King County

Mental Health, Chemical Abuse and Dependency Services Division

CHEMICAL DEPENDENCY PERFORMANCE INDICATORS REPORT

July – December 2003

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Introduction

The King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) developed the Chemical Dependency Performance Indicators Report (CDPIR) to provide the community with timely information about the publicly funded chemical dependency treatment delivery system in King County. This system serves adults and adolescents who do not have adequate resources to pay for treatment and support services.

This is the third edition of the CDPIR. We consider this to be a work in progress. Changes to the format and content will evolve as we identify ways to make the report more meaningful and useful to the reader. MHCADSD will utilize the data to identify and implement changes to enhance the chemical dependency treatment delivery system in King County. We welcome your feedback and suggestions on the usefulness of the information presented as well as comments on the content and format of the document.

The CDPIR includes:

- Data for a three year period for each program funded by MHCASDSD
- Summary program, demographic and financial data for the most recent calendar year
- Appendices that provide detail about the data and define terms used in this report

Data for all program areas except Prevention are presented by biennial quarter: January 1 – June 30; July 1 – December 31. **[Note: Charts use the following labels for biennial quarters: "1H01" means January through June of 2001; "2H01" means July through December 2001, etc.]**

In most program areas, ethnicity data for people who participate in services are shown, but only for the last biennial quarter in the report period. Only one time period is shown because the complexity and ambiguity of the data make it impossible to draw a clear and accurate picture over the three years covered in this report. See Appendix A for details.

The CDPIR is issued twice a year. The next report, for January –June 2004, will be published in September 2004.

In addition to the services provided through MHCADSD and Public Health – Seattle & King County (Public Health)[1], the Division of Alcohol and Substance Abuse (DASA) directly contracts with King County providers for certain services, such as residential treatment. Information about those services is not included in this report, but can be found at http://www-app2.wa.gov/dshs/dasa/about/dasaoverview.htm.

[1] Public Health contracts for Prevention programs; MHCADSD provides or contracts for all other programs included in this report.

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, factors targeted in King County were reviewed and reduced from nine to four in July 2003. The targeted factors for July 2003 through June 2004 are:

- Favorable attitudes among youth toward substance use
- Family management problems with consistent guidelines for behavior and appropriate rewards and consequences for following and not following those guidelines
- 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
- Healthy beliefs and clear standards that oppose teenage use of illegal drugs and alcohol

Additional factors addressed from January 2001 through June 2003 were:

- Community laws, written policies, social practices and expectations that are favorable to alcohol and drug use
- Friends who engage in substance abuse
- Early initiation of substance abuse
- Social skills, including negotiating, saying "no" and dealing with peer pressure
- Having new and challenging opportunities for involvement in society, learning the skills to be successful in those opportunities and getting individual recognition for accomplishments

The following tables show the number of persons participating in prevention programs, grouped by risk or protective factor. Because of the changes to target factors described above, participants are shown separately for three time frames, calendar year 2002, the first half of 2003 and the second half of 2003.

For each time period there are differences in what the data represent:

- A new tool for collecting and reporting Prevention data was implemented in July 2003. Previously similar data were reported for all people who participated in prevention activities. Beginning with the July - December 2003 biennial quarter, unduplicated data, including gender and ethnicity, were only reported for those who participated in prevention programs that consist of multiple episodes held over a period of weeks or months. Because the data collection system is new, data for participants in single events were reported inconsistently and are not available at this time. (See Appendix A for additional details.)
- Although the risk and protective factors remained the same in the first half of 2003 as 2002, the methods by which they were addressed changed with some new strategies, new services and/or new contractors. Such changes, which are always occurring, affect the numbers served in different program areas.
- Age ranges changed in July 2003, counting 12 year-olds as youth and 21 year-olds as adult, rather than child and youth respectively.

Because of the changes above and the difference in the length of the time periods, data should not be compared among the three tables but used separately as information about people receiving services in targeted areas during each period of time.

Age group age ranges: Child - 0-11 Youth - 12-20 Adult - 21 and older

New Prevention Participants, July - December 2003 (Multi-episode programs)

Risk or Protective Factor	Number of Participants				Percent of Age Group				Percent of Risk Factor			
	Age Groups			All	Age Groups			All	Age Groups			All
	Child	Youth	Adult	Ages	Child	Youth	Adult	Ages	Child	Youth	Adult	Ages
Healthy Beliefs and Clear Standards	0	0	0	0	0%	0%	0%	0%				
Favorable Attitudes Toward Problem Behavior	7	25	1	33	1%	5%	1%	3%	21%	76%	3%	100%
Family Management Problems	2	21	147	170	0%	4%	88%	15%	1%	12%	86%	100%
Bonding	471	438	20	929	98%	90%	12%	82%	51%	47%	2%	100%
All Factors	**480**	**484**	**168**	**1,132**	**100%**	**100%**	**100%**	**100%**	**42%**	**43%**	**15%**	**100%**

The "Healthy Beliefs" factor was targeted in July – December 2003 by a media campaign that was in development. Participants will only be reported during the biennial quarter of the active campaign period.

Age group age ranges: Child - 0-12 Youth - 13-21 Adult - 22 and older

New Prevention Participants, January - June 2003 (Single & multi-episode programs)

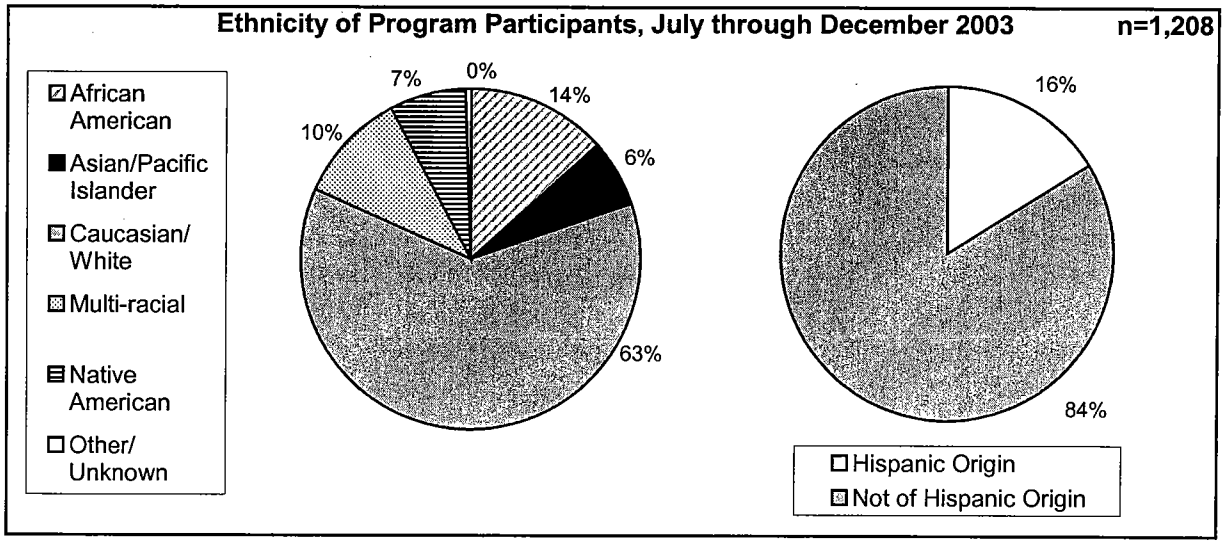
Risk or Protective Factor	Number of Participants				Percent of Age Group				Percent of Risk Factor			
	Age Groups			All	Age Groups			All	Age Groups			All
	Child	Youth	Adult	Ages	Child	Youth	Adult	Ages	Child	Youth	Adult	Ages
Community Laws & Norms Favorable to Drug Use	128	203	601	932	6%	10%	37%	16%	14%	22%	64%	100%
Healthy Beliefs and Clear Standards	263	27	0	290	13%	1%	0%	5%	91%	9%	0%	100%
Favorable Attitudes Toward Drug Use	251	25	381	657	12%	1%	23%	11%	38%	4%	58%	100%
Family Management Problems	930	1,480	234	2,644	44%	71%	14%	45%	35%	56%	9%	100%
Friends Who Use	0	15	0	15	0%	1%	0%	0%	0%	100%	0%	100%
Early First Use of Alcohol and Drugs	187	241	155	583	9%	12%	10%	10%	32%	41%	27%	100%
Bonding	228	67	253	548	11%	3%	16%	9%	42%	12%	46%	100%
Social Skills	112	21	0	133	5%	1%	0%	2%	84%	16%	0%	100%
Opportunities, Skills, and Recognition	0	10	2	12	0%	0%	0%	0%	0%	83%	17%	100%
All Factors	**2,099**	**2,089**	**1,626**	**5,814**	**100%**	**100%**	**100%**	**100%**	**36%**	**36%**	**28%**	**100%**

Age group age ranges: Child - 0-12 Youth - 13-21 Adult - 22 and older

New Prevention Participants, January - December 2002 (Single & multi-episode programs)

Risk or Protective Factor	Number of Participants				Percent of Age Group				Percent of Risk Factor			
	Age Groups			All	Age Groups			All	Age Groups			All
	Child	Youth	Adult	Ages	Child	Youth	Adult	Ages	Child	Youth	Adult	Ages
Community Laws & Norms Favorable to Drug Use	3	986	848	1,837	0%	26%	39%	22%	0%	54%	46%	100%
Healthy Beliefs and Clear Standards	149	71	0	220	6%	2%	0%	3%	68%	32%	0%	100%
Favorable Attitudes Toward Drug Use	795	23	248	1,066	34%	1%	12%	13%	75%	2%	23%	100%
Family Management Problems	726	2,113	518	3,357	31%	55%	24%	40%	22%	63%	15%	100%
Friends Who Use	165	317	250	732	7%	8%	12%	9%	23%	43%	34%	100%
Early First Use of Alcohol and Drugs	52	51	14	117	2%	1%	1%	1%	44%	44%	12%	100%
Bonding	396	230	266	892	17%	6%	12%	11%	44%	26%	30%	100%
Social Skills	58	22	0	80	2%	1%	0%	1%	73%	28%	0%	100%
Opportunities, Skills, and Recognition	1	17	5	23	0%	0%	0%	0%	4%	74%	22%	100%
All Factors	**2,345**	**3,830**	**2,149**	**8,324**	**100%**	**100%**	**100%**	**100%**	**28%**	**46%**	**26%**	**100%**

The charts below show the ethnicity of people who began participating in multiple episode Prevention programs from July through December 2003. (Data for a few people are not available.)

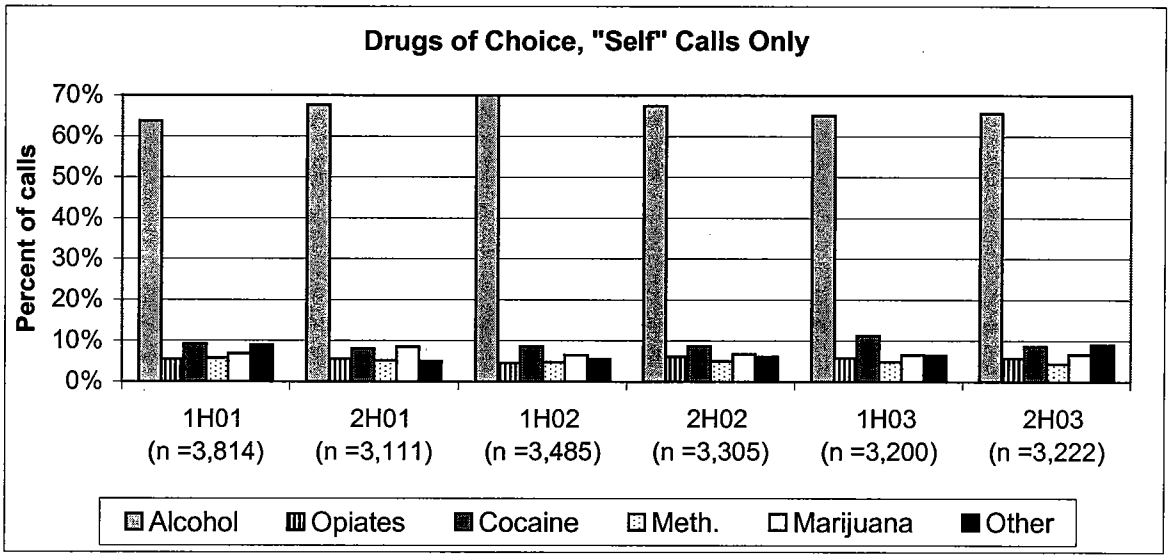


Alcohol/Drug 24-Hour Help Line

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.

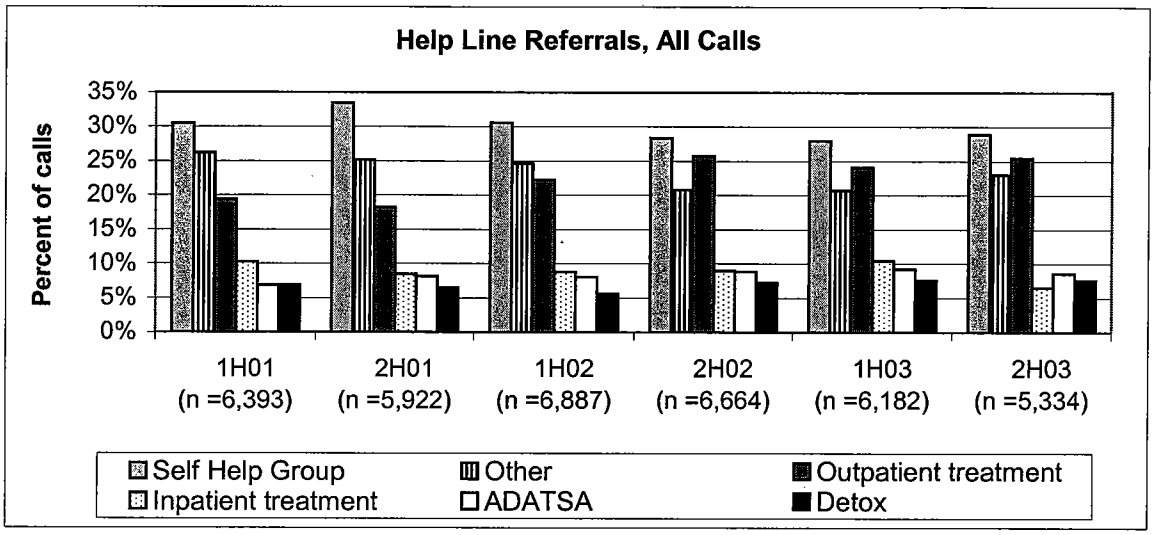


Although limiting the data to "Self" calls provides better information about substances being used by callers, 92% of those calls are about adult use (as shown in the table below). This means that the predominance of alcohol as the drug of choice primarily reflects adult use. Other data (see the Outpatient Youth and Adult drug of choice charts) suggest a significant difference between adult and teen drugs of choice.

Reported Age Group, 2003 Only

	Self		Other		All	
Age of subject of call	#	%	#	%	#	%
Teens & younger	304	8%	673	25%	977	16%
Adults (20 - 60)	3,195	89%	1,931	72%	5,126	82%
Older adults (over 60)	103	3%	74	3%	177	3%
All ages	**3,602**	**100%**	**2,678**	**100%**	**6,280**	**100%**

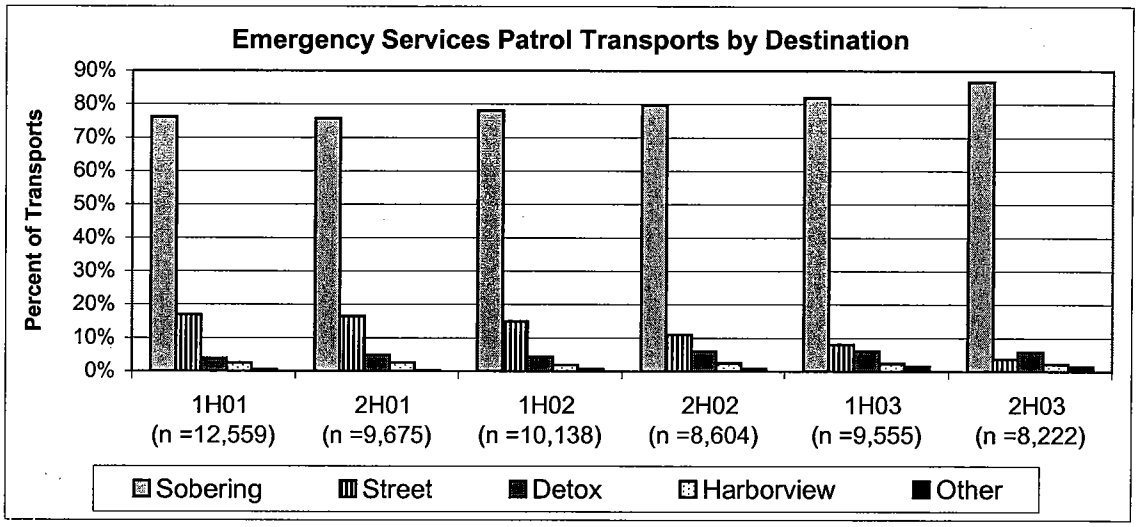
Referrals made by the Help Line are shown in the chart below. More than one referral may be made per call. "Other" includes referrals to medical, housing, domestic violence, legal, mental health, involuntary CD treatment, emergency and police resources. Referrals made to providers of outpatient chemical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



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 decrease in the percentage of transports to the "Street" and increase in percentage of transports to the Sobering Center reflects a change in practice at the Sobering Center. Clients used to be awakened early in the morning; groups of clients were then transported back to the streets. More recent practice has been to let clients sleep until they wake up, at which time, most people walk away from the Center with no transport. The number of people transported to the Sobering Center has remained about the same, but because there are many fewer transports to the "Street", the number of transports to Sobering is a larger percentage of all transports.

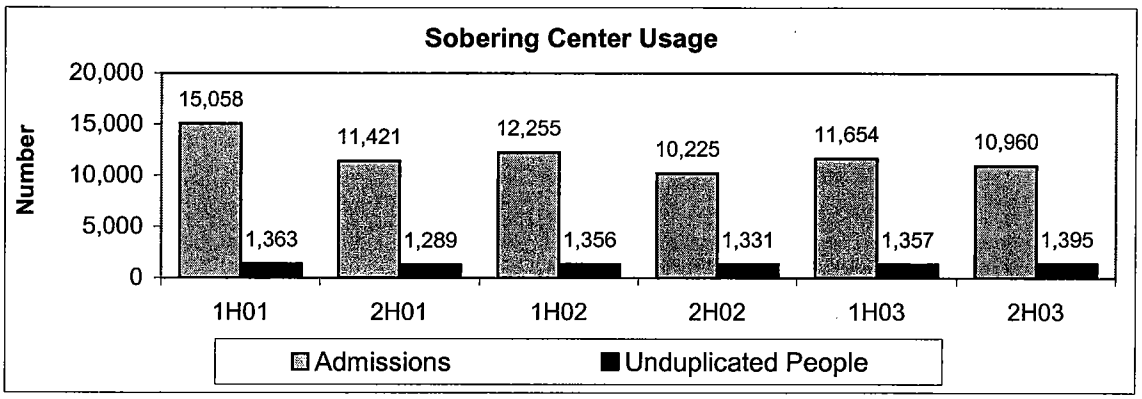
There has been an increase of more than one percentage point in transports to the Detoxification Center during each of the last three biennial quarters compared to previous quarters. This may result from a nurse from the Detoxification Center going to the Sobering Center each morning to see if there are clients interested in detoxification services.

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

Dutch Shisler Sobering Center

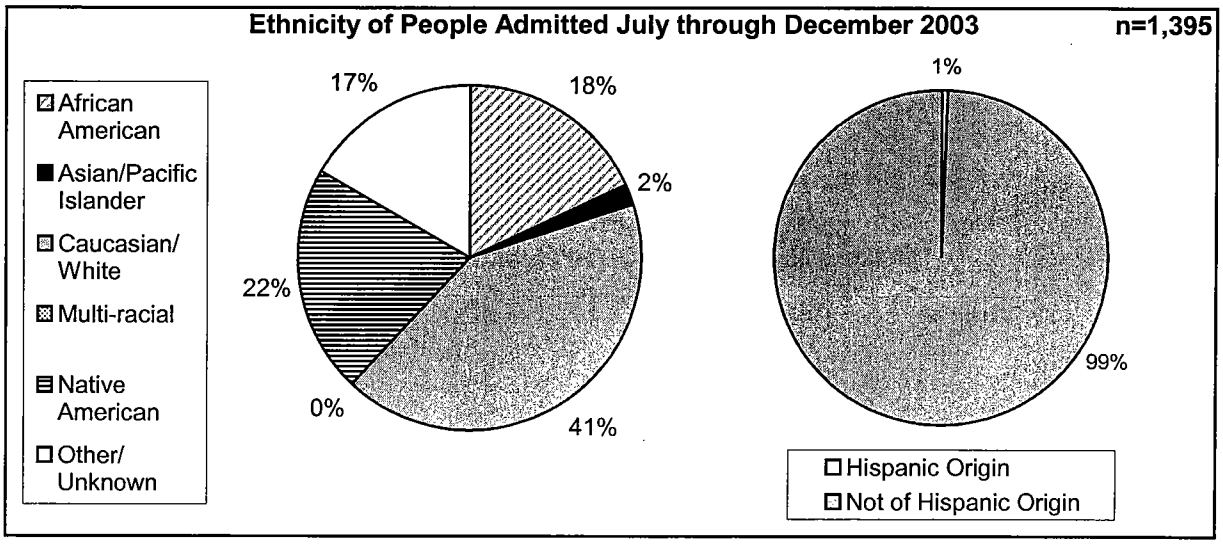
The Dutch Shisler Sobering Center provides adults a safe and secure place to recover from the effects of acute intoxication by alcohol and/or other drugs. Clients receive a medical screening and are referred to treatment and other appropriate services.

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



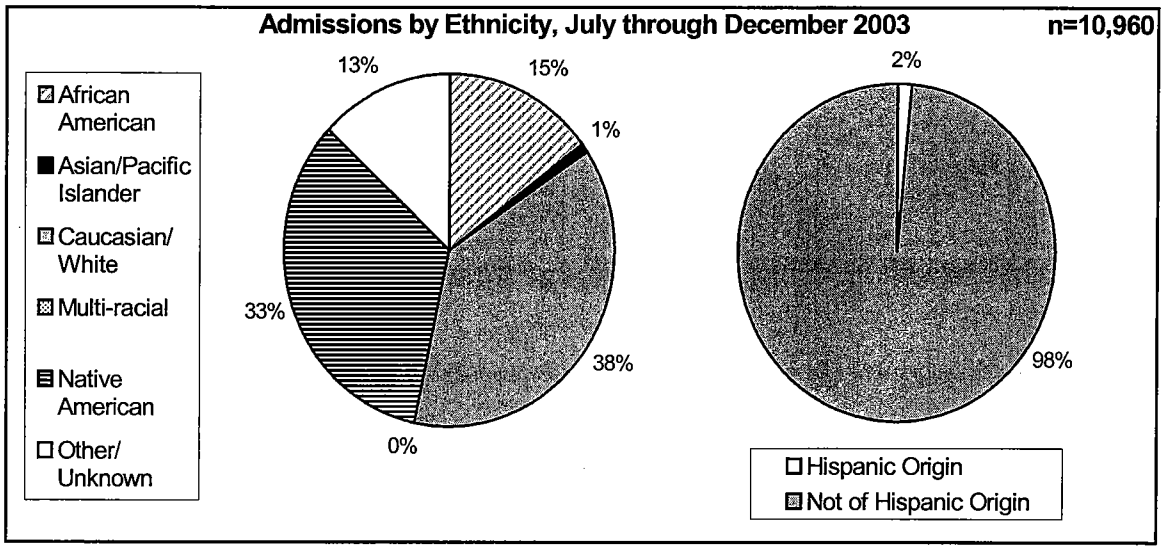
From the data above, it is clear that some individuals are multiple users of the Sobering Center. In the last biennial quarter, 8% (110) of the 1,395 people admitted accounted for 62% of the total admissions. These 110 individuals averaged 62 admissions each during the six-month period, with a range from 25 to 310 admissions.

The following charts show the ethnicity of unduplicated people served by the Sobering Center from July through December 2003. See Appendix A for additional details.



The proportion of people who receive services from the Sobering Center who are Native American is much higher (22%) than the proportion 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, 29% were Native American. A shown in the charts below, 33% of all admissions to the Sobering Center are for Native Americans although they are only 22% of the individuals served.

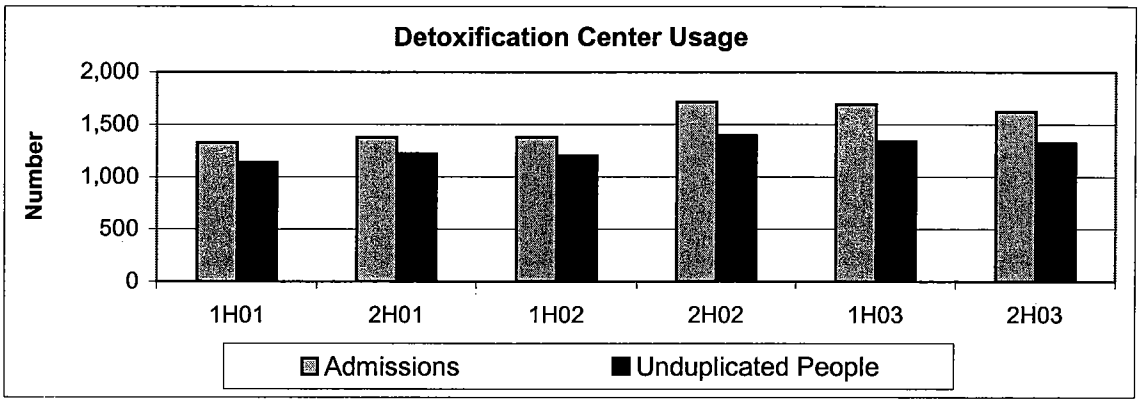


MHCADSD will work with treatment providers to identify and implement strategies to reduce this over representation of Native Americans among both unduplicated clients and those who are admitted many times.

Detoxification Center

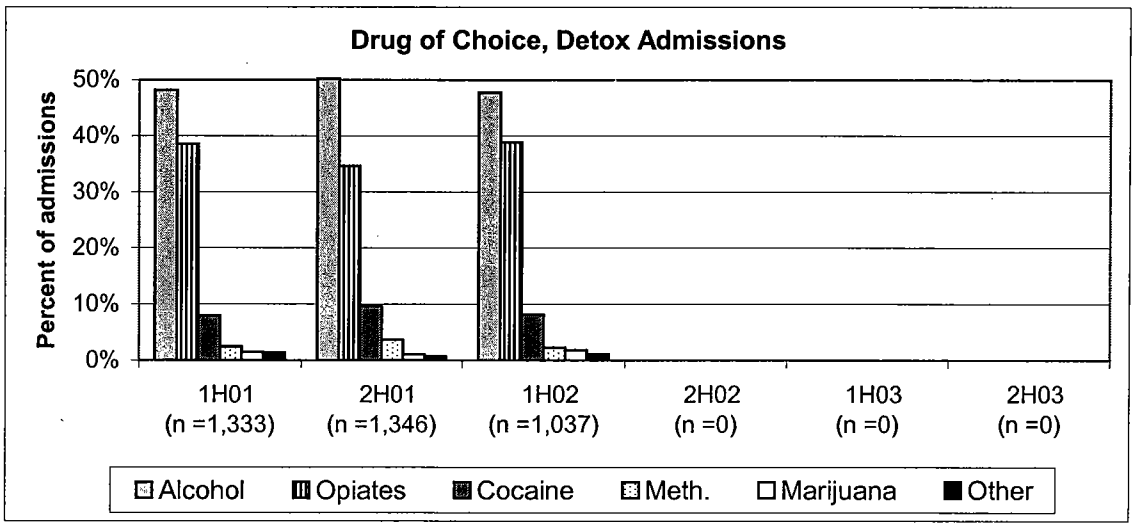
Detoxification services are provided to indigent clients who are recovering from the effects of acute or chronic intoxication or are withdrawing from alcohol or other drugs. Upon successful completion of detoxification services, clients are referred for ongoing treatment and support.

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



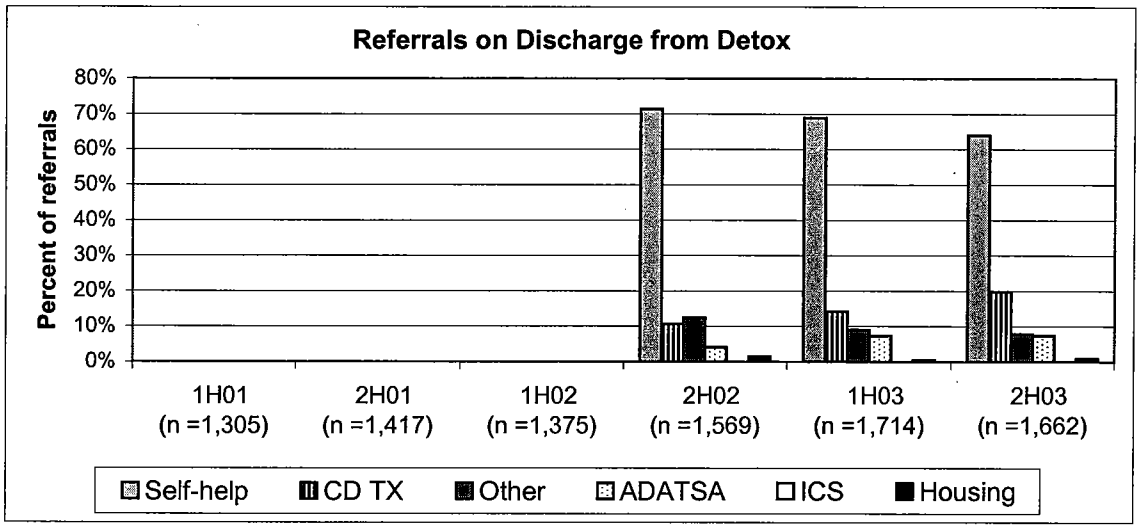
The second half of 2002 and first half of 2003 show an increase from the previous 3 biennial quarters in admissions and people served. This appears to be the result of efforts by MHCADSD to increase the number of people served by the Detoxification Center.

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



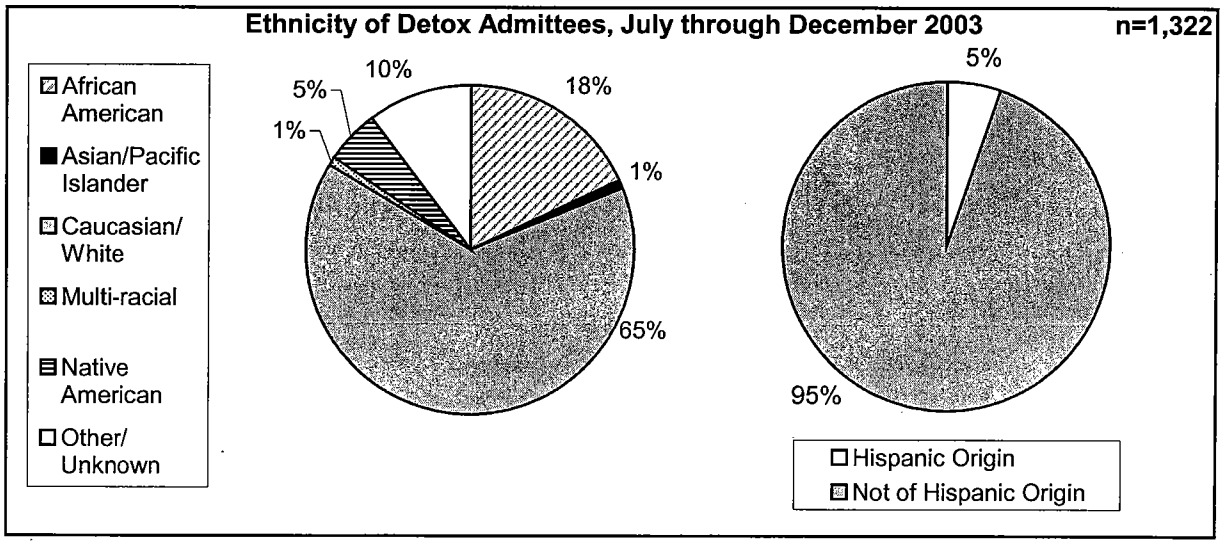
Because alcohol and opiates are substances much more likely to require a medically managed detoxification, their predominance here is not surprising. Data for June 2002 through December 2003 were not available for this report.

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.



Referral data for detoxification were severely affected by changes in 2001 and 2002 to the DASA data collection system (TARGET, see Appendix A). As a result, data prior to July 2002 are not comparable to data since then and are not shown here.

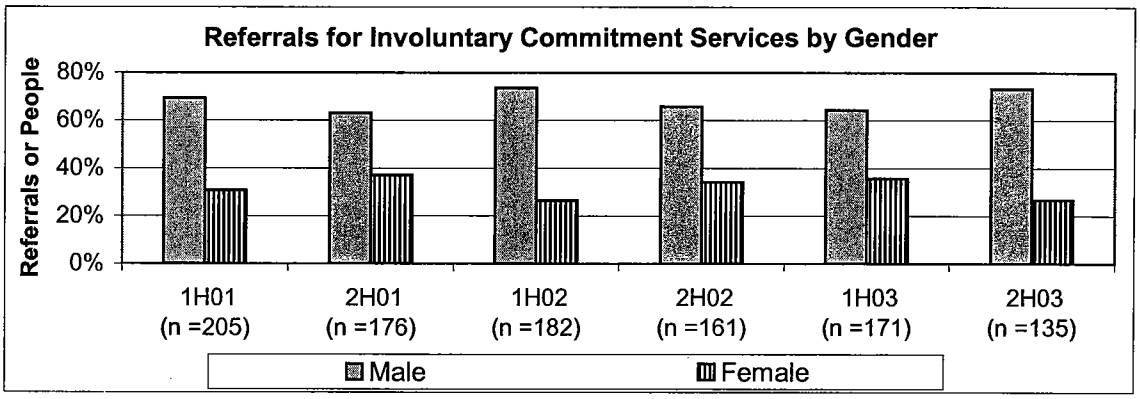
The charts below show the ethnicity of unduplicated people admitted to the Detoxification Center from July through December 2003. See Appendix A for additional details.



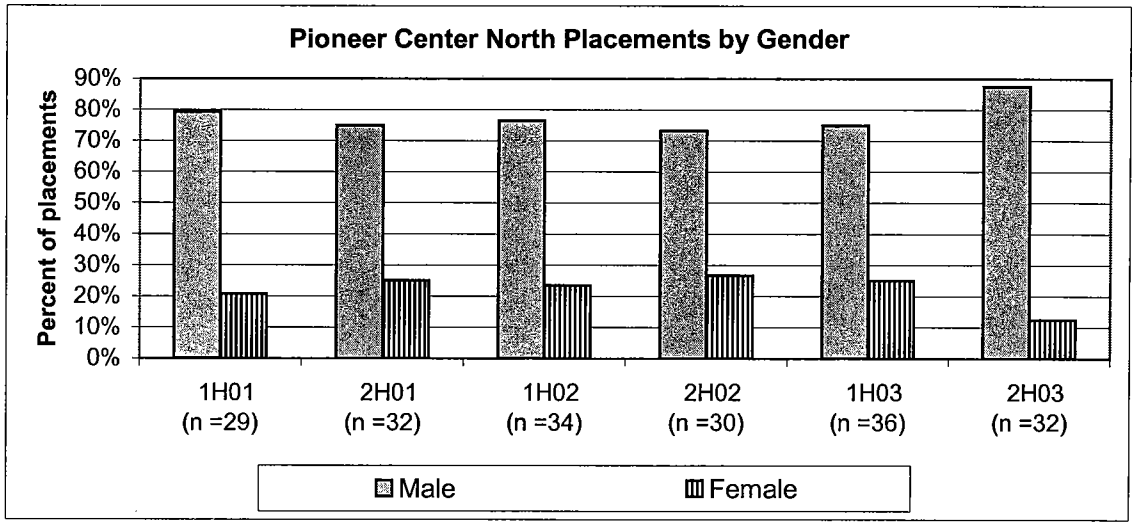
Involuntary Commitment Services

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 referrals received for investigation by gender.



Most of the referrals that result in commitments lead to a placement at Pioneer Center North (PCN) for inpatient treatment. The chart below shows the proportions of males and females among those referred to ICS who were placed at PCN for treatment.

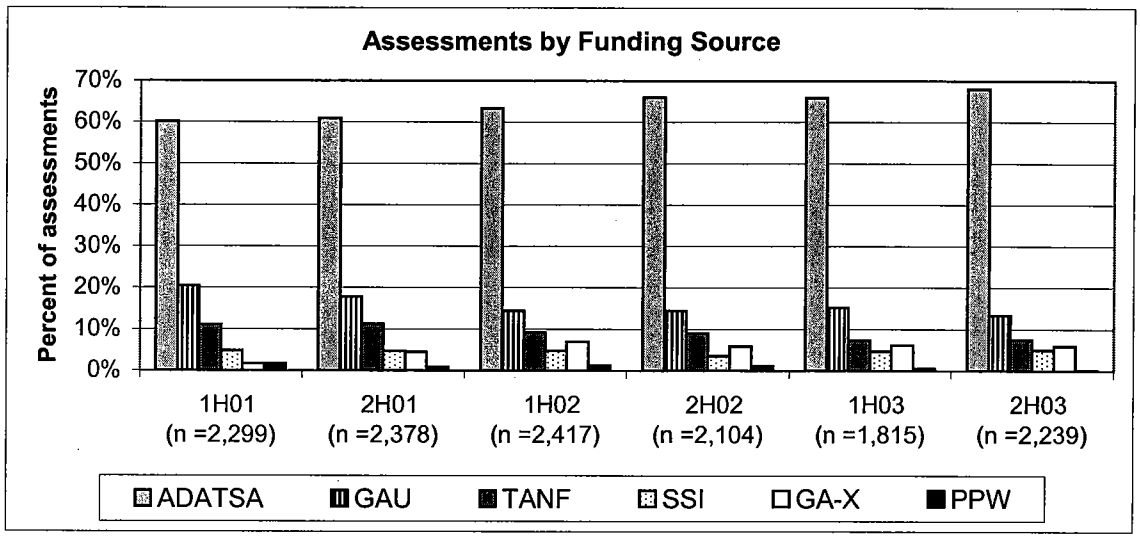


From July through December 2003, 28% of people referred to ICS were female and 13% of PCN placements were for females.

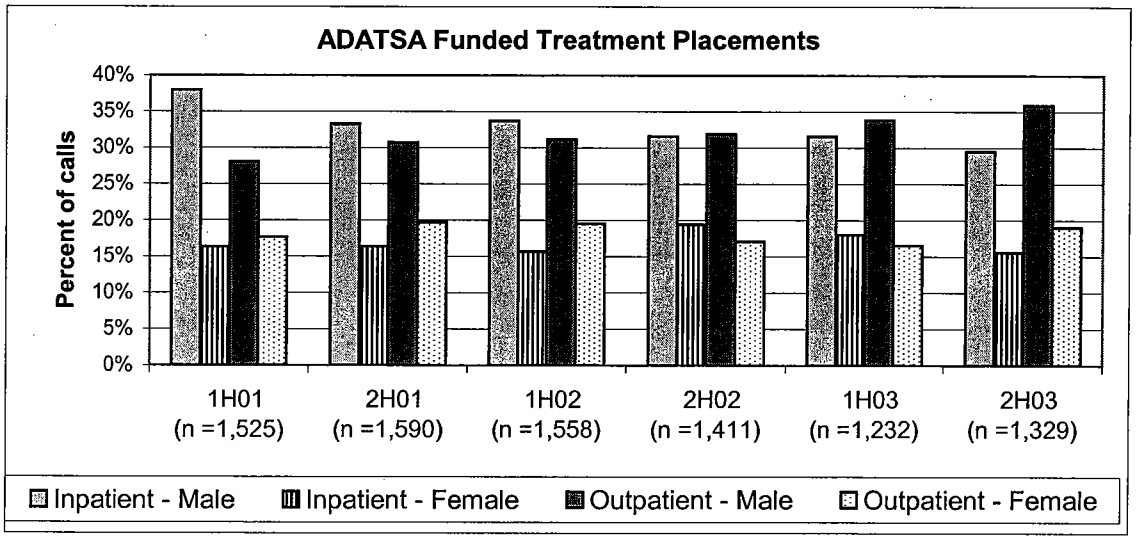
Assessment Center

The Assessment Center determines eligibility for treatment funded through public funding sources. These include the Alcohol and Drug Addiction Treatment and Support Act (ADATSA), General Assistance Unemployable (GAU), Temporary Assistance for Needy Families (TANF), Social Security Income (SSI), General Assistance – Expedited Medicaid (GA-X) and Pregnant and Postpartum Women (PPW). (See Appendix B for information on these funding sources.)

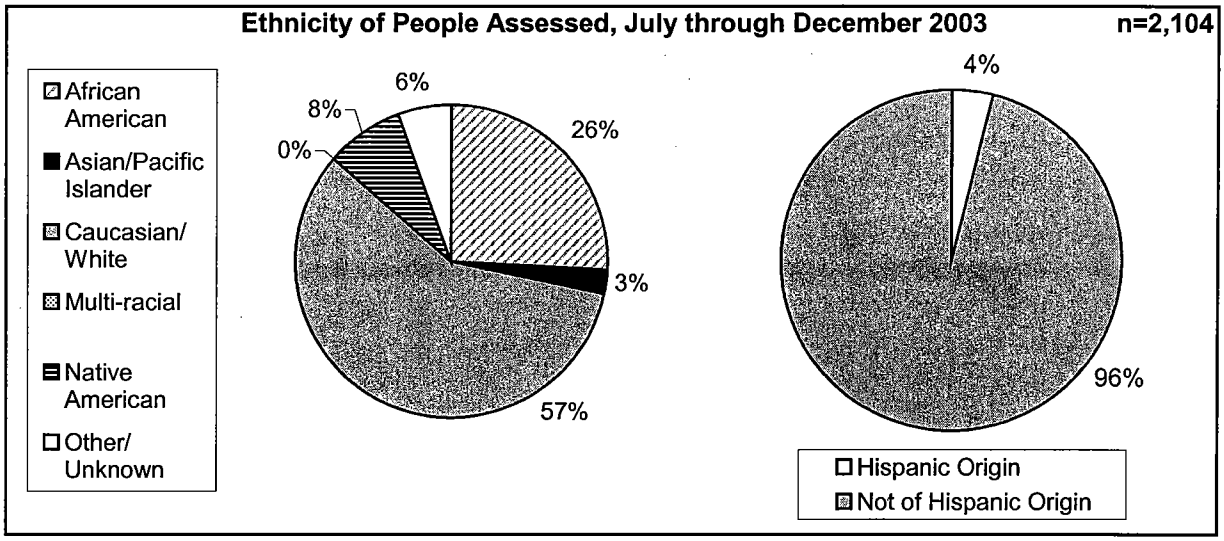
The following chart shows the proportion of assessments by the funding source for which the person assessed was eligible.



The chart below shows the proportion of inpatient and outpatient placements by gender for people who receive ADATSA funded treatment following an assessment.



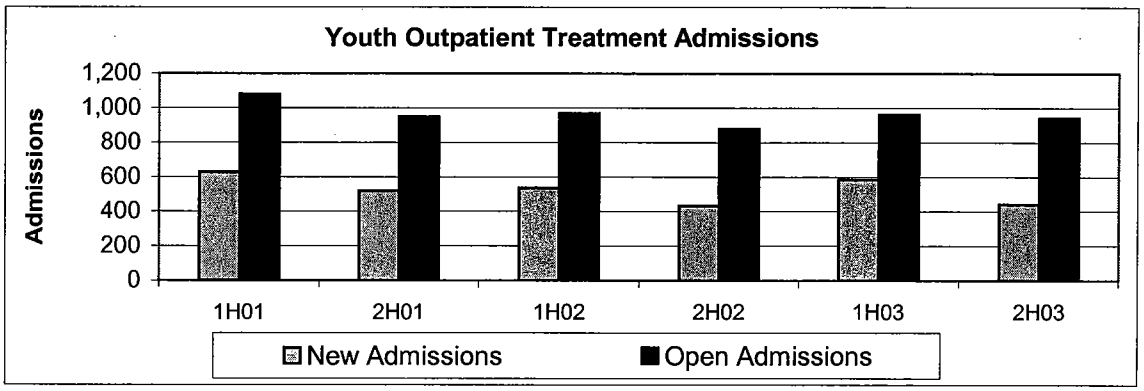
The charts below show the ethnicity of unduplicated people assessed from July through December 2003. See Appendix A for additional details.



Outpatient Treatment - Youth

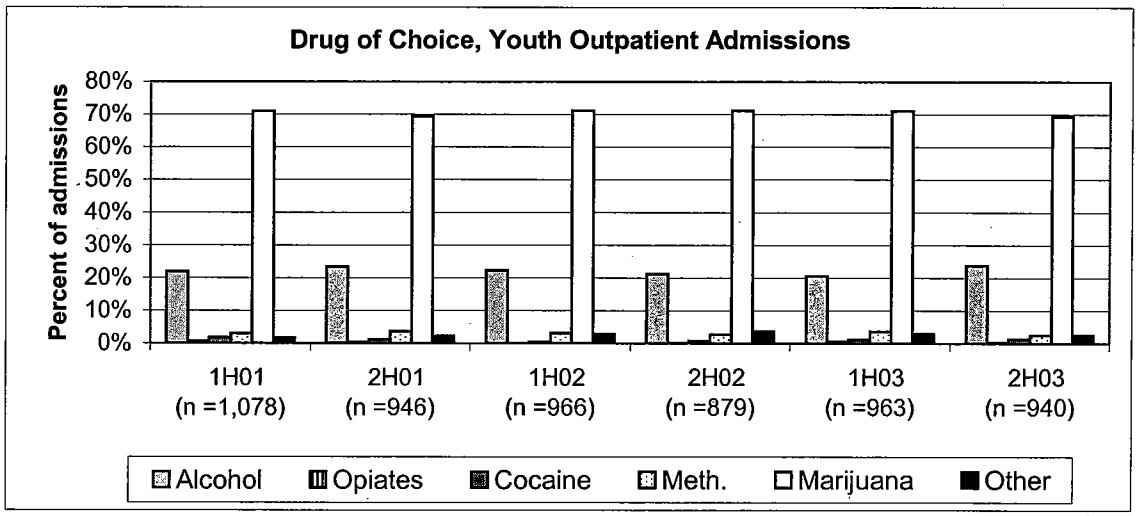
Outpatient treatment services for youth and young adults are targeted for low-income and indigent youth. Services include development of sobriety maintenance skills, family therapy or support, case management and relapse prevention. Services are expected to improve school performance and peer and family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



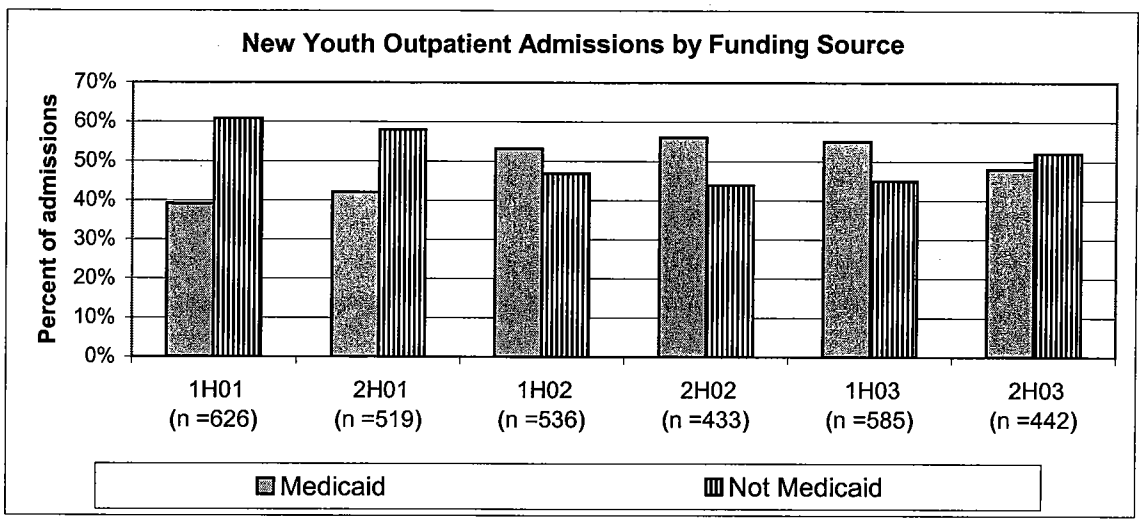
Historically, youth treatment admissions have fluctuated in relation to the school calendar because schools are a major source of referrals. Referrals, assessments and admissions are lower in July, August and December and consistently higher from January through June.

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

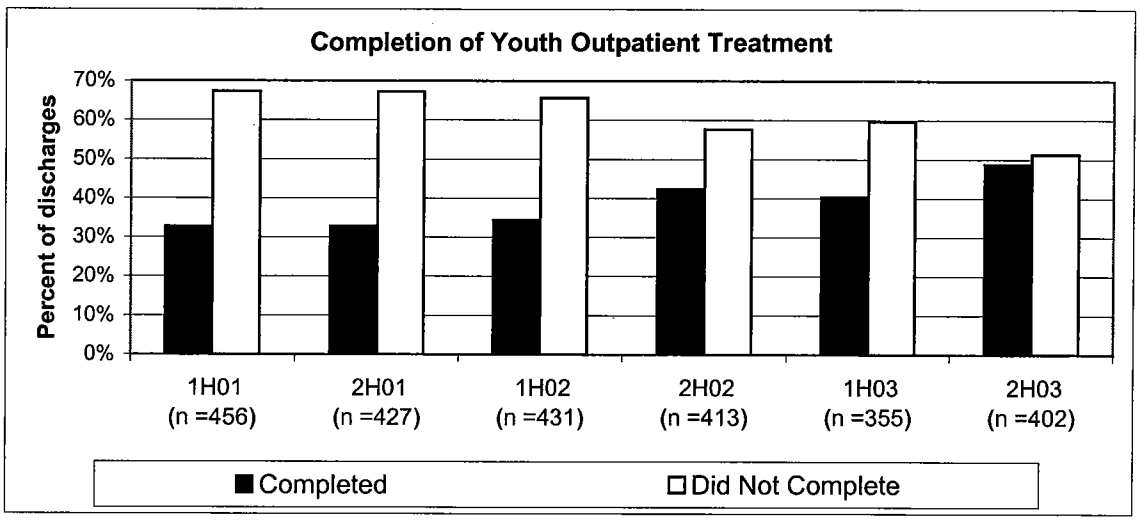


While the most frequently used drug among youth in treatment is marijuana, a significant percentage are using alcohol.

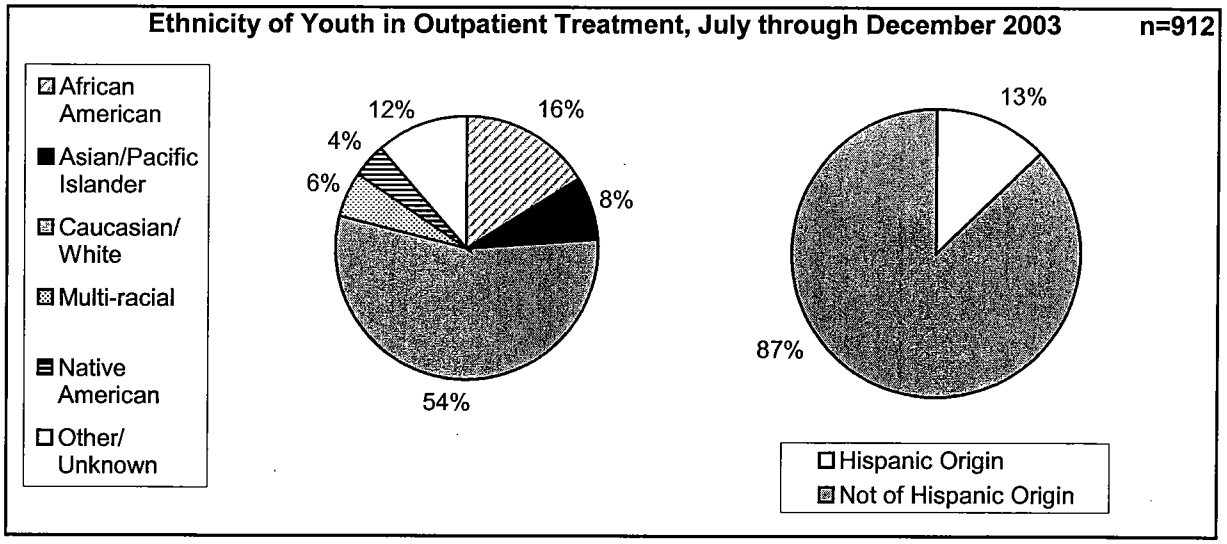
The chart below shows the proportion of newly admitted youth each biennial quarter whose treatment is funded by Medicaid vs. other public funding.



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.)



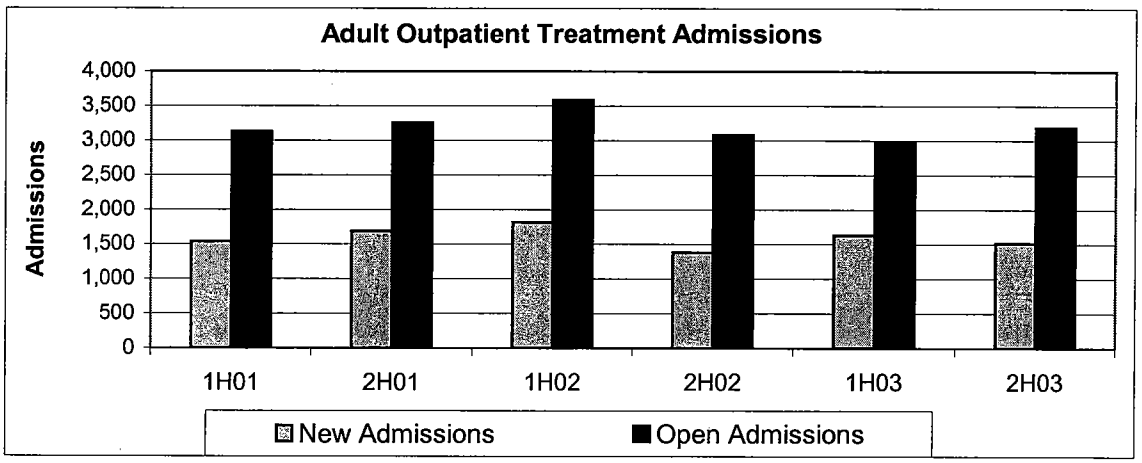
The charts below show the ethnicity of unduplicated youth receiving outpatient treatment from July through December 2003. See Appendix A for additional details.



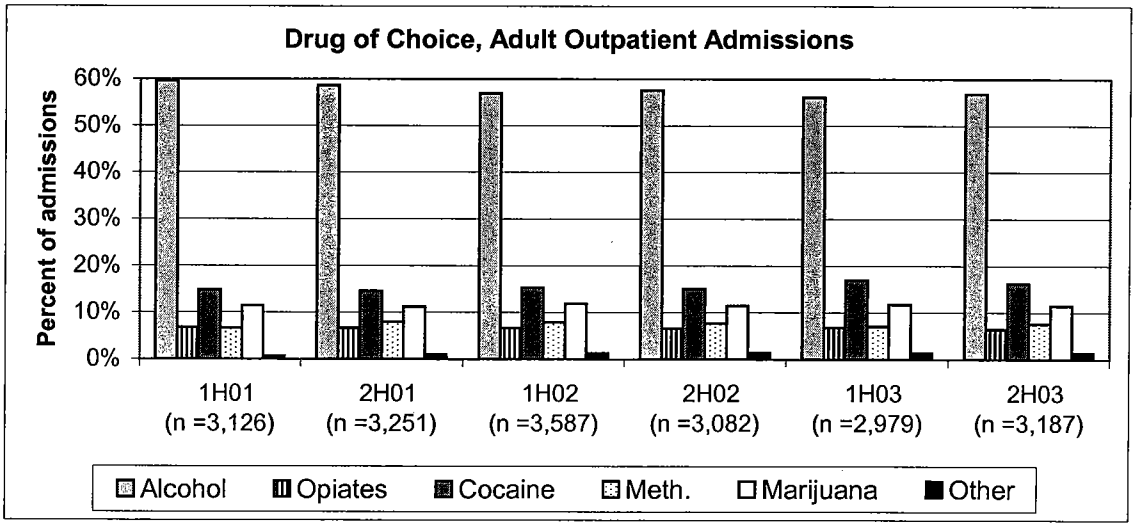
Outpatient Treatment - Adult

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.

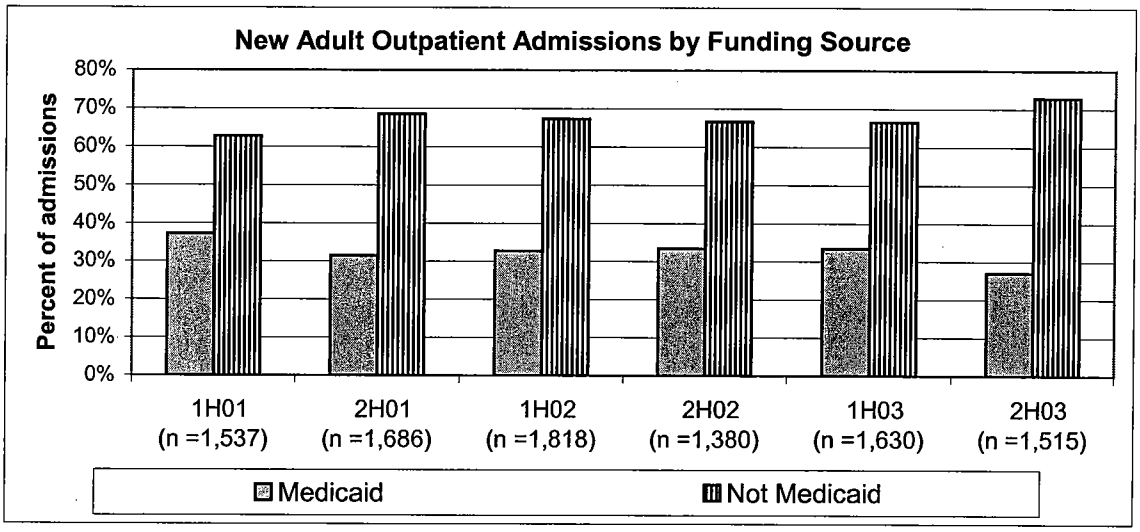
The following chart shows admissions to outpatient treatment for adults, 18 and over. Both "new admissions", which started during the biennial quarter, and "open admissions", which include people who started treatment prior to the start of the quarter and were not yet discharged, are shown.



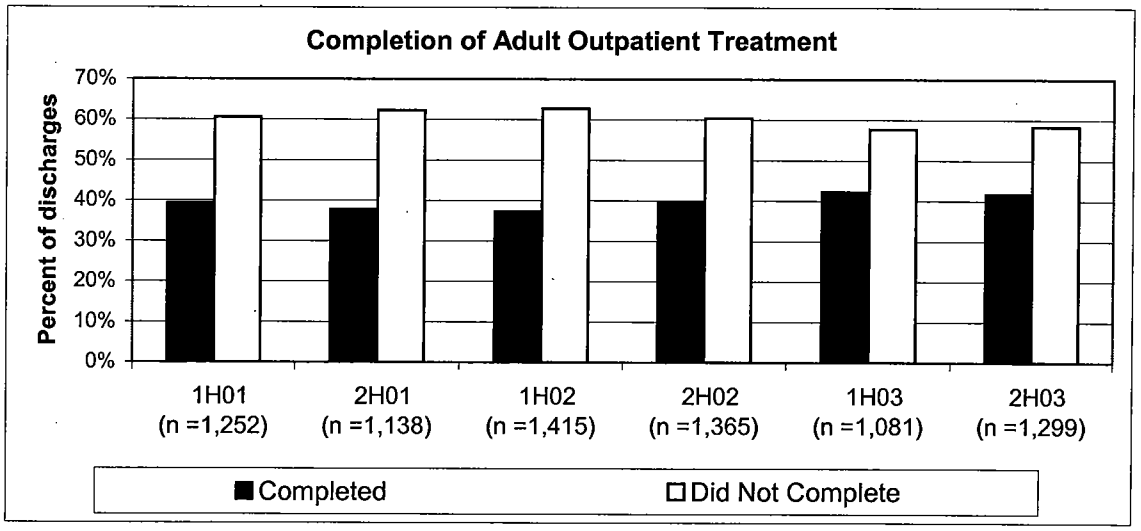
The chart below shows the primary substance used by adults admitted to outpatient treatment.



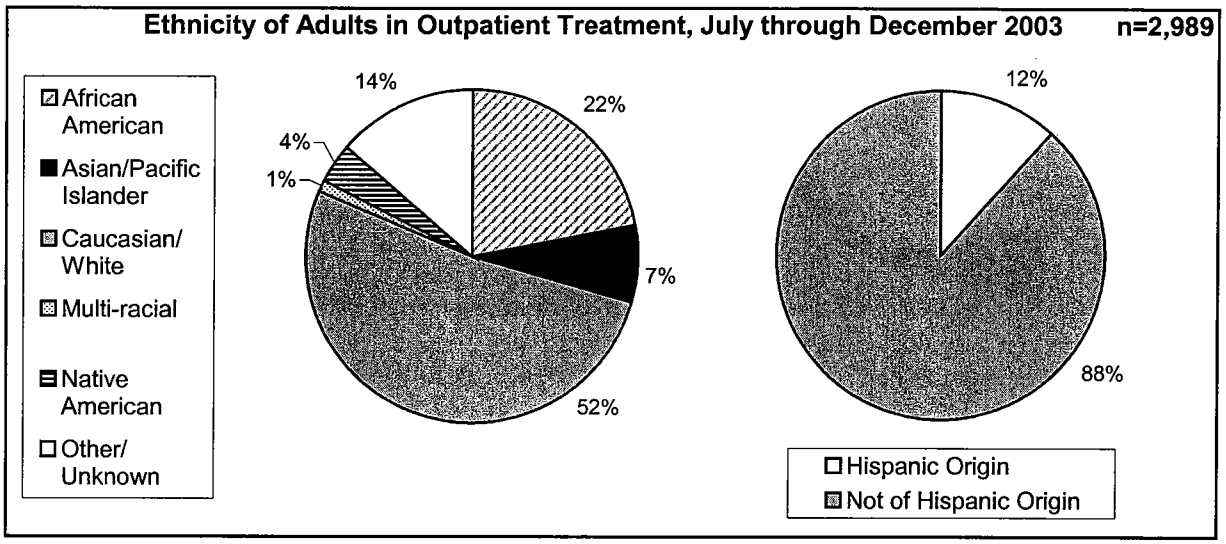
The following chart shows the proportion of newly admitted adults each biennial quarter whose treatment is funded by Medicaid vs. other public funding.



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.)



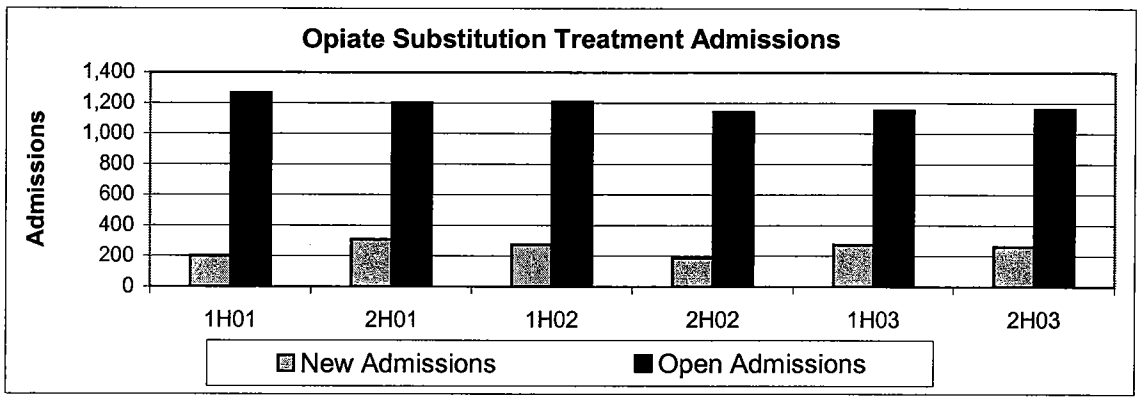
The charts below show the ethnicity of unduplicated adults receiving outpatient treatment from July through December 2003. See Appendix A for additional details.



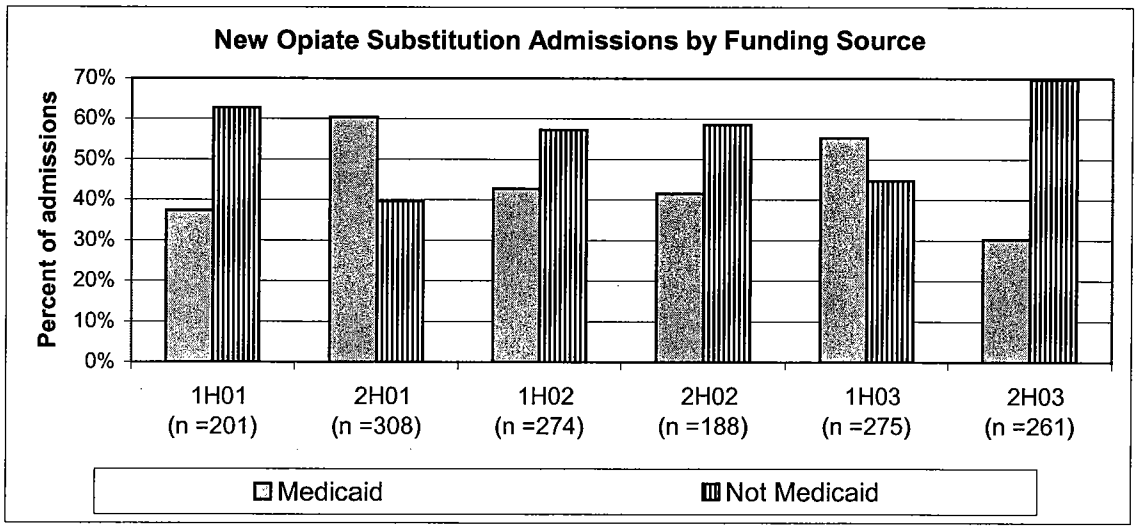
Opiate Substitution Treatment

Opiate substitution 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 opiate substitution treatment. 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.



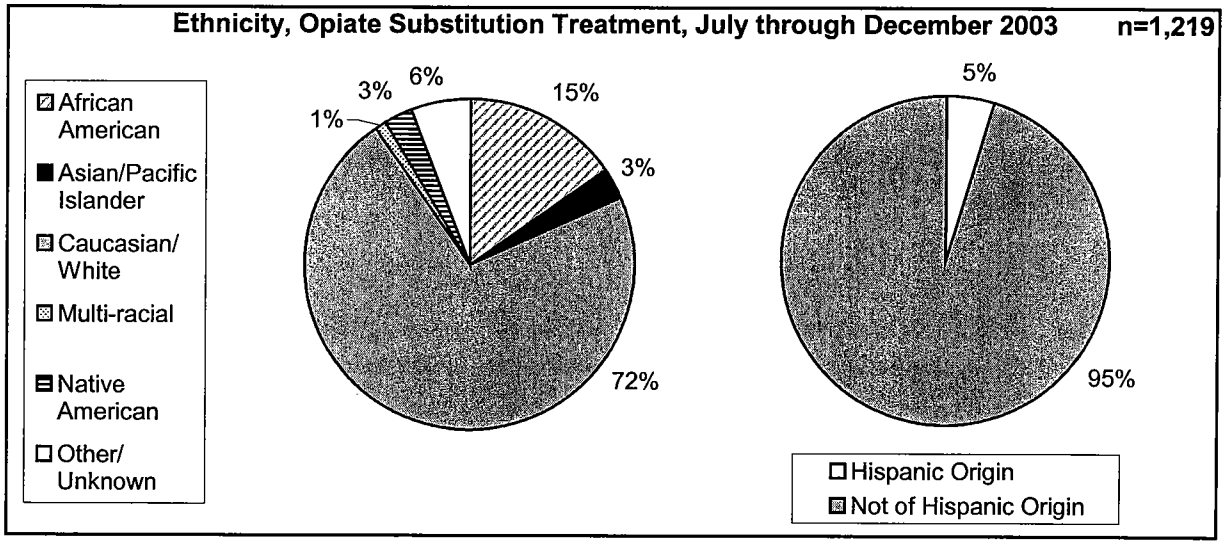
The following chart shows the proportion of newly admitted people each biennial quarter whose opiate substitution treatment is funded by Medicaid vs. other public funding.



The sharp drop in the percentage of new admissions funded by Medicaid is primarily because additional funding for opiate substitution treatment from the MHCADSD Criminal Justice Initiative became available in the middle of 2003. New admissions not funded by Medicaid increased from 123 in the previous biennial quarter to 182 this quarter; about 40% of those were paid for with Criminal Justice Initiative funds.

An additional cause of the decrease in new Medicaid funded admissions is that, over time, Medicaid funding for opiate substitution treatment shifts to people who have been in treatment for a long time (that is, away from the newly admitted). Unless more Medicaid funds are made available, which did not happen in 2003, new admissions for individuals with Medicaid coverage decline.

The following charts show unduplicated people receiving opiate substitution treatment from July through December 2003. See Appendix A for additional details.



Summary Data

Overview

This section provides summary data for the last calendar year in two areas:

- Services and dispositions
- 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 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 and only for the July – December 2003 biennial quarter.

The financial data include a financial plan for 2001, 2002, and 2003 Actuals. 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 shows contracted expenditures for outpatient treatment services in 2001, 2002 and 2003. The chart is broken out by outpatient treatment services for adults and youth, and opiate substitution treatment services. Contracted outpatient services accounted for $6,107,880 of expenditure in 2001, $6,827,446 in 2002 and $6,079,232 in 2003.

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. $2,017,747 were set aside for 2003. For 2003, the Title XIX County Summary Match Report shows that $4,240,366 total dollars were paid to agencies for the treatment services delivered.

Services and Dispositions, January – December 2003

	Number	Percent
Prevention Participants, All Factors	1,132	100%
Healthy Beliefs	0	0%
Favorable Attitudes	33	3%
Family Management Problems	170	15%
Bonding	929	82%

Prevention data are only for July - December 2003

Alcohol/Drug Help Line Calls		
Drug of Choice (about self only)	6,422	100%
Alcohol	4,193	65%
Opiates	367	6%
Cocaine	642	10%
Methamphetamines	297	5%
Marijuana	424	7%
Other	499	8%
Referrals (all calls)	11,516	100%
Self help group	3,270	28%
Other	2,508	22%
Outpatient treatment	2,844	25%
Inpatient treatment	992	9%
ADATSA	1,030	9%
Detox	872	8%
ESP Transports, All Destinations	17,777	100%
Sobering	14,958	84%
Street	1,076	6%
Detox	1,069	6%
Harborview	415	2%
Other	259	1%
Sobering Center Admissions	22,649	
Unduplicated People	2,228	
Detoxification Center		
Admissions	3,313	
Unduplicated People	2,350	
Admissions by drug of choice		
Alcohol		
Opiates	***Accurate data not yet available for 2003***	
Cocaine		
Methamphetamines		
Marijuana		
Other		
Referrals on discharge, all d/c	3,376	100%
Self-help	2,245	66%
CD TX	573	17%
Other	285	8%
ADATSA	249	7%
ICS	1	0%
Housing	23	1%
Involuntary Commitment Services		
Referrals	306	
Unduplicated people	267	
PCN Placements	68	
Assessment Center		
Assessments, all funding	4,061	100%
ADATSA	2,720	67%
GAU	577	14%

	Number	Percent
Assessments (cont.)		
TANF	300	7%
GA-X	246	6%
SSI	198	5%
PPW	13	0%
Other/None	7	0%
Unduplicated people	3,636	
ADATSA tx. placements	2,561	100%
Inpatient total	1,210	47%
Male	781	65%
Female	429	35%
Outpatient total	1,351	53%
Male	894	66%
Female	457	34%
Outpatient Treatment		
Youth		
New admissions	1,027	
Open admissions	1,405	
Unduplicated people (open)	1,309	
Open admissions by drug of choice		
Alcohol	308	22%
Opiates	8	1%
Cocaine	19	1%
Methamphetamines	45	3%
Marijuana	986	70%
Other	39	3%
New admissions by Medicaid status		
Medicaid	534	52%
Not Medicaid	493	48%
Discharges (during year)	968	
Completed treatment	339	45%
Did not complete	418	55%
Excluded from calc.	211	22%
Adult		
New admissions	3,145	
Open admissions	4,494	
Unduplicated people (open)	4,068	
Open admissions by drug of choice		
Alcohol	2,507	56%
Opiates	294	7%
Cocaine	767	17%
Methamphetamines	350	8%
Marijuana	515	11%
Other	61	1%
New admissions by Medicaid status		
Medicaid	957	30%
Not Medicaid	2,188	70%
Discharges (during year)	2,920	
Completed treatment	998	42%
Did not complete	1,382	58%
Excluded from calc.	540	18%
Opiate Substitution Treatment		
New admissions	536	
Open admissions	1,412	
Unduplicated people (open)	1,379	
New admissions by Medicaid status		
Medicaid	231	43%
Not Medicaid	305	57%

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 2003

	Alcohol/Drug Help Line Calls	Detoxification Center Admissions*	Outpatient Youth Admissions	Outpatient Adult Admissions
Total Number	6,422		1,405	4,494
Drug of Choice Percentage				
Alcohol	65%		22%	56%
Opiates	6%		1%	7%
Cocaine	10%		1%	17%
Methamphetamines	5%		3%	8%
Marijuana	7%		70%	11%
Other	8%		3%	1%

*Drug of choice data for 2003 Detox admissions are not yet available.

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.

Demographic Detail, January – December 2003

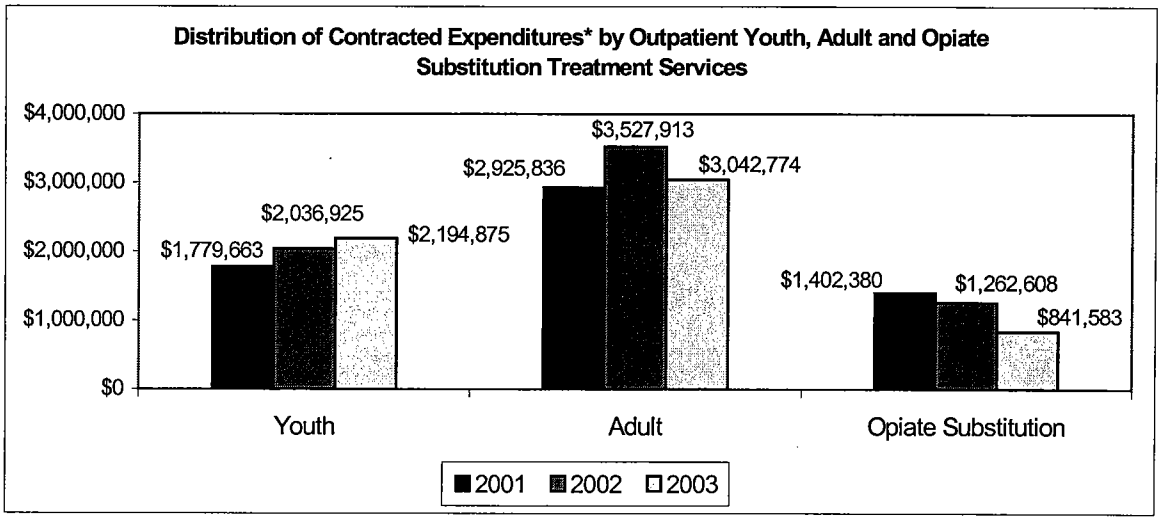
	Prevent.	Sobering	Detox	Ass't Ctr	ICS	Outpatient Youth	Outpatient Adult	Outpatient Opiate Sub.
Unduplicated people served	1,208	2,228	2,350	3,636	209	1,309	4,068	1,379
(Prevention data are only for July - December 2003)								
Gender								
Number of people								
Male	478	1,950	1,691	2,370	179	881	2,712	654
Female	730	281	659	1,265	88	428	1,356	725
Percent of all served								
Male	40%	88%	72%	65%	86%	67%	67%	47%
Female	60%	13%	28%	35%	42%	33%	33%	53%
Race/ethnic group:								
Number of people								
African American	161	387	452	945	40	236	899	212
Asian/Pacific Islander	78	37	19	87	2	104	287	40
Caucasian/ White	748	990	1,502	2,163	192	697	2,103	988
Multi-racial	126		15		1	74	43	17
Native American	89	422	120	251	19	55	164	42
Other/ Unknown	6	392	242	190	13	143	572	80
(blank rather than "0" indicates that the category is not used by the program to collect race/ethinic group data)								
Percent of all served								
African American	13%	17%	19%	26%	19%	18%	22%	15%
Asian/Pacific Islander	6%	2%	1%	2%	1%	8%	7%	3%
Caucasian/ White	62%	44%	64%	59%	92%	53%	52%	72%
Multi-racial	10%	0%	1%	0%	0%	6%	1%	1%
Native American	7%	19%	5%	7%	9%	4%	4%	3%
Other/ Unknown	0%	18%	10%	5%	6%	11%	14%	6%
	100%	100%	100%	100%	128%	100%	100%	100%
Hispanic origin:								
Number of people								
Hispanic origin	195	12	124	141	10	158	485	62
Not Hispanic origin/Unknown	1,013	2,216	2,226	3,495	257	1,151	3,583	1,317
Percent of all served								
Hispanic origin	16%	1%	5%	4%	5%	12%	12%	4%
Not Hispanic origin/Unknown	84%	99%	95%	96%	123%	88%	88%	96%
	100%	100%	100%	100%	128%	100%	100%	100%

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

Financial Summary

King County Substance Abuse Fund
2001 - 2003 Actuals
Financial Plan

	2001 Actual	2002 Actual	2003 Actual
Beginning Fund Balance	**2,042,580**	**1,651,025**	**2,134,747**
Revenues			
Licenses & Permits	0	11,250	0
Federal Grants	5,652,969	6,746,448	5,878,070
State Grants	9,167,772	9,434,433	8,972,371
Intergovernment Payment	1,816,832	1,233,651	233,134
Charges for Services	0	375,422	1,529,611
Miscellaneous	75,606	36,486	25,222
Other Financing Sources	0	382,001	348,118
Current Expense	1,369,874	1,472,341	1,483,696
Total Revenues	**18,083,053**	**19,692,032**	**18,470,223**
Expenditures			
Administration	(1,834,737)	(1,815,266)	(1,651,036)
Cedar Hills Addiction Treatment*	(3,396,365)	(3,576,896)	(3,056,206)
Treatment	(11,078,848)	(11,662,444)	(12,670,318)
Prevention Activities	(2,164,658)	(2,153,704)	(1,983,407)
Total Expenditures	**(18,474,608)**	**(19,208,310)**	**(19,360,967)**
Other Fund Transactions			
DCFM Energy Surcharge Refund			19,898
Total Other Fund Transactions	**0**	**0**	**19,898**
Ending Fund Balance	**1,651,025**	**2,134,747**	**1,263,901**



* Cedar Hills Addiction Treatment Facility closed in October 2002. Subsequent expendtiures are for the Housing Voucher Program.

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 Prevention, Alcohol/Drug 24-Hour Help Line and Emergency Services Patrol.
- Three databases developed by MHCADSD that are used by the Dutch Shisler Sobering Center, Involuntary Commitment Services and the Assessment Center to collect data for those programs.
- The State DASA Prevention database, implemented in July 2003, which contains data submitted by contracted providers about individuals who participate in multiple episode prevention programs.
- The State TARGET database, which contains data submitted by contracted providers about individuals and their treatment services. TARGET data are used for the Detoxification Center and Youth, Adult and Opiate Substitution Outpatient Treatment portions of the CDPIR. (Although the Sobering Center and Assessment Center also submit data to the TARGET system, those data are not used in this report because only minimal TARGET data are collected for the Sobering Center and the TARGET data does not support reporting about ADATSA placements while the MHCADSD Assessment Center database does.)

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 were provided in summary form by the Alcohol, Tobacco and Other Drug Prevention (ATODP) Division of the Seattle-King County Public Health Department. Before July 2003, unduplicated counts of new participants in each program funded through ATODP were reported by all Prevention program providers to ATODP on a biennial quarterly basis. Starting in July 2003, providers began reporting data about individuals who participated in multiple episode 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. Because of inconsistencies in reporting participants for single events, those data are not included in this report.

Each multiple episode 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.

With this version of the Performance Indicators Report, recent demographic data (age, gender and ethnicity) are only available for those participants in multiple episode programs. Because this change happened in the middle of the calendar year, demographic summary data in this report are only for the last biennial quarter rather than all of 2003.

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 MHCADSD Access Sobering Center Database by Sobering Center staff.

Chemical Dependency Performance Indicators Report, Appendix A – Data Notes

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.

Changes were made during 2003 in the way that Detoxification Center admissions are defined and reported. Previously, an individual who moved from one level of care to another (that is, from acute detoxification to sub-acute detoxification or from acute or sub-acute to interim chemical dependency services) was reported as having one continuous admission. Since February 2003, a separate admission has been reported for each level of care. To maintain comparability, admissions where the person had a prior detoxification admission that ended the day before the new admission date were removed from the admission totals. This removed about 60 admissions a month from February 2003 through December 2003.

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.)

As noted in the report, referral data for detoxification were severely affected by changes to TARGET in 2001 and 2002. Because of significant changes in the choices for referrals on discharge and the introduction of new data collection forms and data entry screens for detoxification services, data before July 2002 cannot be compared to more recent data and, therefore, are not shown in the report.

Involuntary Commitment Services

Data for ICS referrals are entered into a database by ICS staff. Data included are for referrals received and the disposition of each of those referrals.

Chemical Dependency Performance Indicators Report, Appendix A – Data Notes

Assessment Center

Data for assessments are entered into the Assessment Center's database by Assessment Center staff.

Outpatient Treatment: Youth, Adult and Opiate Substitution

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 funding source is "County Community Services" (which indicates that the services are funded through King County) at some time during the admission are included.
- 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 Opiate Substitution 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 Opiate Substitution because admissions longer than three years are common for that treatment modality.)
- Opiate Substitution 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.

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, 2003 and will end June 30, 2005.
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).
GAU	General Assistance Unemployable is a Washington program that provides cash assistance to people who are incapable of gainful employment as a result of a physical or mental impairment that is expected to continue for ninety days or more. GAU recipients may be eligible for State funded treatment for chemical dependency.
GA-X	General Assistance – Expedited Medicaid provides Medicaid coverage in addition to GAU cash assistance. GA-X recipients can use Medicaid funding to pay for treatment for chemical dependency.
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.
PPW	Pregnant and Postpartum Women is a program that provides assistance to low-income females who are pregnant or recently had a pregnancy end. PPW recipients can use Medicaid funding to pay for treatment for chemical dependency. PPW recipients have been identified by DASA as a priority population to receive services.

SSI	Supplemental Security Income is a Federal supplemental income program funded by general tax revenues (not Social Security taxes). It helps aged, blind, and disabled people, who have little or no income, by providing monthly cash payments to meet basic needs for food, clothing, and shelter. SSI recipients can use Medicaid funding to pay for treatment for chemical dependency.
TANF	Temporary Assistance for Needy Families, which replaced "Aid to Families with Dependent Children" (AFDC) and "Job Opportunities and Basic Skills Training" (JOBS) in the 1996 federal welfare system reform. The purposes of TANF are: to provide assistance to needy families so that children can be cared for in their own homes; to reduce dependency by promoting job preparation, work and marriage; to prevent out-of-wedlock pregnancies; and to encourage the formation and maintenance of two-parent families. In Washington, TANF recipients can use Medicaid funding to pay for treatment for chemical dependency.
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.