Core Service Report

Comprehensive Outpatient Substance Abuse Treatment

Consumer Category:
Behavioral Health Conditions

Primary Consumer Group:
Persons With or At Risk of Chemical Dependency

February 2007

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COMPANION REPORTS

In addition to the information included in this report, a report of the other core services (80 in total), community leader key informant interviews, United Way - First Call for Help staff focus groups, consumer snapshots, and e-survey of United Way funded executive directors, board presidents, and United Way Community Investment staff are available at http://www.uws.org.

ACKNOWLEDGEMENTS

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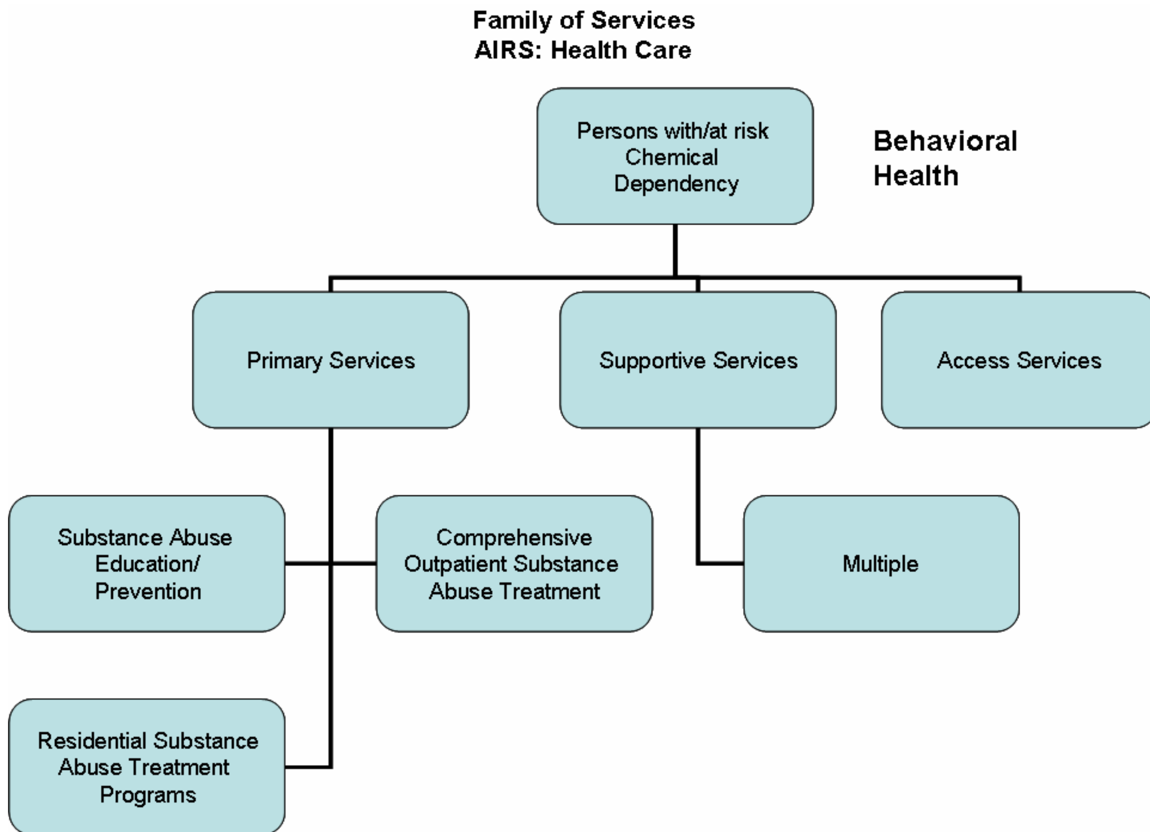
SNAPSHOT

AIRS Code Level I: Health Care
AIRS Code Level II: Substance Abuse Services
Name of Core Service with Complete AIRS Code: Comprehensive Outpatient Substance Abuse Treatment LX-845.115

Investment Committee: Health and Caring for All
Cluster: Substance Abuse

AIRS Definition (newest version): Individuals with problems related to substance abuse who do not require twenty-four hour care, or who have completed inpatient or residential treatment programs and need ongoing but less intensive treatment and/or support.

The Comprehensive Outpatient Substance Abuse Treatment is one of three services in a family of services for persons with or at risk of chemical dependency. (See figure below.)



Core Service Environment
According to The Ohio State University Medical Center, substance-related disorders are caused by multiple factors including genetic vulnerability, environmental stressors, social pressures, individual personality characteristics, and psychiatric problems. Chemical dependency (or addiction) is considered a chronic disease that does not resolve itself spontaneously and is rarely cured completely (McLellan et al., 2000). Like other chronic diseases—including obesity, hypertension, and diabetes, and asthma—sobriety can be maintained through a prescribed treatment regimen administered throughout a person's lifetime.

As it is nationally, funding is Cuyahoga County's major local policy issue. Treatment programs are expensive, and public funding resources are limited. An additional factor is the common belief among lay people that substance abuse problems are attributable to moral failings or weakness of will. This blaming attitude might reduce the public's willingness to devote resources to substance abuse treatment.

Insurance parity, or equal treatment for mental health and addiction treatment, is one of Ohio's major public policy issues affecting private funding for mental health related services through insurance. Coverage for the "diagnosis, care and treatment of biologically based mental illnesses" was written into the new state law SB 116. This law was signed on December 29, 2006 and will take in March 2007. However, it does not include substance abuse treatment.

Greenfield (2005) found that there are two major barriers to policies and full implementation of parity policies: 1) fear of an unmanageable rise in health care costs and, 2) societal stigmas in respect to psychiatric and substance abuse disorders.

Core Service Consumers
The target population addressed in this core service report is persons 12 years and older with problems related to substance abuse who do not require twenty-four hour care, or who have completed inpatient or residential treatment programs and need ongoing but less intensive treatment and/or support.

The 2004 National Survey on Drug Use and Health (NSDUH) found that:

> …[an] estimated 22.5 million Americans met criteria for substance abuse or dependence disorders, representing 9.4 percent of the population aged 12 or older. This was about the same number as in 2002 and 2003. Of these, 3.4 million (15.11 percent) were classified with dependence on or abuse of both alcohol and illicit drugs, 3.9 million (17.33 percent) were dependent on or abused illicit drugs, but not alcohol, and 15.2 million (67.56 percent) were dependent on or abused alcohol but not illicit drugs.

Statewide, according to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS, 2004), there were about 2.7 million Ohioans who suffered from an addictive disorder in FY 2002, with about 93,000 individuals receiving publicly-funded alcohol and other drug treatment services in Ohio's certified treatment programs. Of the eight largest states, Ohio has the highest rate of heavy alcohol use (Ohio Substance Abuse Monitoring Network, 2005).

In 2004, the Alcohol and Drug Addiction Services Board of Cuyahoga County (ADASBCC) estimated there were 85,510 Cuyahoga County persons 12 and older with a chemical

dependency disorder. This number is projected to increase slightly to 86,134 by 2015 because of population shifts.

Core Service Delivery
The definition of the core service for this report is: supervised, structured programs that offer a wide range of ongoing outpatient treatment or support for substance use disorders.

Outpatient substance abuse treatment services may be coordinated by a case manager and may include individual and group counseling, twelve-step meetings, social and recreational activities, educational and vocational services, life skills training, primary health care, perinatal health care, a program for family members, relapse prevention services, a continuing care program and supportive services (such as child care, transportation and parenting skills development). These services are for individuals with substance abuse related problems and need access to treatment in order to maintain their individual recovery plans but do not require the intensity of a day treatment program or 24-hour hospital care. Participants attend the program regularly (at least once a month), but usually more frequently depending on their individual needs.

The American Society of Addiction Medicine (ASAM) defines drug addiction treatment as “an application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive, and /or injurious to health; or to restore appropriate levels of physical, psychological, and/or social functioning” (U.S. Department of Labor, n.d.). Drug addiction treatment can include behavioral modification, medications, or their combination.

All services for substance abuse or dependence start with a good assessment interview by a state-licensed provider. Depending on the severity of symptoms evaluated during this comprehensive assessment process, a recommendation for outpatient treatment can include a referral for a) non-intensive outpatient or b) intensive outpatient.

Based on United Way - First Call for Help’s (FCFH) database (February 2005), there are 30 comprehensive outpatient substance abuse treatment program providers operating from 39 different sites, 27 of which are nonprofit and 3 are government. United Way funded 3 of the providers in FY 2004. FCFH call data shows a decrease in the number of total requests for comprehensive outpatient substance abuse treatment programs in the county: from 2,141 in 2000 to 1,963 in 2004. Over the same five-year period, FCFH had 11,685 requests for information regarding comprehensive outpatient substance abuse treatment programs. Of these requests, they were able to make referrals to 99 percent of callers.

Since 1993, Medicaid has been a federal entitlement program available to alcohol and other drug services clients. In FY 2004, $50 million was spent on treatment services through the Medicaid program. Of this, $30.4 million in federal financial participation (FFP) was leveraged using $19.6 million in state or local matching funds for more than 30,000 medically needy Ohioans. Since Medicaid reimbursement for alcohol/drug treatment and substance abuse education programs was initiated, $360 million has benefited Ohioans (ODASDS 2004 Annual Report).

In FY 2004 and FY 2005, Ohio’s budget included a 10 percent increase for alcohol and drug treatment. The 10 percent increase was directed to local communities while state level spending was frozen at FY 2003 levels.

In Cuyahoga County there was a total of $8.5 million Medicaid dollars for CADAS (Community Alcohol and Drug Addiction Services) in 2004. This was an increase from $7.3 million in FY 2002. CADAS funding covers more than outpatient services. Funding from ADASBCC decreased from $3 million to $1.7 million between 2003 and 2005. During the same period, funding from the Cuyahoga County Juvenile Court also decreased from $589,000 to $468,000. Monies from Justice Affairs of Cuyahoga County increased slightly from $304,000 to $320,000.

As of May 11, 2006, more than $4 million in revenues for comprehensive outpatient substance abuse treatment has been identified countywide. Ninety-one percent of the revenues are from contracts or grants from government organizations. United Way of Greater Cleveland's funds account for 8.4 percent of the total from Investment Committee allocations and designations.

Outpatient services are generally billed in hourly units. Intensive outpatient is a day unit. The average ceiling cost of outpatient substance abuse treatment ranges from around $38 per hour for group counseling to $176 per hour for medical somatic treatment. Clients are expected to pay for service(s) if they do not meet the eligibility guidelines for indigent services. The sliding feel scale of the Alcohol and Drug Addiction Services Board of Cuyahoga County (AADSBCC) is based on the poverty guidelines. There are no payment expectations for Medicaid reimbursable services.

What Works; What Doesn't

It was found that interventions based on motivational interviewing—a non-directive type of therapy that assists clients in identifying the advantages and disadvantages of drinking and alternatives to drinking—were effective and, when added to standard treatment, produced a significant increment of effectiveness.

Matching research has found that clients with high-level anger obtain better results in non-confrontational therapies based on motivational interviewing as compared to CBT and 12-step programs, while the opposite pattern characterizes results for clients with low-level anger.

In terms of research in the substance abuse arena, local experts interviewed as key informants for United Way's core service research felt there is little being done in terms of tracking the effectiveness of treatment programs once an individual is released. Additionally, they felt that agencies need money to evaluate midpoint and long-term outcomes, while the current system looks at the outcomes at the time of discharge.

According to the Ohio Department of Drug and Alcohol Addiction Services (ODADAS), $11 is saved for every dollar spent on treatment because health care costs are cut in half (ODADAS, 2004). In addition, keeping a criminal offender out of prison saves $22,000 a year; keeping one potential foster child at home with his mother saves $30,000 a year; and returning a former substance abuser to the workplace saves $7,000 a year (ODADAS, 2004). ODADAS' tracking of drug-free babies born to clients in its women-specific treatment programs indicates that "as of 2002, more than 7,300 drug-free babies had been born, saving Ohio nearly $338 million in alcohol and other drug-exposed infant care."

Alcohol and drug outpatient treatment programs must be certified by the Ohio Department of Alcohol and Drug Addiction Services. Additionally, programs can be certified by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), and Council on Accreditation of Services for Children and Family Services (COA).

The state of Ohio has exacting licensure requirements for chemical dependency counselors. There are four levels of licensure: chemical dependency counselor assistant, licensed chemical dependency counselor II, licensed chemical dependency counselor III, and licensed independent chemical dependency counselor.

Gap Analysis

The estimated universe of possible consumers is 17,102 including both realized (7,697) and unrealized (9,405) access.

I. FOREWORD

INTRODUCTION

United Way of Greater Cleveland (UW), in partnership with the Cuyahoga County Board of Commissioners, has initiated a large scale core service planning process to generate data and engage in community-wide dialogue about the community's safety net of core service and consumer needs in the Greater Cleveland area. In addition, UW envisions this process as an opportunity to better understand its role in the community and its long term capacity to improve the lives of Greater Clevelanders.

The primary goal of the Cuyahoga County core service research is to identify consumer needs and assess whether there are service gaps/duplications on a community-wide level. The findings from this research will guide future funding decisions at UW, and they will also be used to stimulate dialogue with other funders and groups in the community. United Way intends to continue to fund a broad array of "safety net" services that are important to the Greater Cleveland area. But it is hoped that the research findings will inform how UW dollars may be dispersed to have the greatest impact on current realities, needs, and priorities in the Greater Cleveland community.

METHODOLOGY

United Way contracted with MCS Consulting Service, LLC, to conduct the core service research, which focuses on both the consumers served and services provided. (See Attachment 1 for list of members of the research team.) The research team has obtained information about each core service from multiple data sources. At the end of the research process there will be substantial information available for some services and less for others, which will provide a clearer picture of what information *is* available and where there are *significant gaps*.

The questions addressed are:

- Including public policies, what are the environmental influences that are impacting both service consumers and the capacity for service delivery?
- Who are the service consumers? What are the factors that lead to a need for services? How many consumers are there? How many have there been in the past several years and what factors influenced the historic trend line? What are the projected numbers for the future? What is their demographic profile? Where do they reside? How many are receiving services funded by government and/or United Way?
- What is the philosophy that drives service delivery? Has it changed? What does the service consist of? Who provides the service?
- What are the funding sources? What are the annual revenues from government sources, federated fund raising organizations, foundations, and United Way of Greater Cleveland? What are the historic government funding trends and what is projected for the future? What is the reimbursement amount?
- What works and what doesn't work in service delivery?
- Are there service gaps, duplication, under-utilization?

The primary information sources used for this report are:

- Results of 20 focus groups with 159 direct service staff of United Way member agencies and non-members, and key informant interviews with 93 experts in the respective service areas (February 2005). Participants were asked about consumer populations that are increasing and those with unmet needs; they provided insight about specific service gaps and duplication, as well as services they perceive to be outdated or under-utilized.
- United Way Program Report data for FY 2004 (July 2003 to June 2004). Each year United Way member agencies submit information to their respective investment committees on each funded core service they provide. Among other things, this information includes a demographic profile of the consumers served, the zip codes where the consumers reside, and all revenue sources that support the service. The research team has aggregated this information for each core service.
- United Way - First Call for Help call data (2000 to 2004) - United Way - First Call for Help provides a 24/7 information and referral service through its 211 telephone line The research team analyzed data from its large database, which includes the names of service providers for most core services, the activities they provide and the zip codes in which they and those they serve dare located, the number of calls received, and whether the need was met or unmet. Unmet needs are those for which there was no resource to reference.
- Literature reviews on service trends and issues as well as best practices (i.e., what works/ what doesn't work in service delivery), including impact on the individual/family and on the community.
- Searches for information on public policies that are currently impacting consumers or service delivery.
- U.S. Census and American Community Survey data for various time periods.
- Data from funders on actual consumer populations and funding levels.

(See Attachment 2 for technical notes on the research methodology as well as limitations of the data.)

II. THE CORE SERVICE ENVIRONMENT

CORE SERVICE ENVIRONMENT

According to The Ohio State University Medical Center, there are three different terms used to define substance-related disorders, including the following:

- *Substance abuse* is used to describe a pattern of substance (drug) use leading to significant problems or distress such as failure to attend work/school, substance use in dangerous situations (driving a car), substance-related legal problems, or continued substance use that interferes with friendships and or family relationships. Substance abuse, as a disorder, refers to the abuse of illegal substances or the abusive use of legal substances. Alcohol is the most common legal drug of abuse.
- *Substance dependence* is used to describe continued use of drugs or alcohol, even when significant problems related to their use have developed. Signs include an increased tolerance or need for increased amounts of substance to attain the desired effect, withdrawal symptoms with decreased use, unsuccessful efforts to decrease use, increased time spent in activities to obtain substances, withdrawal from social and recreational activities, and continued use of substance even with awareness of physical or psychological problems encountered by extent of substance use.
- *Chemical dependence* is also used to describe the compulsive use of chemicals (drugs or alcohol) and the inability to stop using them despite all the problems caused by their use.

Also according to The Ohio State University Medical Center:

> Substance-related disorders are caused by multiple factors including genetic vulnerability, environmental stressors, social pressures, individual personality characteristics, and psychiatric problems. However, determining which of these factors are primary and which are secondary has not been determined, in all cases. A psychiatrist or qualified mental health professional usually diagnoses substance abuse. Clinical findings often depend on the substance abused, the frequency of use, and the length of time since last used, and may include weight loss, constant fatigue, red eyes, and little concern for hygiene.

Chemical dependency (or addiction) is considered a chronic disease that does not resolve itself spontaneously and is rarely cured completely (McLellan et al., 2000). Like other chronic diseases—including obesity, hypertension, and diabetes, and asthma—sobriety can be maintained through a prescribed treatment regimen administered throughout a person's lifetime.

National

The 2004 National Survey on Drug Use and Health (NSDUH) found that an "estimated 22.5 million Americans met criteria for substance abuse or dependence (addiction) disorders,

representing 9.4 percent of the population aged 12 or older. [1] This was about the same number as in 2002 and 2003. Of these, 3.4 million (15.11 percent) were classified with dependence on or abuse of both alcohol and illicit drugs, 3.9 million (17.33 percent) were dependent on or abused illicit drugs, but not alcohol, and 15.2 million (67.56 percent) were dependent on or abused alcohol but not illicit drugs."

Based on a new approach to estimating incidence, the 2004 NSDUH shows that non-medical use of pain relievers was the illicit drug category with the largest number of new users. 2.4 million persons used pain relievers non-medically for the first time within the past 12 months. The average age at first-time use was 23.3.

According to the 2003 National Survey on Drug Use and Health, there is also co-occurrence of serious mental illness (SMI) and substance abuse disorders (COD). In 2003, 21.3 percent of adults with SMI were dependent on or abused alcohol or illicit drugs. Among adults with substance dependence or abuse, 21.6 percent had SMI.

It is estimated that 11 percent of all children live in families where at least one parent abuses alcohol and/or other drugs and an estimated 40-60 percent of children in the child welfare system are impacted by substance abuse. (SAMHSA, 2004) The number of baby boomers requiring treatment for illicit drugs is expected to increase from 147,000 in 1995 to 911,000 in 2020. (SAMHSA, 2004)

Ohio
The greatest single drug abuse threat in Ohio seems to be cocaine. Estimates from SAMHSA 1999 National Household Survey on Drug Abuse (NHSDA) indicated that 900,000 Ohio residents 12 years and older reported using cocaine at least once in their lifetime. The threat of heroin abuse continues to increase in Ohio. This threat is complicated by increased rates of addiction due to the purity of the substance. Illicit synthetic drugs (club drugs) have gained popularity among teens and young adults who frequent nightclubs. Ohio law enforcement reports that the availability of club drugs has increased.

Cuyahoga County
ADASBCC (2004) reported that, in Cuyahoga County, alcohol was the primary drug of choice, and marijuana, crack cocaine and heroin were the most commonly used illicit drugs. There were trends of increased crack cocaine use in older individuals and increased heroin use in young people. Among African American youth, PCP is increasing in both availability and use (Ohio Substance Abuse Monitoring (OSAM) Network, 2005). On the positive side, there is limited availability of methamphetamine in Cleveland, which should have the effect of curtailing use. The majority of ADASBCC clients received outpatient care with a large number of them requiring intensive outpatient services.

[1] This survey, formerly called the National Household Survey on Drug Abuse (NHSDA), is a project of the Substance Abuse and Mental Health Services Administration (SAMHSA). It was initiated in 1971 and is the primary source of information on the use of illicit drugs, alcohol, and tobacco by the civilian, non-institutionalized population of the United States aged 12 years old or older. The survey interviews approximately 67,500 persons each year.

PUBLIC POLICY ISSUES

As it is nationally, funding is Cuyahoga County's major local policy issue. Treatment programs are expensive and public funding resources are limited. An additional factor is the common belief among lay people that substance abuse problems are attributable to moral failings or weakness of will. This blaming attitude might reduce the public's willingness to devote resources to substance abuse treatment.

NATIONAL

Federal Policies

National Drug Control Strategy
According to the Office of National Drug Control Policy (2006), the president's fiscal year (FY) 2007 budget supports the three key priorities of the National Drug Control Strategy:

- Priority I – Stopping Use Before it Starts: Education and Community Action – support for effective programs to help communities obtain a drug-free environment and encourage young people to reject drug use.
- Priority II – Intervening and Healing America's Drug Users – focus is on ensuring that treatment is available for those who need it. The budget expands access and choice to a wider array of innovative treatment options including those services offered by faith-based organizations."
- Priority II – Disrupting the Market – targets individuals and organizations profiting from trafficking in illegal drugs.

Insurance Parity
Insurance parity is equal treatment for mental health and addiction treatment. In 1996, Congress enacted a law requiring that if a group health plan offers any mental health benefits, it cannot impose more restrictive annual or lifetime limits on spending for mental illness than on coverage of other health conditions. The federal law, known as the Mental Health Parity Act of 1996, provides limited parity. It does not require an insurer to provide or offer mental health benefits, does not include benefits for chemical dependency treatment, and does not apply to employers with an average of 2 to 50 employees. In addition, the law exempts plans that can show that meeting the law's requirements would increase the plan's cost by one percent or more. The new law took effect January 1, 1998. The original sunset provision (providing that the parity requirements would not apply to benefits for services furnished on or after September 30, 2001) has been extended five times (U.S. Department of Labor, Employee Benefits Security Administration, 2006). The current extension was in effect through December 31, 2006.

In 1999, an administrative directive from President Clinton to the Office of Personnel Management mandated full parity for mental and substance use disorders in coverage for federal employees (Greenfield, 2005).

Several pieces of current federal legislation address the parity issue. The Senate Health, Education, Labor and Pensions (HELP) Committee narrowly defeated a mental health parity amendment to the Health Insurance Marketplace Modernization and Affordability Act (HIMMA, S 1955) (Daly, 2006). A House version of the legislation is also being discussed.

The Help Expand Access to Recovery and Treatment (HEART) Act of 2005 (S 803) legislation was introduced in the Senate and would amend the Employee Retirement Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code of 1986 to provide parity with respect to substance abuse prevention and addiction treatment benefits under group health plans and health insurance coverage (Join Together, 2005). HEART would not mandate insurance companies to offer substance abuse prevention and alcohol and drug treatment coverage, but would require that if an insurer does provide such coverage that it be on par with other medical and surgical benefits. The HEART Act is the companion bill to the Time for Recovery and Equal Access to Treatment in America (TREAT America) Act of 2005 which is the House version.

Greenfield (2005) found that there are two major barriers to policies and full implementation of parity policies: 1) fear of an un-manageable rise in health care costs; and 2) societal stigmas in respect to psychiatric and substance abuse disorders.

STATE

Ohio Laws and Regulations

Insurance Parity

As it is at a national level, insurance parity is one of Ohio's major public policy issues affecting private funding for mental health related services through insurance. According to the National Mental Health Association (2005):

> This would require health insurance to cover mental health and addiction treatment services (behavioral health) the same as other health services. Many insurance plans arbitrarily require higher deductibles, larger co-payments, limited outpatient visits and lower lifetime caps in treating mental illness or substance addiction. Equal treatment focuses on financial equal treatment not benefits equal treatment. Federal law already requires mental health equal treatment for annual and lifetime coverage maximums for businesses of 50 employees and over.

In Ohio, all health plans that cover state employees have implemented full mental health parity, which includes substance use disorders (Greenfield, 2005).

Until December 2006 when coverage for the "diagnosis, care and treatment of biologically based mental illnesses" was written into the new state law SB 116, Ohio was one of 15 states that did not have parity of all mental health and substance abuse disorders under private insurance plans (National Mental Health Association, 2005). The law was signed on December 29, 2006 and will take effect in March 2007.

The bill is somewhat limited in scope, mandating only that companies offer health insurance that includes coverage for seven "biologically based mental illnesses," including schizophrenia, bipolar disorder and obsessive-compulsive disorder. To help gain industry support, advocates also agreed to eliminate a provision in the bill that called for mandates on alcohol and drug addiction coverage. The bill allows insurance companies to opt out of the mental health mandate if they can demonstrate that it causes overall coverage costs to increase by more than 1 percent over a six-month period (The Cleveland Plain Dealer, 2007).

Disability Medical Assistance

In recent United Way sponsored focus group and key informant interviews (2005), local experts identified a number of areas relevant to funding and public policy. Most recently, there has been an effort to advocate for the full restoration of disability medical assistance, which provides access to needed medical services and prescription drugs by providing a cash benefit to indigent individuals. Providers are concerned about chronically ill people coming into treatment as it becomes a liability issue.

III. THE CORE SERVICE CONSUMERS

DEFINITION OF TARGET POPULATION

The target population addressed in this core service report is persons 12 years and older with problems related to substance abuse who do not require twenty-four hour care, or who have completed inpatient or residential treatment programs and need ongoing but less intensive treatment and/or support.

Consumers said to have co-occurring disorders (COD) have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders (Center for Substance Abuse Treatment, 2005). A diagnosis of co-occurring disorders occurs when at least one disorder of each type can be established independently of the other and is not simply a cluster of symptoms resulting from one disorder.

DEMOGRAPHIC CHARACTERISTICS

NATIONAL

Within the estimated 22.5 million Americans who meet criteria for substance abuse or dependence (addiction) disorders there are differences in usage based on demographic characteristics and types of substances (NSDUH, 2004):

Alcohol Use

- 121 million Americans aged 12 or older were current drinkers of alcohol in 2004 (50.3 percent). 55 million (22.8 percent) participated in binge drinking, defined as five or more drinks on at least one occasion in the 30 days prior to the survey. 16.7 million (6.9 percent) were heavy drinkers, defined as binge drinking on 5 or more days in the past month. These numbers are all similar to the corresponding estimates for 2002 and 2003.
- The highest prevalence of binge and heavy drinking in 2004 was for young adults aged 18 to 25 (41.2 and 15.1 percent, respectively). The peak rate of both measures occurred at age 21 (48.2 and 19.2 percent, respectively).
- The rate of underage drinking remained the same in 2004 as in 2002 and 2003. About 10.8 million persons aged 12 to 20 reported drinking alcohol in the month prior to the survey interview in 2004 (28.7 percent of this age group). Of these, nearly 7.4 million (19.6 percent) were binge drinkers, and 2.4 million (6.3 percent) were heavy drinkers.
- Among persons aged 12 to 20 in 2004, past month alcohol use rates were 16.4 percent among Asians, 19.1 percent among blacks, 24.3 percent among American Indians or Alaska Natives, 26.4 percent among those reporting two or more races, 26.6 percent among Hispanics, and 32.6 percent among whites.

- Among pregnant women aged 15 to 44, 11.2 percent reported past month alcohol use and 4.5 percent reported past month binge drinking, based on combined 2003 and 2004 data.
- 32.5 million persons aged 12 or older in 2004 (13.5 percent) drove under the influence of alcohol at least once in the 12 months prior to the interview. This was similar to the rate in 2003.
- Young adults aged 18 to 22 enrolled full time in college were more likely than their peers not enrolled full time (this category includes part-time college students and persons not enrolled in college) to use alcohol, binge drink, and drink heavily in 2004. Binge and heavy use rates for college students were 43.4 and 18.6 percent, respectively, compared with 39.4 and 13.5 percent, respectively, for other persons aged 18 to 22.

Illicit Drug Use

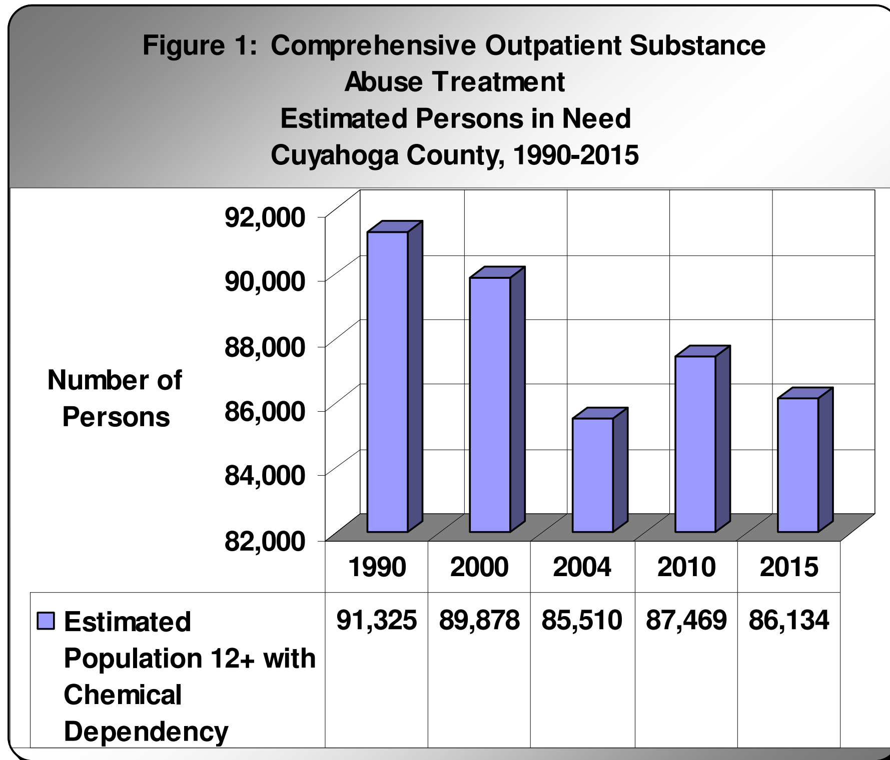
- In 2004, 19.1 million Americans, or 7.9 percent of the population aged 12 or older, were current illicit drug users. Current drug use means use of an illicit drug during the month prior to the survey interview.
- The rate of illicit drug use among persons aged 12 or older in 2004 was similar to the rates in 2002 and 2003 (8.3 and 8.2 percent). Among youths aged 12 to 17, the rate declined between 2002 and 2004 (11.6 percent in 2002, 11.2 percent in 2003, and 10.6 percent in 2004).
- Marijuana was the most commonly used illicit drug in 2004, with a rate of 6.1 percent (14.6 million current users). There were 2.0 million current cocaine users, 467,000 of whom used crack. Hallucinogens were used by 929,000 persons, and there were an estimated 166,000 heroin users. All of these estimates are similar to estimates for 2003.
- Between 2002 and 2004, past month marijuana use declined for male youths aged 12 to 17 (9.1 percent in 2002, 8.6 percent in 2003, and 8.1 percent in 2004), but it remained level for female youths (7.2, 7.2, and 7.1 percent, respectively) during the same time span.
- The number of current users of Ecstasy had decreased between 2002 and 2003, from 676,000 to 470,000, but the number did not change between 2003 and 2004 (450,000).
- In 2004, 6.0 million persons were current users of psychotherapeutic drugs taken non-medically (2.5 percent). These include 4.4 million who used pain relievers, 1.6 million who used tranquilizers, 1.2 million who used stimulants, and 0.3 million who used sedatives. These estimates are all similar to the corresponding estimates for 2003.
- There were significant increases in the lifetime prevalence of use from 2003 to 2004 in several categories of pain relievers among those aged 18 to 25. Specific pain relievers with statistically significant increases in lifetime use were Vicodin®, Lortab®, or Lorcet® (from 15.0 to 16.5 percent); Percocet®, Percodan®, or Tylox® (from 7.8 to 8.7 percent); hydrocodone products (from 16.3 to 17.4 percent); OxyContin® (from 3.6 to 4.3 percent); and oxycodone products (from 8.9 to 10.1 percent).
- Among youths aged 12 to 17, rates of current illicit drug use varied significantly by major racial/ethnic groups in 2004. The rate was

highest among American Indian or Alaska Native youths (26.0 percent). Rates were 12.2 percent for youths reporting two or more races, 11.1 percent for white youths, 10.2 percent for Hispanic youths, 9.3 percent for black youths, and 6.0 percent for Asian youths.

- In 2004, 19.2 percent of unemployed adults aged 18 or older were current illicit drug users compared with 8.0 percent of those employed full time and 10.3 percent of those employed part time. However, of the 16.4 million illicit drug users aged 18 or older in 2004, 12.3 million (75.2 percent) were employed either full or part time.

Estimated Persons in Need

In 2004, the Alcohol and Drug Addiction Services Board of Cuyahoga County (ADASBCC) estimated that, in addition to the 7,697 persons who received outpatient treatment services in the county, there were 77,813 persons who needed but did not receive treatment, or were receiving treatment through the non-public service system. This number is projected to increase slightly to 86,134 by 2015 as a result of population shifts. (See Figure 1.)



Sources:
* US Census: 1990, STF 1 (P11); 2000, SF3 (P8); 2004, American Community Survey; 2010 & 2015, Ohio Department of Development, (July, 2003). Note: Age 12+ in 2004, 2010, & 2015 was prorated from ages 10+ using ratios from 2000 age group data.
** The Cuyahoga County Alcohol and Drug Addiction Services Board estimates that 77,813 persons in addition to the 7,697 served in 2004 needed substance abuse treatment. Thus, totaling these numbers, the estimated number of persons in need in Cuyahoga County is 85,510 in 2004.

It is recognized that this is a conservative estimate of persons in need of comprehensive outpatient substance abuse treatment programs because persons with chemical dependencies who have not reached a critical level requiring intervention may not come to the attention of providers, and self-reports of use may underestimate the need. However, it is a number that begins to offer some clarity about the extent of need in Cuyahoga County.

REALIZED ACCESS TO SERVICE

Realized access to service is represented by the number of consumers actually served. Locally, it includes the actual number of consumers reported by agencies funded by United Way and by government funders from which it was possible to obtain data. Thus, it is an underestimate of actual numbers of consumers receiving service.

National (NSDUH, 2004):

- In 2004, 3.8 million people aged 12 or older (1.6 percent of the population) received treatment in the past 12 months for a drug or alcohol use problem. Of these, 2.3 million received treatment at a specialty facility for substance use treatment, including 1.7 million at a rehabilitation facility as an outpatient, 947,000 at a rehabilitation facility as an inpatient, 775,000 at a hospital as an inpatient, and 982,000 at a mental health center as an outpatient. Non-specialty treatment locations were self-help groups (2.1 million persons), private doctor's offices (490,000 persons), emergency rooms (453,000 persons), and prisons or jails (310,000 persons). (Note that the estimates of treatment by location include persons reporting more than one location.)
- Persons dependent on or abusing a substance in the past 12 months, or who received specialty treatment for a substance use problem within the past 12 months, are classified as needing treatment. In 2004, the number of persons aged 12 or older needing treatment for an alcohol or illicit drug use problem was 23.48 million (9.8 percent). Of these, 2.33 million (10 percent) received treatment at a specialty facility in the past year. Thus, 21.15 million people (90 percent) needed but did not receive treatment at a specialty facility in 2004. The number needing but not receiving treatment did not change significantly from 2002 to 2004.
- Of the 21.1 million people who needed but did not receive treatment in 2004, an estimated 1.2 million (5.8 percent) reported that they felt they needed treatment for their alcohol or drug use problem. Of the 1.2 million persons who felt they needed treatment, 441,000 (35.8 percent) reported that they made an effort but were unable to get treatment, and 792,000 (64.2 percent) reported making no effort to get treatment.
- Among people who needed but did not receive treatment and felt they needed treatment for a substance use problem, the most often reported reasons for not receiving treatment were not ready to stop using (40.0 percent) and cost or insurance barriers (34.5 percent). However, among the people who made an effort but were unable to get treatment, 42.5 percent reported cost or insurance barriers, and

only 25.3 percent reported that they were not ready to stop using. These results are based on 2003 and 2004 combined data.

- The number of persons needing treatment for an illicit drug use problem in 2004 (8.1 million) was higher than the number needing treatment in 2003 (7.3 million); similarly, the number of persons receiving treatment for drug use at a specialty facility was higher in 2004 (1.4 million) than in 2003 (1.1 million). These 2004 estimates were similar to the corresponding estimates in 2002 (7.7 million needing treatment, 1.4 million receiving treatment).
- 6.6 million people needed but did not receive treatment for an illicit drug use problem in 2004. Of these, 598,000 (9.0 percent) felt they needed treatment. This number increased from 362,000 in 2002 and from 426,000 in 2003. Of the 598,000 persons who felt they needed treatment in 2004, 194,000 (32.4 percent) reported that they made an effort but were unable to get treatment, and 404,000 (67.6 percent) reported making no effort to get treatment.

Ohio

A large number of individuals with significant drug or alcohol problems do not receive treatment. Statewide, according to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS, 2004), in FY 2002 there were about 2.7 million Ohioans suffering from an addictive disorder, with about 93,000 individuals receiving publicly funded alcohol and other drug treatment services in Ohio's certified treatment programs. Of the eight largest states, Ohio has the highest rate of heavy alcohol use (Ohio Substance Abuse Monitoring Network, 2005).

ODADAS priorities include treating youth who are using Ecstasy; providing treatment for older adults addicted to prescription drugs; and developing programs with multi-system collaboration at state and local levels to reduce recidivism and addiction among adult, non-violent felony offenders. An increasing number of states and communities are initiating system-level changes, or are developing integrated programs for co-occurring disorders.

Cuyahoga County

In FY 2003/2004, United Way funded 1,466 Cuyahoga County residents 12 years and older for comprehensive outpatient substance abuse treatment programs. (See Attachment 3.) The number of actual annual consumers funded by the Alcohol and Drug Addition Services Board (ADASBCC) in CY 2004 was 7,697. Approximately 818 persons 12 and older were funded by the Cuyahoga County Juvenile Court and 45 by Ryan White Title I. These are assumed to be duplicated numbers across funders. No demographics were reported by funders other than United Way.

While 46.5 percent of the county's total 12+ population is male and 53.5 percent is female, agencies funded by United Way served slightly more females (51.1 percent) than males (48.8 percent) in comprehensive outpatient substance abuse treatment programs. ADASBCC reports anecdotally that, in CY 2003, approximately two-thirds of their clients were male.

According to the U.S. Census, in 2000, 69 percent of the county's total 12 and older population were Caucasian, 26 percent were African American, and 2 percent were Asian. United Way funded outpatient substance abuse treatment programs for 40.6 percent Caucasian and 44.5 percent African Americans ages 5 and older. ADASBCC reports anecdotally that approximately one-third of its clients were African American in CY 2003.

Approximately 14 percent of UW funded consumers were Hispanic compared to 3 percent of the county's 12+ population.

The majority, 63.2 percent, of those funded by United Way for comprehensive outpatient substance abuse treatments reported annual household income between $0-$9,999; 10 percent were from households with incomes between $10,000-$14,999; 3.9 percent from households with incomes between $15,000-$19,999; 4.6 percent from households with incomes between $20,000-$29,999; 5 percent from households with incomes $30,000 and above; and the rest were unreported.

In 2000, 29 percent of the county's population 12 years and older resided in the City of Cleveland and 71 percent in the suburbs. (See Attachment 4.) In FY 2004, 10 percent of consumers funded by United Way resided in Cleveland, 9 percent in the suburbs, and the rest were unknown. United Way funded consumers for whom zip code data were provided were distributed across most zip codes.

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

The definition of the core service for this report is: supervised, structured programs that offer a wide range of ongoing outpatient treatment or support for substance use disorders.

BACKGROUND ON CORE SERVICE

Outpatient substance abuse treatment services may be coordinated by a case manager and may include individual and group counseling, twelve-step meetings, social and recreational activities, educational and vocational services, life skills training, primary health care, perinatal health care, a program for family members, relapse prevention services, a continuing care program and supportive services (such as child care, transportation and parenting skills development). Participants attend the program regularly (at least once a month), but usually more frequently, depending on their individual needs.

All services for substance abuse or dependence start with a thorough assessment interview by a state-licensed provider. Substance abuse and substance dependence are diagnosed with specific symptoms defined in the Diagnostic and Statistical Manual, Version IV (DSM-IV). ODADAS has specific protocols for determining the correct level of care, based mostly on the potential for (or existence and severity of) withdrawal symptoms and the required intensity of care. Outpatient treatment is Level I (residential treatment is a Level II, Level III is sub-acute care, and Level IV is acute care). Per ODADAS definition, Level I Treatment includes Level I Day Treatment, Level I Non-Intensive Outpatient, and Level I Intensive Outpatient. ODADAS defines outpatient treatment as the following:

Outpatient treatment provides a range of services in an ambulatory setting such as a clinic or home. Each individual client's needs are assessed to determine duration, type, and intensity of service provision. Outpatient treatment services must also be provided to clients receiving ambulatory detoxification. Minimum treatment services required by ODADAS classification standards and defined by the ODADAS taxonomy for Level I are: Assessment, Individual Counseling, Group Counseling, Family Counseling, Crisis Intervention, and Case Management (ODADAS, 2002).

The American Society of Addiction Medicine (ASAM) defines drug addiction treatment as "an application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive, and /or injurious to health; or to restore appropriate levels of physical, psychological, and/or social functioning" (U.S. Department of Labor, n.d.). Drug addiction treatment can include behavioral modification, medications, or a combination.

Outpatient programs use approaches that permit the rehabilitation of addicts in their real-life settings (U.S. Department of Labor, n.d.).

Such treatment costs less than inpatient treatment and often is more suitable for individuals who are employed or have extensive social supports. Low-intensity programs may offer little more than drug education and admonition. Other outpatient models, such as intensive day treatment, can be comparable to residential programs in services and effectiveness, depending on the

individual patient's characteristics and needs. In many outpatient programs, group counseling is emphasized.

For persons with co-occurring disorders (COD), the integration of substance abuse treatment and mental health services has become a major treatment initiative (Center for Substance Abuse Treatment, 2005). The focus is on treatment of the whole person and recognizes the importance of ensuring that entry into any one system can provide access to all needed systems.

Approaches to Treatment

Model/leading programs increase clients' access to a broad spectrum of programs including health; mental health; social, educational, and vocational services; as well as primary care, HIV/AIDS services, and acute care. These services are provided by qualified, specialized staff and consultants. Model/leading programs also provide transportation to and from treatment facilities for clients and families whose low income or location affects access to programs or influences program retention.

The U.S. Department of Labor offers an overview of several methods of treatment, both within the inpatient and outpatient systems:

- *Network therapy* – An approach to rehabilitation in which specific family members and friends are enlisted to provide ongoing support and to promote attitude and behavioral changes. Network members are part of the therapist's working "team" and are not subjects of treatment.
- *Detoxification* – The process whereby individuals are withdrawn from drugs in an inpatient or outpatient setting, typically under the care of a physician. Detoxification is not designed to address the psychological, social, and behavioral problems associated with addiction, and therefore it does not typically produce lasting behavioral changes necessary for recovery.
- *Group therapy* – Traditionally, the most popular approach to the problem of addiction. Group approaches include, for example, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). All group approaches share an appreciation of the healing power of the connection with others.
- *Relapse prevention* – A cognitive behavioral program that consists of a collection of strategies intended to enhance self-control. Specific techniques include exploring the positive and negative consequences of continued use, self-monitoring to recognize drug cravings early on and to identify high-risk situations for use, and developing strategies for coping with and avoiding high-risk situations and the desire to use.
- *Education* – In addition to the drug-related physical and psychological issues that must be addressed during treatment, individuals typically need to be trained for life beyond drug use. This will often involve pursuing a high school diploma or GED or taking college-level courses. Research has shown a positive correlation between education and a drug-free lifestyle after treatment.
- *Life skills* – As with education, individuals need to be retrained on basic life skills. Treatment programs will often incorporate lessons on personal hygiene, opening a bank account, food shopping, and keeping a clean house into their treatment regimen.
- *Workforce development* – Treatment programs recognize that recovering drug abusers will need to either return to their place of work or find new employment. While workforce development is easier for individuals with certain skills, recovering addicts often need to

start fresh. A critical component of drug treatment is providing the necessary skills for obtaining employment after treatment is completed.

Treatment for chemical dependence is centered on achieving sobriety through abstinence from mood altering chemicals or by teaching harm reduction. The harm reduction treatment of substance abuse is a philosophy based on accepting patients at various levels of substance use, and recognizes that continued usage is not the criterion for termination of treatment.

> Some patients at intake declare their use to be problematic, and some complain that they are only coming in to please a judge. Either way, the patient can be treated in a harm reduction program. The harm reduction practitioner seeks to reduce the negative effects on a patient's life of his or her misuse of substances, i.e. effects on the patient's medical health, mental health, relationships, without abstinence necessarily being the goal of treatment (Futterman and Silverman, 2004).

The harm reduction treatment theory contrasts abstinence-based substance abuse treatment where:

> …declaring oneself an addict is seen as evidence of a patient's readiness for treatment and can thus be a requirement to get services. Complete abstinence from the use of all addictive substances is a requirement to be in treatment and is the goal of treatment. If someone is not deemed ready for the work at intake, they may be referred to a different level of care such as an inpatient detoxification unit or they may be told that they are not ready to commit to abstinence yet, and thus should return when they are ready to do the hard work required to achieve sobriety.

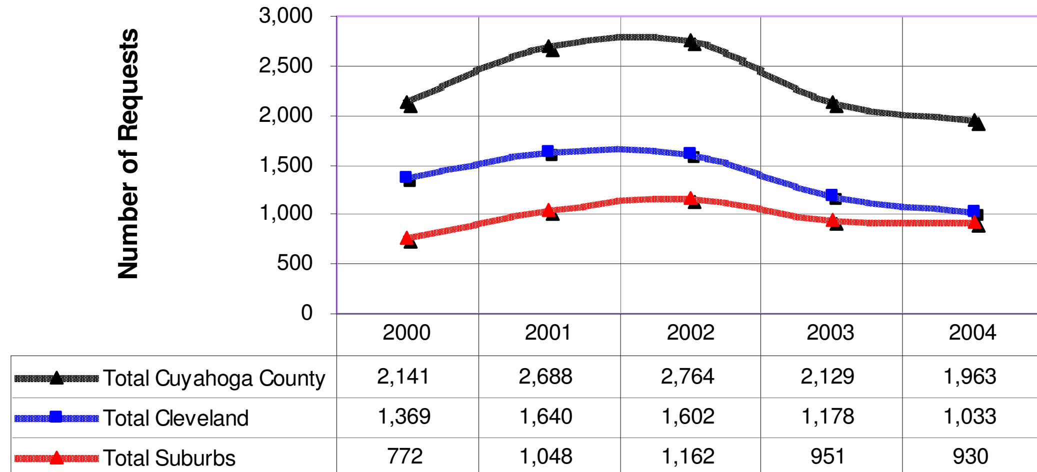
Integrating abstinence-based treatment techniques into a harm reduction theory has been found to be more powerful than either model separately (Futterman and Silverman, 2004).

United Way - First Call for Help Call Data
Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 30 comprehensive outpatient substance abuse treatment program providers operating from 39 different sites, 27 of which are nonprofit and 3 are government. (See Attachments 5 and 6.) To be coded for this service by FCFH, individuals may seek the following services: outpatient substance abuse treatment, day substance abuse treatment, or drug counseling. Of the 39 facilities, 15 are located outside of the Cleveland zip code area, with the remaining 25 situated within Cleveland. In FY 2004 (July 2003 to June 2004), United Way funded 3 of the providers. Note that ADASBCC reports that there are 36 ODADAS-certified alcohol and other drug (AOD) service providers in Cuyahoga County. ADASBCC contracts with 29 agencies with 55 sites offering outpatient services

Overall, United Way - First Call for Help call data shows a decrease in the number of total requests for comprehensive outpatient substance abuse treatment programs in the county: from 2,141 in 2000 to 1,963 in 2004 (8 percent decrease) with a 25 percent decrease in Cleveland (1,369 to 1,033 requests) and a 20 percent increase in the suburbs (772 to 930 requests). (See Figure 2 and Attachment 7.) The following zip codes experienced the highest average number of calls from 2000-2004:

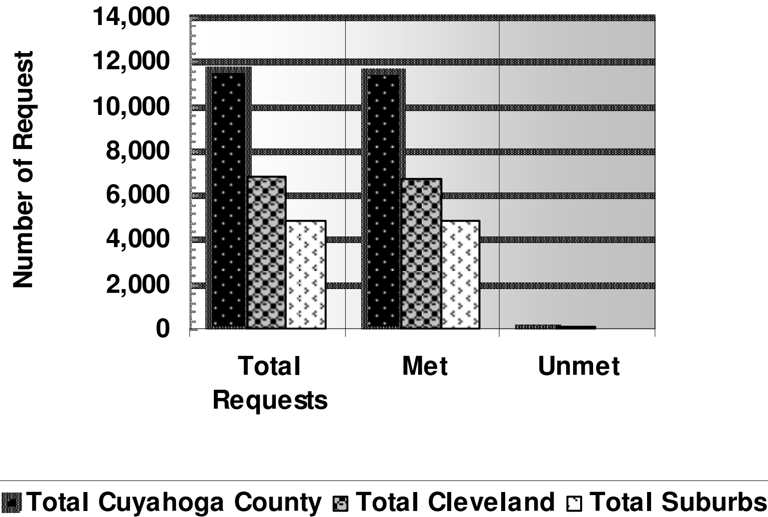
- 44105 Cleveland/Newburgh Hts./Garfield Hts.), 243 average calls;
- 44108 (Cleveland/Bratenahl), average 141 calls;
- 44102 (Cleveland/Brooklyn), average 124 calls;
- 44120 (Shaker Hts./Cleveland), average 119 calls;
- 44104 (Cleveland), average 111 calls;
- 44110 (Cleveland/East Cleveland), average 106 calls; and
- 44112 (East Cleveland/Cleveland), average 103 calls.

Figure 2: Comprehensive Outpatient Substance Abuse Program
United Way - First Call for Help Requests 2000-2004
Greatest Increase/(Greatest Decrease)



	2000	2001	2002	2003	2004
Total Cuyahoga County	2,141	2,688	2,764	2,129	1,963
Total Cleveland	1,369	1,640	1,602	1,178	1,033
Total Suburbs	772	1,048	1,162	951	930

Over the same five-year period, United Way - First Call for Help had 11,685 requests for information regarding comprehensive outpatient substance abuse treatment programs. (See Figure 3 and Attachment 8.) Of these requests, they were able to make referrals to 99 percent of callers; however, 1 percent of all Cuyahoga County callers (101) had an unmet need, meaning there was no agency to which to refer the caller. Callers from both the City of Cleveland and the suburbs had a less than 1 percent unmet need rate. Over the five-year period, only three zip codes had unmet needs larger than 2 percent. These zip codes were 44120 (Shaker Hts./Cleveland) with the largest number (17) of unmet needs, followed by 44105 (Cleveland/Newburgh Hts/Garfield Hts) at 11.



FUNDING OF CORE SERVICES

Major Government Funders

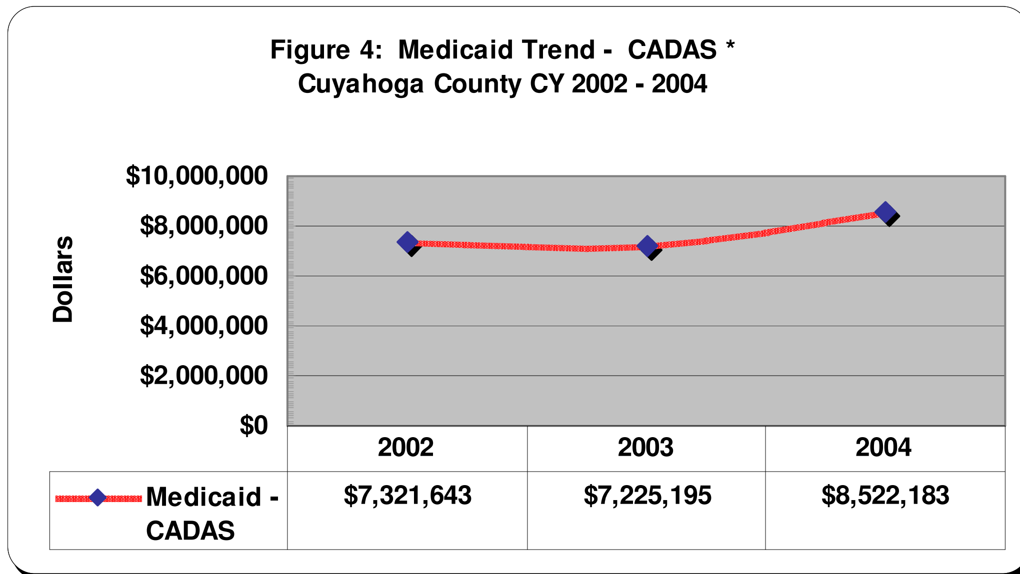
The major sources of government funding for comprehensive outpatient substance abuse treatment are:

- Medicaid;
- Strengthening Communities – Youth;
- Substance Abuse Prevention and Treatment Block Grant (SAPT);
- Title I of the Ryan White CARE Act;
- Ohio General Revenue Funds and Ohio Special Revenue Fund; and
- Cuyahoga County General Revenue Fund.

Funding of the public service system for substance abuse prevention and treatment is from federal, state, and county sources—the majority of which is allocated to the Alcohol and Drug Addiction Board of Cuyahoga County (ADASBCC) that in turn funds 93 programs and projects administered by 54 agencies. ADASBCC was created through authorization H.B.317 to reduce the incidence and prevalence of chemical abuse and dependency in Cuyahoga County. Medicaid reimburses on a fee-for-service methodology. The ADASBCC reimbursement process has shifted from a grant-based to a performance-based system. With decreased funding and increased competition, providers must demonstrate compliance with government funding requirements, improved treatment performance, improved clinical practice, delivery of quality service, and documented value.

Below is further explanation of the major government funding sources.

Medicaid
Since 1993, Medicaid has been a federal entitlement program available to alcohol and other drug services clients. In FY 2004, $50 million was spent on treatment services through the Medicaid program. Of this, $30.4 million in federal financial participation (FFP) was leveraged using $19.6 million in state or local matching funds for more than 30,000 medically needy Ohioans. Since Medicaid reimbursement for alcohol/drug treatment and substance abuse education programs was initiated, $360 million has benefited Ohioans (ODASDS 2004 Annual Report). In FY 2004, $8.5 million Medicaid dollars were available to ADASBCC for treatment and prevention services. This was an increase from FY 2002 of $7.3 million. (See Figure 4.)



* Includes the following core services: Comprehensive Outpatient Substance Abuse Treatment, Residential Substance Abuse Treatment Programs, and Substance Abuse Education and Prevention.

Strengthening Communities – Youth
The Strengthening Communities – Youth (SCY) project is administered by the Criminal Justice Service Agency of the Cuyahoga County Department of Justice Affairs (DJA) and funded by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA). The project seeks to create a system of care around adolescent substance abuse and help communities fill gaps in treatment, infrastructure, and continuum of care. This program is being funded for a five-year period that began in April 2002 and will end in April 2007. Funding for the program totals $3.75 million, or $750,000 per year. The project is designed to (1) improve service delivery in the alcohol and drug treatment, education, mental health, child welfare and juvenile justice child-serving systems, and (2) improve service delivery at the client level for teens who are criminally involved. During the life of this grant, 225 youth between the ages of 12-17 will be served. In an evaluation conducted in 2004, about halfway through the program, 100 youth had been served and over $400,000 in treatment funding was made available to those who were not Medicaid eligible. (ADASBCC, 2004).

Substance Abuse Prevention and Treatment Block Grant (SAPT)
ODADAS (2006) allocates a portion of the Substance Abuse Prevention and Treatment Block Grant funds to the 50 ADAMHS/ADAS boards on a per capita/needs basis.

- Approximately 18.24 percent of the total base allocation is allocated for prevention to each board, which is also applied towards the federal requirement that a minimum of 20 percent of the annual SAPT Block Grant award must be expended on prevention services.
- Treatment dollars are split with 65 percent allocated on a straight per capita basis, 10 percent based on Medicaid paid claims using state fiscal year 2004 Medicaid data from MACSIS and 25 percent allocated factoring in the Research Triangle Institute (RTI) prevalence estimates from social indicator modeling. RTI used 40 social indicators to create a smaller subset of six indicators that were used in a series of logistic regression models to calculate the need per board. This new formula was created by ODADAS staff and a team of ADAMHS/ADAS board executive directors to help allocate resources where most needed. By statutory authority, each board determines how to spend allocated funds to best meet their community's needs.

Title I of the Ryan White CARE Act
Authorized under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and administered by the Department of Health and Human Services Health Resources and Services Administration, Ryan White Title I funds provide emergency assistance to eligible metropolitan areas (EMAs) that are most severely affected by the HIV/AIDS epidemic. Formula grants are based on number of living cases of AIDS, and discretionary grants are available. To be eligible, an area must have reported at least 2,000 AIDS cases during the previous five years and have a population of at least 500,000. Ryan White Title I funds can be used for many different kinds of outpatient and ambulatory health services, including substance abuse treatment. Local Title I HIV health services planning councils make allocation decisions. In FY 2006 $301 million was allocated nationally from Title I. In 2006 Cleveland received $3.349 million: $1.793 million in formula grants and $1.314 in supplemental funding with another $214,208 for Minority AIDS Initiative funding.

STATE

Ohio General Revenue Fund and Ohio Special Revenue Fund
The state of Ohio allocated $6.5 million in FY 2003 to Cuyahoga County for Alcohol and Drug Addiction Services, and $7.2 million in FY 2004 (Ohio Legislative Services Commission, n.d.). This funding matches federal Medicaid funding for treatment and prevention services and funds subsidy payments to local boards to purchase treatment services from local providers. The source of these dollars includes both general revenue funds from various line items and from the Statewide Treatment and Prevention State Special Revenue Fund line item which comes from liquor profits and liquor permit fees pursuant to ORC sections 4301.10 and 3701.141, respectively as well as from $75 of the driver's license reinstatement fee paid by individuals convicted of drunk driving, pursuant to ORC 4511.191.

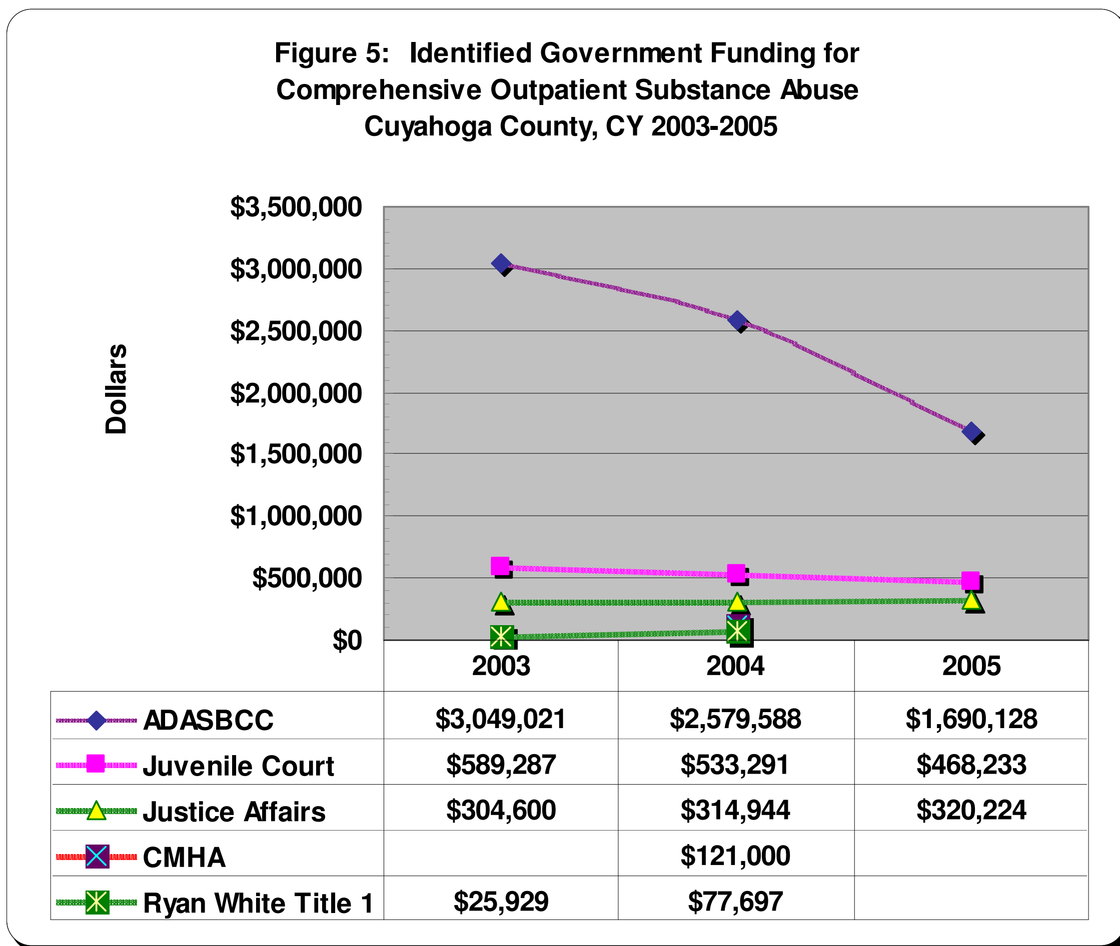
LOCAL

Cuyahoga County General Revenue Fund
The county funds the Alcohol and Drug Addiction Services Board of Cuyahoga County (ADASBCC) out of its general revenue fund (GRF). It provides a network of prevention and

treatment services to combat alcoholism and drug abuse among youth and adults. Overall county GRF dollars to the ADASBCC have been increasing from $5.3 million in 2003 to $10.1 million in 2006.

Trends of Identified Government Funders in Cuyahoga County

Between calendar years 2003 and 2005, ADASBCC funding for comprehensive outpatient substance abuse treatment programs in Cuyahoga County decreased from $3 million to $1.7 million. (See Figure 5 and Table 1.) Over this same time frame, the funding from Cuyahoga County Juvenile Count also decreased from $589,287 in CY 2003 to $468,223 in CY 2005. The Cuyahoga County Department of Justice Affairs experienced an increase from $304,600 in 2002 to $320,224 in 2004. Ryan White Title I funding increased between 2003 and 2004. Information was not available for 2005. Funding information from CMHA (Cuyahoga Metropolitan Housing Authority) was found only for 2004.



	2003	2004	2005
ADASBCC	$3,049,021	$2,579,588	$1,690,128
Juvenile Court	$589,287	$533,291	$468,233
Justice Affairs	$304,600	$314,944	$320,224
CMHA		$121,000	
Ryan White Title 1	$25,929	$77,697	

Source: Alcohol and Drug Addiction Services Board of Cuyahoga County, Cuyahoga County Juvenile Court, Cuyahoga County Department of Justice Affairs, Cuyahoga Metropolitan Housing Authority, Ryan White Title I

Table 1 provides more detail on the sources of funding by governmental level over the same time period. Federal sources are largest, representing more than 60 percent of ADASBCC funds, and county sources have increased dramatically in the past few years as state sources have decreased equally dramatically.

Table 1: Alcohol and Drug Addiction Services Board of Cuyahoga County Historical Funding: Outpatient Services CY 2003 TO CY 2005, Cuyahoga County

Funding Sources	CY 2003		CY 2004		CY 2005	
	#	%	#	%	#	%
Federal	$1,906,553	62.5%	$1,654,290	64.1%	$1,138,977	67.4%
State	$964,710	31.6%	$425,374	16.5%	$5,915	0.3%
County	$177,758	5.8%	$499,924	19.4%	$545,235	32.3%
TOTAL	**$3,049,021**	**100.0%**	**$2,579,588**	**100.0%**	**$1,690,128**	**100.0%**

NOTE: The above funding represents adult outpatient services only. It does not include funding for services provided to adolescents, detoxification services, medically assisted treatment or prevention services.

IDENTIFIED REVENUES

As of May 11, 2006, more than $4 million in revenues for comprehensive outpatient substance abuse treatment has been identified countywide, excluding Medicaid dollars. (See Table 2). This includes information from foundations; federated fundraising organizations; regional, county and municipal government; and United Way of Greater Cleveland. Note that other funding sources such as private insurance and individual fees are not included.

Ninety-one percent of the revenues are from contracts or grants from government organizations. ADASBCC and the court systems are primary funders of the service. United Way of Greater Cleveland's funds account for 8.4 percent of the total from Investment Committee allocations and designations.

Medicaid dollars have not been entered under the countywide total for this core service because not all Medicaid services are a one-to-one match with United Way core services. Medicaid service—Community Alcohol and Drug Addiction (CADAS) ($8,522,183 in 2004)—falls into AIRS 1 Health Care and has been entered as an aggregate total for that AIRS Level. CADAS includes the following core services: comprehensive outpatient substance abuse treatment, residential substance abuse treatment programs, substance abuse education and prevention.

Table 2: Identified Annual Revenue for Core Services: Countywide and United Way of Greater Cleveland Comprehensive Outpatient Substance Abuse, 2003/2004.

Funder	Period	A		B	
		Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Cleveland Foundation,The				9,000	
Reuter Foundation, The		18,000			
Woodruff Foundation, The		22,400			
Total - Foundations & Trusts		**40,400**	**1.01%**	**9,000**	**0.44%**
Department of Alcohol and Drug Addiction Services				295,400	
Subtotal State of Ohio		***0***	***0.00%***	***295,400***	***14.29%***
Board of Alcohol & Drug Addiction Services (410 Board)	2004	2,579,588		939,650	
Cuyahoga Metropolitan Housing Authority (CMHA)	2004	121,000			
HIV Services Planning Council Ryan White Title I	2004	77,697			
Justice Affairs	2004	314,944			
Juvenile Court	2004	533,291		41,445	
Subtotal Cuyahoga County Funding Sources		***3,626,520***	***90.62%***	***981,095***	***47.46%***
Community Development Block Grant				22,537	
Subtotal City of Cleveland Funding Sources		***0***	***0.00%***	***22,537***	***1.09%***
Medicaid *				20,363	
Medicare				380,998	
Subtotal Third Party Payee/Direct Bill		***0***	***0.00%***	***401,361***	***19.42%***
All Other Funding - Not Elsewhere Classified				21,859	
Subtotal Other Govt Funding Sources		***0***	***0.00%***	***21,859***	***1.06%***
Total - Contracts/grants from government organizations		**3,626,520**	**90.62%**	**1,722,252**	**83.32%**
Private Pay/Fee for Service				900	
Total - Program Service Fees		**0**	**0.00%**	**900**	**0.04%**
Subtotal Non - UWGrCle Support		**3,666,920**	**91.63%**	**1,732,152**	**83.80%**
Total - UWGrCle designations applied to program		**7,895**	**0.20%**	**7,895**	**0.38%**
Total - UWGrCle investment committee allocation		**274,944**	**6.87%**	**274,944**	**13.30%**
AIDS Funding Collaborative		52,000		52,000	
Total - Special UWGrCle grants applied to programs		**52,000**	**1.30%**	**52,000**	**2.52%**
Subtotal UWGrCle Support - 4001, 4701 & 4703		**334,839**	**8.37%**	**334,839**	**16.20%**
Total Support/Revenue		**4,001,759**	**100%**	**2,066,991**	**100%**

* Medicaid dollars have not been entered under countywide total for this core service because not all Medicaid services are a one-to-one match with United Way core services. Medicaid service - CADAS ($8,522,183 in 2004) - falls into AIRS 1 Health Care and has been entered as an aggregate total for that AIRS Level. CADAS includes the following core services: Comprehensive Outpatient Substance Abuse Treatment, Residential Substance Abuse Treatement Programs, Substance Abuse Education and Prevention.

REIMBURSEMENT/COST

Outpatient services are generally billed in hourly units. Intensive outpatient is a day unit. (See Table 3.) Medicaid ceiling prices of outpatient substance abuse treatment ranges from around $38 per hour for group counseling to $176 per hour for medical somatic treatment. Private providers may charge more. Clients are expected to pay for the service(s) if they do not meet the eligibility guidelines for indigent services. The board's sliding fee scale is based on the poverty guidelines. There are no payment expectations for Medicaid reimbursable services.

Table 3: Cost of Core Service

SERVICE	
Definition of Unit of Service:	Outpatient services are hourly. Intensive outpatient is a day unit.
Average Market Price and/or Cost: Medicaid ceiling prices are as follows: Assessment Case management Crisis intervention Group counseling Individual counseling Intensive outpatient Medical somatic	 $96.24 $78.17 $129.59 $38.08 $87.28 $136.90 $176.28
Range of Purchase of Service Reimbursement Amounts by Government:	Clients are expected to pay for the service(s) if they do not meet the eligibility guidelines for indigent services. The board's sliding fee scale is based on the poverty guidelines. There are no payment expectations for Medicaid reimbursable services.

Source: ADASBCC, 2005

Substance abuse is a rising problem and there are treatment barriers for those seeking help in the Cleveland area. A lack of health insurance is a major concern for individuals seeking substance abuse treatment. The average cost of treatment claims per non-Medicaid client was $1,276, with the average cost of treatment claims for Medicaid clients at $1,531 (ODADAS, 2005).

V. WHAT WORKS; WHAT DOESN'T

IMPACT ON INDIVIDUALS/FAMILIES

What Works

Treatment improvement protocols (TIPs) are developed by the Center for Substance Abuse Treatment (CSAT), which is part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (DHHS). They provide best-practice guidelines for the treatment of substance use disorders. CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are then distributed to facilities and individuals across the country. The audience for the TIPs includes practitioners in mental health, criminal justice, primary care and other healthcare and social service settings, as well as public and private treatment facilities. Additionally, the Center for Substance Abuse Treatment also provides many publications that address substance abuse treatment. These can be found on the Center's website at http://csat.samhsa.gov/publications.aspx.

Overall, treatment of alcohol addiction seems to be somewhat effective. A meta-analysis by Agosti (1995) found that these interventions are frequently effective for reducing alcohol consumption but not for enabling clients to achieve permanent, complete abstinence. Meta-analyses by Andreasson and Ojehagen (2003) found that alcohol treatment generally produces reduced drinking, compared to waiting-list or other no-treatment control groups. The average effect size of 0.37 is considered small in magnitude.

Andreasson and Ojehagen (2003) conducted a systematic review and evaluation of the hundreds of studies that have been performed on alcohol dependence treatment. They used a systematic procedure for weighing and combining evidence from diverse studies in order to bring order to this extensive, complex field. Their procedure took into account the number of supportive studies, the number of unsupportive studies, and the methodological quality of the research on a particular intervention for each type of intervention examined.

Andreasson and Ojehagen's (2003) review found that interventions based on motivational interviewing—a non-directive type of therapy that assists clients in identifying advantages and disadvantages of drinking and alternatives to drinking—were effective and, when added to standard treatment, produced a significant increment of effectiveness. ("Standard treatment" consists of general counseling techniques and case management.) Cognitive-behavioral therapy (CBT) for alcoholism focuses on changing drinking-related behavior and teaches coping skills, social skills, identification and avoidance of risky situations, impulse control, and relapse prevention. In this review, CBT produced better results than no treatment in most but not all of the studies. CBT outperformed alternative interventions in one third of the investigations, but in one study it was found to be less effective than 12-step treatment.

Twelve-step programs are based on the philosophy of Alcoholics Anonymous, which views alcoholism as a disease that is never cured but can be managed by means of committed effort, peer support, and spirituality. Andreasson and Ojehagen's review found 12-step programs to be more effective than no treatment, with effects generally similar to alternative treatments, but with higher rates of complete abstinence achieved by its participants. This review found that marital

therapy seems to add an increment of effectiveness to individual therapy, apparently because the marital relationship is strongly affected by a spouse's alcohol abuse and because effective work on this relationship can increase the drinker's ability to control his or her alcohol consumption.

Andreasson and Ojehagen reviewed a number of matching studies that investigated whether different types of intervention were more or less effective for clients with different characteristics. In other words, this type of research focuses on the question of which interventions are more appropriate for which clients, rather than on the simpler question of the overall effectiveness of different types of therapy. For example, matching studies have found that psychodynamic therapy may be more effective than CBT for clients without significant general psychopathology, while CBT seems more effective than dynamic therapy for clients who do have significant mental health problems.

Matching research has found that clients with high-level anger obtain better results in non-confrontational therapies based on motivational interviewing as compared to CBT and 12-step programs, while the opposite pattern characterizes results for clients with low-level anger. Twelve-step programs demonstrate their maximum level of effectiveness with clients whose social networks do not support sobriety, which seems to make the peer support aspect of 12-step programs especially important. CBT is more effective than 12-step programs in treatment of clients with low levels of dependence, while 12-step programs seem most appropriate for clients with high degrees of addiction. However, the magnitude of treatment-matching effects is generally small, which suggests that matching clients to treatments may slightly increase treatment effectiveness, but probably not dramatically.

Outcome Research on Treatment of Drug Abuse and Addiction
Fridell (2003) performed a comprehensive series of meta-analyses of several categories of outcome research on treatment for drug abuse and addiction. His meta-analysis of treatment for opiate dependence found significant positive effects for behavioral, cognitive, psychoeducational, psychodynamic, and family systems therapies, with typical effect sizes in the medium range. Supportive treatment based on non-specific counseling techniques (empathy, warmth, opportunities to vent emotions) has not been found to be effective. Client retention rates were higher for therapies that placed significant emphasis on clients' emotions, compared to interventions focused primarily on behavior and abstinence.

Fridell's (2003) meta-analysis of outcome research on cocaine abuse produced less evidence of treatment success, compared to opiate abuse. This analysis found that behavioral, psychoeducational therapies reduce cocaine abuse to a significant, but small, degree, with many treatment failures. Therapies that focus on emotions and relationships (e.g., dynamic and family therapy), and those based on support within the therapist-client relationship seem to have no discernable effect of subsequent rates of cocaine abuse. However, therapies emphasizing emotions and relationships were generally more successful at retaining clients in treatment. This pattern suggests that optimal treatment packages might combine both components, so that some focus on emotions could act to retain clients in treatment and some emphasis on behavior change could act to reduce cocaine abuse.

Studies of therapy for marijuana abuse have focused on teenagers living with their families. Outcome research on this population has produced inconsistent results. Nine of the 13 studies reviewed by Fridell (2003) produced non-significant results (i.e., indicated no effects of treatment). This review identified two studies of behavior therapy and two investigations of

family therapy that produced significant reductions in clients' use of marijuana. The effect sizes documented by these studies were of moderate to large magnitude.

What Doesn't Work

In terms of research in the substance abuse arena, local experts interviewed as key informants for United Way's core service research (2005) felt there is little being done in terms of tracking the effectiveness of treatment programs once an individual is released. Additionally, they felt that agencies need money to evaluate midpoint and long-term outcomes, while the current system looks at the outcomes at the time of discharge. Key informants are interested in looking at outcomes that are beyond six to eighteen month time frames.

> *In terms of outcome, people should put money where their mouth is if they are really interested in knowing what is happening with those folks post-discharge and really getting to some consensus around that piece and working with the planning entities in order to make it happen so that the outcome expectations are in alignment, and providers don't have to scramble and try to answer multiple questions in a different way.*

Some also felt that a segment of the Hispanic community, the illegal alien (or "not documented") population, needs further research. Lastly, a local expert stated that the research conducted by academic institutions such as Cleveland State University and Case Western Reserve University should be utilized more frequently.

IMPACT ON COMMUNITY

According to the Ohio Department of Drug and Alcohol Addiction Services (ODADAS), $11 is saved for every dollar spent on treatment because health care costs are cut in half (ODADAS, 2004). In addition, keeping a criminal offender out of prison saves $22,000 a year; keeping one potential foster child at home with his mother saves $30,000 a year; and returning a former substance abuser to the workplace saves $7,000 a year (ODADAS, 2004). ODADAS tracking of drug-free babies born to clients in its women-specific treatment programs indicates that, "As of 2002, more than 7,300 drug-free babies had been born, saving Ohio nearly $338 million in alcohol and other drug-exposed infant care."

In addition to the devastating effects of substance abuse on users, drug and alcohol abuse harms society in a variety of indirect ways. One of every 10 employees has a substance abuse problem, which costs employers about $7000 per year per employee in lost productivity (ODADAS, 2004). With 6.7 million workers in Ohio, this results in an annual cost of approximately $4.7 billion per year.

Illegal drugs and alcohol cost taxpayers more than $143 billion annually in health care costs, extra law enforcement, auto crashes, crime, and lost productivity (SAMHSA, 2004). Teens in juvenile detention are considered at high risk for substance abuse, as are maltreated and runaway youth (SAMHSA, 2004).

ACCREDITATIONS/STANDARDS/CERTIFICATIONS

Alcohol and drug outpatient treatment programs must be certified by the Ohio Department of Alcohol and Drug Addiction Services. ODADAS certifies program sites, therefore each certificate is issued for a specific address. Additionally, programs can be certified by the Joint

Commission on Accreditation of Health Care Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), and Council on Accreditation of Services for Children and Family Services (COA).

The state of Ohio has exacting licensure requirements for chemical dependency counselors. There are four levels of licensure:

- A *chemical dependency counselor assistant* must be employed in a paid or volunteer position in an appropriate organization, must have 40 hours of approved education in chemical dependency, and must work under supervision.
- A *licensed chemical dependency counselor II* must have an associate's degree in a behavioral science or a bachelor's degree in any field, 5000 hours of relevant paid or volunteer work experience, 270 hours of chemical dependency education, and must pass a written and oral examination.
- A *licensed chemical dependency counselor III* must have a bachelor's degree in a behavioral science, 4000 hours of professional experience as a chemical dependency counselor, 270 hours of professional training, and must pass a written and oral examination.
- A *licensed independent chemical dependency counselor* must have a master's degree in a behavioral science, 6000 hours of professional chemical dependency counseling experience, 270 hours of professional education, and must pass two written and one oral examination.

VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for Comprehensive Outpatient Substance abuse Treatment:

- The Alcohol and Drug Addiction Services Board of Cuyahoga County places the actual number of consumers served in 2004 at 7,697 (unduplicated count). This number reflects only the consumers who accessed treatment using public funds administered by the board (ADASBCC, 2005) and is considered realized access. The consumers funded by United Way (1,466), Juvenile Court (818), and Ryan White Title I (45) are considered duplicated with ADASBCC's figures.

- ADASBCC estimates that 77,813 Cuyahoga County individuals who need alcohol and other outpatient drug treatment are either not receiving services or are receiving them from other unaccounted-for services. The primary reasons services are not obtained include:

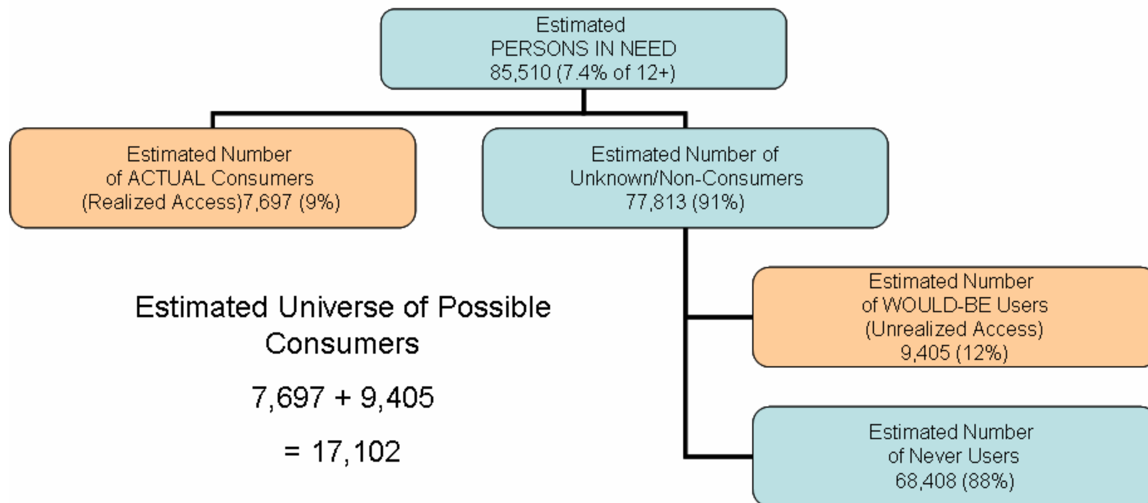
  - Some of the 77,813 may be accessing services in the private sector through insurance benefits and are utilizing private centers, hospitals and employee assistance programs.
  - There is lack of available funding and other resources to meet the need.
  - Consumers may not be seeking services. About 20 percent of individuals in need of service may actually seek service (ADASBCC, 2004).

- A conservative estimate of 85,510 Cuyahoga County residents ages 12+ are in need of comprehensive outpatient substance abuse treatment programs. This is based on an estimate from ADASBCC including those who receive service and those who need it, but do not receive it. (7,697 + 77,813 = 85,510)

- Applying the ADASBCC figure of 20 percent actual seekers to the estimated persons in need (85,510) equals 17,102, the estimated universe of possible consumers. (85,510 x 20% = 17,102)

- Subtracting the actual consumers (7,697) from the estimated persons in need (85,510) equals the would-be consumers (9,405). These persons would consume the service if they were aware of it, if enough services existed, or if they could afford it.

- Including both realized (7,697) and unrealized (9,405) access, the estimated universe of possible consumers for comprehensive outpatient substance abuse treatments is 17,102 persons 12+. (See Figure 6.)



Service Site Index
Another way of viewing service need is through the Service Site Index which measures the ratio of possible consumers per service site.

Countywide, according to United Way - First Call for Help (February 2005), there are 39 service sites for comprehensive outpatient substance abuse treatment services. This is a ratio of 439 possible consumers (estimated 17,102 total) to one service site countywide. Service providers report to United Way - First Call for Help which zip codes are included in their respective service areas. The Service Site Index in Attachment 9 lists the number of sites located in each zip code, and the number of service sites that report servicing a particular zip code. Dividing the estimated number of possible consumers in each zip code by the number of service sites that could serve that zip code provides a ratio of consumers to service sites for each zip code. This is a measure of potential service accessibility by possible universe of service consumers per zip code area. Note that this measure does not include the service capacity of providers, for example, the possible number of outpatient treatment hours on a daily basis. It is only capturing whether there is a possibility of being a consumer. The lower the ratio, the greater is the chance of being a consumer.

The ratios on the Service Site Index range from a high of 19:1 in zip codes 44107 (Lakewood/Cleveland) and 44130 (Parma/Cleveland), to a low of 1:1 in zip code 44040 (Gates Mills/Mayfield Village) and 44114 (Cleveland). In addition to 44107, two other zip codes have ratios greater than 15 consumers per service site:

- 44105 (Cleveland/NewburghHts/ GarfieldHts - 17:1) (high minority area); and
- 44102 (Cleveland/Brooklyn - 16:1) (high minority area).

(See Map in Attachment 10.) Since all comprehensive outpatient substance abuse treatments report that they serve all zip codes across the county, the variability in the index scores is the result of differences in the number of service consumers rather than in the number of sites serving a given zip code.

Service Capacity
According to ADASBCC, there are 36 ODADAS-certified alcohol and other drug (AOD) service providers in Cuyahoga County. The board contracts with 29 agencies with 55 sites offering outpatient services. The numbers referenced above do not include private providers.

Lack of funding is the primary reason for the differences between service capacity and actual numbers served. Funding has remained flat over the last 10 years. While the cost for providing service continues to rise, the number of clients decreases. Another reason is lack of capacity in physical environments; there is only one residential agency for adolescents, so capacity is limited. Finally, there may be constraints due to the type of services the agency provides. For example, there are two methadone providers in Cleveland and only nine in Ohio. Capacity to serve the intravenous drug user (IVDU) population using methadone is limited to the total number of clients both agencies can serve given their available funding resources. IVDU clients who receive outpatient services at board-funded agencies are at or over capacity. Adolescents who need residential services are at capacity as well (ADASBCC, 2005).

Availability of appropriate treatment is a concern in the Cleveland area. Specific concerns are for limitations for clients needing detoxification, clients with an inability to pay, and clients without health insurance.

VII. SUMMARY

The following are the major findings from this research:

- According to The Ohio State University Medical Center, substance-related disorders are caused by multiple factors including genetic vulnerability, environmental stressors, social pressures, individual personality characteristics, and psychiatric problems.
- Chemical dependency (or addiction) is considered a chronic disease that does not resolve itself spontaneously and is rarely cured completely. Like other chronic diseases—including obesity, hypertension, and diabetes, and asthma—sobriety can be maintained through a prescribed treatment regimen administered throughout a person's lifetime.
- As it is nationally, funding is Cuyahoga County's major local policy issue. An additional factor is the common belief among lay people that substance abuse problems are attributable to moral failings or weakness of will.
- Insurance parity, or equal treatment for mental health and addiction, is one of Ohio's major public policy issues affecting private funding for services through insurance. Ohio passed a parity law in December 2006; however, it did not include substance abuse services.
- Greenfield (2005) found that there are two major barriers to policies and full implementation of parity policies: 1) fear of an unmanageable rise in health care costs, and 2) societal stigmas in respect to psychiatric and substance abuse disorders.
- In Cuyahoga County there was a total of $8.5 million Medicaid dollars for CADAS in 2004. This was an increase from FY 2002 of $7.3 million. Funding covers more than outpatient services.
- As of May 11, 2006, more than $4 million in revenues for comprehensive outpatient substance abuse treatment has been identified countywide.
- Research has found that interventions based on motivational interviewing were effective and, when added to standard treatment, produced a significant increment of effectiveness.
- Matching research has found that clients with high-level anger obtain better results in non-confrontational therapies based on motivational interviewing, compared to CBT and 12-step programs, while the opposite pattern characterizes results for clients with low-level anger.
- In terms of research, local experts interviewed as key informants for United Way's core service research felt there is little being done in terms of tracking the effectiveness of treatment programs once an individual is released.
- The estimated universe of possible consumers is 17,102 including both realized (7,697) and unrealized (9,405) access.
- Countywide, there are 39 service sites for speech and hearing services. This is a ratio of 439 possible consumers (estimated 17,102 total) per service site countywide.

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ATTACHMENTS

Attachment 1: Researcher List

MCS

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Thanks to ***The Center for Community Solutions*** for providing multiple sources of information.

Attachment 2: Technical Notes

Technical Notes:
Methodology, Caveats, Limitations of Data

The following provides descriptions, definitions, methodologies, caveats, or limitations of data for the following components of the core service reports:

- Unit of Analysis
- First Call for Help Data
- Funding Information for Core Services
- Consumer and Financial Data: Caveats
- Gap Analysis Methodology & Limitations
- Service Site Index

Unit of Analysis

The core service is the unit of analysis. United Way of Greater Cleveland either funds or could fund 80 core services. These are the object and subject of the research, specific to Cuyahoga County. A separate report has been developed for each service. It must be noted that the aggregate of any quantifiable data across all of the reports does not comprise a picture of the totality of health and human services in Cuyahoga County because there are many more than 80 services that comprise the community's safety net.

The unit of analysis for estimates of service consumers is the individual, the family, or the household.

United Way - First Call for Help Data

For most core services, United Way First Call for Help (FCFH), the community's resource and referral service data, was used in tables that show the number of service providers and service sites, the geographic location of service providers by zip code, the service area by zip code as reported by providers of the respective services, and to show unmet need and greatest increase/decrease in calls received by FCFH for a particular core service.

It is important to remember that FCFH receives calls from a variety of sources that include people calling on behalf of a prospective consumer such as social workers, provider agencies, relatives, etc. Not all calls come directly from a prospective consumer, so some of the zip codes are for hospitals and business addresses, although the numbers for these zip codes are relatively small.

Calls also may be from people who are not interested in receiving a service, but wish instead to make a contribution to a program such as clothing, household items, food, books, crafts supplies, etc.

Because, in many instances, FCFH codes its data with a different level of core services than the 80 core services identified by the United Way Community Investment staff as fundable services, it was necessary to develop a crosswalk. This crosswalk was used for a number of services,

however, seven services did not have a match in the FCFH database. The staff of United Way - First Call for Help gave explanations which follow each core service):

- Adolescent/Youth Counseling: A caller asking about help with their troubled teenager would be referred by the type of counseling rather than age. (Example: counseling for drugs, family, sexual abuse, etc.)
- Advocacy: FCFH does not receive calls from people about advocacy.
- Child Care: Calls are directed to Starting Point.
- Condition Specific Rehabilitation Services: FCFH would refer caller back to their primary care physician for a referral.
- Early Intervention for Mental Illness: FCFH does not receive calls for this, but if they did, they would refer to the county's Help Me Grow program.
- Family Support Centers: FCFH defines data by specific service rather than type of agency. Depending on the call, the caller may be referred to General Counseling or Early Intervention for Infants and Toddlers with Disabilities, and so on.
- Preschools: Calls are directed to Starting Point.

A different match was used for other services that had no crosswalk.

- Medical Transportation and Senior Ride: FCFH uses "Paratransit" as they do not differentiate between senior transportation, medical transportation, and transportation for the disabled.
- Outpatient Mental Health Facilities: FCFH uses "Mental Health Drop-in Centers."

It must also be noted that, for the most part, the FCFH database does not include for-profit agencies. In the case of home health care providers, we contacted the Long Term Care Ombudsman for a more complete list of provider agencies which includes for-profit organizations.

There were several instances where the FCFH database did not code a United Way-funded agency with the core service for which they were receiving funding. In these instances, the agency was added manually to the Service Provider Table along with their site locations. The core services with the respective United Way of Greater Cleveland agencies that were added are:

- Case/Care Management – Care Alliance, Cystic Fibrosis, Epilepsy Foundation, Golden Age Centers
- Comprehensive Outpatient Substance Abuse Treatment – The Covenant
- Disease/Disability Information – The Muscular Disease Society of Northeastern Ohio
- Early Intervention for Infants and Toddlers with Disabilities – United Cerebral Palsy
- Medical Expense Assistance – North Coast Health Ministry
- Medical Transportation (Paratransit in FCFH) – Kidney Foundation of Ohio
- Senior Centers – Catholic Charities Services Corporation, Jewish Community Center of Cleveland, Jewish Family Service Association of Cleveland, University Settlement House.
- Volunteer Development – Neighborhood Leadership Institute

It must also be noted that when numbers are low for trend data reported, the high percentages are slightly exaggerated.

Funding Information for Core Services

We collected financial information for each core service on a countywide level from multiple sources including major government funders, foundations, federated fund raising organizations, and United Way of Greater Cleveland. While we were successful in gathering a substantial amount of data, there is much that has not been collected. It must also be noted that even if we had all major public and private funding gathered, this would not create a total picture of health and human service funding in Cuyahoga County because there are more than 80 core services provided. The following provide highlights of data collected and some of the limitations for each source. It is important to note that funding in each source is changing and represents point in time amounts. The typical period for trend data, when available, is 2002, 2003, and 2004. Note: some services are funded by private insurance or other self-pay arrangements.

Foundation Funding
We attempted to obtain foundation funding amounts for each core service from the latest annual report or 990 PF (foundation tax return to the IRS) of each major foundation that funds social services in Greater Cleveland. Wherever a description of the grant purpose was given, we used our best judgment to match the grant to the appropriate core service. If the grant fell within more than one core service area, it was not listed. When no description was given, the grant was treated like a general operating grant and assigned to a core service only when the mission of the grant recipient fell mainly within one particular core service. In-kind donations, grants for capital and equipment expenses and administrative salaries were not used. When grants were $10,000 or greater, they were listed by name of the foundation. All others were placed under Other Foundations and not listed. Typically, we did not attempt to provide trend financial data for foundation funding of core services because of the changing nature of funded programs from year to year.

Federated Funding Sources
We approached the major federated funders of core services in Greater Cleveland for funding and consumer information. Some data provided was for a single point in time; others provided three years of trend data. We often had to do a cross walk of United Way of Greater Cleveland funded core services against those funded by federated agencies to agree on the services.

Government Funding
We approached every major government funder for funding amounts for each core service and also did Internet searches for some federal government sources. Due to the constant state of change in government funding, it is important to note that the data provided is a snapshot in time and that many of the programs funded in 2004 have changed definition, are funded through different revenue sources, or no longer exist at all due to a lack of funding. This is particularly true of Community Development Block Grant dollars which have decreased due to shifting federal priorities.

Every effort was made to appropriately match government funding data to the correct core service area; however, this was not always possible as frequently the service definitions were not a one-to-one match. It was necessary, in some instances, to take the closest match or use the sore service which represented a majority of the services being provided.

In other cases, it was not possible to select a specific core service. An example is Medicaid in which Medicaid-defined services crossed over more than four core services in some instances. In cases where Medicaid is a significant source of revenue, the data was entered as an

aggregate total at the appropriate AIRS level. These aggregates are footnoted under the appropriate funding table.

Every effort was made to include data from municipalities. However, many did not respond after repeated requests for information. We would like to thank those who took the time to help with this project.

Medicaid Funding
A significant portion of Medicaid funding was NOT entered under the countywide total in the core service reports for two reasons: first, because many of the Medicaid services are not a one-to-one match with United Way core services, and second because some Medicaid services fall into more than one AIRS Level 1 categories. In the first instance, Medicaid funding was entered as an aggregate total at the AIRS 1 level, and in the second instance Medicaid funding was entered as an aggregate total under Third Party Payee/Direct Bill in the combined Master Revenue file of funding across all nine AIRS Levels. They are as follows:

Entered as Aggregate Total Under Appropriate AIRS Level

- Medicaid Service - Home Care ($17,787,703 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: daily living aids and home health care.
- Medicaid Service - CADAS ($8,522,183 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: comprehensive outpatient substance abuse treatment, residential substance abuse treatment programs, substance abuse education and prevention.
- Medicaid Service - Therapy ($2,257,394 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: condition specific rehabilitation, and speech & hearing.
- Medicaid Service - CMH ($67,773,487 in 2004) - Falls into AIRS 1 Mental Health Care & Counseling and includes the following core services: supportive therapies, adolescent/youth counseling, children's residential treatment facilities, early intervention for mental illness, general counseling services (outpatient mental health facilities), and psychiatric day treatment.

Entered as Aggregate Total Under Third Party Payee/Direct Bill

- Medicaid Service - Inpatient Hospital ($188,329,269 in 2004) - Falls into two different AIRS 1 categories: Basic needs and health care. It includes the following core services: condition specific rehabilitation and medical expense assistance.
- Medicaid Service - Waiver ($128,921,354 in 2004) – This category included all PASSPORT services. Since we reported PASSPORT separately, in order to avoid duplication, we deducted the PASSPORT total of $52,676,048 from this number and reported the remaining $76,245,306. This total falls into AIRS 1 Basic Needs, Health Care and Individual & Family Life and includes the following core services: adult day care, home-delivered meals, home health care and in-home assistance.
- Medicaid Service - Habilitation ($55,550,307 in 2004) - Falls into AIRS 1 Health Care and Individual & Family Life and includes the following core services: condition specific rehabilitation services, early intervention for infants and toddlers with disabilities/delays, and residential living options for people with disabilities.

United Way of Greater Cleveland Funding
Financial data for core services funded by United Way of Greater Cleveland was for FY 2004 (July 2003 to June 2004). It included allocations through the community investment committees

and donor designations that United Way funded agencies applied to the respective core services. It is important to note that not all United Way funded agencies applied donor designated gifts, which are unrestricted, to the core service for which they receive United Way funding. It did not include donor designations that non-United Way funded agencies used for any of the 80 core services.

United Way Agency Revenues
Annually United Way-funded agencies submit revenue budgets to United Way for each funded core service. This information for FY 2004 is reported. However, all of the agency data may not be included in the countywide data as agencies may have assigned dollars from unrestricted grants to a specific core service, or allocated a portion of grant monies that fell within two or more core service areas. It was not always possible to match countywide government or foundation funding with that reported by the agencies and that gathered from other funding sources.

Consumer and Financial Data: Caveats

The following applies to revenue sources on tables and graphs and their corresponding consumer data used in the consumer demographics and zip code tables.

All Core Services
Data was self-verified by the funder/provider. Whenever data provided by a funder appeared to be inconsistent or incorrect, an attempt was made to contact the funder. If the funder responded, the data was either adjusted according to their instructions, or the reason for discrepancies footnoted. If they did not respond, or if they said it was correct, the data was left as submitted.

Demographic and zip code data provided by the funder/provider is frequently taken from consumer intake forms which may have missing or incomplete data, or from provider agency databases which contain data entry errors or incomplete consumer intake forms. Whenever possible, the funder was asked for corrected data. In cases where a correction was not possible, the data was counted as either unknown or missing. The usage of these terms is footnoted at the bottom of each table and is explained more fully in the Gap Analysis section of this attachment.

It was not always possible to get information in the format requested as each funder tracks data differently, using different service definitions, terminology and variables. Wherever possible, data was matched to a consistent report format.

When a funder could not provide consumer demographics, but could provide an estimated percentage of consumers by category, we took the total number of consumers and applied the percentages to come up with estimated numbers for the consumer tables. For example, Medicaid tracks individual recipients throughout the year, entering new data if there is a change, each time a claim occurs. Thus, a consumer who has a birthday between claims will appear in the system for that year with two different ages.

To resolve this, the percentage of consumers in each age range was determined for the total number of duplicated consumer ages. Those percentages were then applied to the total number of unduplicated consumers for the year in order to reach a total number of unduplicated consumers for each age range.

The time periods for both revenue and consumers vary by funder/provider. United Way Program Report data is for FY 2004 (July 2003 to June 2004). Other funder/provider data is for either a January to December or July to June fiscal year.

Gap Analysis Methodology & Limitations

Based on Anderson's (1964) seminal needs assessment model, realized access is defined as the number of consumers who receive service while unrealized access is the estimated number of consumers who need and would utilize a service, but are not currently receiving it. This could be considered the service gap. Unrealized consumer access to services drives the need for change in the social service delivery system. Ensuring unrealized consumer access to services requires new models of service delivery related to access, effective use of resources, data management, and funding. There were multiple steps used to conduct a gap analysis:

- *Estimate of persons in need of the service*: Unless local research was conducted to determine need for a given service, this estimate was obtained by either using U.S. Census data for Cuyahoga County or applying percentages from national studies and reports to the census data. All references and percentages are footnoted in the respective graphs or tables. In most cases this percentage was also applied to actual 1990 Census figures and population projections 2005 through 2015 that were done by the Ohio Department of Development.
- *Estimate of number of ACTUAL consumers in the public systems (realized access):* Data submitted to United Way by funded agencies was aggregated to determine the number of consumers for each core service. The period was FY 2004, which is July 2003 through July 2004.
  - In some cases data was "unknown," defined as data not collected by agency because no tracking system was available or the type of service delivered made it difficult (i.e., group presentations, telephone information and referral, and drop-ins). This also represents data not completed by consumers either deliberately or inadvertently on intake forms.
  - In other cases, data was missing that, for United Way data, represented computational errors or incorrect completion of online reports. For all other data, "missing" represents data funders/providers were unable to provide.
  - There was no check of the accuracy of data submitted by agencies.
  - Major government funders were asked to provide information about the number of consumers for the respective core services that they funded. In most cases, services were not defined in the same way as the United Way core services which are based on the Alliance for Information and Referral Systems (AIRS) taxonomy. To accommodate these differences, customized crosswalks were developed.
  - We assumed that the numbers of consumers across funding sources were not unduplicated and thus made a judgment about which numbers would be the best estimate of an unduplicated number.
  - The estimate of consumers is not inclusive since it does not include numbers of consumers who use their personal resources to pay for services, nor for other private resources such as insurance or agency fundraising. In addition, it was not always possible to obtain information from some government funders.
- *Estimate of number of "unknown/non-consumers":* This is the difference between the estimated number of actual consumers and the estimate of persons in need.

- *Estimate of number of "would-be users" (unrealized access)*: This is the estimate of persons who would use a service if it were available, typically based on research.
- *Estimate of number of "never users":* This is the difference between the estimated number of unknown/non-consumers and would-be users.
- *Estimate of "universe of possible consumers":* This is the total of those actually receiving the service (realized access) and those would-be users (unrealized access).

We recognize that this is not a perfect method for assessing either realized or unrealized access to core services. However, we opted to use an imperfect method rather than no method to demonstrate both the complexity and the usefulness of quantifying realized and unrealized access to services as a first step toward a more rigorous methodology. In the business sector this would be a form of market analysis. We also recognize that actual consumer numbers are not unduplicated across funders, or across core services. Thus, there is much work yet to be done to gain realistic estimates of needs.

The numbers we provided are on a countywide level. We recognize that there could be, and often are, differences by demographics and geographical area. In the Actual Consumer Demographics attachment, we have identified the profile of the base consumer group from census, but have little on the estimated persons in need. Occasionally, there is information from other research that describes differences among different racial, ethnic, gender, age, or income groups that is discussed in the narrative. There is also inconsistent information for consumers funded by various governmental bodies. In other words, some funders provided demographic data and others did not. In the Actual Consumer Zip Codes attachment, we have also attempted to identify the geographic profile of the estimated persons in need and actual consumers. However, this information has the same limitations as the demographics.

Service Site Index

For many services a service site index was developed. It provides a ratio of estimated consumers per service site on a countywide level and for each zip code within the county. The ratio is based on the number derived from the gap analysis described in the previous section and on the number of providers who reported to United Way – First Call for Help whether a specific service site includes a given zip code in its service area. A provider site is located in a single zip code, but could serve multiple zip codes. The ratio is a measure of potential service accessibility by estimated universe of service consumers per zip code area. This measure does not include the capacity of providers to offer the service, for example, the number of consumers that can be served on a daily basis. It is only capturing whether there is a possibility of being a consumer. The lower the ratio, the greater is the chance of receiving service. The index also gives an indication of which zip codes have higher ratios which means that consumers have a lower probability of receiving a service as well as any patterns in zip codes that have high percentages of African Americans, Asians, or Hispanics. A map is also attached which provides a graphic picture of the estimated consumers by zip code.

Based on the numbers of providers that report to FCFH whether they serve a given zip code, we had assumed that there would be greater variability across zip codes. In reality, many report that they serve the entire county. Thus the variability across zip codes is often primarily because of differences in the population numbers rather than in service sites that offer service in a given zip code.

Specific Service Issues

Senior Services
"Senior Centers" was used as a catch-all category when the funder-defined service covered more than one senior success core service and could not be accurately allocated among the separate core services. Often, funding for transportation and home-delivered meals was not broken out from senior activities and supportive services at the municipal level, so it was placed under Senior Centers. Because the core services for congregate and home-delivered meals and senior ride were tracked separately, funding for these core services was not included under Senior Centers to avoid duplication of resources, even though senior center activities can and do include congregate meals.

Senior Ride includes disabled individuals of all ages as well as seniors for most funders with the notable exception of Western Reserve Area Agency on Aging (WRAAA) that requires an individual to be 60 years of age or older in order to receive services. If the transportation service was not provided by a senior center, the number of consumers reflects the number of riders using the system and contains duplicates (e.g. paratransit).

Home improvement/accessibility data includes programs for low-income families and people of all ages with disabilities, as well as seniors.

References

Anderson, Ronald M. (1995, March). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior,* 36(1): 1-10.

Wan, Thomas T. H., Odell, Barbara Gill, & Lewis, David T. (1982). *Promoting the well-being of the elderly: A community diagnosis.* New York: The Halworth Press.

Attachment 3: Actual Consumer Demographics

Core Service Comprehensive Outpatient Substance Abuse Treatment - Adult LX 845.115									
			Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source****					
	Total Population (%)*	Total Population 12+ (%)**	Estimated Population 12+ with Chemical Dependency (%) ***	UW Program Report Data (99.4%)	ADASBCC (%)	CC Juvenile Court (%)	CC Justice Affairs (%)	CMHA (%)	Ryan White Title I (%)
PERIOD	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004	7/1/2003-6/30/2004	7/1/2003-6/30/2004	2004	2004	2004
TOTAL	1,393,978	1,160,037	85,510	1,466	7,697	818	Missing	Missing	45
Percent		83.2%	7.4%						
GENDER									
Male	47.2%	46.5%	N/A	48.8%	0.0%	0.0%	0.0%	0.0%	0.0%
Female	52.8%	53.5%	N/A	51.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Data*****				0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data******				0.0%	100.0%	100.0%	100.0%	100.0%	100.0%
RACE*****									
White alone	67.1%	69.2%	N/A	40.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Black or African American alone/combination	27.9%	26.0%	N/A	44.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Asian alone/combination	2.1%	2.1%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
American Indian and Alaska Native alone/combination	0.7%	0.7%	N/A	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	0.1%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Some other race alone/combination	2.1%	1.9%	N/A	13.8%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Data*****				0.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data******				0.0%	100.0%	100.0%	100.0%	100.0%	100.0%
HISPANIC*******	3.3%	2.9%	N/A	14.1%	0.0%	0.0%	0.0%	0.0%	0.0%
AGE									
0-4				0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
5-9				0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
10-14	4.1%	5.0%	N/A	1.8%	0.0%	0.0%	0.0%	0.0%	0.0%
15-19	6.4%	7.7%	N/A	11.5%	0.0%	0.0%	0.0%	0.0%	0.0%
20-34	19.1%	22.9%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
35-54	29.3%	35.2%	N/A	41.0%	0.0%	0.0%	0.0%	0.0%	0.0%
55-64	8.7%	10.5%	N/A	43.7%	0.0%	0.0%	0.0%	0.0%	0.0%
65-74	7.8%	9.3%	N/A	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%
75+	7.8%	9.4%	N/A	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Data*****				0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data******				0.1%	100.0%	100.0%	100.0%	100.0%	100.0%
INCOME********									
Average Household Size	2.4	N/A	N/A						
$0-$9,999	11.3%	N/A	N/A	63.2%	0.0%	0.0%	0.0%	0.0%	0.0%
$10,000-$14,999	6.9%	N/A	N/A	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15,000-$19,999	6.7%	N/A	N/A	3.9%	0.0%	0.0%	0.0%	0.0%	0.0%
$20,000-$29,999	13.6%	N/A	N/A	4.6%	0.0%	0.0%	0.0%	0.0%	0.0%
$30,000 and above	61.5%	N/A	N/A	5.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Data*****				13.3%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data******				0.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Totals	100.0%	N/A	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Attachment 3: Actual Consumer Demographics (continued)

* U.S. Census 2000, SF1 (P1); SF4 (PCT 144)
** U.S. Census 2000, SF3 (P8); SF4 (PCT 3); SF4 (PCT 144)
*** The Cuyahoga County Alcohol and Drug Addiction Services Board estimates that 77,813 persons in addition to the 7,697 served in 2004 needed outpatient substance abuse treatment. Thus, totaling these numbers, the estimated number of persons in need in Cuyahoga County is 85,510 in 2004, or 7.748%.
****Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
*****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms.
*******Missing Data - represents computational errors or incorrect completion of online report.
********The race categories and data utilize US Census SF4 "Race Iterations," which allow for multiple races to be selected by census respondents. As a result, totals will add to > 100% of population. Universe is "Total Races Tallied." Except "White Alone", all racial categories are "... alone or in combination with some other race". This method isolates and minimizes the non-minority population ("White alone").
*********Hispanic - Amount in this field is from data provided by clients on intake forms and may not be accurate as clients may either deliberately or inadvertently provide incomplete data, or data may not be collected by the agency.
**********The U.S. Census reports income by household or family, not individuals. Estimates by income category were derived by applying the ratio of "total county population (1,393,978) to total households (571,606) = 2.4. The number of households in each income category was multiplied by 2.4 to arrive at an estimate of individuals by income category. The assumption is that the average household size applies to each income category which may result in more conservative estimates for children and the "old old" which may actually have larger proportions of persons in the lower income categories.

Attachment 4: Actual Consumer Zip Codes

Core Service: Comprehensive Outpatient Substance Abuse Treatment LX-845.115										
				Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****					
	City/Town (% Cleveland)	Total Population (%)*	Total Population 12+ (%)**	Estimated Population 12+ with Chemical Dependency (%)***	UW Program Report Data (%)	ADASBCC (%)	CC Juvenile Court (%)	CC Justice Affairs (%)	CMHA (%)	Ryan White Title I (%)
Period		1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004	7/1/2003-6/30/2004	7/1/2003-6/30/2004	2004	2004	2004
TOTAL		1,393,978	1,160,037	85,510	1,466	7,697	818	Missing	Missing	45
Percent			83.2%	7.4%						
44017	Berea	1.4%	1.4%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
44022	Bentleyville	1.3%	0.8%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44040	Gates Mills/Mayfield Village	0.2%	0.2%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44070	North Olmsted	2.4%	2.5%	N/A	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
44101	Cleveland (100%)	0.0%	0.0%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44102	Cleveland/Brooklyn (95%)	3.7%	3.6%	N/A	2.9%	0.0%	0.0%	0.0%	0.0%	0.0%
44103	Cleveland (100%)	1.8%	1.7%	N/A	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
44104	Cleveland (100%)	2.1%	1.8%	N/A	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
44105	Cleveland/NewburghHts/ GarfieldHts (75%)	3.9%	3.7%	N/A	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
44106	Cleveland/Cleveland Hts (60%)	2.3%	2.4%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
44107	Lakewood/Cleveland	4.0%	4.2%	N/A	1.8%	0.0%	0.0%	0.0%	0.0%	0.0%
44108	Cleveland/Bratenahl (90%)	2.6%	2.5%	N/A	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%
44109	Cleveland/Brooklyn Hts (98%)	3.3%	3.2%	N/A	1.8%	0.0%	0.0%	0.0%	0.0%	0.0%
44110	Cleveland/East Cleveland (98%)	1.9%	1.8%	N/A	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
44111	Cleveland (100%)	3.1%	3.0%	N/A	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%
44112	East Cleveland/Cleveland	2.4%	2.3%	N/A	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%
44113	Cleveland (100%)	1.4%	1.4%	N/A	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44114	Cleveland (100%)	0.3%	0.3%	N/A	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%
44115	Cleveland (100%)	0.6%	0.5%	N/A	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%
44116	Rocky River	1.5%	1.6%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
44117	Euclid/Cleveland	0.9%	0.9%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
44118	ClevelandHts/UniversityHts/ ShakerHts	3.2%	3.3%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
44119	Cleveland/Euclid (50%)	1.0%	1.0%	N/A	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%
44120	Shaker Hts/Cleveland	3.4%	3.3%	N/A	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%
44121	University Hts/South Euclid	2.5%	2.5%	N/A	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
44122	Beachwood/Highland Hills/ShakerHts	2.5%	2.6%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44123	Euclid	1.3%	1.3%	N/A	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	3.1%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
44125	Valley View/Garfield Hts	2.1%	2.2%	N/A	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
44126	Fairview Park/Cleveland	1.2%	1.3%	N/A	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
44127	Cleveland (100%)	0.6%	0.6%	N/A	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
44128	Warrensville Hts/Cleveland	2.4%	2.4%	N/A	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
44129	Brooklyn/Parma/Cleveland	2.1%	2.2%	N/A	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44130	Parma/Cleveland	3.8%	4.0%	N/A	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
44131	Independence/Seven Hills/BrooklynHts	1.5%	1.6%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
44132	Euclid	1.1%	1.1%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
44133	North Royalton	2.0%	2.1%	N/A	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
44134	Parma/Cleveland	2.9%	3.0%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
44135	Cleveland/Linndale (90%)	2.0%	2.0%	N/A	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%
44136	Strongsville	3.1%	3.1%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
44137	Maple Hts/Cleveland	1.9%	1.9%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
44138	Olmsted Twp/Olmsted Falls	1.3%	1.3%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
44139	Bentleyville/Glenwillow/Solon	1.6%	1.6%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44140	Bay Village	1.1%	1.2%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
44141	Brecksville	1.0%	1.0%	N/A	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
44142	Brookpark/Cleveland	1.5%	1.6%	N/A	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
44143	Highland Hts/Richmond Heights	1.7%	1.8%	N/A	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
44144	Brooklyn/Cleveland	1.6%	1.6%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
44145	Westlake	2.3%	2.4%	N/A	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
44146	Walton Hills/Oakwood/Bedford	2.3%	2.4%	N/A	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
44147	Broadview Hts	1.1%	1.1%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
44149	Strongsville				0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Cuyahoga County Zip Codes******					80.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing*****					0.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Unknown ******					0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Cuyahoga County*******		**100.0%**	**100.0%**	**N/A**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Total Known Cleveland		**36.8%**	**29.5%**	**N/A**	**10.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Total Known Suburbs		**83.9%**	**70.5%**	**N/A**	**9.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Unknown & Missing					**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Attachment 4: Actual Consumer Zip Codes (continued)

* U.S. Census, 2000, SF1 (P1)
** U.S. Census 2000, SF3 (P8)
*** The Cuyahoga County Alcohol and Drug Addiction Services Board estimates that 77,813 persons in addition to the 7,697 served in 2004 needed outpatient substance abuse treatment. Thus, totaling these numbers, the estimated number of persons in need in Cuyahoga County is 85,510 in 2004, or 7.748%.
****Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
*****Missing Data - For United Way - represents computational errors or incorrect completion of online report. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County. For all other data - represents data funder was unable to provide.
******Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County.
******** Totals vary because of rounding. County total population 1,393,978 does not correspond to the total of zipcodes because some zipcodes include data from adjacent counties

Attachment 5: Profile of Core Service Providers – 2005

PROFILE OF CORE SERVICE PROVIDERS - 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
Total Number of Providers	30	3
Number of Providers by Type		
Nonprofit	27	3
For-profit	-	-
Government	3	-
Other	-	-
Total Number of Sites	39	7
Number of Service Sites per Provider		
1	23	1
2 – 5	7	2
6 – 10	-	-
11+	-	-
Geographical Location of Service Sites, by ZIP Code		
44017 – Berea	-	-
44022 – Bentleyville	-	-
44040 – Gates Mills/Mayfield Village	-	-
44070 – North Olmsted	-	-
44101 – Cleveland	-	-
44102 – Brooklyn/Cleveland	1	-
44103 – Cleveland	3	-
44104 – Cleveland	1	-
44105 – Newburgh Hts/Garfield Hts	1	-
44106 – Cleveland Hts/Cleveland	3	-
44107 – Cleveland/Lakewood	1	1
44108 – Cleveland/East Cleveland	-	-
44109 – Cleveland/Brooklyn Hts	1	-
44110 – Cleveland/Bratenahl	-	-
44111 – Cleveland	-	-
44112 – Cleveland/East Cleveland	2	-
44113 – Cleveland	2	2
44114 – Cleveland	2	1
44115 – Cleveland	7	3
44116 – Rocky River	1	-
44117 – Cleveland/Euclid	-	-
44118 – Euclid/University Hts	2	-
44119 – Cleveland/Euclid	-	-
44120 – Cleveland/Shaker Hts	1	-
44121 – University Hts/South Euclid	-	-
44122 – Orange/Warrensville Hts	3	-
44123 – Euclid	-	-
44124 – Pepper Pike/Mayfield Village	1	-
44125 – Valley View/Garfield Hts	-	-
44126 – Cleveland/Fairview Park	-	-
44127 – Cleveland	-	-
44128 – Cleveland/Warrensville Hts	-	-

Attachment 5: Profile of Core Service Providers - 2005 (continued)

PROFILE OF CORE SERVICE PROVIDERS - 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
44129 – Cleveland/Brooklyn/Parma	-	-
44130 – Cleveland/Parma	3	-
44131 – Seven Hills/Brooklyn Hts	1	-
44132 – Euclid	-	-

Attachment 6: Providers and Functions – 2005

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	**Services**
AIDS Taskforce of Greater Cleveland	Substance Abuse Services
Alternatives Agency	Outpatient Substance Abuse Treatment – Offenders
Bellefaire Jewish Children's Bureau	Family Substance Abuse Counseling
Catholic Charities Services of Cuyahoga County	Outpatient Substance Abuse Treatment for Adults, Outpatient Substance Abuse Treatment for Hispanics, Outpatient Substance Abuse Treatment for Teens
City of - Cleveland Department of Public Health	Substance Abuse - Outpatient And/Or Day Treatment, Substance Abuse - Outpatient And/Or Day Treatment – Inmates
Cleveland Treatment Center	Outpatient Treatment/Counseling, Substance Abuse Treatment/ Addicted Women
Community Action Against Addiction	Chemical Dependency Treatment- Targeted To Poly Drug Users, Chemical Dependency Assessment/Treatment
Community Assessment and Treatment Services	Outpatient Substance Abuse Treatment - Men, Outpatient Substance Abuse Treatment - General, Outpatient Substance Abuse Treatment – Offenders
The Covenant	Chemical Dependency Day Treatment – Adolescents
East Side Catholic Center and Shelter	Comprehensive Outpatient Drug Abuse Treatment Programs
Free Clinic of Greater Cleveland	Substance Abuse Counseling – Outpatient
Fresh Start	Intensive Outpatient Treatment - Men - Fresh Start Iv, Intensive Outpatient Treatment - Women - Fresh Start Iv
Glenbeigh Hospital and Outpatient Centers	Intensive Outpatient Programs
Huron Hospital	Mental Health and Substance Abuse
Kaiser Permanente of Ohio	Substance Abuse - Intervention/Outpatient/Day Treatment
Laurelwood Hospital	Substance Abuse - Intervention, Outpatient And/Or Day Treat
McIntyre Foundation	Substance Abuse Assessment and Counseling
MetroHealth Medical Center	Outpatient Chemical Dependency Services
New Directions	Outpatient Treatment - Chemical Dependency - Youth, Intensive Outpatient Treatment - Chemical Dependency – Youth
North East Ohio Health Services	Outpatient Drug Treatment - Deaf, Mental Health Services for Chemically Dependent
Northern Ohio Recovery Association	Intensive Outpatient Substance Abuse Program for Youth Peer Recovery Support Services
Orca House	Comprehensive Outpatient Substance Abuse Treatment
Recovery Resources	Substance Abuse - Intensive Outpatient Services, Substance Abuse Treatment - AIDS/HIV, Substance Abuse Treatment for Women
The Salvation Army	Substance Abuse - Outpatient Treatment

Attachment 6: Providers and Functions – 2005 (continued)

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	**Services**
Southwest General Health Center	Substance Abuse - Outpatient Treatment
St. John West Shore Hospital	Substance Abuse – Outpatient
St. Vincent Charity Hospital	Substance Abuse Detoxification/Treatment
United States Department of Veterans Affairs	Substance Abuse - Counseling - Outpatient And/Or Day Treat, Substance Abuse Treatment – Evenings
Women's Center of Greater Cleveland	Substance Abuse Treatment

Bold represents agencies funded by United Way for this service.

Attachment 7: United Way - First Call for Help Comprehensive Outpatient Substance Abuse Treatment Requests – 2000-2004: Greatest Increase/Greatest Decrease

LX-845.115 Comprehensive Outpatient Substance Abuse Treatment								
United Way - First Call for Help Requests 2000-2004								
Greatest Increase/(Greatest Decrease)								
Zip Code		TOTAL REQUESTS					%Change*	Avg. # Calls 00-04
		2000	2001	2002	2003	2004	00&04	
44105	Cleveland/NewburghHts/GarfieldHts	270	305	279	245	114	(58%)	243
44108	Cleveland/Bratenahl	193	171	137	125	78	(60%)	141
44102	Cleveland/Brooklyn	82	192	134	94	120	46%	124
44120	Shaker Hts/Cleveland	102	149	165	119	59	(42%)	119
44104	Cleveland	107	184	105	124	37	(65%)	111
44110	Cleveland/East Cleveland	72	132	206	56	64	(11%)	106
44112	East Cleveland/Cleveland	147	106	101	72	91	(38%)	103
44128	Warrensville Hts/Cleveland	80	143	111	55	64	(20%)	91
44109	Cleveland/Brooklyn Hts	89	60	79	51	99	11%	76
44113	Cleveland	44	78	102	88	17	(61%)	66
44107	Lakewood/Cleveland	43	36	103	63	75	74%	64
44111	Cleveland	52	53	87	41	88	69%	64
44115	Cleveland	51	54	118	49	34	(33%)	61
44135	Cleveland/Linndale	31	54	19	54	76	145%	47
44118	ClevelandHts/UniversityHts/ShakerHts	40	48	73	25	36	(10%)	44
44137	Maple Hts/Cleveland	9	26	39	78	43	378%	39
44114	Cleveland	13	29	33	58	46	254%	36
44127	Cleveland	65	29	29	24	27	(58%)	35
44132	Euclid	62	5	23	61	25	(60%)	35
44129	Brooklyn/Parma/Cleveland	20	22	27	78	25	25%	34
44130	Parma/Cleveland	5	49	25	43	44	780%	33
44117	Euclid/Cleveland	22	73	10	22	33	50%	32
44125	Valley View/Garfield Hts	24	12	31	39	35	46%	28
44121	University Hts/South Euclid	13	6	56	19	39	200%	27
44122	Beachwood/Highland Hills/ShakerHts	20	30	30	16	40	100%	27
44124	Pepper Pike/Mayfield Hts./Lyndhurst	22	50	17	26	13	(41%)	26
44145	Westlake	2	11	45	6	27	1250%	18
44134	Parma/Cleveland	26	7	12	11	28	8%	17
44101	Cleveland	80	0	0	0	0	(100%)	16
44123	Euclid	11	10	21	16	21	91%	16
44136	Strongsville	9	7	32	18	15	67%	16
44142	Brookpark/Cleveland	8	1	19	36	13	63%	15
44070	North Olmsted	7	11	25	9	12	71%	13
44131	Independence/SevenHills/BrooklynHts	8	15	5	2	34	325%	13
44147	Broadview Hts	25	2	12	13	12	(52%)	13

Attachment 7: United Way - First Call for Help Comprehensive Outpatient Substance Abuse Treatment Requests – 2000-2004: Greatest Increase/Greatest Decrease (continued)

LX-845.115 Comprehensive Outpatient Substance Abuse Treatment								
United Way - First Call for Help Requests 2000-2004								
Greatest Increase/(Greatest Decrease)								
Zip Code		TOTAL REQUESTS					**%Change***	**Avg. # Calls 00-04**
		2000	**2001**	**2002**	**2003**	**2004**	**00&04**	
44126	Fairview Park/Cleveland	5	11	17	15	14	180%	12
44133	North Royalton	8	4	19	7	15	88%	11
44119	Cleveland/Euclid	10	8	2	0	28	180%	10
44144	Brooklyn/Cleveland	1	20	13	12	2	100%	10
44138	Olmsted Twp/Olmsted Falls	6	4	15	17	1	(83%)	9
44139	Bentleyville/Glenwillow/Solon	1	13	13	1	19	1800%	9
44143	Highland Hts/Richmond Heights	2	12	12	13	0	(100%)	8
****Total Cuyahoga County**		**2,141**	**2,688**	**2,764**	**2,129**	**1,963**	**(8%)**	**2,337**
****Total Cleveland**		**1,369**	**1,640**	**1,602**	**1,178**	**1,033**	**(25%)**	**1,364**
****Total Suburbs**		**772**	**1,048**	**1,162**	**951**	**930**	**20%**	**973**
* Extremely high percentages are due to low numbers.								
** These totals do not reflect the sum of the numbers above which are the zip codes reflecting the greatest increase or decrease. Rather, they are the total of calls from ALL zip codes many of which do not appear on this table.								

Attachment 8: United Way - First Call for Help Comprehensive Outpatient Substance Abuse Treatment 2000-2004: Unmet Need

LX-845.115 Comprehensive Outpatient Substance Abuse Treatment United Way - First Call for Help Requests 2000-2004 Unmet Need					
Zip Code		TOTALS 00-04			%
		Requests	**Met**	**Unmet**	**Unmet**
44130	Parma/Cleveland	166	161	5	3%
44120	Shaker Hts/Cleveland	594	577	17	3%
44123	Euclid	79	77	2	3%
44070	North Olmsted	64	63	1	2%
44104	Cleveland	557	549	8	1%
44112	East Cleveland/Cleveland	517	510	7	1%
44110	Cleveland/East Cleveland	530	523	7	1%
44115	Cleveland	306	302	4	1%
44142	Brookpark/Cleveland	77	76	1	1%
44135	Cleveland/Linndale	234	231	3	1%
44107	Lakewood/Cleveland	320	316	4	1%
44136	Strongsville	81	80	1	1%
44134	Parma/Cleveland	84	83	1	1%
44129	Brooklyn/Parma/Cleveland	172	170	2	1%
44102	Cleveland/Brooklyn	622	615	7	1%
44111	Cleveland	321	318	3	1%
44105	Cleveland/NewburghHts/GarfieldHts	1,213	1,202	11	1%
44108	Cleveland/Bratenahl	704	699	5	1%
44125	Valley View/Garfield Hts	141	140	1	1%
44103	Cleveland	784	779	5	1%
44127	Cleveland	174	173	1	1%
44106	Cleveland/Cleveland Hts	363	361	2	1%
44109	Cleveland/Brooklyn Hts	378	376	2	1%
	*** Total Cuyahoga County**	**11,685**	**11,584**	**101**	**1%**
	*** Total Cleveland**	**6,822**	**6,764**	**58**	**1%**
	*** Total Suburbs**	**4,863**	**4,820**	**43**	**1%**

FCFH DATA NOTES

Met = service request resulting in referral to an organization. (Does not mean agency was able to provide the service.)
Unmet = service request for which there was no referral.

Note: Zip Codes shared by Cleveland and surrounding suburbs whose boundaries fall 50% and greater within the city of Cleveland are highlighted and totaled as Cleveland. Others are totaled as Suburbs.

* These totals do not reflect the sum of the numbers above which are the zip codes reflecting unmet need in 2004. Rather, they are the total of calls from ALL zip codes some of which do not appear on this table.

Attachment 9: Service Site Index

Core Service: Comprehensive Outpatient Substance Abuse Program LX-845.115

Service Site Index

Zip	Number of Sites*****	City/Town (% Cleveland)	Proportion of Minorities in Geographical Area	Total Population (#)*	Total Population 12+ (#)**	Estimated Persons in Need - Estimated Population 12+ with Chemical Dependency (#)***	Estimated Universe of Possible Consumers per Geographical Area (#)****	Number of Service SITES Serving Geographical Area (Per Agencies Reported Intended Service Area to First Call for Help)*****	Potential Service ACCESSIBILITY by Service Consumers per Geographical Area Ratio of CONSUMERS to Service SITES
Period				1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/2005	
TOTAL	39			1,393,978	1,160,037	85,510	17,102	39	439:1
Percent					83.2%	7.7%	20.0%		
44117		**Euclid/Cleveland**	**African Am 53.1%**	**12,078**	**10,564**	**818**	**164**	**39**	**4:1**
44105	**1**	**Cleveland/NewburghHts/ GarfieldHts**	**African Am 61.9%**	**54,834**	**43,067**	**3,337**	**667**	**39**	**17:1**
44106	**3**	**Cleveland/Cleveland Hts (60%)**	**African Am 62.2%**	**32,417**	**27,700**	**2,146**	**429**	**39**	**11:1**
44110		**Cleveland/East Cleveland (98%)**	**African Am 74.7%**	**26,536**	**20,769**	**1,609**	**322**	**39**	**8:1**
44120	**1**	**Shaker Hts/Cleveland**	**African Am 76.7%**	**47,349**	**38,006**	**2,945**	**589**	**39**	**15:1**
44103	**3**	**Cleveland (100%)**	**African Am 80.2%**	**25,348**	**19,990**	**1,549**	**310**	**39**	**8:1**
44108		**Cleveland/Bratenahl (90%)**	**African Am 94.9%**	**36,456**	**28,796**	**2,231**	**446**	**39**	**11:1**
44112	**2**	**East Cleveland/Cleveland**	**African Am 95.2%**	**33,222**	**26,225**	**2,032**	**406**	**39**	**10:1**
44128		**Warrensville Hts/Cleveland**	**African Am 95.8%**	**33,612**	**27,885**	**2,160**	**432**	**39**	**11:1**
44104	**1**	**Cleveland (100%)**	**African Am 97.5%**	**28,904**	**21,034**	**1,630**	**326**	**39**	**8:1**
44115	**7**	**Cleveland (100%)**	**African Am 98.4%**	**8,186**	**5,820**	**451**	**90**	**39**	**2:1**
44114	**2**	**Cleveland (100%)**	**Asian 20.3%**	**3,891**	**3,363**	**261**	**52**	**39**	**1:1**
44109	**1**	**Cleveland/Brooklyn Hts (98%)**	**Hispanic 20.3%**	**45,783**	**36,696**	**2,843**	**569**	**39**	**15:1**
44102	**1**	**Cleveland/Brooklyn (95%)**	**Hispanic 20.4%**	**52,108**	**41,318**	**3,201**	**640**	**39**	**16:1**
44113	**2**	**Cleveland (100%)**	**Hispanic 23.5%**	**19,466**	**16,205**	**1,256**	**251**	**39**	**6:1**
44017		Berea		19,005	16,606	1,287	257	39	7:1
44022		Bentleyville		17,720	9,438	731	146	39	4:1
44040		Gates Mills/Mayfield Village		2,883	2,483	192	38	39	1:1
44070		North Olmsted		34,081	28,950	2,243	449	39	12:1
44101		Cleveland (100%)		-	0	0	-	-	0
44107	1	Lakewood/Cleveland		56,710	48,957	3,793	759	39	19:1
44111		Cleveland (100%)		42,967	35,276	2,733	547	39	14:1
44116	1	Rocky River		21,122	18,105	1,403	281	39	7:1
44118	2	ClevelandHts/UniversityHts/ ShakerHts		45,279	37,910	2,937	587	39	15:1
44119		Cleveland/Euclid (50%)		13,493	11,512	892	178	39	5:1
44121		University Hts/South Euclid		35,185	29,460	2,283	457	39	12:1
44122	3	Beachwood/Highland Hills/ShakerHts		34,883	30,192	2,339	468	39	12:1
44123		Euclid		18,363	15,258	1,182	236	39	6:1
44124	1	Pepper Pike/MayfieldHts/Lyndhurst		40,334	35,461	2,747	549	39	14:1
44125		Valley View/Garfield Hts		29,876	25,301	1,960	392	39	10:1
44126		Fairview Park/Cleveland		17,196	14,798	1,147	229	39	6:1
44127		Cleveland (100%)		8,403	6,462	501	100	39	3:1
44129		Brooklyn/Parma/Cleveland		29,658	25,107	1,945	389	39	10:1
44130	3	Parma/Cleveland		53,615	46,873	3,632	726	39	19:1
44131	1	Independence/Seven Hills/BrooklynHts		20,666	18,189	1,409	282	39	7:1
44132		Euclid		15,322	12,783	990	198	39	5:1
44133		North Royalton		28,685	24,182	1,874	375	39	10:1
44134		Parma/Cleveland		40,396	34,516	2,674	535	39	14:1
44135		Cleveland/Linndale (90%)		28,561	23,656	1,833	367	39	9:1
44136		Strongsville		43,858	36,284	2,811	562	39	14:1
44137		Maple Hts/Cleveland		26,107	21,566	1,671	334	39	9:1
44138		Olmsted Twp/Olmsted Falls		18,046	15,223	1,179	236	39	6:1
44139		Bentleyville/Glenwillow/Solon		22,231	18,078	1,401	280	39	7:1
44140		Bay Village		16,076	13,378	1,037	207	39	5:1
44141	1	Brecksville		13,676	11,461	888	178	39	5:1
44142		Brookpark/Cleveland		21,132	18,110	1,403	281	39	7:1
44143		Highland Hts/Richmond Heights		23,730	20,302	1,573	315	39	8:1
44144		Brooklyn/Cleveland		21,805	18,710	1,450	290	39	7:1
44145	1	Westlake		31,972	27,407	2,123	425	39	11:1
44146		Walton Hills/Oakwood/Bedford		31,648	27,316	2,116	423	39	11:1
44147		Broadview Hts		15,954	13,289	1,030	206	39	5:1

* U.S. Census 2000, SF1 (P1)

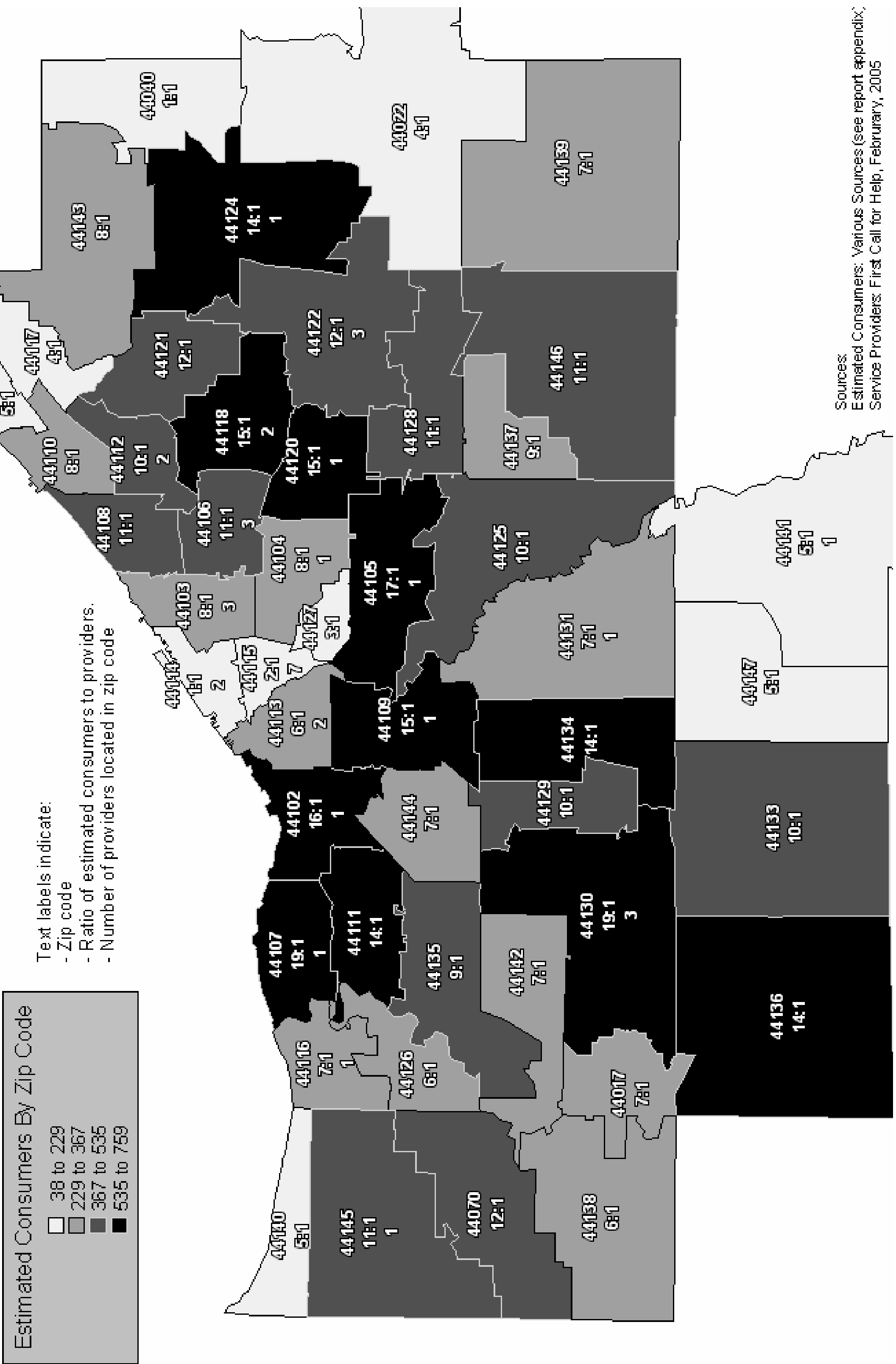
** U.S. Census 2000, SF3 (P8)

*** The Cuyahoga County Alcohol and Drug Addiction Services Board estimates that 77,813 persons in addition to the 7,697 served in 2004 needed outpatient substance abuse treatment. Thus, totalingthese numbers, the estimated number of persons in need in Cuyahoga County is 85,510 in 2004, or 7.748%. Estimates for all zip codes were estimated at 7.748% of Population Age 12+.

**** The estimated universe of possible consumers in 2004 was 17,102 (the estimated number of actual consumers in 2004, 7,697, plus the estimated number of would-be users, 9,405), or 20.0% of the 85,510 estimated persons in need in 2004. The 20.0% rate has been applied to County and all zip codes. It is ADASBCC's estimate of those consumers in need who actually would use service if available.

***** United Way First Call for Help Call Data, February 2005

Attachment 10: Map



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