under 18. Both "new admissions", which started during the biennial quarter, and "in treatment", which includes youth who started treatment prior to the start of the quarter and were not yet discharged, are shown.



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. Although that fluctuation was evident in 2006 and earlier years, new admissions in 2007 through 2009 remained level across half-year periods.

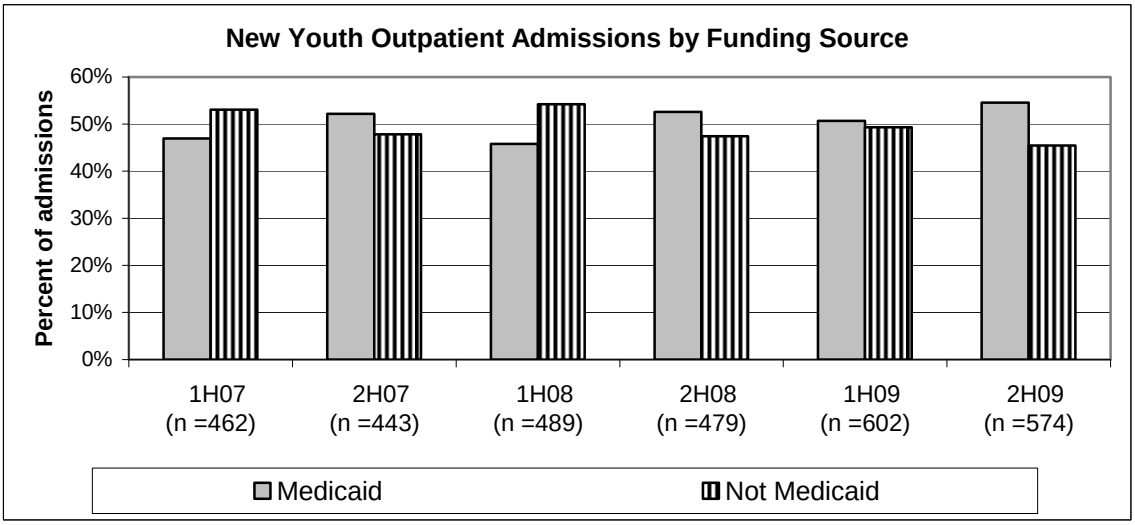
A decrease in admissions emerged in 2005 and continued through 2006. MHCADSD identified several issues that contributed to this trend including inadequate reimbursement rates, reductions in the funding that supports school prevention/intervention specialists and a shortage of qualified youth Chemical Dependency Counselors. Working with providers, schools and DASA, MHCADSD implemented several strategies to improve referral networks, review school drug and alcohol policies, address the shortage of qualified treatment staff, and increase vendor rates. During 2007, those efforts helped to reverse the decline and new admissions increased. In addition to the higher level of new admissions, the number of all youth in treatment has increased steadily from the first half of 2007 through the second half of 2009 because a larger percentage of youth are remaining in treatment longer than six months.

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

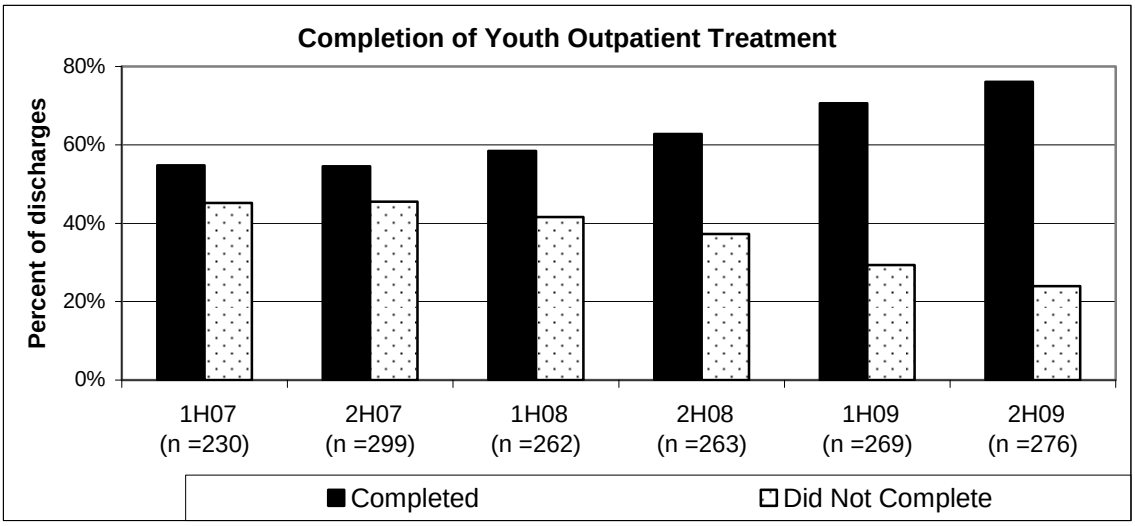


While the most frequently used drug among youth in treatment is marijuana, a significant percentage of youth are using alcohol.

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

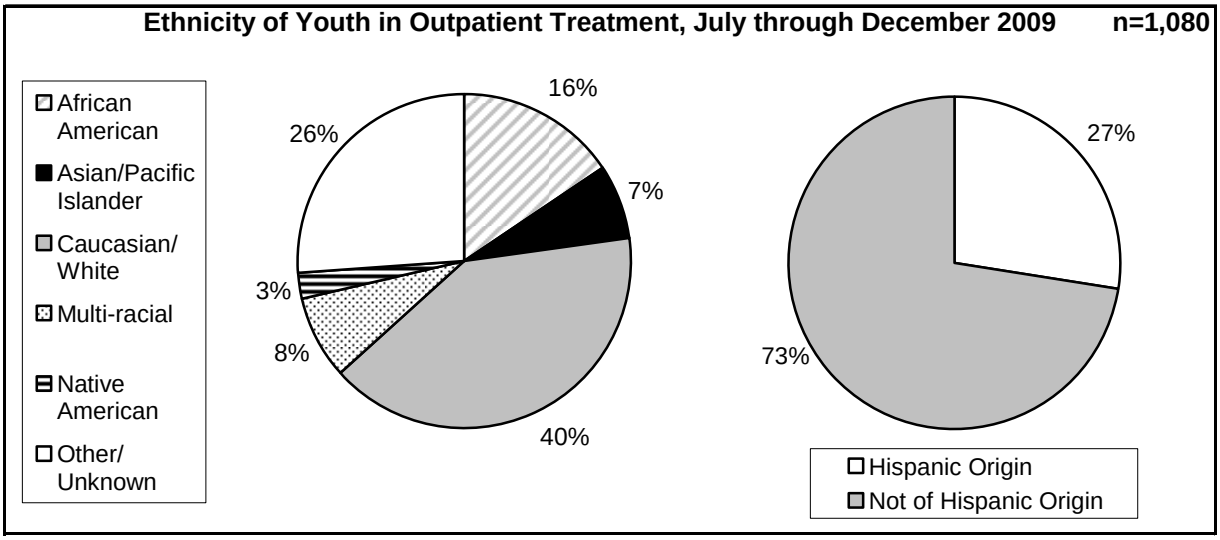


The following chart shows rates for successfully completing treatment for youth who were discharged during the quarter. (See Appendix A for details on how the rate is determined.)



The statewide completion rate, excluding King County, for youth outpatient treatment for the second half of 2009 was 54 percent compared to 71 percent for King County.

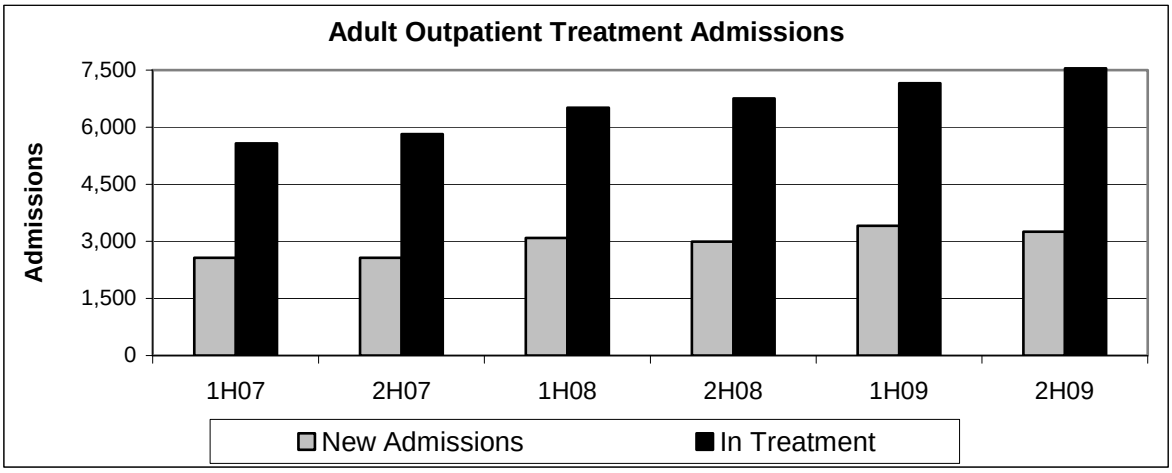
The charts below show the ethnicity of unduplicated youth receiving outpatient treatment from July through December 2009. See Appendix A for additional details.



Outpatient Treatment - Adult

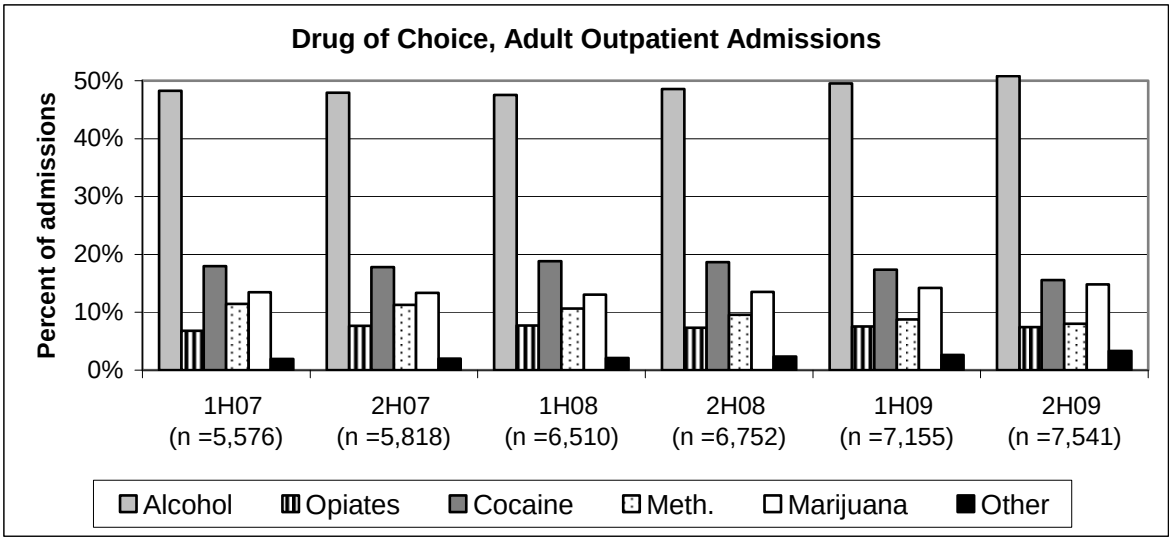
Outpatient treatment services provide treatment to low-income and indigent adults who need treatment to recover from addiction to drugs and/or alcohol. Services are designed to assist clients to achieve and maintain sobriety, and can include individual face-to-face treatment sessions, group treatment, 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 "in treatment", which includes people who started treatment prior to the start of the quarter and were not yet discharged, are shown.

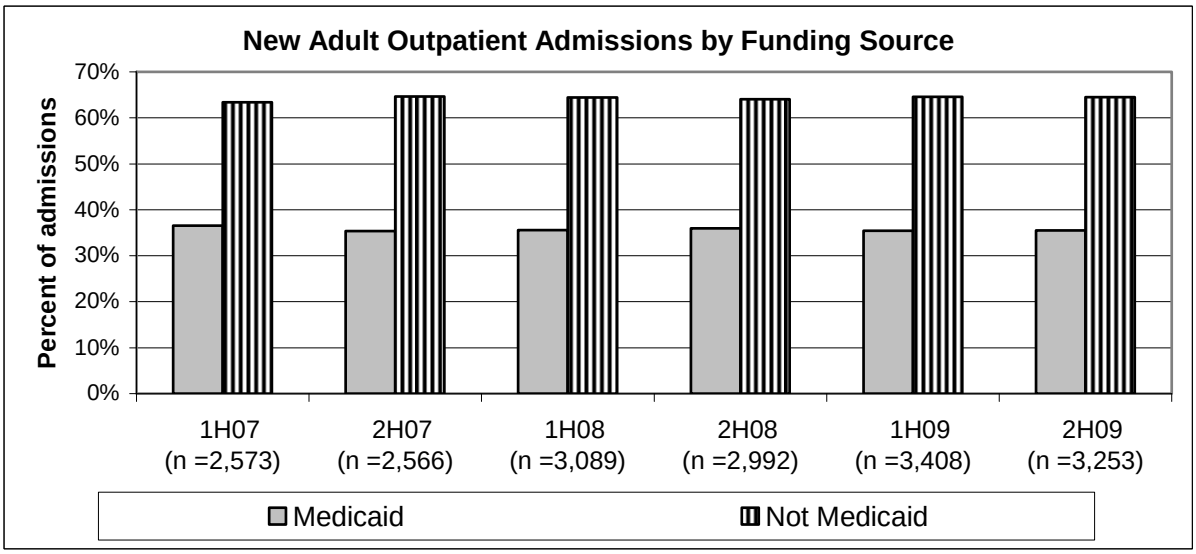


The total number of people in treatment has continued to increase since early 2006 because people are remaining in treatment longer. This longer treatment duration reflects increased funding to pay for treatment and to meet other needs that can interfere with engagement in treatment, as well as the often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

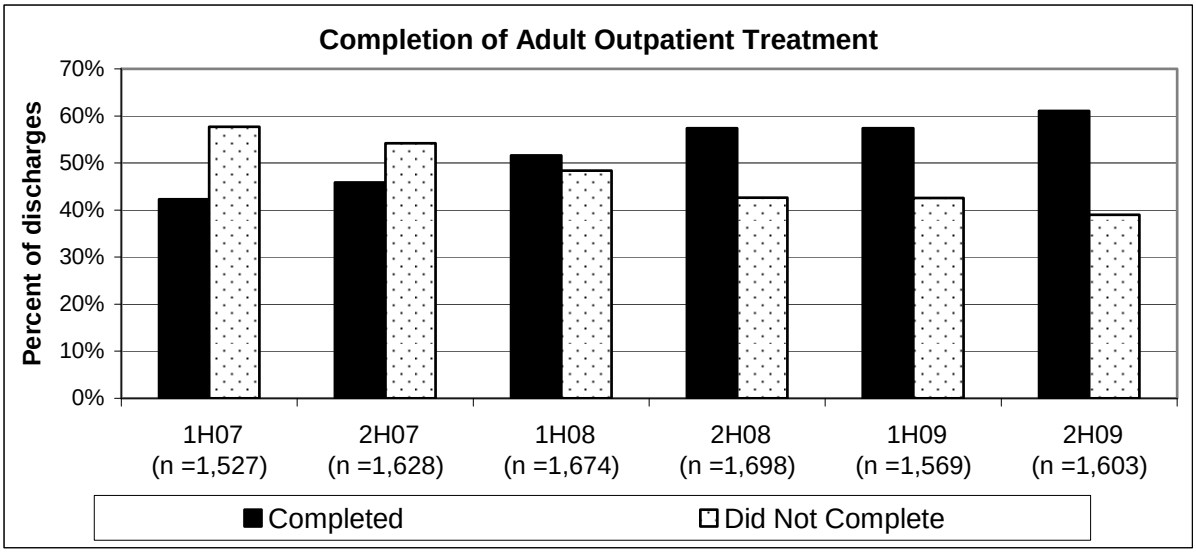
The chart below shows the primary substance used by adults admitted to outpatient treatment.



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

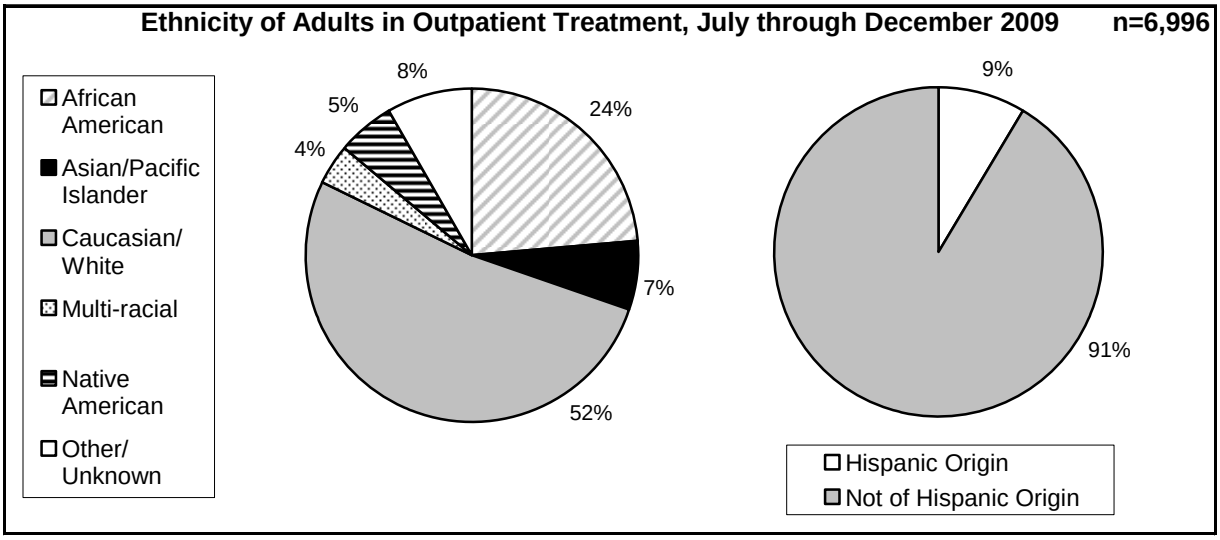


The chart below shows rates for successfully completing treatment for adults who were discharged during the quarter. (See Appendix A for details on how the rate is determined.)



The statewide completion rate, excluding King County, for adult outpatient treatment for the second half of 2009 was 53 percent compared to 58 percent for King County.

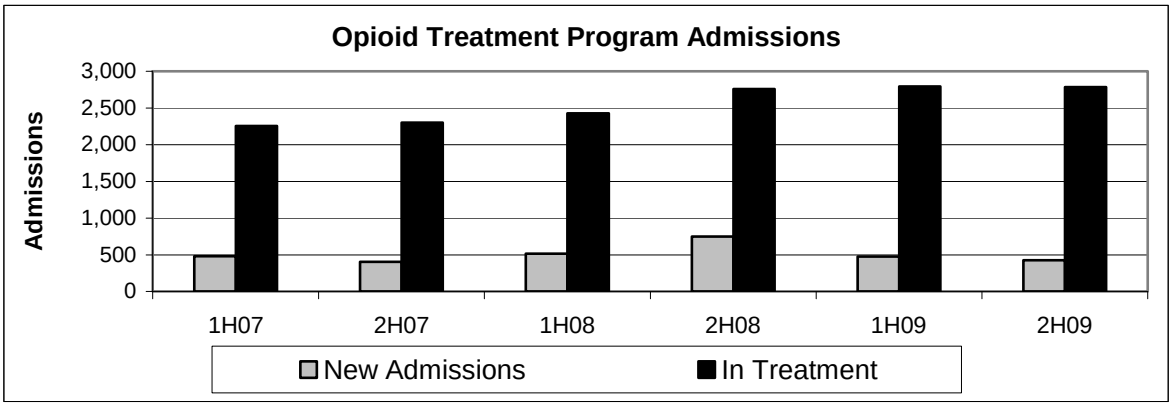
The charts below show the ethnicity of unduplicated adults receiving outpatient treatment from July through December 2009. See Appendix A for additional details.



Opioid Treatment Programs

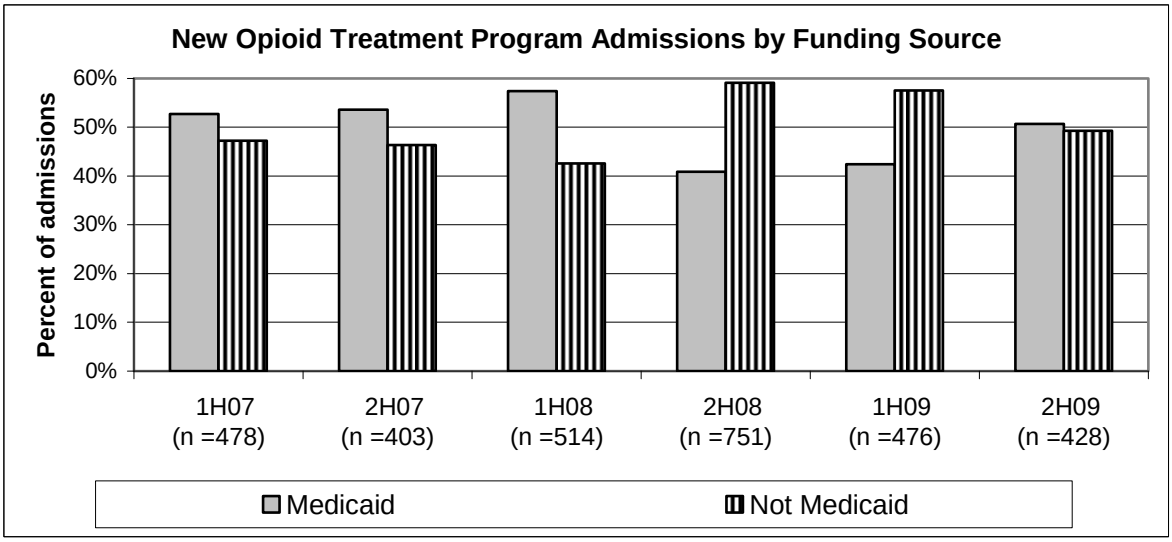
Opioid treatment programs provide medically supervised treatment services to persons with chronic opiate addictions. In addition to physical exams and medical monitoring, clinics provide individual and group counseling, medications, urinalysis screening, referral to other health and social services,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

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



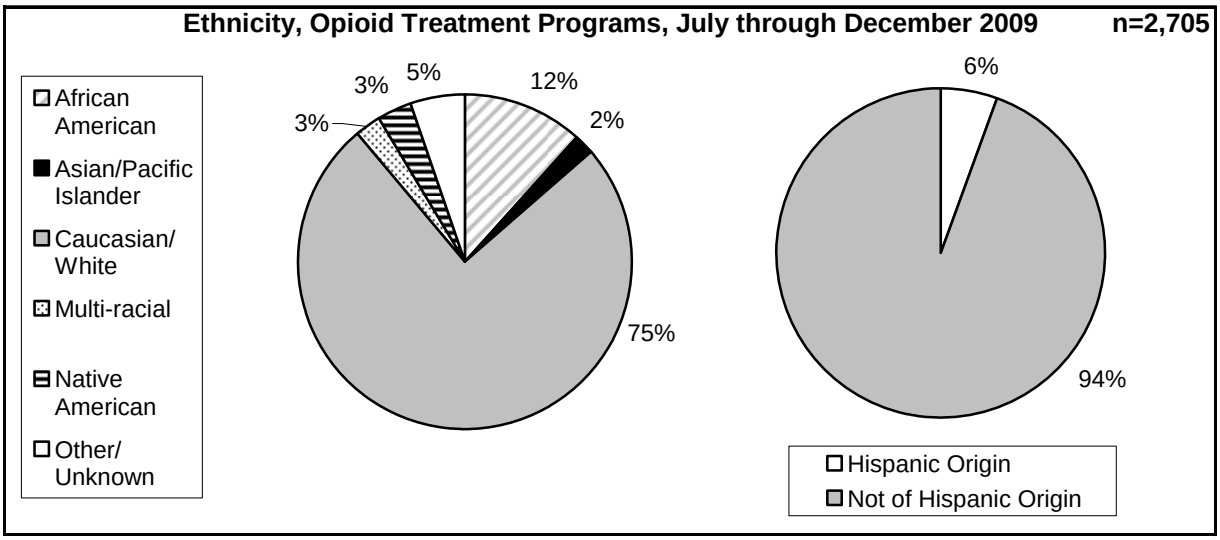
New admissions and all people in treatment both increased in the second half of 2008 as Mental Illness and Drug Dependency Action Plan funding from local sales tax became available.

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



The large increases during the second half of 2008 and first half of 2009 in the percentage and numbers of Not Medicaid admissions reflect MIDD funds that were directed to opioid treatment programs when MIDD funding first became available.

The following charts show unduplicated people receiving opioid treatment from July through December 2009. See Appendix A for additional details.



Summary Data

Overview

This section provides summary data for the current calendar year about services and dispositions and about demographics of individuals served. It also provides summary data for the last three calendar years for financial revenues and expenditures.

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, which is the same time period as the last two biennial quarters 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 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, U.S. Census Bureau 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 Source: U.S. Census Bureau, 2005-2006 American Community Survey, B17001A-I tables.)

The financial data (see page 25) include a financial plan for 2007, 2008, and 2009 Actuals, and the expenditures for outpatient treatment services that were funded by the Mental Illness and Drug Dependency Action Plan (MIDD). The financial plan shows the beginning fund balance, revenues received by type of revenue, expenditures made by category of expenditure, and the ending fund balance. The chart at the bottom of the page combines the contracted expenditures for outpatient treatment services from the financial plan with the MIDD expenditures, which started in October 2008. The chart is broken out by outpatient treatment services for adults and youth, and opioid treatment programs. Total contracted outpatient services accounted for $11,237,163 in 2007, $12,927,347 in 2008, and $15,614,479 in 2009.

Title XIX (Medicaid) dollars are not included in the financial plan figures. Title XIX dollars combine state and federal funds to pay for treatment services. Money is set aside from the MHCADSD biennium contract with the State and allocated to chemical dependency treatment agencies to provide treatment services. These dollars are then matched with federal dollars and disbursed by the state directly to agencies for treatment services provided to Medicaid recipients. For 2009, the Title XIX County Summary Match Reports and agency reports as recorded in the MHCADSD Invoice Processing System show that $8,621,529 was paid to agencies for treatment services utilizing a total of $3,744,085 in state match. This is an increase of 9.3 percent or $733,785 paid to agencies for treatment services above the amount paid in 2008, and a decrease in the amount of state match of 5 percent or $199,787 when compared to match utilization in 2008.

Services and Dispositions, January – December 2009

	Number	Percent
Prevention Participants	3,985	100%
Age Group		
Child	1,424	36%
Youth	1,865	47%
Adult	596	15%
Unknown	100	3%
Risk/Protective Factor		
Favorable Attitudes	2,028	51%
Family Management	528	13%
Bonding	117	3%
Early Initiation	1,312	33%
Program Type		
Best Practices	3,627	91%
Promising Practices	264	7%
Innovative Practices	94	2%
ESP Transports		
All Destinations	13,939	100%
Sobering	10,401	75%
1811 Eastlake	445	3%
Street	610	4%
Detox	857	6%
Harborview	391	3%
Other	1,235	9%
Sobering Center		
Admissions	23,803	
Unduplicated People	2,284	
Detoxification Center		
Admissions	3,398	
Unduplicated People	2,395	
Admissions by drug of choice	3,398	100%
Alcohol	1,938	57%
Opiates	996	29%
Cocaine	286	8%
Methamphetamines	71	2%
Marijuana	35	1%
Other	72	2%
Referrals on discharge, all d/c	3,404	100%
Self-help	2,476	73%
CD TX	585	17%
Other	83	2%
ADATSA	257	8%
ICS	0	0%
Housing	3	0%

	Number	Percent
Involuntary Commitment Services		
Referrals	134	
Unduplicated people	127	
PCN Placements	94	
Outpatient Treatment		
Youth		
New admissions	1,176	
In Treatment	1,666	
Unduplicated people (open)	1,560	
Open admissions by drug of choice		
Alcohol	515	31%
Opiates	12	1%
Cocaine	21	1%
Methamphetamines	30	2%
Marijuana	1,049	63%
Other	39	2%
New admissions by Medicaid status		
Medicaid	618	53%
Not Medicaid	558	47%
Discharges (during year)	1,044	
Completed treatment	400	73%
Did not complete	145	27%
Excluded from calc.	499	48%
Adult		
New admissions	6,661	
In Treatment	10,408	
Unduplicated people (open)	9,109	
Open admissions by drug of choice		
Alcohol	5,194	50%
Opiates	791	8%
Cocaine	1,684	16%
Methamphetamines	888	9%
Marijuana	1,520	15%
Other	331	3%
New admissions by Medicaid status		
Medicaid	2,363	35%
Not Medicaid	4,298	65%
Discharges (during year)	6,185	
Completed treatment	1,879	59%
Did not complete	1,293	41%
Excluded from calc.	3,013	49%
Opioid Treatment Programs		
New admissions	904	
In Treatment	3,220	
Unduplicated people (open)	3,029	
New admissions by Medicaid status		
Medicaid	419	46%
Not Medicaid	485	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 - December 2009

	Detoxification Center Admissions*	Outpatient Youth Admissions	Outpatient Adult Admissions
Total Number	3,398	1,666	10,408
Drug of Choice Percentage			
Alcohol	57%	31%	50%
Opiates	29%	1%	8%
Cocaine	8%	1%	16%
Methamphetamines	2%	2%	9%
Marijuana	1%	63%	15%
Other	2%	2%	3%

There is a dramatic difference between the Youth and Adult Outpatient use of marijuana.

Demographic Detail, January – December 2009

					Outpatient			King County Residents Below Fed. Pov. Level	
	Prevention	Sobering	Detox	ICS	Youth	Adult	Opioid Tx.	Youth (12 - 17)	Adult (over 17)
Unduplicated people served	3,985	2,284	2,395	127	1,560	9,109	3,029	15,199	130,235
Gender									
Number of people									
Male	1,728	1,970	1,721	103	1,084	6,032	1,665	8,031	59,077
Female	2,157	262	674	24	476	3,077	1,364	7,168	71,158
Percent of all served									
Male	43%	86%	72%	81%	69%	66%	55%	53%	45%
Female	54%	11%	28%	19%	31%	34%	45%	47%	55%
("Unknown gender" counts are not included)									
Race/ethnic group:									
Number of people									
African American	360	541	489	27	234	2,148	352	3,770	16,655
Asian/Pacific Islander	499	46	50	2	111	574	57	1,932	19,081
Caucasian/ White	2,000	914	1,461	63	685	4,767	2,276	6,248	81,731
Multi-racial	343	58	57	7	121	365	77	1,413	5,289
Native American	83	324	148	20	40	470	101	390	2,204
Other/ Unknown	700	401	190	8	369	785	166	1,446	5,275
Percent of all served									
African American	9%	24%	20%	21%	15%	24%	12%	25%	13%
Asian/Pacific Islander	13%	2%	2%	2%	7%	6%	2%	13%	15%
Caucasian/ White	50%	40%	61%	50%	44%	52%	75%	41%	63%
Multi-racial	9%	3%	2%	6%	8%	4%	3%	9%	4%
Native American	2%	14%	6%	16%	3%	5%	3%	3%	2%
Other/ Unknown	18%	18%	8%	6%	24%	9%	5%	10%	4%
	100%	100%	100%	100%	100%	100%	100%	100%	100%
Hispanic origin:									
Number of people									
Hispanic origin	535	234	150	6	396	814	167	2,713	13,668
Not Hispanic origin/Unknown	3,450	2,050	2,245	121	1,164	8,295	2,862	12,486	116,567
Percent of all served									
Hispanic origin	13%	10%	6%	5%	25%	9%	6%	18%	10%
Not Hispanic origin/Unknown	87%	90%	94%	95%	75%	91%	94%	82%	90%
	100%	100%	100%	100%	100%	100%	100%	100%	100%

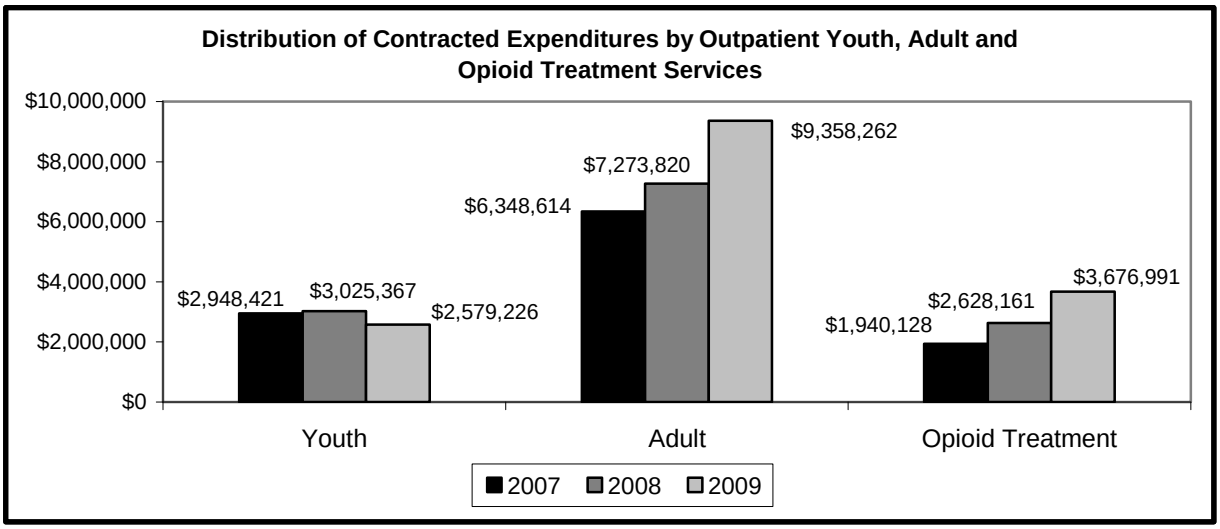
(Percentages may not add up to 100% because of rounding)

Financial Summary

King County Substance Abuse Fund
2007 - 2009 Actuals
Financial Plan

	2007 Actual	2008 Actual	2009 Actual
Beginning Fund Balance	**2,537,729**	**2,419,423**	**2,897,187**
Revenues			
Licenses & Permits	0	0	0
Federal Grants	5,275,547	6,481,269	8,709,395
State Grants	13,851,485	14,187,246	11,684,814
Intergovernment Payment	1,171,853	1,170,582	1,191,409
Charges for Services	328,009	711,003	396,513
Miscellaneous	57,983	124,292	52,470
Other Financing Sources	253,758	187,809	0
Current Expense	3,154,107	3,217,189	3,166,986
Total Revenues	**24,092,741**	**26,079,389**	**25,201,587**
Expenditures			
Administration	(2,562,610)	(2,456,563)	(2,635,653)
Housing Voucher Program *	(494,887)	(510,182)	(419,781)
Treatment	(20,163,206)	(21,706,250)	(20,240,312)
Prevention Activities	(990,344)	(928,631)	(1,023,512)
Total Expenditures	**(24,211,047)**	**(25,601,626)**	**(24,319,258)**
Other Fund Transactions			
Adjustment Prior Yr Expenditures			
DCFM Energy Surcharge Refund			
Total Other Fund Transactions	**0**	**0**	**0**
Ending Fund Balance	**2,419,423**	**2,897,187**	**3,779,515**

MIDD Expenditures for Treatment	**0**	**593,967**	**2,044,041**



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 Emergency Services Patrol.
- A database developed by MHCADSD that is used by the Dutch Shisler Sobering Support Center and Involuntary Commitment Services to collect data for those programs.
- The State 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").
- "Other" is grouped with "Unknown" into "Other/Unknown".

Chemical Dependency Performance Indicators Report, Appendix A – Data Notes

Program Specific Data Notes

Prevention

Prevention data shown in the report are from the state Prevention database. Providers report demographic data about individuals who participate in multiple session prevention programs but report 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.

Emergency Services Patrol

Individually identified data are not currently collected for this service.

Sobering Center

Data for services are entered into the MHCADSD 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.

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 at the Detoxification Center 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 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. These conditions include admissions funded by MIDD. 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. (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:

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

Chemical Dependency Performance Indicators Report, Appendix A – Data Notes

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, charitable choice, 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 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.
AODPP	Alcohol and Other Drug Prevention Program
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, 2009 and will end June 30, 2011.
CD TX	Chemical dependency treatment.
ESP	Emergency Services Patrol (see program description).
ICS	Involuntary Commitment Services (see program description).
KCCOP	King County Community Organizing Program
MHCADSD	The Mental Health, Chemical Abuse and Dependency Services Division of the King County Department of Community and Human Services.
MIDD	The Mental Illness and Drug Dependency Action Plan is a King County initiative funded with a one tenth of one cent sales tax to provide programs designed to stabilize people suffering from mental illness and chemical dependency, and to divert them from jails and emergency rooms by getting them proper treatment.
TARGET	Treatment Assessment and Report Generation Tool is a data collection and reporting system that is maintained by the Washington State Department of Social and Human Services and contains data submitted by contracted treatment providers about the publicly funded chemical dependency treatment that they provide.

Chemical Dependency Performance Indicators Report, Appendix C - Program Providers for January - December 2009

Provider	Prev.	ESP	Sober. Ctr	Detox	ICS	Outpatient		OTP
						Youth	Adult	
Alpha Center							x	
Asian Counseling Referral Service						x	x	
Auburn Youth Resources	x					x		
Catholic Community Services							x	
Center for Human Services	x					x	x	
Community Psychiatric Clinic						x	x	
Consejo Counseling & Referral Svcs						x	x	
Downtown Emergency Service Center							x	
Encompass	x							
Evergreen Healthcare							x	
Evergreen Treatment Services								x
Friends of Youth	x					x		
Girl Scouts-Western WA	x							
Greater Maple Valley Community Center	x							
Harborview Medical Center Addictions Program							x	
Integrative Counseling Services							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							
Muckleshoot Indian Tribe							x	
Navos							x	
Neighborhood House	x							
New Traditions							x	
Northshore Family and Youth Services						x		
Pioneer Human Services			x				x	
Recovery Centers of King County				x			x	
Renton Area Youth and Family Services	x					x		
Ruth Dykeman Youth and Family Services						x		
Ryther Child Center						x		
SafeFutures Youth Center	x							
SeaMar Community Health Centers						x	x	
Seattle Counseling Services						x	x	
Seattle Indian Health Board							x	
Snoqualmie Indian Tribe							x	
Sound Mental Health						x	x	
Therapeutic Health Services						x	x	x
Valley Cities Counseling and Consultation						x	x	
Vashon Youth & Family Services	x							
Washington Asian/Pacific Islander Families Against Substance Abuse (WAPIFASA)	x					x		
Youth Eastside Services						x		