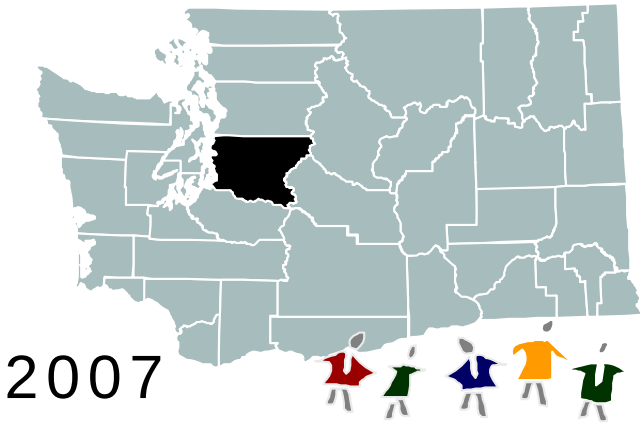
King County

Strategic Plan for

Substance Abuse
Prevention | Intervention | Treatment | Aftercare Services



Developed by:

King County Department of Community and Human Services (DCHS):

Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD)
Substance Abuse Prevention and Treatment Services
and
Community Services Division (CSD)
Community Organizing Program

Submitted to:

Washington State Department of Social and Health Services
Division of Alcohol and Substance Abuse
and
Washington State Department of Community, Trade and Economic Development
Community Mobilization Against Substance Abuse and Violence

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EXECUTIVE SUMMARY

Biennial Plan Purpose

Each biennium the King County Alcohol and Substance Abuse Administrative Board (KCASAAB) initiates a treatment service planning process and prevention services need assessment. The process results in a document intended to advise the county on local prevention and substance abuse policy and guide expenditures on chemical dependency treatment and substance abuse prevention services.

Annually, the KCASAAB will review the progress on the initiatives detailed in the Plan. The county Substance Abuse Prevention and Treatment Coordinator and the Department of Community and Human Services Mental Health Chemical Abuse and Dependency Division (MHCADSD) assists the KCASAAB in discharging their duties.

In addition to advising the County on prevention and substance abuse services the plan meets the following requirements:

- RCW 70.96A.320: Alcoholism and other Drug Addiction Program.
- RCW 70.96A.350: Criminal Justice Treatment Account.

It also meets Community Mobilization's federal requirements under:

- Title IV, Part A: Safe and Drug-Free Schools and Communities Act.

The plan covers a six year period of time - July 2007 through June 2013. The plan is intended to be a living document. It will be updated as the needs of the community evolve. At a minimum the plan will be updated every two years. The next formal update of the plan will be July 2009.

The need for a six-year strategic plan as opposed to a shorter term plan emerged in response to the following:

- Recognition that major changes related to needs assessment do not occur each biennium
- Interest in taking a longer-term perspective
- Agreement by funding agencies and stakeholders that this is in their best interest

For several years DASA and Community Mobilization Against Substance Abuse and Violence/Community, Trade, Economic Development Department (CM) staff have discussed collaborating with community partners to coordinate strategic planning at the county level. Toward this end, DASA, the Chemical Dependency section of the Association of County Human Services (ACHS) and CM agreed to work together to build a new strategic planning process.

The County Strategic Plan addresses county-specific needs, resources and implementation strategies for community-based substance abuse prevention, intervention, treatment and aftercare/support services (P-I-T-A).

P-I-T-A OVERVIEW AND DEFINITIONS

P = Prevention	I = Intervention	T = Treatment	A = Aftercare

Substance abuse dependency services are viewed as existing on a continuum of prevention, intervention, treatment and aftercare. As with all continuums, the boundaries between one discipline and the next are not always clearly drawn. A comprehensive substance abuse continuum combines many programs, policies, and practices in order to produce significant changes and reduce substance abuse in communities. A continuum of care may include local services ranging from prenatal parenting classes, to student assistance programs, to outpatient and residential treatment, to community-based ongoing sobriety support services.

This description includes a definition of each segment of the continuum and describes where the boundaries usually are drawn and how the boundaries can be bridged. Although the P-I-T-A continuum may appear to be a sequential process, in fact, an individual may enter or leave the continuum at any point. The ultimate goal is to reduce the need for treatment related services though increasingly successful community prevention strategies and programs.

Prevention Overview and Definitions

The goal of prevention is to foster a climate in which:

- Alcohol use is acceptable only for those of legal age and only when the risk of adverse consequences is minimal. Tobacco and illegal drugs are not used at all.
- Prescription and over-the-counter drugs are used only for the purposes for which they are intended.
- Other abusable substances, such as gasoline or aerosols, are used only for their intended purposes.
- Pregnant and women who may become pregnant do not use alcohol, tobacco, or other drugs.

What does prevention look like?

As classified by the Institute of Medicine (IOM), prevention programs can be described by the audience or intervention level for which they are designed: **Universal, Selective, and Indicated.**

- **Universal** prevention programs/strategies reach the general population– such as all students in a school or all parents of middle school students. For example, the Communities that Care program is a community-wide strategy to prevent substance abuse (and for Community Mobilization programs, to also prevent violence).

- **Selective** prevention programs target groups at risk or subsets of the population– such as children of drug users or poor school achievers. For example, Strengthening Families Program is designed to help substance-abusing parents improve their parenting skills and reduce their children's risk factors.

- **Indicated** prevention programs identify individuals who are exhibiting early signs of problem behavior(s) and target them with special programs to prevent further onset of difficulties. For example, Functional Family Therapy provides services for youth ages 10-18, and their families, whose problems range from acting out to conduct disorder to alcohol/substance abuse.

Intervention

The goal of intervention is to reduce the risk of harm and decrease problem behaviors that result from continued use of substances. The intent of the designated intervention is to take action that decreases risk factors related to substance use, abuse or dependency as well as enhance protective factors and provide ongoing services as appropriate.

The specific goal of each individual client is determined by his/her consumption pattern, the consequences of his/her use and the setting in which the intervention is delivered.

Intervention techniques vary based on the specific population being served and may be delivered to participants throughout the P-I-T-A continuum. For example, early intervention programs may include a student assistance program that provides structured assessments of individual students who beginning to use drugs and to experience problem behaviors. Intervention may also include case management for chronic public inebriates that focuses on harm reduction.

Intervention services include but are not limited to:

- School intervention – pre-assessment, screening, information/education and referral
- Mentoring
- Services Assessment
- Brief Intervention and Referral to Treatment
- Detoxification
- Outreach
- Case Management to facilitate referral to treatment

While Intervention is identified as a distinct category within the P-I-T-A continuum, there is overlap between indicated prevention strategies, treatment services and aftercare.

Treatment

The goal of treatment is to improve social functioning through complete abstinence of alcohol and drugs for individuals diagnosed with chemical dependency. Treatment is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual suffering from alcoholism or from another drug dependency designed to enable the affected individual to achieve and maintain sobriety, physical and mental health and a maximum functional ability. For further information see the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC) 2-R.

Diagnosis

Treatment therapies are linked to the Diagnostic and Statistical Manual, IV-Txt Revision (DSM-IV TR) under diagnosis of Substance Use Disorder. The diagnosis describes a continuum of progressive escalation that begins with Substance Use, progresses to Substance Abuse, and may conclude with Substance Dependence.

Definition of Substance Use Disorder

Persons who are diagnosed with substance abuse (also referred to as misuse or harmful use), or substance dependence, begins with an initial episode of substance use. Use of a substance, whether licit or illicit, does not constitute a substance use disorder even though it may be unwise and strongly disapproved of by family, friends, employers, religious groups, or society at large.

Substance use is not considered a medical disorder. For a medical disorder to be present, substance use must occur more frequently; occur at high doses; and/or result in a magnitude of problems (Technologies for Understanding and Preventing Substance Abuse and Addiction, US Government Office of Technology Assessment Appendix C: Perspectives on Defining Substance Abuse).

The term substance abuse or substance misuse is sometimes used to refer to any substance use by adolescents because their use of substances is illegal and poses developmental and physical risks associated with substance use at an early age.

Substance Use Disorders are separated into two categories:

- **Substance Abuse (also referred to as Misuse)**
- **Substance Dependence**

Substance Abuse/Misuse

The DSM-IV TR defines substance abuse as problematic use without compulsive use, significant tolerance, or withdrawal. A diagnosis for substance abuse is made when one or more of the following occur within a 12 month period:

- Recurrent substance use resulting in a failure to fulfill major role obligations
- Recurrent substance use in situations that are physically hazardous
- Substance-use related legal problems
- Substance use despite having persistent or recurrent social or interpersonal problems

Related substance abuse treatment services include but are not limited to:

- Alcohol Drug Information School
- Outpatient treatment

Substance Dependence

The DSM-IV TR defines substance dependence as a syndrome involving compulsive use, with or without tolerance and withdrawal. A diagnosis for substance dependence is made when three or more of the following occur within a 12-month period:

- Tolerance, withdrawal, use in larger amounts or over a longer period than intended
- Persistent desire or unsuccessful efforts to cut down
- Great deal of time spent in activities necessary to obtain the substance
- Reduction in social, occupational, or recreational activities because of substance use
- Substance use continues despite knowledge of problems

Related treatment services for individuals diagnosed with substance dependence disorder include but are not limited to:

- Detoxification service
- Outpatient treatment/intensive outpatient treatment
- Intensive inpatient treatment
- Recovery House services
- Opiate substitution treatment

Aftercare

The goal of aftercare is to support the substance abusing or chemically dependent person's abstinence after primary care. Aftercare, also referred to as relapse prevention, is the stage following more intensive services.

Related aftercare and relapse prevention services for individuals who are part of a treatment continuum include but are not limited to:

- Periodic outpatient aftercare
- Relapse/recovery groups
- Recovery support group
- Oxford House
- Access to Recovery wrap around

Biennial Plan Initiatives

The following is a summary of the goals that are outlined in the plan:

Prevention Goals

1. Improve the bonding of children and youth to their community, family and peers living in King County
2. Decrease the risk associated with community laws and norms favorable to drug use
3. Decrease the risk associated with early initiation of alcohol and other drugs
4. Decrease the risk associated with family management problems
5. Decrease the risk associated with favorable attitudes toward the problem behavior
6. Decrease the risk associated with transition and mobility

Community Mobilization Goals

1. Decrease the risk associated with early initiation of alcohol and other drugs
2. Decrease the risk associated with family management problems
3. Decrease the risk associated with favorable attitudes toward the problem behavior
4. Decrease the risk associated with transition and mobility

Intervention Goals

1. Decrease the risk associated with early initiation of alcohol and other drugs
2. Decrease the risk associated with family management problems
3. Decrease the risk associated with favorable attitudes toward the problem behavior
4. Decrease the risk associated with transition and mobility

Treatment Goals

1. Increase youth admissions to treatment – *more treatment, better treatment, beyond treatment*
2. Increase pregnant and parenting women admissions to substance abuse treatment services
3. Increase the percentage of individuals receiving services in the mental health plan who are also admitted to chemical dependency services

4. Increase treatment admissions of those 65 years of age and older
5. Increase professional development for Chemical Dependency Professionals (CDP) to include cultural sensitivity and working with specific ethnic and cultural populations, GLBT populations, homeless and veterans populations, GAIN administration and other evidence based practices.

Aftercare Goals

1. Increase the number of treatment clients that acquire housing
2. Increase client employability, employment and prosocial gainful activity

INTRODUCTION

County Demographics

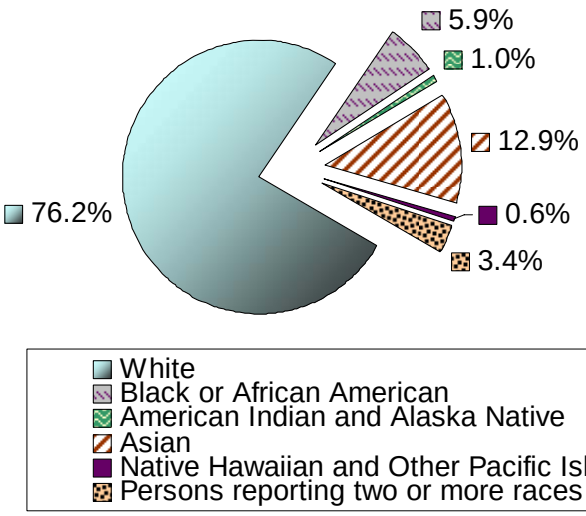
King County is the most populous county in Washington State and is located on Puget Sound. It covers 2,134 square miles, nearly twice as large as the average county in the United States. With more than 1.8 million people, it also ranks as the 13th most populous county in the nation.

According to the 2000 U.S. Census, King County's total population stood at 1,737,034 which comprises approximately one-third of Washington State's total population of 5,894,121. For 2005, the estimated total population of King County rose to 1,793,583. King County's population growth rate of 3.3% from April 2000 through June 2005 is about half the rate for Washington State.

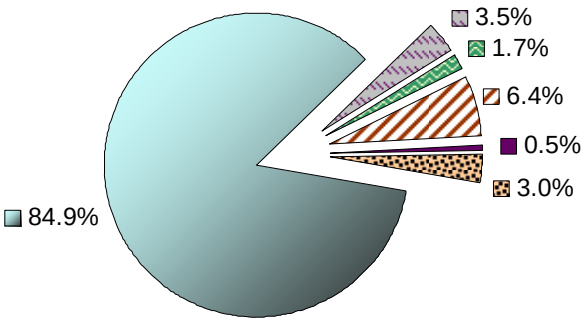
Other population data from the 2000 U.S. Census Bureau and updates showed:

- In 2003, a lower rate of people lived below poverty in King County (9.4%) than Washington (11%).
- A larger percentage of foreign born persons live in King County (15.4%) than Washington (10.9%).
- More than 18% of King County residents (ages 5 and above) speak a language other than English at home. This compares to 14% of Washington State residents
- In 2005, King County had a sizeable population of Latinos and Hispanics (6.7%); however, this is lower than that for Washington (8.8%).
- King County is more diverse racially than Washington State as reflected in the charts below.

King County Population by Race, 2005 U.S. Census Bureau

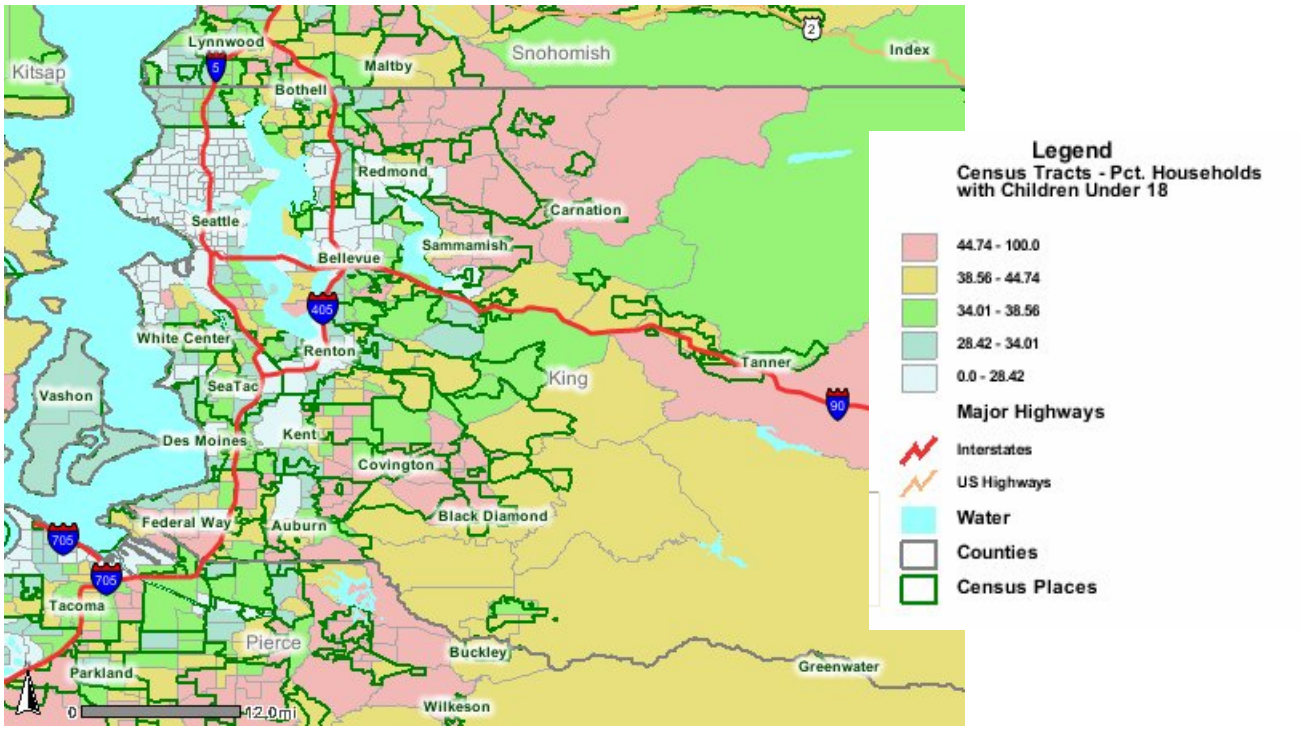


Washington State Population by Race, 2005 U.S. Census Bureau



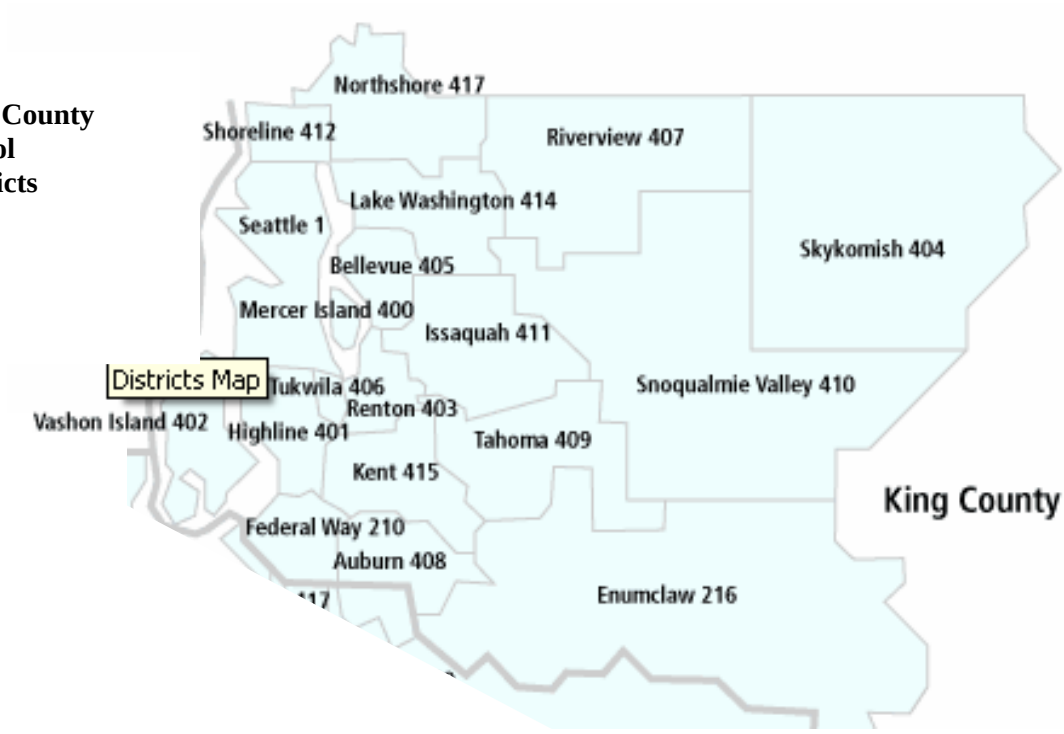
Washington State is the fourth largest refugee resettlement state in the United States. The majority of refugees who reside in King County are from Southeast Asia (65%), followed by the former Soviet Union/Eastern Europe (21%), Africa (10%), and the Middle East (2.4%).

There is quite a range related to the percent of households with children less than 18 years old when comparing different King County sub-regions (see map below).



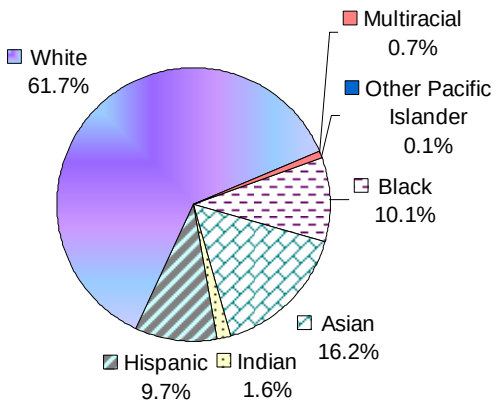
As shown in the below map, 19 school districts ranging from rural to suburban to urban are in King County.

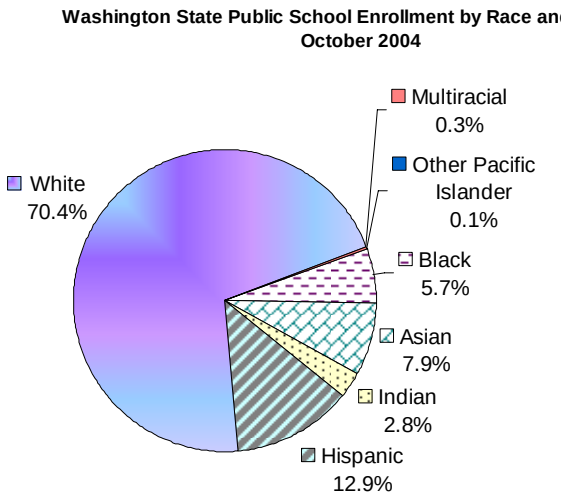
King County School Districts



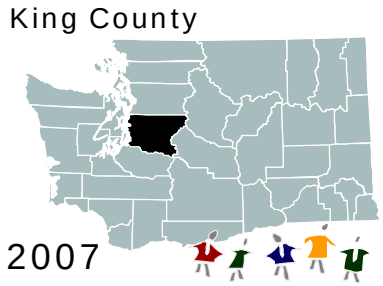
According to the Office of Superintendent of Public Instruction (OSPI), a total of 255,475 students were enrolled in public schools as of October 2004. The population of public school students in King County is more diverse than Washington State.

King County Public School Enrollment by Race and Ethnicity, October 2004





An additional 37,088 students were enrolled in private schools. Additional school data is included in the appendices (see **Appendix 1**) and is provided by the four different regions (Central, East, North and South) in King County.



PART I

Initial Networking
& Community Assessment

Organizations Involved in the Planning Process

A DASA REQUIRED SECTION

King County Department of Community and Human Services (DCHS) staff in the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) and the Community Services Division (CSD) consulted with and gathered information from various local key informants, service providers, government entities and community groups including using existing provider meetings and other meetings, focus groups, a survey, and interviews:

- Alcohol and Drug 24-Hour Helpline
- Asian Counseling and Referral Services
- Auburn Youth Resources
- Avalon Center
- Catholic Community Services
- Center for Career Alternatives
- Center for Human Services
- Central Youth and Family Services
- Chemical Dependency System Management Group
- Community Psychiatric Clinic
- Consejo Counseling and Referral Services
- Department of Health Washington State Partnership for Youth
- Downtown Emergency Services Center
- Harborview Medical Center
- Encompass
- Evergreen Treatment Service
- Friends of Youth
- Girl Scouts – Totem Council
- Greater Maple Valley Community Center
- Harborview Medical Center

- High Utilizer Group
- Iwasil/Boys and Girls Clubs of King County
- Intercept Associates
- Kent Youth and Family Services
- King County Health and Safety Networks
- King County Aging and Disabilities Services
- King County Alcoholism and Substance Abuse Administrative Board
- King County Community Organizing Program Core Advisory Board
- King County Meth Action Team
- King County Public Defenders Association
- King County Prevention Interested Parties
- King County SOAR: A United Way project to impact adolescents
- Lifelong AIDS Alliance
- Mercer Island Youth and Family Services
- Muckleshoot Tribe
- Neighborhood House
- Public Health-Seattle & King County
- Puget Sound Educational Service District
- Opiate Substitution Treatment Coordination Oversight Committee
- Recovery Centers of King County
- Renton Youth and Family Services
- Ruth Dykeman Youth and Family Services
- Safe and Drug-free Schools and Communities Coordinators/Tobacco Coordinators
- SafeFutures Youth Center
- School Superintendents of King County School Districts
- SEAMAR
- Seattle Counseling Services
- Seattle School District
- Seattle Indian Health Board
- Snoqualmie Tribe
- Sound Mental Health (formerly Seattle Mental Health)
- Therapeutic Health Services

- United Way Cross System Planning, Impact Council on Physical Health, Mental Health and Chemical Dependency
- United Indians of All Tribes Foundation
- Valley Cities Counseling and Consultation
- Vashon Youth and Family Services
- Washington Pacific Islander Families Against Substance Abuse
- Youth Eastside Services

Specific to the Criminal Justice Population

A DASA REQUIRED SECTION

- King County Alcohol/Drug Treatment and Prevention Coordinator
- King County Community Center Alternative Programs
- King County Drug Court
- King County Jail
- King County Juvenile Drug Court
- King County Mental Health Court
- King County Prosecutor's Office
- King County Regional Justice Center
- King County Sheriff's Office
- King County Superior Court

Community Assessment

In 2003, the need for substance abuse treatment among King County adults at or below 200% of poverty level was 13.6% but the treatment penetration rate is only 21.2%. In 2003, the overall admissions to outpatient treatment were 5,508 while admissions to opiate substitution treatment were 705.

From January 2004 through June 2006, there were a total of 18,857 assessments in King County with 90% resulting in an outpatient admission (includes intensive outpatient, outpatient and MICA outpatient).

Overall outpatient admissions have increased when comparing the six month time period January-June 2000 to January-June 2006 (12.62%), admissions increased considerably when comparing January-June 2003 to time period January-June 2006 (21.24%). This is attributable to a variety of factors including increased treatment dollars to counties (e.g., treatment expansion), accompanying treatment system functional adjustments that offer and then provide to clients a

wider range of services (e.g., ATR), and collaborative relationships with other service systems that broaden the access to treatment services (e.g., Public Health).

A complete report on admission and caseload data are included as an appendix.

Assessment of Service Needs for Selected Populations
A DASA REQUIRED SECTION

Persons with Disabilities
According to the King County Division of Disabilities, of 9,000 participants in their services, approximately 500 individuals who were cognitively impaired were in need of substance abuse treatment. This is 5.56% of their population.

In 2006, national data indicated that as a group, those who are cognitively impaired tended to have a rate of substance abuse than other groups of individuals in disability services, or about 10%. Prevention was not addressed in the literature but a well researched treatment program is in existence at Wright State University.

A cooperative multi-year project began in January 2006 with a minimal amount of funding ($75,000) provided by the King County Division of Developmental Disabilities. The funding provided program development/evaluation time (.25 full time equivalent staff time, or approximately 10 hours per week), and other services as needed to achieve the initial project goals. The project goals were stated as:

- Estimate the need for chemical dependency treatment for those enrolled the Washington State Developmental Disability System in King County;
- Outreach to individuals who are cognitively impaired (mentally retarded) and provide chemical dependency screening;
- Develop and deliver an effective chemical dependency treatment program for individuals who are cognitively impaired (mentally retarded);
- Evaluate the chemical dependency treatment program by gathering qualitative data and initial quantitative data; and
- Secure sufficient capacity for a more thorough evaluation of the treatment effectiveness of the program developed, and to provide training to other chemical dependency treatment agencies within two years.

The literature search, Substance Abuse Mental Health Services Administration Treatment Improvement Protocol 29 served as the guides for local implementation of services. In September 2006 Seattle Mental Health was awarded under an RFP that included an evaluation component that will guide King County to further develop this local option of outreach and access, substance abuse treatment and aftercare. The program is entitled STAR and a Developmental Disabilities (DD) counselor who is also a CDP provides the treatment and aftercare services tailored to the individual client cognitive needs, and includes other services of team and case management support services, services for mental health needs and psychiatric medication management, and, 24/7 crisis services.

As the program progresses in start-up, the STAR admissions to date are 34 with drug of choice being 37.5% alcohol, 37.5% cocaine, 25% marijuana, 6.3% methamphetamine, and 6.3% other (other opiates and inhalants). There were no other drug mentions.

Earlier this year, King County staff did an initial minor review of the need for substance abuse treatment services to individuals with ADHD, dyslexia, and traumatic brain injury, especially undiagnosed. Preliminary data indicate that these are prevalent in the chemically dependent population in need of treatment. It is hoped that the information and protocol developed through the STAR program will help inform treatment providers on how to effectively work with individuals with varying degrees of cognitive impairments.

Youth

According to the Office of Superintendent of Public Instruction (OSPI), a total of 255,475 students were enrolled in public schools as of October 2004. There were 37,088 students enrolled in private schools. Assuring a full continuum of care for children and youth not only protects individuals, but our schools and communities, and, expenditure of public funds.

Prevention to children, youth, their parents, siblings and families includes all phases of prevention and includes universal, selective and indicated prevention programming in order to prevent and delay onset of first use, reduce risk and increase protection.

The 2004 Healthy Youth Survey (HYS) key findings:

- The percentage of students who reported drinking alcohol in the past month of the survey jumps dramatically from 6th grade (4.7%) through 12th grade (40.1%). The 8th grade rate is 14.6%, then doubles to 31.2% for 10th grade.

- The percentage of students who reported using marijuana or hashish in the past month of the survey jumps dramatically from 6th grade (1.7%) through 12th grade (18.6%). The 8th grade rate is 6.6% then more than doubles to 15.9% for 10th grade.

- The percentage of students who reported ever seriously considering attempting suicide in the past year of the survey remained steady from 8th grade (13.7%) to 12th grade (13.7%), but with a peak of 18.1% for 10th grade.

- The percentage of students who reported being bullied in the past month of the survey drops dramatically from 6th grade (28.8%) through 12th grade (12.2%). The 8th grade rate is 27.2% then decreases to 20.4% for 10th grade. The steepest change was from 10th to 12th grade.

A fuller analysis of the HYS 2004 data by King County, county sub-regions and Washington State are included in the appendices, however, below is a review of data by factor category (risk factor and protective factor) and by domain within the category.

Risk Factors

In the Community domain, the highest ranked risk factor is "Transitions and Mobility" for 8th grade (49.3%), 10th grade (61.1%) and 12th grade (50.3%). (Data unavailable at the 6th grade.) "Community Laws and Norms Favorable to Drug Use" is the highest ranked risk factor at 6th

grade (35.6%), and it is also among the top three risk factors for 8th (25.4%), 10th (36.6%) and 12th grades (35.1%).

In the Family Domain, the highest ranked risk factor is "Parental Attitudes Favorable to Antisocial Behavior" for 8th grade (30.4%), 10th grade (53.7%) and 12th grade (53.5%). The second highest risk factor is "Poor Family Management" for 8th grade (39.4%), 10th grade (43.9%) and 12th grade (43.3%). Family Domain items were not asked on the 6th grade HYS.

In the Individual-Peer Domain, the highest ranking risk factors for 8th grade, 10th and 12th grade are related to antisocial behaviors and rewards. For 6th grade, the top risk factor is "Perceived Risk of Drug Use."

In the School Domain, the top risk factor for 6th grade is "Low Commitment to School" (45.3%). "Academic Failure" is the highest risk factor for 8th grade (42.6%), 10th grade (44.7%) and 12th grade (44.9%).

Protective Factors
In the Community domain, the protective factor showing the lowest level of students protected is "Rewards for Prosocial Involvement" for all grades, 6th grade (40.8%), 8th grade (58.8%), 10th grade (58.4%) and 12th grade (55%).

In the Family Domain, the following protective factors are closely ranked as having the lowest levels of 6th grade students protected: "Opportunities for Prosocial Involvement" (59.3%) and "Rewards for Prosocial Involvement" (61.8%). The protective factor showing the lowest level for students protected at the 8th grade is "Rewards for Prosocial Involvement" (58.8%). (Data at the 10th grade and 12th grade levels were unavailable for Family Domain items.)

In the Individual-Peer Domain, the protective factor showing the lowest level of students protected is "Prosocial Involvement" for all grades: 6th grade (44.9%), 8th grade (48.3%), 10th grade (43%) and 12th grade (44.6%).

In the School Domain, the protective factor showing the lowest level of students protected is "Rewards for Prosocial Involvement" for 8th grade (53.2%) and 12th grade (43.3%). This same protective factor is closely ranked with "Opportunities for Prosocial Involvement" as having the lowest levels of 10th grade students protected, with rates of 58.9% and 56.6% respectively. For 6th grade, data was only available for the one school protective factor of "Rewards for Prosocial Involvement" and the rate was 50.5%.

Youth System of Care

More Treatment, Better Treatment, Beyond Treatment

We have found that simply locking our youth up won't solve the problem. And while we need to hold teens accountable for their actions, as a community we must provide drug and alcohol treatment and community support.

We know that treatment works. Yet many teens in our nation's juvenile justice system—some experts estimate the figure is as high as 80 percent—receive no treatment for drug and alcohol abuse at all. We have changed that in King County based on our involvement in Reclaiming Futures.

Our treatment programs work in a coordinated fashion and take advantage of the wealth of new evidence-based practices. They involve families, address cultural and gender issues, and coordinate with judges, probation programs, and schools.

Recent studies show effective drug and alcohol treatment requires a "network" of community support for the young person's success in the community. Teens with substance-abuse issues who receive care through this network fare much better than those not receiving it. After 12 months, less than half as many of these youth are back in confinement and more than twice as many are abstaining from subsequent drug and alcohol use. Since we have been involved in the Reclaiming Futures Initiative we have seen dramatic increases in both treatment completion and treatment retention.

As a result of our system changes, we are able to identify substance-abuse problems as early as possible, match individual teens with appropriate and culturally relevant treatment options, mobilize a range of positive influences within the young people's lives, and deliver care and treatment through a coalition of service providers.

Using the Global Assessment Individual Need (GAIN) assessment tool which is administered in King County to youth being evaluated for and/or entering treatment, cumulative results from November 2005 through 2006 indicate that 33% reported being homeless/runaway at some time in their life; 42% had involvement with juvenile justice within the last 90 days; 31% had a mental health "internalizing disorder" within the past 12 months; and 51% had an "externalizing disorder" within the past 12 months. Again, intervening and accessing youth at an earlier point in their substance use and abuse can potentially increase the opportunity for the individual youth to not progress further in substance abuse or chemical dependency, and perhaps avoid other life altering events.

A National Survey on Drug Use and Health report indicated that in 2005, 8.8% of youths aged 12 to 17 experienced a major depressive episode (MDE) in the past year and that youth who experience a MDE are more likely to initiate alcohol use or drug use than youth who have not experienced an MDE. A specific organized system ensures each youth receives the continuum of care, including parents and families members due to the far reaching effects of substance abuse.

Youth outpatient admissions in King County have trended down since time period January-June 2000. When comparing January-June 2006 time period to January-June 2004, there was a 24% decline in youth outpatient admissions. Yet for this same time period retention at 90 days is an impressive 69% and continue to increase.

Alcohol remains the most prevalent primary drug at time of admission to youth outpatient treatment and over that period, ranged from 39% of admissions to nearly 46%. Marijuana was next and ranged from nearly 21% to nearly 28%. The next prevalent drugs were cocaine that ranged from 14% to nearly 19%; methamphetamine that ranged from 5% to 13%; heroin from

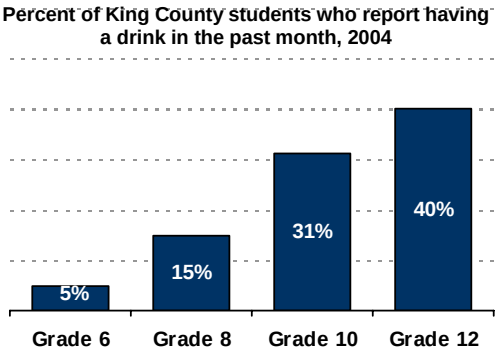
nearly 5% to nearly 7%; and other that ranged from 1.5% up to 4.4%.

According to key informants, several factors contribute to low admissions. They include: 1) a large reduction in school district Prevention/Intervention staff that were a major source of number of referrals to agencies and resultant admission to services; 2) a lack of and decline in certified chemical dependency professionals to serve youth within our local system that has been occurring over the past several years; 3) a lack of outreach funds to the agency; 4) a low vendor rate that only covers a portion of actual service cost; 5) the 69% treatment retention rate that keep treatment slots filled with no new openings available due to staffing issues.

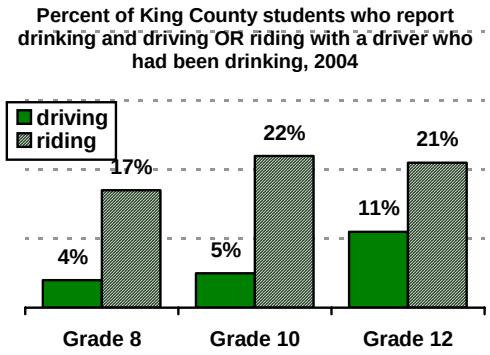
A complete report on treatment completion and retention are included as an appendix.

Chart 7: Are King County children and youth using alcohol?

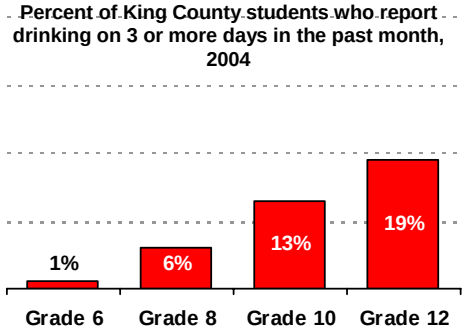
…recently?



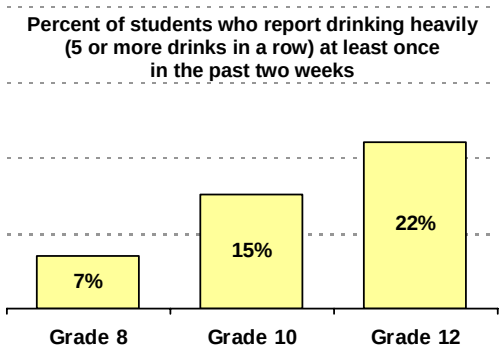
…while driving?



…frequently?



…heavily?



How do King County students who drank during the past month get their alcohol? 2004

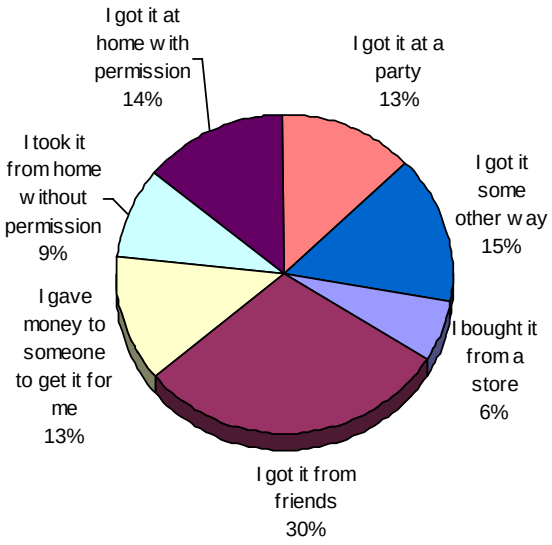
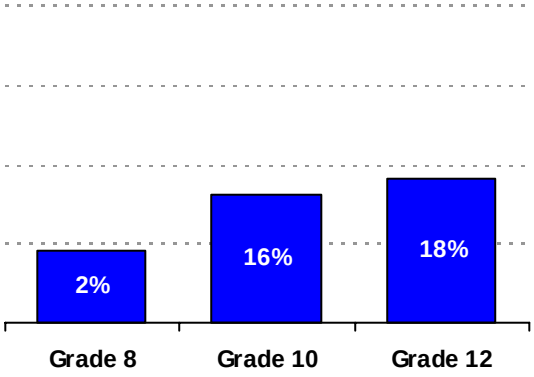
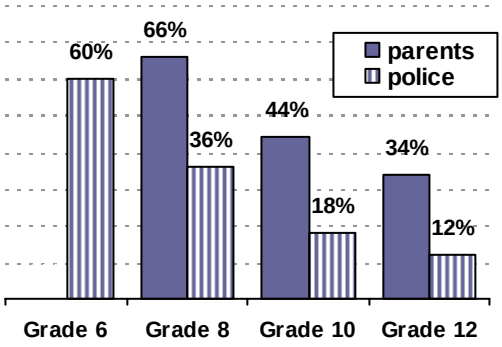


Chart 8: How strong are the barriers to drinking in King County?

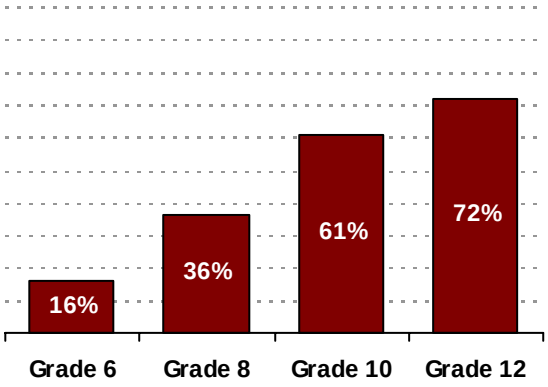
Percent of King County students who feel that their parents* think it is only "a little bit wrong" or "not wrong at all" for their teen to drink alcohol regularly, 2004



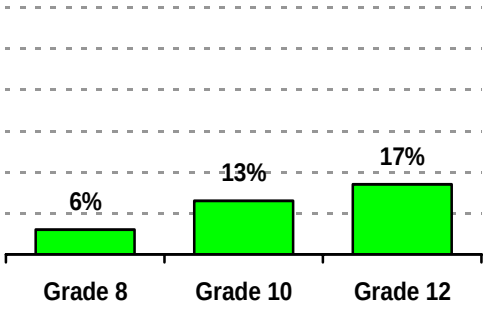
Percent of King County students who think they will get caught by parents* or police if they drink alcohol, 2004



Percent of King County students who think it is easy to get alcohol when they want, 2004



Percent of King County students who report being drunk or high at school in the past year, 2004



* Questions about parental attitudes are included at the discretion of the school districts. Results may not reflect a representative sample of all students in the community.

Pregnant and Parenting Women

According to the WA State Department of Health Center for Health Statistics, for women between the ages of 15 to 44, the King County live birth rate has held fairly steady with 56.4 per 1,000 in 2005 compared to the 1996 birth rate of 57.0.

Pregnant and parenting women (PPW) prevention includes warnings on alcoholic beverages of potential teratogenic effects of alcohol on the developing fetus, medical provider relationship with the woman and initiation of a discussion of use of drugs and alcohol prior to and during pregnancy, and facilitating treatment entry when indicated (e.g. *Did You Ask*, WA State Department of Health). Other prevention services directed at girls and young women should also be included, as well as parenting as prevention to maintain healthy communication within families.

Parenting as prevention is related to the risk factor of family management problems and the protective factor of family bonding. Risk to the children can be reduced by increasing parenting skills and healthy family interaction and bonding. Children of substance abusing parents are at a higher risk of developing addiction/alcoholism themselves but parents in recovery who use healthy parenting and family management skills can increase protection of their children.

Pregnant/parenting (PPW) outpatient admissions in King County have been declining from an all time high at time period July-December 2001. In comparing January-June 2006 to January-June 2004, the decline in admissions for this population is 47%.

Due to reluctance to enter treatment when pregnant due to fear of legal ramifications, case finding, outreach, and case management to support inclusion of other system involvement to support treatment entry is essential to PPW treatment. Also essential is women-specific programming. Last year the one women-only outpatient program in King County closed their outpatient unit, and another program ceased service specifically to this population in 2005.

Parents with Children

Prevention includes information on the role of parenting in potentially preventing or managing early substance abuse in their children, information about and skill building of family management and family bonding, and behavioral clues that may indicate alcohol/drug usage by their youth and resources for assistance. Children of parents who are chemically dependent are at higher risk of substance abuse themselves.

Outpatient admissions of parents with children have increased considerably (38.6%) when comparing January-June 2000 to January-June 2006. The King County treatment system has established service system that supports recovering parents and families by providing funded child care services available at seven treatment sites; specialized therapeutic childcare (including transportation and in-home visits) available at four Childhaven sites located in four sectors of the county; respite care through privately licensed foster homes for parents entering inpatient treatment, detoxification services, medical hospitalization such as surgery; as well as evening and weekend respite as needed by parents generally.

There is an 8.6% drop from January-June 2005 compared to January-June 2006 which is partially contributable to a women-only program ceasing outpatient services although this alone would not account for the entire decline.

Elderly

According to a 2006 *Area Plan on Aging*, the King County aging population (60 years old and older) is expected to grow from 239,857 in 2000 to 313,456 in 2010. In terms of the share of the total population, the aging population is forecast to change from 13.8% in 2000 to 16.8% in 2010. Among concerns raised in this report:

- Poverty rates have increased for older people.
- Rates of disability in King County are higher among adults 65 and older, and a higher number of adults with disabilities are in the 21-64 age group.
- Affordable housing designed to accommodate mobility and safety is needed.
- Problems of mental illness and depression are increasing.
- Close to 90 percent of depressed older patients in primary care get no treatment or inadequate treatment, despite the availability of effective treatment.

Elderly/aged/older adult outpatient admissions defined as 65 years of age or older has remained fairly steady since January 2001. Since then through December 2006 there have been a total of 122 admissions. When the Opiate Substitution Treatment (OST) admissions of 34 are included, the time period total rises to 156.

Gay, Lesbian, Bisexual and Transgender Persons

According to the *GLSEN 2001 National School Climate Survey*, 33% of gay, lesbian, bisexual and transgender (GLBT) students in high school had attempted suicide in the prior year compared to 8% of the heterosexual respondents. This study also found that more than 83% of GLBT students reported verbal harassment while at school and more than 74% of transgender students reported sexual harassment. Additionally, more than 21% reported that they had been punched, kicked or injured with a weapon because of their sexual orientation.

Marginalization, stigma and alienation contributes to increased use of alcohol and other drugs not only as an initial emotional response or potentially a coping mechanism for those so predisposed, but according to key informants bars and clubs are proffered to youth as an important social venue for the GLBT community by many within the community. Even before youth reach the legal drinking age, many are taught that in order to meet people and socialize they must frequent the very venues that encourage excessive alcohol use as well as drug use.

Marginalization, stigma and alienation can cross over into a treatment milieu so specific programming, group processes, staff training and agency policies are needed to ensure treatment will be accessed by GLBTQ youth and adults when needed, and then will engage and retain them in treatment. Treatment outreach and engagement appear to be a significant challenge for the treatment system.

GLBTQ outpatient admissions skyrocketed 50% when comparing January-June 2003 to January-June 2006. A sexual orientation/gender orientation question was not asked for data collection in the TARGET system until early 2002 time period. The January-June 2006 data indicates that

individuals that identify themselves as GLBTQ are 6% of all admits while according to various studies, the proportion of the general population that self identifies as GLBTQ is 7-10%; however, many cities and locales can claim a higher percentage.

The treatment system can not rely on special population agencies to address all the needs of the GLBTQ population in King County. Expertise in outreach, intervention and engagement in treatment needs to be addressed at every agency. Additionally, little is actually known about the reasons behind lower numbers of treatment completions by GLBTQ persons in King County. Those admitted to treatment list methamphetamine as primary substance nearly three times as often as those who do not self identify as GLBTQ. More evaluation of GLBTQ client satisfaction and engagement in treatment is needed if programs are to better adapt to the treatment needs of the GLBTQ population.

Self-identified GLBTQ individuals Admitted to Treatment More Likely to be Discharged as Not Amenable to Treatment or to Withdraw Against Program Advise

	Gay/Lesbian/Bisexual						**Total**	
	Yes		**No**		**Unknown**			
	N	**%**	**N**	**%**	**N**	**%**	**N**	%
Completed Treatment	103	35.6%	1,602	39.7%	175	40.8%	1,880	39.5%
Not Amenable to Treatment	44	**15.2%**	311	**7.7%**	26	**6.1%**	381	8.0%
No Contact	65	22.5%	1,013	25.1%	119	27.7%	1,197	25.2%
Rule Violation	14	4.8%	438	10.8%	32	7.5%	484	10.2%
Withdrew Against Program Advice	63	**21.8%**	676	**16.7%**	77	**17.9%**	816	17.2%
Total	289	100%	4,040	100%	429	100%	4,758	100%

Count of Treatment Discharges by type for outpatient and opiate substitution admissions between the months of January and December 2006. Data is taken from the DASA Treatment Analyzer with a run date of May 29, 2007.

There is an additional area that key informants continue to advocate for specialized services. Specific resources to initially engage in treatment and then retain in treatment, is needed for men who have sex with men (MSM) who inject methamphetamine. Key informants indicate that current available treatment does not access this particular population, and for those who have attempted treatment have found it not useful or pertinent to them. A recent study on treating crystal methamphetamine addiction among gay and bisexual men noted that only a small percentage of users who want treatment actually receive it (12%), citing barriers such as need for treatment services to be tailored specifically to MSM, the need for interventions by healthcare providers, the need for targeted prevention programs, an inappropriate media response of underreporting accurate information, and the need for more research.

IV Drug Users

According to the *Recent Drug Abuse Trends in Seattle-King County Area* (June 2006), for the year 2005, emergency department reports for selected illicit drugs by type of case, 16.5% of them were individuals seeking detoxification and/or treatment for heroin. This report also documented indications from a local incidence study that 21% of non-infected IDUs acquire hepatitis C each year, and that 10% IDUs that have not previously had hepatitis B acquire it. Additionally, heroin/opiate/morphine-involved deaths (n=74) did not change in 2005 with a rate of 4.1 per 100,000 population.

In an effort to combat drug-related deaths, King County has outreach and wait list services through the Public Health-Seattle & King County needle exchange program; these are basic necessary social and harm reduction supports to individuals who are intravenous drug users (IDU) in need of OST, while awaiting an opening in an OST program. Currently the list is 430.

Through this service, indigent individuals can be assisted through the application process in order to complete application for public assistance financial programs for which they may be eligible and complete the chemical dependency assessment through local treatment programs.

Intravenous drug users (IVDU) admissions, who have ever used a needle, as a proportion of all admits, has remained fairly steady from January-June 2000 (22.9%) through January-June 2006 (22.7%). In comparing admissions over time, there was an approximately 12% increase in these admits when comparing January-June 2006 to January-June 2000, but a substantially higher increase when comparing to January-June 2003 (38%).

For those IVDU whose needle use was current (within 30 days), these outpatient admits have decreased considerably when comparing January -June 2000 to January-June 2006 (80.9%). Simultaneously in the same time period, OST admissions decreased by only 18%. Comparing January-June 2003 to the same January-June 2006, there was a 32% increase while OST admissions increased by nearly 40%.

In viewing retention in OST for admissions from January 2000 through March 2006, 48.5% stayed in treatment at least one year; approximately 57% stayed in treatment for at least 9 months; 70% stayed in treatment for at least 6 months; and approximately 85% remained in treatment for at least 3 months. These data indicate client turn-over is low so that the available admissions are low, and the clients are staying in treatment as is the intention of this modality.

However, an identified barrier from key informants for the specific group of individuals from the wait list who enter OST and are approved and begin receiving SSD while maintaining in treatment, is the spend down that they are unable to meet without being forced to choose between basic living needs (such as a stable living situation) or their treatment needs, partially due to the high cost of living in King County. Treatment strives to assist people toward stabilization and this barrier directly interferes. Clients may return to the wait list services at the needle exchange for assistance and intervention on this issue as they often cannot hurdle this systemic barrier within the treatment program that has no funding to absorb spend down as in the mental health system nor to maintain specific staffing to assist. A detoxification is initiated for clients without the financial wherewithal to pay the spend down, when vouchers are not available.

Treatment Expansion

Assessment of Expanded Services for SSI, GA-U, TANF & Youth

A DASA REQUIRED SECTION

SSI (without Aged)
From July 2005 to June 2006, King County met approximately 84% of expected performance. There was an increase in the time period July 2006 through March 2007 when 105% of the expectation was met.

SSI Aged
From July 2005 to June 2006, King County met approximately 80% of expected performance. There was a slight increase in time period July 2006 through March 2007 when 84% of the expectation was met.

GAU
From July 2005 to June 2006, King County met approximately 130% of expected performance. From July 2006 through March 2007 there was a slight decrease of 118% of the expectation was met.

TANF
From July 2005 to June 2006, King County met approximately 76% of expected performance. From July 2006 through March 2007 76% of the expectation was maintained.

Youth
From July 2005 to June 2006, King County met approximately 80.7% of expected performance. From July 2006 through April 2007 76.4% of the expectation was maintained

Assessment of Service Needs for Persons in the Criminal Justice System

A DASA REQUIRED SECTION

King County has invested a great deal of time and resources to address the needs of those involved in the criminal justice system. The intent of the King County Criminal Justice Continuum of Care Initiative is to assure that persons who are significantly impaired by substance abuse, mental illness or both and involved repeatedly or for significant duration in the criminal justice system "receive a continuum of treatment services that is coordinated, efficient, and effective, and that reduces their rate of re-offense and jail time." This model requires that services begin pre-incarceration and continue through post-release, community-based treatment with few if any gaps in service. Such offenders should have access to coordinated housing, pre-vocational, employment, crisis, and treatment services that are continually evaluated for effectiveness in reducing the rate of re-arrest.

Project Components:

1. Co-occurring Disorders (COD) and Jail Transition Services Programs (12-month benefit)

Community Psychiatric Clinic (CPC) and Seattle Mental Health (SMH) provide integrated mental health and chemical dependency treatment, including housing stabilization, for appropriate and eligible adult offender-clients referred from a local specialty court (Drug Diversion Court, King County District Mental Health Court, or Seattle Municipal Mental Health Court). Approximately 50% of specialty court referrals originated from Drug Diversion Court. The services are co-located and treat both disorders equally. Since August 2003, 317 specialty court clients were admitted into COD treatment through February 2007.

The COD program was expanded to accommodate referrals from the King County Correctional Facility (KCCF) in Seattle, Regional Justice Center (RJC) in Kent, and the municipal jails in King County. Program referrals were made from KCCF and the RJC beginning in late 2005, and referrals from the Auburn, Enumclaw, Issaquah, Kent, and Renton municipal jails began in early 2006. Through February 2007, 97 individuals were admitted to COD treatment at CPC and SMH directly upon release from jail via the Jail Transition Services Program.

2. Community Linkages via Criminal Justice Liaisons

SMH provides five criminal justice liaisons: two staff at KCCF, and one each at the RJC, the King County Community Corrections Division's Community Center for Alternative Programs (CCAP), and South/East King County (municipal jails) to engage, refer, and link eligible offenders to post-release treatment and support services. Combined, the liaisons received 4,795 referrals from September 2003 through February 2007.

3. Enhanced Screenings in the Jail, and Placement

Jail Health Services and the Mental Health, Chemical Abuse & Dependency Services Division (MHCADSD) are assisting the King County Community Corrections Division in enhancing screening of offenders in the jail with possible mental illness and/or chemical dependency treatment needs. Enhanced screening was implemented in the King County Jail via Intake Services in August 2005 and data are available since January 2006. During 2006, enhanced screenings were conducted for 147 inmates: 43 (29%) for chemical dependency, 52 (35%) for mental illness, and 52 (35%) for both chemical dependency and mental illness.

4. Assistance in Applying for Publicly Funded Benefits

An Alcohol and Drug Addiction Treatment and Support Act (ADATSA) case monitor, three Washington State Department of Social and Health Services (DSHS) financial workers, and a DSHS social worker are assisting potentially eligible offender-clients in applying for publicly funded treatment services and benefits prior to and after release. The assigned financial workers processed 1,354 DSHS applications from May 2004 through February 2007. The assigned case monitor conducted 611 jail-based ADATSA assessments from February 2004 through February 2007, of which 89% were eligible for ADATSA benefits and treatment placement.

5. Opioid Dependency and Methadone Voucher Services

A Jail Health Services (JHS) social worker engages opioid-dependent inmates at KCCF and RJC and has provided assessment, case management, and release planning services for 321 unduplicated inmate-patients during 2006 and 104 in 2007 through February. Twenty methadone voucher recipients were admitted into opiate substitution treatment at Therapeutic Health Services and Evergreen Treatment Services upon release from KCCF and the RJC in 2007 through February. Nearly 200 such vouchers were issued in 2004-2006.

6. Housing Voucher and Case Management Program (6-month benefit)

Dedicated housing options are available for eligible specialty court and CCAP clients in King County via the Housing Voucher and Case Management Program. The program, managed by SMH, provides permanent housing search, case management and stabilization services to clients who are homeless with substance abuse and/or mentally health disorders. From May 2003 through January 2007, 714 clients were placed in the program.

7. Substance Abuse Services at CCAP

Intensive outpatient and outpatient chemical dependency treatment services are available to eligible and clinically appropriate offender-clients who are court-ordered to CCAP by King County District or Superior Courts. Chemical dependency treatment services are provided via contract with CPC; 375 clients were admitted to the program from April 2004 through February 2007. CPC provides brief therapy and relapse prevention services for CCAP participants who are ineligible for treatment or awaiting treatment placement. CPC staff also facilitates educational classes and cognitive-behavioral programming for the general population at CCAP. These activities focus primarily on alcohol/drug abuse education, relapse prevention and life skills training.

8. Related Program: *Transitional Recovery Program* at the Regional Justice Center (RJC)

Pioneer Human Services provides chemical dependency treatment services at the RJC to offender-clients referred from King County Drug Diversion Court (primarily) or JHS. Nearly 290 Drug Court and JHS clients (195 men and 93 women) completed the 60-day program from February 2005 through March 2007.

9. Project Evaluation and Outcomes

Debra Srebnik, Ph.D., was hired as the Project Evaluator in July 2003 and her work will assist in determining whether the Criminal Justice Continuum of Care Initiative has a positive impact on lowering re-arrest rates over time among project participants and, as a result, reduce criminal justice system costs associated with this population. If successful, King County hopes the initiative, sentencing alternatives, and jail use limits will avoid or significantly delay the need to build another detention facility for adult offenders. A process evaluation report was issued in July 2005. A preliminary outcomes report was issued in September 2005 with a follow-up report issued in February 2006. Additional outcomes will be presented in future reports.

Gaps in Services to Criminal Justice Population

There is continued need to provide structure and support for those being released from the criminal justice system. The list below identifies gaps for adults transitioning from jail to the community. This list was developed as part of statewide exercise based on GAINS Sequential Intercept model)

1. Lack of peer counselors in the community and difficulty obtaining associated State certification for peer counselors (some are certified and some are not); some counties have local, non-certified training available (e.g., King and Whatcom Counties).

2. Lack of physical plant space, including program and office space, in jails for community-based agencies to connect eligible persons with services prior to release:

    - Jail clearance and other barriers;
    - Program space in some jails has been converted to increase housing capacity

3. Lack of statewide electronic health record technology whereby jails and community mental health and chemical dependency treatment agencies might more efficiently share information under HIPAA restrictions:

    - Differences in data systems between the publicly funded mental health and chemical dependency treatment systems
    - Need routine access to mental health and chemical dependency treatment data for the purposes of continuity of care

4. Lack of availability bridge resources to ensure those in need get connected to appointments and services upon release, particularly during the first 30-60 days after release from custody:

    - Need a system that provides quick and routine access to psychotropic medications in a continuous, monitored manner upon release; some jails provide up to 7-day supply of release medications; DOC provides 30-day supply to individuals exiting prison unless the sanction is less than 45 days (no meds provided in such cases); jails should provide at least a 10-day supply of medications at release;
    - Delayed access to prescribers is common in the community with the inability of some agencies to retain prescribers due to limited resources;
    - Inmates can not apply for benefits until they are within 45 days of release with a defined release date;
    - Lack of qualified chemical dependency professionals (CDPs) in the community

5. Lack of sufficient Release Plans that are realistic and include clear objectives; mentally ill and chemically dependent inmates need counseling, case management, and care coordination in achieving those objectives:

    - Release planning should start immediately after booking; its not uncommon for a fully "planned" prisoner to get an "unplanned" release;
    - Need standardized release documents across the State utilizing the same screening and

assessment tools, and release plan format;
- Extreme delays in competency restoration cases with inmates awaiting competency evaluations at Western State Hospital

6. GAU-funded clients are ineligible for mental health services; GAU will pay for crisis services and other limited benefits for up to 90 days only:

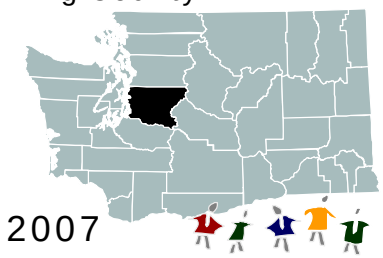
    - Loss of Title XIX Medicaid and other funding if incarcerated longer than 30 days
    - Unwillingness of agencies to send case managers into the jail because they won't be paid for services provided in the jail;
    - HB 1290 Jail Services Funds have helped significantly to alleviate some of these issues; its critical to sustain this funding;

7. Lack of cross systems coordination to the detriment of defendants with co-occurring mental health and substance abuse disorders; bifurcated funding streams; need holistic approach vs. "siloed" approach.

8. Lack of affordable housing for individuals with mental health and chemical dependency disorders who are involved with the criminal justice system:

    - Transitional housing is difficult to find for specific populations such as those with children, those on methadone maintenance, those in need of supported housing, and those with medical problems;
    - Lack of permanent supported housing;
    - Almost impossible to place sex offenders and individuals with a history of arson;
    - HB 2060 and 2163 are helpful, but they are not the entire answer to this problem.

King County



2007

PART II

Mobilization & Capacity Building

Persons and Organizations Involved in the Planning Process

A DASA REQUIRED SECTION

As previously stated as the process for the community assessment, both DCHS Divisions (MHCADSD and CSD) consulted with and gathered information from various local key informants, service providers, government entities and community groups that included using existing provider meetings and other meetings, focus groups, a survey, and interviews:

- Alcohol and Drug 24-Hour Helpline
- Asian Counseling and Referral Services
- Auburn Youth Resources
- Avalon Center
- Catholic Community Services
- Center for Career Alternatives
- Center for Human Services
- Central Youth and Family Services
- Chemical Dependency System Management Group
- Community Psychiatric Clinic
- Consejo Counseling and Referral Services
- Department of Health Washington State Partnership for Youth
- Harborview Medical Center
- Encompass
- Evergreen Treatment Services
- Friends of Youth
- Girl Scouts – Totem Council
- Greater Maple Valley Community Center
- Harborview Medical Center
- High Utilizer Group

- Iwasil/Boys and Girls Clubs of King County
- Intercept Associates
- Kent Youth and Family Services
- King County Health and Safety Networks
- King County Aging and Disabilities Services
- King County Alcoholism and Substance Abuse Administrative Board
- King County Community Organizing Program Core Advisory Board
- King County Meth Action Team
- King County Public Defenders Association
- King County Prevention Interested Parties
- King County SOAR: A United Way project to impact adolescents
- Lifelong AIDS Alliance
- Mercer Island Youth and Family Services
- Muckleshoot Tribe
- Neighborhood House
- Public Health-Seattle & King County
- Puget Sound Educational Service District
- Opiate Substitution Treatment Coordination Oversight Committee
- Recovery Centers of King County
- Renton Youth and Family Services
- Ruth Dykeman Youth and Family Services
- Safe and Drug-free Schools and Communities Coordinators/Tobacco Coordinators
- SafeFutures Youth Center
- School Superintendents of King County School Districts
- SEAMAR
- Seattle Counseling Services
- Seattle School District
- Seattle Indian Health Board
- Snoqualmie Tribe
- Sound Mental Health (formerly Seattle Mental Health)
- Therapeutic Health Services
- United Way Cross System Planning, Impact Council on Physical Health, Mental Health and

Chemical Dependency

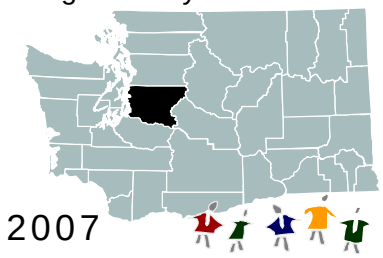
- United Indians of All Tribes Foundation
- Vashon Youth and Family Services
- Washington Pacific Islander Families Against Substance Abuse
- Youth Eastside Services

Specific to the Criminal Justice Population

A DASA REQUIRED SECTION

- King County Alcohol/Drug Treatment and Prevention Coordinator
- King County Community Center Alternative Programs
- King County Drug Court
- King County Family Treatment Court
- King County Jail
- King County Juvenile Drug Court
- King County Mental Health Court
- King County Prosecutor's Office
- King County Regional Justice Center
- King County Sheriff's Office
- King County Superior Court

King County



2007

PART III

Planning & Goal Formation

TREATMENT EXPANSION POPULATIONS

Plan for Expanded Services

A DASA REQUIRED SECTION

Supplemental Security Income (SSI)

Recipients of Supplemental Security Income (SSI) become eligible after being diagnosed by a physician as suffering from a physical or psychiatric disability determined to last more than one year, or to be considered permanent. SSI recipients primarily enter the treatment system when prompted to do so by the criminal justice system, (if they have been arrested), by their doctor (if prescribed), by their DSHS social worker. There is a large population of SSI clients that are served in the Mental Health System. We have developed a matrix which documents the number of SSI clients that are served in the MH system and have begun aggressive outreach efforts to those specific programs. We have partnered with the state Division of Alcohol and Substance Abuse and have scheduled a series of meetings with each provider. These meetings are intended to identify areas to expand treatment services to this population. We have increased outreach efforts to SSI recipients that are housed but at risk of loosing housing as a result of addiction issues. A CDP is part of a community mobile health team that connects these individuals to treatment. In addition we will be expanding outreach services to the local needle exchange to help identify patients who qualify and are in need of services. Efforts will continue to provide substance abuse treatment services to this population.

General Assistance – Unemployable Adults

GAU recipients qualify for public assistance after being diagnosed by a physician as suffering from a physical or psychiatric disability determined to last at least 3 months. GAU eligible clients primarily enter the treatment system as a requirement of their DSHS eligibility. A chemical use assessment is required by DSHS in cases where alcohol or other drug use is documented as being a contributing factor in the recipients' incapacity. In the previous biennium King County far exceeded expectations in this area and will continue to seek out and provided treatment services to this population. We have been partnering with the individuals implementing the GAU pilot project and will continue to coordinate entry to services to this population through the community health clinics and other referral entities that serve GAU clients. Meetings have been and will continue to be held with CSO offices to encourage the referral to treatment for eligible GAU clients. As with other areas of treatment expansion, we have meet with providers and given them the information that treatment expansion categories

have been expanded so there is no longer a limit on the number of GAU clients that can be admitted to treatment.

Temporary Assistance to Needy Families (TANF)

Recipients of Temporary Assistance to Needy Families (TANF) qualify for public assistance when parenting a child or children and their reported resources are below the qualifying threshold. TANF recipients are required to participate in the creation of an Individual Responsibility Plan (IRP). If chemical use is identified as a barrier to employment on the IRP, the TANF recipient is mandated to participate in a chemical use assessment and follow any and all treatment recommendations if a substance use disorder is diagnosed. We continue to work with the CSO offices and the TANF out stationed counselors to increase the number of TANF clients served.

Youth

Youth enter the treatment system from many referral sources; Juvenile Rehabilitation Administration (JRA), County Juvenile Justice Program, schools, and family. According to key informants, several factors contribute to low admissions. They include: 1) a large reduction in school district Prevention/Intervention staff that were a major source of number of referrals to agencies and resultant admission to services; 2) a lack of and decline in certified chemical dependency professionals to serve youth within our local system that has been occurring over the past several years; 3) a lack of outreach funds to the agency; 4) a low vendor rate that only covers a portion of actual service cost; 5) the 69% treatment retention rate that keep treatment slots filled with no new openings available due to staffing issues. We have made youth admissions a priority and are beginning to see increased admissions in this area. Along with our partners at the state Division of Alcohol and Substance Abuse we have met with providers and together identified treatment expansion increased capacity goals and opportunities for expanding services. We have increased coordination with the Juvenile Justice System and the Puget Sound ESD to assure timely admission to treatment.

CRIMINAL JUSTICE TREATMENT (CJTA) ACCOUNT

The Use of the CJTA Allocation

A DASA REQUIRED SECTION

The following plan details how funds from the CJTA will be expended. An estimated 105,036 offenders with an addiction problem have charges filed by a prosecuting attorney in Washington State. We estimate that 19,887 of these individuals reside in King County. In addition we estimate that 42,015 individuals in Washington State fit the CJTA eligibility criteria, i.e., have a substance abuse problem that, if not treated would result in addiction, against whom charges are filed by a prosecuting attorney. Of these we estimate that approximately 7,955 nonviolent offenders reside in King County and may be eligible for drug court.

The CJTA panel through periodic meetings regarding use of the CJTA funds plays an important part in determining the needs of clients served under the Prevention, Intervention, Treatment and Aftercare (PITA) continuum of care. In addition committee members are encouraged to

participate in program development and problem solving. The CJTA panel unanimously decided to continue to provide a full continuum of treatment services for clients served in the King County Drug Diversion Court Program. This is outlined further in the plan.

A plan for the use of the Innovative Grant Portion of the CJTA funds is included in this plan. The selected program meets the criteria for all three areas of the Innovative funds.

1. Innovation Project: The project serves the co-occurring population that other residential programs are not able to serve.
2. Best Practice Project: The program uses a SAMHSA best practice model for the delivery of co-occurring services.
3. Regional Project: King and Pierce County jointly fund and provide oversight to the program.

The following plan will enhance treatment services by providing immediate access to residential programs and comprehensive case management services. In King County based on the number of persons eligible for receiving services under this model (7,955) we have chosen to and will continue to use these funds under a drug court model.

Implementation of the plan will accomplish the following goals and objectives:

- **Develop stability in the client's basic life conditions**
  75 percent of clients served under this model will complete the treatment program and be linked with appropriate on-going services;

- **Provide clear assessments and evaluations of any provisional diagnoses, diagnoses, or ongoing medical conditions including an integrated, comprehensive treatment plan for recovery**
  100 percent of clients will receive an assessment and evaluation of their present condition, medications, a provisional diagnosis and developed a treatment plan moving toward recovery from their addition and their mental health issues;

- **Assist the client with enrollment for entitlements and other available funding for treatment and support services in the community**
  100 percent of clients will be reviewed for eligibility for Medicaid, all clients who were not enrolled in Medicaid will be assisted in applying for GAU and as applicable, GAX.

Panel Members

Judge Wesley Saint Claire, King County Superior Court
Dan Satterberg, King County Prosecutor Office
Chief Gregory Dymerski, King County Sheriff Office
Captain Michael Pendrak, King County Sheriff Office
David Chapman, Executive Director, Associated Counsel for the Accused
Ron Jackson, Executive Director, Evergreen Treatment Services
Barbara Miner, Director and Superior Court Clerk, Judicial Administration

Mary Taylor, King County Drug Court Program Manager
Jim Vollendroff, King County Drug and Alcohol Coordinator

Background of the King County Drug Court

King County Drug Diversion Court was implemented in August 1994 and was the twelfth drug court in the country and the first in Washington State. From the drug court's inception in King County to the present, 2,920 defendants have opted into the drug court program. Of those that have opted in, 500 are currently active in the program and 1,030 have graduated.

The King County Drug Diversion Court currently contracts with twelve community-based treatment agencies across a wide geographical area and eight residential programs across the state. Contracted services include intensive outpatient treatment, opiate substitution therapy and full-time ancillary service case managers. Additionally, the Drug Court employs one treatment liaison and five Drug Court-based case managers responsible for orienting Drug Court participants to the program, conducting initial assessments, and referring participants to appropriate treatment. The Drug Court staff is also responsible for the exchange of information between the treatment agencies and the court.

Eligibility criteria has continued to expand in King County Drug Court. In April, 2001, simple possession cases were filed directly into King County District Court and defendants charged for the first time with simple possession became eligible for a misdemeanor. The remaining possession cases, typically those with greater drug involvement, were referred to Drug Court. Later that year, King County Drug Court expanded its eligibility criteria to include another population of cases, those charged with solicitation to commit delivery of a controlled substance, also known as facilitator cases. In 2002, select property crimes became eligible and in March, *2006* the drug court criteria was again expanded to include Delivery or Possession with Intent to Deliver

The attached Division of Alcohol and Substance Abuse (DASA) Treatment Analyzer (TA) report shows a 73.2% treatment completion rate for those clients funded with the use of CJTA funds. This compares to a County treatment completion rate average for non-CJTA clients of 42.3%

A research overview by the Center for State Courts cites studies which estimate that drug courts nationwide have an average one year retention rate of 60%.[1] The King County Drug Court retention rate is at 59 %.[2] This retention rate was achieved despite working with a demonstrably more difficult–to–treat population. The Urban Institute's multi-site, longitudinal study of drug courts across the country provides the following preliminary information.[3]

	King County	Nationally
Homeless during prior six months	53%	23%

[1] Amanda B. Cissner, Michael Rempel: (2005), The State of Drug Court Research Moving Beyond 'Do They Work?' New York: Center for Court Innovation.
[2] Of 319 defendants who opted in between 6/15/04 - 6/15/05.
One year later 59% were retained, i.e., graduated or still active in treatment and 41% were not retained (terminated, deceased, closed, or on bench warrant.
[3] Sheila Rossman (2006): National Drug Court Evaluation Multi-Longitudinal Impact Study: Mid-baseline Update. Washington DC: The Urban Institute

Unemployed	80%	60%
# of prior arrests after age 18	11	6.5
"Heavy" user of drugs in past 6 months	46%	37%
Anti-social personality disorder	57%	39%
% Depression (scoring 10+ on depression scale	46%	39%

The addition of intensive inpatient treatment in conjunction with effective case management services together with major changes on day to day operations have increased retention, completion and graduation rate in King County.

Narrative of Allocation Plan for CJTA Expenditures

Inpatient
The need for inpatient treatment has continued among drug court participants in the current biennium. The most recent CJTA statistics show that King County has sent 100 unduplicated clients to residential treatment services between July, 2006 and March 31, 2007 using CJTA funds.

The gap in treatment services before CJTA funds were available and the need for inpatient treatment was dramatically demonstrated by data collected by Drug Court staff on 17 Drug Court defendants who were booked in the King County jail during the first six months of 2002. Each of the defendants was assessed by treatment staff as being in need of inpatient treatment and were referred to inpatient at the time of their booking in the jail. However, as the data revealed, inpatient treatment was not available on demand. The time between referral and entry to inpatient treatment averaged 72 days - all of those days spent in custody because treatment was not available.

This has changed with the use of CJTA funds for residential services. Drug Court staff are now able to send participants to one of 8 contracted residential providers and secure a bed in a manner of days.

Case Management Youth
With the addition of Juvenile Drug Courts being covered by CJTA funds we will be able to provide a limited amount of funds to cover this vital service.

Outpatient Treatment
Dedicated funding for drug court clients receiving outpatient services and immediate access to Opiate Substitution Treatment is critical. Without CJTA dedicated funds, wait times would be necessary and expansion of services impossible.

Transportation
Drug Court participants need assistance with transportation. Without assistance, transportation to and from treatment becomes a barrier to treatment.

Proposal
The consensus of the local CJTA panel was to submit a proposal designed to enhance existing

services, assure sustainability of the current budget and add a small amount for case management services for Juvenile Drug Court.

Full continuum of Inpatient Services purchased

Intensive Inpatient
Inpatient services consist of a concentrated program of individual and group counseling, education and activities for detoxed alcoholics and addicts and their families. Treatment length varies based on individual client need utilizing the American Society of Addiction Medicine Criteria. Length of stay varies from 14-30 days.

Recovery House
Recovery House is often used as a step down from Inpatient Services. The goal is to provide a program of care and treatment with social, vocational, and recreational activities to aid in patient adjustment to abstinence and to aid in job training, employment, or other types of community activities. Length of stay varies from 30-90 days.

Long-term Treatment
Long term offers services and a program of treatment with personal care services for chronically impaired alcoholics and addicts. With impaired self-maintenance capabilities. Participants referred to this level of care need personal guidance to maintain abstinence and health. Length of stay varies from 90-120 days.

Case Management Services
Active Case Management services have proven effective in both keeping participants engaged in treatment and increasing the number of participants successfully completing treatment. Clinical case management, which is both strength and field based, will continue. The role of the case managers is one of coordination of client services, which decreases premature participant termination. Case management services, which we describe as field/strength based, are an important component of the program. Case managers partner with clients **in the community** to ensure success and minimize early termination from the program. Their role is to connect the client to housing, employment, vocational, healthcare and other ancillary services

Transportation
The CJTA funds can be used to purchase transportation in an amount not to exceed 10% of the total budget for services. Transportation will be provided to clients to maximize client participation and reduce barriers to treatment. We will provide transportation in a variety of ways including taxi vouchers, bus passes and reimbursement for mileage when appropriate.

Conclusion

The above services will continue to enhance King County Drug Court's continuum of care and reduce barriers to treatment. Treatment on demand is one of the key elements of a successful drug court program. Continued immediate access to inpatient will enhance the existing program and reduce the time participants are housed in local correctional facilities. Additionally, the

continuation of case management will assist those who are in the chronic stages of addiction, and need assistance to be successful. Many Drug Court programs are designed to assist the more functional addict, while those who need treatment the most and utilize the most resources are terminated from treatment due to "lack of motivation". This proposed plan will allow the King County Drug Court to continue to engage and assist the most difficult to serve client population.

The Use of CJTA Innovative Grant Allocation

A DASA REQUIRED SECTION

2007-2009 King County Criminal Justice Treatment Account (CJTA) Plan
Innovative Project – King County

Specify the type of project (innovation, best practice, or regional project). The CJTA innovated grant can be used for the following three types of projects:

Innovation, best practice, regional project with Pierce County.

King and Pierce Counties have collaborated to implement a Co-ed Chemical Dependency Co-occurring Disorders Residential Treatment Program for eligible CJTA funded clients.

The program assists individuals with an addiction or a substance abuse problem, against whom a prosecuting attorney in Washington State has filed charges, or who are non-violent offenders within a drug court program as defined in RCW 70.96A.055 and RCW 2.28.170. Individuals may also need Opiate Substitute Treatment dosing while in residential treatment. Individuals eligible for services have a co-occurring mental disorder, an emergent medical condition and/or a history of multiple admissions and subsequent premature discharges from other residential treatment programs.

In a couple sentences, describe the project (innovation, best practice or regional project) and how it will enhance treatment services.

Complex and challenging clients, who are chemically addicted, criminally involved and mentally ill require intensive and integrated residential treatment to increase their chances of success in recovery. Optimally, the integrated residential treatment approach emphasizes addiction rehabilitation and mental health symptom stabilization and combines stabilization of significant health issues and complex medication regimens, rehabilitation addiction treatment, and mental health treatment or treatment linkages. These services occur in a safe and medically/psychiatric monitored environment. Individualized treatment is an essential part of the program, as is a review of provisional diagnoses, current and past medication regimens, addictions treatment and mental health symptom stabilization.

King County and Pierce County, following a Request for Proposals selected and contracted with Pioneer Human Services to open a regional co-ed co-occurring disorders residential treatment program. The program began admitting clients in March 2006 and reached full capacity (16 beds) by mid-April 2006. King County is utilizing ten beds and Pierce County is utilizing six beds.

In order to provide and maintain a therapeutic environment, and ensure both patient and staff safety, this integrated co-occurring treatment program requires both sufficient staffing in terms of staff to patient ratio and dually-qualified professional staff

Additionally, an integrated residential mode of treatment requires the service provider access pharmacy services, manage medications, provide on-site storage for medication, and deliver complex medication regimens. Additionally, the contract between the counties and the providers requires the use of more medical staff (including contracted staff), and higher medical staff qualifications to accommodate a client population that could present challenges and may need a higher level of medical expertise, including psychiatric evaluations and psychiatric medication management on a frequent basis. The psychiatrist providing on-call availability must be certified in addictions, able to prescribe bueprenorphine, and on-site services.

The service provider must provide King County clients access to opiate substitution services while in residential treatment. OST dosing is partially done on-site by one provider.

Linkages to ongoing outpatient mental health services and the provision of mental health services as part of the stabilization process remains a key component of the program. The agency is a subcontractor of Seattle Mental Health and provides a range of services to clients enrolled in the King County Regional Support Network (RSN). Clients can include those in this co-occurring disorder residential treatment program. Cost for outpatient mental health services are borne by the King County RSN for those eligible for enrollment in the RSN. For clients not eligible for RSN services, mental health services can be provided by ATR funding if appropriate.

Prevention

A DASA REQUIRED SECTION

List of Priority Risk and Protective Factors

RISK FACTORS

Community Domain
Availability of Drugs
Community Laws and Norms Favorable Toward Drug Use
Low Neighborhood Attachment and Community Disorganization
Transitions and Mobility

Family Domain
Family Management Problems

Peer-Individual
Early First Use of Drugs
Favorable Attitudes Toward the Problem Behavior
Friends Who Engage in the Problem Behavior
PROTECTIVE FACTORS

Community Domain

Bonding: Opportunities, Skills and Recognition

Family Domain
Bonding and Attachment: Opportunities, Skills and Recognition

Peer-Individual
Bonding: Opportunities, Skills and Recognition

The overlapping risk and protective factors between the Alcohol and Other Drug Prevention Program (AODPP) and the Community Organizing Program (COP) are:

- Community Laws and Norms Favorable Toward Drug Use;
- Family Management Problems;
- Favorable Attitudes Toward the Problem Behavior; and
- Bonding: Opportunities, Skills and Recognition

Risk and protective factors to be addressed by each program as follows:

AODPP

- Early First Use of Drugs; and
- Transitions and Mobility

COP

- Availability of Drugs;
- Family Conflict;
- Friends Who Engage in the Problem Behavior; and
- Low Neighborhood Attachment and Community Disorganization

A DASA REQUIRED SECTION

AODPP will obtain DASA approval before proceeding with implementation of any prevention programs. For non-Best Practices or Promising Approaches, King County will submit a narrative to DASA describing how the prevention program and practice complies with the Center for Substance Abuse Prevention *Principles of Effective Substance Abuse Prevention*.

For July through December 2007, AODPP will contract for 80% Best/Promising Practices. These are: *All Stars; Communities That Care; Creating Lasting Family Connections; Guiding Good Choices; Home Visiting; Incredible Years; Life Skills Training Program; Mentoring: Big Brothers Big Sisters; Parenting Skills Program; Project Alert; Make Parenting a Pleasure;* and *Strengthening MultiEthnic Families and Communities.* Other science-based practices include Partners in Prevention; Media and Drug Prevention; Youth Resiliency Camp; and MPowerment Project. However, we are awaiting DASA approval prior to proceeding with contracting and implementation.

For services commencing January 1, 2008, AODPP will include a section in the Mental Health, Chemical Abuse and Dependency Services Division competitive bid process. Four sections will be included in this process, and they are AOD prevention, youth outpatient, adult outpatient, and ADATSA. In this bid process, AODPP will award no less than 50% to Best/Promising practices programs. Again, AODPP will obtain DASA approval before proceeding with implementation of any prevention programs.

The COP is committed to implementing a best practice or promising approach where it is appropriate for communities. These will be identified as we move into implementation in July 2007. COP will submit an Implementation Plan on the CTED/OSPI web system after April 16, 2007 which will include actual activities planned and evaluation expected on each prevention program/strategy.

Monitoring Prevention Programs for Fidelity
A DASA REQUIRED SECTION
The AODPP plan to monitor prevention programs for fidelity is as follows.

King County will administer a competitive bid process to include the requirement that applicants describe the Best Practice or Promising Approach and whether it would be delivered with complete fidelity or as an adaptation. For any proposed adaptations, the applicant was required to provide written evidence that the program developer had been contacted and agreed to the program modification(s).

For successful bidders, King County will review the adaptations and, if approved, write this into the contracts with prevention providers. This would provide clarity regarding what specific adaptation was accepted, if any; otherwise the provider will be mandated to deliver the Best Practice or Promising Approach with fidelity. DASA approval will be obtained prior to contracts.

The contract between King County and the prevention provider would identify the Best Practice or Promising Approach to be implemented with fidelity or as an adaptation as well as measurable outputs, such as number of series, sessions and participants.

King County will require the prevention contractor to submit monthly reports, both in narrative form and via a web-based prevention management information system. King County contract monitors will verify the accuracy of the data and measure how closely the implementation is to the established Best Practice or Promising Approach.

As required, King County contract monitors will conduct an on-site visit to the prevention provider service location to observe the actual service provision and discuss the prevention program, including adherence to fidelity issues. King County will require the contractor to complete a fidelity tool based upon the Wyoming 21st Century State Incentive Grant Program Fidelity Adaptation draft document, revised 1/28/2003 (see **Appendix 9**). If a Best Practice or Promising Approach has an established assessment of fidelity, these documents will also be reviewed.

King County will require prevention providers to submit interim and final evaluation reports. The reports will include a narrative related to the organization's efforts to deliver the Best Practice or Promising Approach as intended, with fidelity or as an adaptation.

PREVENTION

ALCOHOL AND OTHER DRUG PREVENTION
GOAL 1
Improve the bonding of children and youth to their community, family and peers living in King County

OBJECTIVE 1
Increase opportunities, skills and recognition for prosocial involvement in the community among children and youth in King County

TASKS
1. Determine need and prioritize where to focus community-based services for children and youth
2. Conduct a competitive bid process
3. Select organizations to deliver services
4. Obtain approval to subcontract with the organizations
5. Develop and process contracts with organizations
6. Monitor and evaluate community-based services for children and youth

ACCOMPLISHMENT DATE:
January 2013

INDICATORS
Pre-Post Surveys which are relevant to the program, such as "Required Measure (RM) Community" and "Assigned Measure (AM) Bonding Attachment"

OBJECTIVE 2
1. Increase use of effective communication skills among families in King County
2. Increase opportunities, skills and recognition for prosocial involvement among families in King County

TASKS
1. Determine need and prioritize where to focus family-based services
2. Conduct a competitive bid process
3. Select organizations to deliver services
4. Obtain approval to subcontract with the organizations
5. Develop and process contracts with organizations
6. Monitor and evaluate family-based services

ACCOMPLISHMENT DATE:
January 2013

INDICATORS
Pre-Post Surveys which are relevant to the program, such as "RM Family," "AM Family Cohesion," "AM Family Involvement" and "Parent/Child Bonding –Family Attachment Scale"

OBJECTIVE 3
Increase opportunities, skills and recognition for prosocial involvement with peers, youth service agency staff and volunteers in King County

TASKS
1. Determine need and prioritize where to focus youth services
2. Conduct a competitive bid process
3. Select organizations to deliver services
4. Obtain approval to subcontract with the organizations
5. Develop and process contracts with organizations
6. Monitor and evaluate youth services

ACCOMPLISHMENT DATE
January 2013

INDICATORS
Pre-Post Surveys which are relevant to the program, such as "RM Individual/Peer" and "AM Social Skills"

GOAL 2
Decrease the risk associated with community laws and norms favorable to drug use

OBJECTIVE 1
Reduce policies and social practices favorable toward alcohol and other drug use among children and youth in King County

TASKS
1. Determine need and prioritize where to focus community-based services and strategies
2. Conduct a competitive bid process
3. Select organizations to deliver community-based services/efforts
4. Obtain approval to subcontract with the organizations
5. Develop and process contracts with organizations
6. Monitor and evaluate community-based services and strategies

ACCOMPLISHMENT DATE
January 2013

INDICATORS
Pre-Post Surveys which are relevant to the program, such as "RM Community" and "Perceived Availability of Drugs and Handguns"

GOAL 3
Decrease the risk associated with early initiation of alcohol and other drugs

OBJECTIVE 1
Increase refusal and resistance skills among children and youth in King County

TASKS
1. Determine need and prioritize where to focus programs for children and youth
2. Conduct a competitive bid process
3. Select organizations to deliver services
4. Obtain approval to subcontract with the organizations
5. Develop and process contracts with organizations
6. Monitor and evaluate programs for children and youth

ACCOMPLISHMENT DATE
June 2013

INDICATOR
Pre-Post Surveys which are relevant to the program, such as “RM Individual/Peer,” “AM Refusal Skills,” “AM Assertiveness,” “AM Decision Making Skills,” “AM Social Skills” and “AM Personal Competence”

GOAL 4
Decrease the risk associated with family management problems

OBJECTIVE 1
Improve attitudes about family management skills (use of different forms of punishment and discipline and monitoring approaches) involving families in King County

OBJECTIVE 2
Improve use of family management skills (discipline strategies, techniques for setting limits, approaches to monitoring youth behaviors) by parents/caregivers in King County

TASKS
1. Determine need and prioritize where to focus family-based services
2. Conduct a competitive bid process
3. Select organizations to deliver services
4. Obtain approval to subcontract with the organizations
5. Develop and process contracts with organizations
6. Monitor and evaluate family-based services

ACCOMPLISHMENT DATE
June 2013

INDICATOR
Pre-Post Surveys which are relevant to the program, such as “RM Family,” “AM Family Management Attitudes,” “AM Family Management - Skills,” “AM Communication Skills” and “AM Family Involvement”

GOAL 5
Decrease the risk associated with favorable attitudes toward the problem behavior

OBJECTIVE 1
Increase media literacy among children and youth in King County

OBJECTIVE 2
Increase refusal and resistance skills among children and youth in King County

OBJECTIVE 3
Decrease attitudes that support the use of alcohol and other drugs by children and youth in King County

TASKS
1. Determine need and prioritize where to focus children/youth-focused services
2. Conduct a competitive bid process
3. Select organizations to deliver services
4. Obtain approval to subcontract with the organizations
5. Develop and process contracts with organizations
6. Monitor and evaluate children/youth-focused services

ACCOMPLISHMENT DATE
June 2013

INDICATOR
Pre-Post Surveys which are relevant to the program, such as “RM Individual/Peer,” “AM Favorable Attitudes,” “AM Refusal Skills,” “AM Assertiveness,” “AM Decision Making Skills,” “AM Social Skills” and “AM Personal Competence”

GOAL 6
Decrease the risk associated with transition and mobility

OBJECTIVE 1
Increase strategies to ease transitions between schools among students in King County

TASKS
1. Determine need and prioritize where to target student-focused services
2. Conduct a competitive bid process
3. Select organizations to deliver services
4. Obtain approval to subcontract with the organizations
5. Develop and process contracts with organizations
6. Monitor and evaluate student-focused services

ACCOMPLISHMENT DATE
June 2013

INDICATOR
Pre-Post Surveys which are relevant to the program, such as “RM Individual/Peer,” “AM

Social Skills" and "AM Personal Competence"

COMMUNITY MOBILIZATION

GOAL 1
Increase sense of community attachment to prevent substance abuse and violence

OBJECTIVE 1
Engage communities in implementing community-based prevention of substance abuse and violence strategies

TASKS
1. Work with local communities and coalitions with the community organizing strategy based on Communities That Care (CTC) to determine appropriate prevention strategies based on local data and emerging trends.
2. Identify target populations.
3. Select appropriate evidence based prevention strategies matching targeted risk and protective factors with target population.
4. Assess availability of partners and leverage other funding sources.
5. Develop mini grant proposal and review for appropriate use of community mobilization prevention funding.
6. Evaluate both coalition and program effectiveness.

ACCOMPLISHMENT DATE:
2 year benchmark: June 2009
6 year benchmark: June 2013

INDICATORS
- At 2 year benchmark 2009, increased number of communities by 20% focusing on immigrant and refugee communities.
- At 6 year benchmark 2013, increased number of evidence based programs by 20%.
- State Community Scorecard used to measure coalition effectiveness where appropriate
- Coalition Assessment Survey Tool used to measure every community coalition.
- Pre-Post surveys used to measure effectiveness of every prevention event and program.

OBJECTIVE 2
Decrease community laws and norms favorable to substance and firearm use

TASKS
1. Work with local communities and coalitions with a community organizing strategy based on CTC to determine appropriate prevention strategies based on local data and emerging trends.
2. Identify target populations.
3. Select appropriate evidence based prevention strategies matching targeted risk and protective factors with target population.
4. Assess availability of partners and leverage other funding sources.
5. Develop mini grant proposal and review for appropriate use of community mobilization prevention funding.

6. Evaluate both coalition and program effectiveness.

ACCOMPLISHMENT DATE:
2 year benchmark: June 2009
6 year benchmark: June 2013

INDICATORS
- At 2 year benchmark 2009, increased number of community coalitions working on reducing norms of substance abuse and violence by 20%.
- At 6 year benchmark 2013, increased number of communities with norms of nonuse for youth by 20%.
- State Community Scorecard used to measure coalition effectiveness where appropriate.
- Coalition Assessment Survey Tool used to measure every community coalition.
- Pre-Post surveys used to measure effectiveness of every prevention event and program.

OBJECTIVE 3
Increase opportunities, skills and recognition for youth prosocial involvement in their communities in King County

TASKS
1. Work with local communities and coalitions with a community organizing strategy based on CTC to determine appropriate prevention strategies based on local data and emerging trends.
2. Identify target populations.
3. Select appropriate evidence based prevention strategies matching targeted risk and protective factors with target population.
4. Assess availability of partners and leverage other funding sources.
5. Develop mini grant proposal and review for appropriate use of community mobilization prevention funding.
6. Evaluate both coalition and program effectiveness.

ACCOMPLISHMENT DATE
2 year benchmark: June 2009
6 year benchmark: June 2013

INDICATORS
- At 2 year benchmark, increased opportunities for youth prosocial involvement by 20%.
- At 6 year benchmark, increased opportunities, skills and recognition for youth-led activities by 20%.
- State Community Scorecard used to measure coalition effectiveness where appropriate.
- Coalition Assessment Survey Tool used to measure every community coalition.
- Pre-Post surveys used to measure effectiveness of every prevention event and program.

GOAL 2
Decrease family management problems for youth and families in King County

OBJECTIVE 1
Increase use of family management and communication skills for youth and their families to

reduce risk of substance abuse and violence

TASKS
1. Work with local communities and coalitions with a community organizing strategy based on CTC to determine appropriate family management strategies based on local data and emerging trends.
2. Identify target youth and their families.
3. Select appropriate evidence based prevention strategies for youth and their families matching identified risk and protective factors with target population.
4. Assess availability of partners and leverage other funding sources.
5. Develop mini grant proposal and review for appropriate use of community mobilization prevention funding.
6. Evaluate both coalition and program effectiveness.

ACCOMPLISHMENT DATE
2 year benchmark: June 2009
6 year benchmark: June 2013

INDICATORS
- At 2 year benchmark 2009, increased number of community coalitions implementing family management and family communication skill programs by 20%.
- At 6 year benchmark 2013, increased number of evidence based family management, communication skill development programs for youth and families by 10%.
- State Community Scorecard used to measure coalition effectiveness where appropriate.
- Coalition Assessment Survey Tool used to measure every community coalition.
- State pre-post test survey for family management.
- Pre-Post surveys used to measure effectiveness of every prevention event and program.

Objective 2
Decrease favorable parental attitudes and involvement in problem behavior

TASKS:
1. Work with local communities and coalitions with a community organizing strategy based on CTC to determine appropriate family substance abuse and violence prevention strategies based on local data and emerging trends.
2. Identify target families.
3. Select appropriate evidence based prevention strategies for parents/caregivers matching identified risk and protective factors with target population.
4. Assess availability of partners and leverage other funding sources.
5. Develop mini grant proposal and review for appropriate use of community mobilization prevention funding.
6. Evaluate both coalition and program effectiveness.

ACCOMPLISHMENT DATE:
2 year benchmark: June 2009
6 year benchmark: June 2013

INDICATORS

- At 2 year benchmark 2009, increased number of parents/caregivers receiving substance abuse and violence prevention information by 30%.
- At 6 year benchmark 2013, increased perception of harm of substance use and violence by parents/caregivers by 80% of those involved in prevention programs.
- State Community Scorecard used to measure coalition effectiveness where appropriate.
- Coalition Assessment Survey Tool used to measure every community coalition.
- State pre-post test survey for attitude change and perception of harm.
- Pre-Post surveys used to measure effectiveness of every prevention event and program.

GOAL 3
Increase healthy beliefs and clear standards for youth in order to prevent substance use and violence

OBJECTIVE 1
Increase the perception of harm among youth regarding substance use and violence

TASKS

1. Work with local communities and coalitions with a community organizing strategy based on CTC to determine appropriate youth substance abuse and violence prevention strategies based on local data and emerging trends.
2. Identify target youth.
3. Select appropriate evidence based prevention strategies for youth matching identified risk and protective factors with target population.
4. Assess availability of partners and leverage other funding sources.
5. Develop mini grant proposal and review for appropriate use of community mobilization prevention funding.
6. Evaluate both coalition and program effectiveness.

ACCOMPLISHMENT DATE
2 year benchmark: June 2009
6 year benchmark: June 2013

INDICATORS

- At 2 year benchmark 2009, increased number of youth participating in prevention programming to increase perception of harmful effects of substance use and violence by 30%.
- At 6 year benchmark 2013, increased perception of the harmful effects of substance use and violence by 85% of youth participating in prevention programming.
- State Community Scorecard will be used to measure coalition effectiveness where appropriate.
- Coalition Assessment Survey Tool used to measure every community coalition.
- State pre-post test survey for individual youth rebelliousness and depression.
- Pre-Post surveys used to measure effectiveness of every prevention event and program.

Objective 2: Increase peer bonding and opportunities for prosocial involvement to reduce substance use and violence.

TASKS:
1. Work with local communities and coalitions with a community organizing strategy of CTC to determine appropriate youth substance abuse and violence prevention strategies based on local data and emerging trends.
2. Identify target youth.
3. Select appropriate evidence based prevention strategies for youth matching identified risk and protective factors with target population.
4. Assess availability of partners and leverage other funding sources.
5. Develop mini grant proposal and review for appropriate use of community mobilization prevention dollars.
6. Evaluate both coalition and program effectiveness.

ACCOMPLISHMENT DATE:
2 year benchmark: June 2009
6 year benchmark: June 2013

INDICATORS:
- At 2 year benchmark 2009, increased number of positive peer bonding opportunities for youth by 30%.
- At 6 year benchmark 2013, increased number of positive peer bonding and youth-led strategies by 50%.
- State Community Scorecard used to measure coalition effectiveness where appropriate.
- Coalition Assessment Survey Tool used to measure every community coalition.
- State pre-post test survey for individual youth rebelliousness and depression.
- Pre-Post surveys used to measure effectiveness of every prevention event and program.

INTERVENTION

GOAL 1
Intervene early in youth substance abuse

OBJECTIVE 1
Increase outreach and services to youth experiencing problems at school due to substance abuse

TASKS
1. Determine need and prioritize locations in conjunction with local stakeholders
2. Develop school-based outreach and services with local stakeholders
3. Determine funding need and available funding
4. Secure funding to reduce any gap

ACCOMPLISHMENT DATE
January 2008

INDICATOR
- Number of youth outreach hours
- Number of youth assessments
- Number of youth treatment admissions

OBJECTIVE 2
Increase outreach and services to homeless youth

TASKS
1. Determine need and prioritize locations in conjunction with local stakeholders
2. Determine funding need and available funding
3. Secure funding to reduce any gap

ACCOMPLISHMENT DATE
January 2009

INDICATOR
- Number of youth outreach hours
- Number of youth assessments
- Number of youth treatment admissions

GOAL 2
Establish a multi-system chronic care model that addressees chemical dependency and mental health issues in addition to physical health issues

OBJECTIVE 1
Research and report on a comprehensive system of chronic care specific to King County need

TASKS
1. Research existing models
2. Hold meetings with local stakeholders
3. Review and define population
4. Map resources needed throughout King County
5. Determine data infrastructure needs
6. Determine funding need
7. Initiate system partnerships

ACCOMPLISHMENT DATE
July 2010

INDICATOR
Completed report

OBJECTIVE 2
Implement the chronic care model

TASKS
1. Present report to local stakeholders
2. Establish system partnerships
3. Develop implementation plan with partners
4. Secure needed funding

ACCOMPLISHMENT DATE
December 2012

INDICATOR
Chronic care model operational

GOAL 3
Provide supports to those on the waiting list for opiate substitution treatment

OBJECTIVE
Maintain opiate substitution treatment wait list services

TASK
1. Determine adequate funding need and available funding
2. Secure funding to reduce any gap
3. Determine level of need for medical detoxification services

ACCOMPLISHMENT DATE
December 2007

INDICATORS
- Number on the opiate substitution waitlist
- Number of opiate substitution treatment admissions from the wait list

GOAL 4
Increase treatment admissions within 30 days from detoxification services

OBJECTIVE
Develop a plan to reduce barriers at this intervention point

TASKS
1. Develop a data report from current data
2. Review King County data in conjunction with provider
3. Solicit input from local stakeholders on barriers
4. Establish barriers and solutions in conjunction with provider

ACCOMPLISHMENT DATE
July 2009

INDICATOR
Completed plan

TREATMENT

GOAL 1
Increase youth admissions to treatment – *more treatment, better treatment, beyond treatment!*

OBJECTIVE 1
Complete review of existing services, needed services, gaps and system barriers with the purpose of implementing additional evidence-based practices

TASKS
1. Complete informant interviews and meetings with stakeholders
2. Complete data review
3. Determine areas of barrier to access and admissions
4. Map system gaps and barriers
5. Hold stakeholder meeting to solicit input on review determination

ACCOMPLISHMENT DATE
January 2008

INDICATOR
Review completed

OBJECTIVE 2
Implement changes in youth continuum of care as determined by the review

TASKS
1. Develop implementation plan
2. Collaboration meetings with youth system of care providers

ACCOMPLISHMENT DATE
December 2009

INDICATOR
- Youth assessments
- Youth treatment admissions

GOAL 2
Increase pregnant and parenting women admissions to substance abuse treatment

OBJECTIVE 1
Review the existing system of care to pregnant and parenting women

TASKS

1. Map services and resources
2. Determine system access points and current utilization
3. Determine system transition points and related barriers
4. Conduct stakeholder meetings to review determinations and recommended changes
5. Determine funding need

ACCOMPLISHMENT DATE
August 2009

BENCHMARK
Review completed

OBJECTIVE 2
Implement system service changes

TASKS
1. Secure funding
2. Contract for services

ACCOMPLISHMENT DATE
January 2010

INDICATOR
- Assessments of pregnant and parenting women
- Admissions of pregnant and parenting women

GOAL 3
Increase the percentage of individuals receiving services in the mental health plan who are also admitted to chemical dependency services

OBJECTIVE
Increase the percentage of mental health clients who receive concurrent chemical dependency treatment services from point of intake into mental health services

TASKS
1. Review the King County service data and national averages of concurrent treatment
2. Conduct stakeholder meetings
3. Provide technical assistance to mental health plan providers that are also certified chemical dependency providers when significantly below the national average

ACCOMPLISHMENT DATE
January 2009

INDICATOR

Chemical dependency admissions at mental health plan provider

GOAL 4
Increase treatment admissions of those 65 years of age and older

OBJECTIVE 1
Improve service provision

TASKS
1. Review system of care for the population
2. Ensure cultural competencies
3. Determine local need for service
4. Conduct stakeholder meetings
5. Initiate partnerships
6. Determine barriers to service
7. Implement findings

ACCOMPLISHMENT DATE
December 2009

INDICATOR
- Assessments of those 65 years of age and older
- Treatment admissions of those 65 years of age and older

GOAL 5
Increase professional development for Chemical Dependency Professionals (CDP) to include cultural sensitivity and working with specific ethnic and cultural populations, GLBT populations, homeless and veterans populations, GAIN administration and other evidence based practices.

OBJECTIVE
Workforce development

TASKS
1. Allocate funding
2. Assign internal coordinator
3. Develop application process for CDP training funds in King County
4. Establish regular periodic communication on training funds availability

ACCOMPLISHMENT DATE
March 2008

INDICATOR
Number of trainings completed

AFTERCARE

GOAL 1
Increase client employability, employment and prosocial gainful activity

OBJECTIVE
Work training available to clients

TASKS
1. Determine local resources
2. Determine local funding
3. Form partnerships
4. Provide services to clients

ACCOMPLISHMENT DATE
June 2013

INDICATOR
Number of clients employed at end of treatment

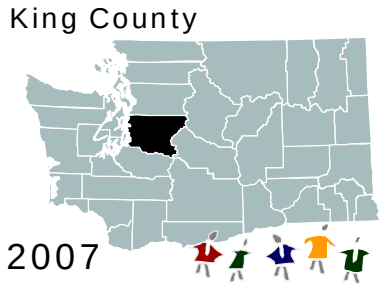
GOAL 2
Increase the number of treatment clients that acquire housing

OBJECTIVE
Housing for treatment clients

TASKS
1. Determine local resources
2. Determine local funding
3. Form partnerships
4. Provide services to clients

ACCOMPLISHMENT DATE
June 2013

INDICATOR
Number of homeless clients admitted to treatment who found housing by treatment completion



PART IV

Evaluation

Evaluation: Monitoring Substance Abuse Services

Ongoing Program Monitoring

For ongoing program monitoring purposes, King County will monitor access, utilization and outcomes of substance abuse services through the DASA Treatment Analyzer (TA) and TARGET system. Outlined below is ongoing plan.

Monitoring Substance Abuse Services

MONITORING TREATMENT

Access

Access to services is defined as admissions to treatment, assessment or detoxification services. Key questions regarding access include:

- For all clients: Are treatment admissions increasing or decreasing over time?
- For important subgroups of clients:
  - Are admissions for important subgroups increasing or decreasing over time?
  - Are admissions for important subgroups at expected levels?

Utilization

Utilization refers to how much of the service is being received. It will be measured by examining length of stay and retention statistics. Key questions regarding utilization include:

- For all clients in OP:
  - On average, how long are clients remaining in OP?
  - What percent are remaining in TX for at least 90 days?
- For important subgroups of clients in OP:
  - On average, how long are important subgroups of clients remaining in OP?
  - What percent are being retained for at least 90 days.
  - For opiate substitution clients, what percentage are retained at 3, 6, 9 and 12 months following admission?
- For opiate substitution clients:
  - What percent of clients are retained in treatment at 3, 6, 9 and 12 months?
  - Do retention rates vary by the age, ethnicity or gender of the clients?

Outcomes

Outcomes include both the immediate results of the service, as well as more distant, post-discharge measures. Key questions regarding outcomes include:

- For all clients in OP:
  - What is the overall completion rate for all clients? Does that rate vary depending on client characteristics?
  - What percent of clients were arrested after discharge? Did the arrest rate for completers differ from non-completers?
  - What percent of clients became employed after discharge? Did the employment rate and wages for completers differ from non-completers?
- For all clients assessed:
  - What percent of assessed clients enter treatment? Is that rate increasing over time?
- For all clients receiving detoxification services:
  - What percent of those receiving detox completed their stay?
  - What proportion of clients entered treatment after receiving detox?

The table below lists the services area (domain), the monitoring issues, and the appropriate DASA-TA report.

Evaluation Table: A Summary of Monitoring Activities

Service Domain	Program Monitoring Issue	DASA-TA Report
Access	Trend in Overall Admissions	**OP Admissions:** contains data on OS admissions as well.
	Trend in Subgroup admissions	**OP Admissions:** filters exist which allow users to specify the population for this report

		in over 60 ways.
	Trends in admissions for each expansion subpopulation and progress toward goals	**TX Expansion:** reports provide county data as well as data on the performance of individual agencies.
Utilization	Length of Stay in Outpatient Treatment	**OP Completion:** median lengths of stay broken out by completion status, race, age and other characteristics
	90 Day Retention: Outpatient	**OP Retention:** provides retention percentages for up to 180 days following admission.
	Retention in Opiate Substitution	**OS Retention:** 3, 6, 9 & 12 month retention data.
Outcomes	Outpatient Completion	**OP Completion:** can be filtered to include only CJTA-funded clients.
	Arrests	**Felony Arrest**
	Employment	**Employment Outcomes**
	Detox completion	An ad hoc query is necessary to calculate the detox completion rate.
	Detox recipients entering treatment	**Detox to Treatment**
	Assessed clients entering treatment	**Assessment Results**

Prevention Services Data Collection Assurance Plan

A DASA REQUIRED SECTION

The AODPP will ensure that all service data has been obtained and reported to DASA per contract. This includes the following DASA Performance Based Prevention System (PBPS) elements:

- Participant demographics for single events and recurring services
- Description of single service and recurring services
- Participant attendance for all recurring programs
- Pre- and post-test responses
- Prevention training information

The AODPP will monitor that all subcontractors complete service data input into the PBPS by the 15th of each month for the prior month services as contracted. The Program Monitors will communicate with subcontractors who are unable to complete PBPS input in a timely manner to discuss the issues and to determine a need for extension beyond the 15th. The AODPP Manager will provide in writing any extension request to the DASA Region 4 Regional Administrator prior to the 15th.

The AODPP will monitor that all subcontractors complete pre- and post-test data input into the PBPS by

30 days after the completion of each survey instrument. The Program Monitors will communicate with subcontractors who are unable to complete PBPS input in a timely manner to discuss the issues and to determine a need for extension, and approve a time-specific extension. The Program Monitors will assure the data input was completed as scheduled.

COP has developed evaluations for all its programs. COP will be implementing the CTED Evaluation Protocols for 2007-08 which will include but not be limited to:

- Communities That Care domain survey (bubble sheets)
- Community Mobilization Scorecard
- Program outcomes (on-line reporting system)
- Specific best practice pre-post test evaluation

COP has developed their own indicators that directly relate to the risk factors identified by each mini grant. KCCOP will analyze and aggregate this data every six months and intends to report it on the on-line system.

CJTA Innovated Grant Program(s): Monitoring Completion, Retention and Criminal Activity

A DASA REQUIRED SECTION

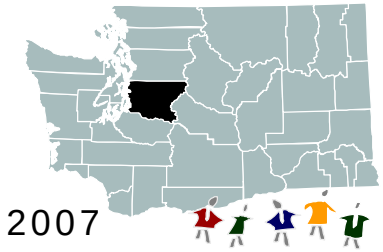
Treatment Completion and Retention Data:

1. In calendar year 74.6 percent of clients completed the BICOR program were linked to ongoing services.
2. 100 percent of clients received a psychiatric evaluation.
3. Of the 74.6 percent that completed treatment the average retention was 53 days.

Expected outcomes and monitoring activities include:

1. Engagement and retention in treatment monitored through census logs and tracking of clients through to discharge;
2. Linkage to ongoing treatment and support services monitored through required reports and review of client case files
3. Placement in transitional or semi-permanent/permanent housing monitored through required reports and review of client case files;
4. Decreased substance abuse monitored through required reports and review of client case files;
5. Increased involvement in meaningful substance-free activities as identified by the client monitored through required reports and review of client case files;
6. Reduced involvement of program participants in criminal activity will be collected by reviewing pre-treatment arrests with post treatment arrests.

King County



2007

Appendices

Appendix 1 - Subregional Analysis

Appendix 2 - HYS – Bolan Analysis

Appendix 3 - King County Strategic Plan

Appendix 4 - OP Rate Study, 11-06

Appendix 5 - King County Provider Network Listing

Appendix 6 - Other Sources