

Consumer Group Snapshot

Persons With or at Risk of Chemical Dependency, Including Dual Diagnosed

Consumer Category:
Behavioral Health Conditions



February 2007

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<p>DEFINITION</p>	<p>According to The Ohio State University Medical Center, there are three different terms used to define substance-related disorders, including the following:¹</p> <ul style="list-style-type: none"> • <i>Substance abuse</i> is used to describe a pattern of substance, or drug, use leading to significant problems or distress such as failure to attend work/school, substance use in dangerous situations such as driving a car, substance-related legal problems, or continued substance use that interferes with relationships with family and friends. The disorder of substance abuse refers to the abuse of illegal substances or the abusive use of legal substances. Alcohol is the most commonly abused legal drug. • <i>Substance dependence</i> is used to describe a continued use of drugs or alcohol. This includes using when significant problems related to their use have developed. Hallmarks of dependence include an increased tolerance of substances or the need to use increasing amounts of the substance to attain the desired effect, symptoms of withdrawal when use is decreased, unsuccessful efforts to decrease use, an increase in time spent in activities to obtain substances, withdrawal from recreational and/or activities, and continued use of substance even with the awareness of physical or psychological problems experienced with substance use. • <i>Chemical dependence</i> is used to describe the compulsive use of chemicals or substances (drugs or alcohol) and the inability to discontinue usage despite all the problems caused by their use.
<p>THE CONSUMERS</p>	<p>See Attachment 1: Family of Services & Attachment 2: Consumer Matrix</p>
<p><i>Stage One:</i> At Risk (Estimated Number/ Percent County Population)</p>	<p>Used illicit drugs (a) used marijuana/hashish daily in past year; (b) used an illicit drug other than marijuana at least 52 times in past year (drugs include inhalants, hallucinogens, cocaine, or non-medical use of prescription-type stimulants, pain relievers, sedatives, or tranquilizers); (c) used heroin in any form or injected cocaine or stimulants at least once in the past year; and (d) had 5 or more drinks on 5 or more separate occasions in the past month.² No estimates for Cuyahoga County are available.</p>
<p><i>Stage Two:</i> In Crisis (Estimated Number/ Percent County Population)</p>	<p>Individuals in crisis are those who are substance dependent and meet the criteria for alcohol or drug dependence in the past year as defined in the 4th edition of the <i>Diagnostic and Statistical Manual of Mental Disorders</i> (DSM-IV, American Psychiatric Association, 1994)</p> <p>There are an estimated 85,510 persons 12 years and older in 2000,³ or 6.3 percent of the</p>

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county population who are substance dependent. Note that substance dependence is multigenerational.

Co-occurrence of serious mental illness (SMI) and substance abuse disorders:

- Among adults with SMI in 2003, 21.3 percent were dependent on or abused alcohol or illicit drugs.
- Among adults with substance dependence or abuse, 21.6 percent had SMI.⁴

Stage Three: Recently Stabilized (Estimated Number/ Percent County Population)

Those who received any type of treatment for a substance use problem in the past year.

7,697 unduplicated persons treated by Alcohol and Drug Addiction Services Board (ADASB) for comprehensive outpatient and 1,184 for residential substance abuse treatment in Cuyahoga County, CY 2004. Total is 8,881, 0.6 percent county population. Many others would have received treatment through private insurance or other systems.

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Age by Generation

Substance dependence and abuse crosses generations; however, 18-22 are peak ages.

Illicit Drug or Alcohol Dependence in Past Year

Age	Percent
12	0.6
13	1.5
14	3.2
15	4.5
16	6.7
17	9.3
18	10.5
19	11.3
20	12.5
21	14.8
22	12.7
23	9.3
24	8.5
25	8.4
26-29	8.3
30-34	5.8
35-39	5.2
40-44	5.9
45-49	4.3
50-54	3.1
55-59	2.4
60-64	0.9
65 and older	0.9

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004.

In 2003, there were nearly 1.7 million admissions to publicly funded substance abuse treatment programs. Most individuals admitted for treatment were 21-45. Below are the percentages by age of admissions. Most were 21 to 45 years.

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Percentage of Admissions by Age Group

Age	Percent
11 or younger	0.2
12 – 17	8.5
18 – 20	6.5
21 – 25	13.3
26 – 30	11.3
31 – 35	13.6
36 – 40	15.6
41 – 45	14.2
46 – 50	9
51 – 55	4.5
56 – 60	1.8
61 – 65	0.7
66 or older	0.5
unknown age	0.2

Source: National Institute on Drug Abuse. (2005). NIDA InfoFacts: Treatment Trends. Retrieved March 30, 2007 from <http://www.nida.nih.gov/PDF/InfoFacts/TreatmentTrends05.pdf>

Risk Factors

Substance abuse and chemical dependency is caused by multiple factors, however, it has not been determined which are primary and which secondary:⁵

- Genetic vulnerability;
- Environmental stressors;
- Social pressures;
- Individual personality traits; and
- Psychiatric problems.

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The following are risk factors among children and adolescents per National Institute on Drug Abuse (2003). (These increase a person's chances for drug abuse; however, most do not start using drugs or become addicted.)⁶

RISK FACTORS	DOMAIN WHERE INTERVENTIONS CAN TAKE PLACE	PROTECTIVE FACTORS
Early aggressive behavior	Individual	Self-Control
Lack of parental supervision	Family	Parental monitoring
Lack of attachment and nurturing by parents or caregivers	Family	Strong bond between children & parents
Ineffective parenting	Family	Parental involvement in the child's life; clear limits and consistent enforcement of discipline
Caregiver who abuses drugs	Family	
Maltreated youth; involvement in child welfare system	Family	
Academic failure	School	Academic competence
Poor classroom behavior or social skills	School	
Drug availability	School	Anti-drug use policies
Association with drug-abusing peers	Peer	
Poverty	Community	Strong neighborhood attachment

Historic Trend Line

No change in number of persons with substance dependence or abuse 2002 to 2003.⁷ No long-term trends are available because of methodology changes in the SAMSHA survey instrument.

Influencing Factors Underlying Historic Trend Line (+/-)

N/A

Life Trajectory

Excessive use of drugs ⇒ Recovery (fewer hospitalizations; minimal institutional care; improved medication management and increased compliance; increased proficiency in coping)

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	and social skills; Reduced criminal activity; longer periods of abstinence and fewer relapses) ⇒ Gainful employment; more stable life situations
Consumer Impact Strategy	Population will be drug and alcohol free. ⁸
Future Projection	Anticipate unprecedented level of substance-related health problems among baby boomers because of the size of the cohort and their relatively higher use relative to earlier cohorts. ⁹
THE SAFETY NET: Which of the 80 safety net core services are needed to empower consumers to positively alter their life trajectory?	
<i>Stage One:</i> At Risk	Primary Service <ul style="list-style-type: none"> • Substance Abuse Education/Prevention Supportive Services <ul style="list-style-type: none"> • General Counseling Services (Outpatient Mental Health Facilities)
<i>Stage Two:</i> In Crisis	Primary Services <ul style="list-style-type: none"> • Comprehensive Outpatient Substance Abuse Treatment • Residential Substance Abuse Treatment Supportive Services <ul style="list-style-type: none"> • Case Management (for multiple diagnosed) • Child Care, for parents while in treatment • Children’s Residential Treatment • Employment Preparation • Family Support Centers • General Counseling Services (Outpatient Mental Health Facilities) • Parenting Education • Vocational Rehabilitation
<i>Stage Three:</i> Recently Stabilized	Those who have received treatment for chemical dependency.
Intended or Unintended Philosophy Underlying Service Delivery (i.e., assumptions about what will work)	<ul style="list-style-type: none"> • <i>Historic philosophy:</i> Segregated system of care: health care, substance abuse system, mental health treatment, social services¹⁰ • <i>Current philosophy:</i> a multidimensional model that lasts a considerable length of time and is intense in its application, according to Francuch (1999).¹¹ This means that no drug

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and alcohol treatment programs should adopt a one-sided approach based on one preferred modality. Major models include:

- Residential treatment model, drug-free social sub-model or medical sub-model;
- Day treatment model, drug-free or medical approaches;
- Outpatient drug-free model (By definition, this model never contains within its frame any medical approach.);
- Medical outpatient model, e.g. methadone clinics;
- Self-help group model, e.g. AA, NA, etc.;
- Dual-diagnosed: needs to combine all available methodologies of treatment developed by mental health professionals with all available treatment methodologies developed by substance abuse treatment professional sin all their forms and conditions.

- *Current philosophy—Addressing Dual Diagnosis:* The President’s New Commission on Mental Health, established in 2002 by President Bush to conduct a comprehensive study of the U.S. mental health service delivery system and making recommendations based on its findings, has as one of its primary recommendations screening for co-occurring mental and substance use disorders and linking them with integrated treatment strategies. Per the report:

“The Commission supports implementing systematic screening procedures to identify mental health and substance use problems and treatment needs in all settings in which children, youth, adults, or older adults are at high risk for mental illnesses or in settings in which a high occurrence of co-occurring mental and substance use disorders exists. In addition to specialty mental health and substance abuse treatment settings, screening for co-occurring disorders should be implemented when an individual enters the juvenile or criminal justice systems, child welfare system, homeless shelters, hospitals, senior housing, long-term care facilities, nursing homes, and other settings where populations are at high risk. Screening should also occur periodically after an individual enters any of these facilities.

“When mental health problems are identified, children, youth, adults, and older adults should be linked with appropriate services, supports, or diversion programs. Additionally,

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given the high incidence of substance use disorders among parents of children in the child welfare system, where indicated, these parents should be screened for co-occurring disorders and linked with appropriate treatment and supports.

“The Commission supports coordinated and, where appropriate, integrated mental health and substance abuse screening, assessment, early intervention, and treatment for co-occurring disorders in all Federally funded adult and child health and human services, criminal and juvenile justice programs, and veteran's services. Health and mental health training programs that receive HHS (Department of Health and Human Services) funding should include co-occurring disorders in curriculum design and training experiences.

“The Center for Medicare and Medicaid Services (CMS) should be encouraged to develop and implement policy guidance to promote access and use of covered services by Medicaid and Medicare beneficiaries with co-occurring mental and substance use disorders.”¹²

What Works?

Prevention:

- Most prevention efforts are directed toward young people
- Interventions based on teaching *refusal skills* have showed promise as a substance abuse prevention strategy (Botvin & Botvin, 1992). Reductions are short-term; however, there is considerable value in preventing drug abuse for time periods up to three years.¹³
- *Competency enhancement* approaches are more comprehensive than the strategies discussed so far. These prevention programs teach specific psychosocial skills directly related to substance use and are also applicable to other problem behaviors common in young people.¹⁴
- A review by Brounstein et al. (1998) presented general guidelines, based on evaluation research that should be considered in the design of prevention programs. These include: a) the dosage effect; generally, the more programming is provided, the larger the beneficial effects on participants, although this pattern levels off at very high doses; b) targeting middle school students; and c) avoiding scare tactics and a judgmental, lecturing tone.¹⁵

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	<p><i>Treatment:</i></p> <ul style="list-style-type: none"> • Research has shown that comprehensive and sustained substance abuse treatment:¹⁶ <ul style="list-style-type: none"> ○ Can help individuals reduce or stop using illegal or dangerous drugs, thereby greatly improving their functioning in the family, at work, and in society; and ○ Is as effective as the treatments for other chronic conditions, including diabetes and asthma. • Research has demonstrated that a variety of effective approaches to substance abuse treatment exist that can help people achieve long-term control. • Extensive experience has revealed a number of issues that are key to successful substance abuse treatment: <ul style="list-style-type: none"> ○ Treatment should be readily available to individuals who need it. ○ Individuals need to be engaged in treatment of an adequate length of time. For example, participation in outpatient or residential programs for less than 90 days is of limited or no effectiveness. Patients should receive a minimum of 12 months of methadone maintenance treatment. ○ “Recovery” from drug addiction is a dynamic process that requires a person to decide to “stay sober” one day at a time. Recovery is a long-term effort, often requiring multiple episodes of treatment. ○ Addiction often occurs simultaneously with other physical or mental health problems. The treatment plan must take those into consideration. ○ Treatment programs work better if they are tailored to the person’s characteristics and needs. No single type of treatment is appropriate for everyone. ○ Treatment must be reassessed periodically so it can be adjusted as needed. • Overall, treatment of alcohol addiction seems to be somewhat effective. A meta-analysis by Agosti (1995) found that these interventions are frequently effective at reducing alcohol consumption but not at enabling clients to achieve permanent, complete abstinence.¹⁷ 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.¹⁸
<p>What Doesn't Work</p>	<p><i>Prevention:</i></p> <ul style="list-style-type: none"> • School-based programs consisting entirely of information dissemination are completely ineffective at preventing drug and alcohol use in youth although they may increase

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knowledge.¹⁹

- “Interventions based on *affective education* include efforts to help youth express their feelings, strengthen their self-esteem, and clarify their values, with the rationale being that positive change in emotional functioning reduces the likelihood of substance use. Tobler’s (1992) meta-analysis found that these interventions are ineffective, producing no effects on knowledge, attitudes, values, or self-reported drug use.”²⁰
- “The most widely used drug prevention program in the U.S. is Drug Abuse Resistance Education (DARE), which is delivered by police officers who visit school classrooms, was found to be less effective than more interactive prevention programs in its effects on drug knowledge, drug attitudes, and drug use” (Ennett, Tobler, Ringwalt, & Flewelling, 1994).²¹ The D.A.R.E. curriculum is designed to be delivered sequentially from grades K-12. First developed in 1983, D.A.R.E. has undergone multiple revisions as research findings increased knowledge of effective substance abuse prevention among school-aged youth.

Although research does not support DARE program effectiveness, a large proportion of public schools still receive DARE funding although the Department of Education took the program off its approved list in 2001.²² “Nonetheless, every year, U.S. schools pour millions of dollars into substance-abuse education that has not been shown to be effective—\$750 million to \$1 billion alone for DARE, or Drug Abuse Resistance Education, by far the nation's largest school-based drug-prevention program, but one that is not on federally approved lists. The 16-week curriculum brings local police officers into classrooms to give lessons and share off-the-street experiences, driving home the point that drug use is wrong. Under the No Child Left Behind Act of 2001, which includes a component known as Safe and Drug-Free Schools, every public school is supposed to provide some kind of drug-prevention education. If the schools use federal funds for such efforts, they must use programs on the government's lists of those with ‘demonstrated effectiveness.’ Schools may use programs not on the list if they use local funds, which many choose to do.”

The revamped/updated DARE curriculum, still being funded by both Department of Justice and Department of Education, may be at risk for significant reductions over the next several years.

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- The few programs shown to be successful are often not the ones used in schools according to a recent study from North Carolina University (2002).²³ “Despite an abundance of evaluative evidence concerning the effectiveness of several school-based substance use prevention curricula, many of the nation’s middle schools continue to implement curricula that are either untested or ineffective.” Data was collected in 1999 from a representative sample of 1,905 of the nations’s public and private schools that include middle school grades. They found that although 82 percent of schools used some kind of program, only 35 percent of public schools and 13 percent of private schools were using one that researchers had found effective.

Treatment:

- Behavioral, psycho-educational therapies reduce cocaine abuse to a significant, but small, degree, with many treatment failures²⁴

Community-wide Strategies to Impact Life Trajectories

Ten drug and alcohol policies that will save lives, according to the Boston University School of Public Health. (n.d.):²⁵

“Preventing Underage Drinking:

1. Increase alcohol prices through taxes, particularly on beer.
2. Limit alcohol advertising & promotional activities that target young people.
3. Adopt laws that will prevent alcohol-related deaths & injuries among young people.

“Treating Addiction:

4. Require and enforce equal insurance coverage for drug and alcohol treatment.
5. Support the development & use of effective medications for addiction treatment.
6. Make screening for alcohol and drug problems a routine part of every primary care & emergency room visit.
7. Give higher payments to providers who get better results.

“Reducing & Preventing Crime:

8. Require effective treatment & continuing supervised after care programs instead of incarceration for non-violent drug & alcohol offenders.
9. Reveal policies that prevent ex-offenders from returning to full participation in society.
10. Support the work of community coalitions.”

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First Call for Help

Between 2000 and 2004, there were 29,283 requests for services for those with or at risk of chemical dependency. Of these, 245 (1 percent) were unmet, meaning that there was no agency to which to refer callers. See Attachment 3: First Call for Help for more detail.

RESOURCES

Identified Resources (2003-04)

Identified Chemically Dependent Revenues		
As of 5/11/06		
	Community	UW*
Comprehensive Outpatient SA Treatment	\$4,001,759	334,839
Residential SA Treatment	1,949,54	30,228
SA Education/Prevention	16,804,040	92,606
Total	\$20,805,799	457,673

* UW revenues are included in community totals.

NOTE: This does not include all monies for this consumer group. See Attachment 4 for details and Attachment 5 for Revenue Checklist. Note that \$12.5 million for SA Education/Prevention is from the Department of Education and \$1.3 million is from the Department of Justice Affairs.

Government Resource Trend Line (2002-2004)

Variable pattern across the years

Future Direction of Government Funding

- ↓
- The president’s proposed budget for FY 2007 proposes legislative changes in Medicaid that would reduce federal Medicaid funding by \$4.9 billion over the next five years, of which \$2.9 billion would be achieved by shifting costs to states. Some increases will offset some of the cuts to states. The net of the proposed legislative change is a cut of \$1.5 billion. The regulatory changes would reduce federal funding by an additional \$12.2 billion over 5 years.²⁶
 - Funding levels in the president’s proposed budget for FY 2007 support the 3 key priorities of the *National Drug Control Strategy*. In total, recommended funding for FY 2007 is \$12.7 billion, an increase of \$109.1 million (+1 percent) over the FY 2006 enacted level of \$12.5 billion.²⁷ However, funding for Department of Education and Department of Health and Human Services for drug control funding has been reduced. Priorities:
 - “Priority 1 – Stopping Use Before it Starts: Education and Community Action – support

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for effective programs to help communities obtain a drug-free environment and encourage young people to reject drug use. Select recommendations are:

- ◆ “Dept of Education: Student Drug Testing: increased ; Safe and Drug-Free Schools State Grant Program, no funding; it was rated as ‘Ineffective’ by the PART (Program Assessment Rating Tool) due to the program’s inability to demonstrate effectiveness and the fact that grant funds are spread too thinly to support quality interventions. Requests money for a new program which will provide grants to Local Educational Agencies for Research-Based Assistance for drug prevention and school safety programs to carry out evidence-based best practice or test a promising program.
- “Priority 2 – Intervening and Healing America’s Drug Users – continues to focus on ensuring that treatment is available for those who need it. This budget expands access and choice to a wider array of innovative treatment options including those services offered by faith-based organizations. Select recommendations are:
 - ◆ “Substance Abuse and Mental Health Services Administration – Expanding Choice: incentives to encourage states to provide a wider array of innovative treatment options to those in need of recovery by voluntarily using their Substance Abuse Block Grant funds for drug treatment vouchers, also to including faith based entities.
 - ◆ “Office of Justice Programs – Drug Court Program – Increased funding to provide alternatives to incarceration by using the coercive power of the court to force abstinence and alter behavior with a combination of escalating sanctions, mandatory drug testing, treatment, and strong aftercare program.”
- “Priority 3 – Disrupting the Market – targets individuals and organizations profiting from trafficking in illegal drugs.”

The president’s budget also does not include funding for the Safe and Drug-Free Schools State Grant Program, which was rated as “Ineffective” due to the program’s inability to demonstrate effectiveness and the fact that grant funds are spread too thinly to support quality interventions. Funding for prevention programs are also threatened at the state level.

Return on Investment

During the past two decades, five major studies have estimated the economic costs of alcohol abuse in the United States by using the "cost of illness" approach, which expresses the multidimensional impact of a health problem in dollars. The most recent estimate of the

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overall economic cost of alcohol abuse was \$185 billion for 1998, which is a projection based on the comprehensive cost estimate of \$148 billion for 1992.

More than 70 percent of the estimated costs of alcohol abuse for 1998 were attributed to lost productivity (\$134.2 billion), including losses from alcohol-related illness (\$87.6 billion), premature death (\$36.5 billion), and crime (\$10.1 billion). The remaining estimated costs included health care expenditures (\$26.3 billion, or 14.3 percent of the total), such as the costs of treating alcohol abuse and dependence (\$7.5 billion) and the costs of treating the adverse medical consequences of alcohol consumption (\$18.9 billion); as well as property and administrative costs of alcohol-related motor vehicle crashes (\$15.7 billion, or 8.5 percent); and criminal justice system costs of alcohol-related crime (\$6.3 billion, or 3.4 percent).²⁸

In 2002, the economic cost of drug abuse was estimated to be \$180.9 billion.²⁹ These costs included:

- lost productivity of victims and incarcerated perpetrators of drug- related crime;
- lost legitimate production due to drug-related crime careers;
- other costs of drug-related crime, including Federal drug traffic control, property damage, and police, legal, and corrections services;
- premature deaths;
- lost productivity due to drug-related illness; and
- health care expenditures.

In 2000, Americans spent about \$36 billion on cocaine, \$10 billion on heroin, \$5.4 billion on methamphetamine, \$11 billion on marijuana, and \$2.4 billion on other substances.³⁰

\$11 is saved for every dollar spent on drug treatment because health care costs associated with abuse are cut in half.³¹

Per the “Domestic Policy for a More Perfect Union” recommendation from Rand: “Pursue a drug control strategy that emphasizes treatment and conventional sentences over foreign interdiction and eradication.”³²

- “Research has shown that, given current budget allocations, the most cost-effective way

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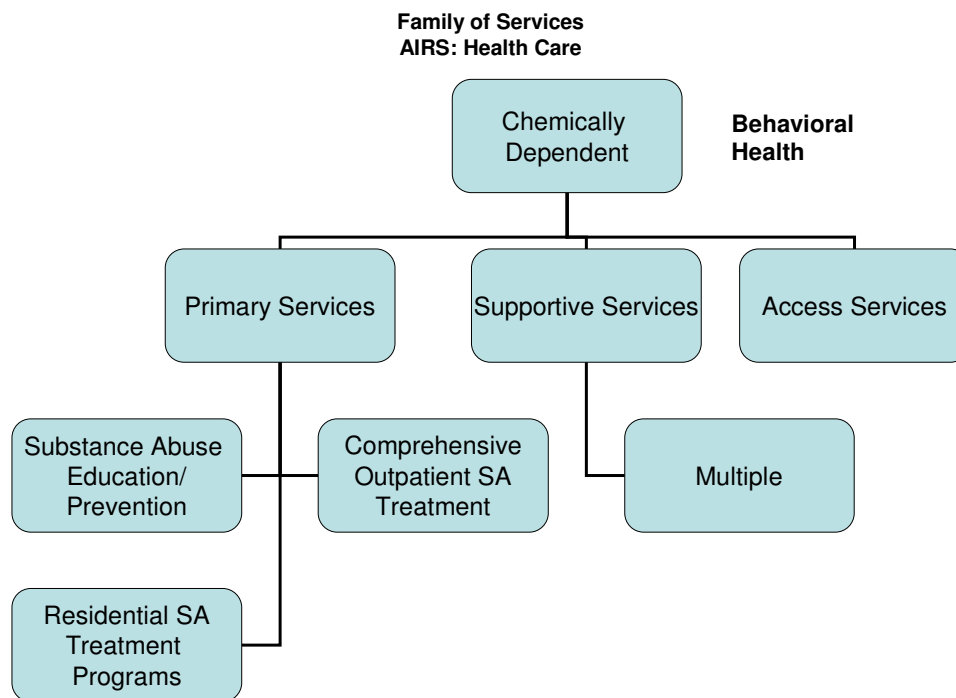
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to reduce cocaine consumption in the United States is to spend more money on domestic drug treatment programs. Each additional million dollars spent on treatment results in a reduction of cocaine consumption - nationwide - by a net present value of more than 100 kilograms.

- “The second most cost-effective strategy is to impose conventional sentences (not mandatory minimums) on high-level drug dealers prosecuted at the federal level.
- “At the other end of the spectrum, two of the least promising strategies include the interdiction of cocaine en route from source countries and the eradication and seizure of cocaine products abroad using traditional tactics. For each additional million dollars spent, traditional tactics of foreign eradication and seizure would reduce cocaine consumption in the United States by a net present value of only 10 kilograms--just one-tenth the amount reduced by domestic treatment programs.
- “Newer tactics of foreign eradication and seizure are being employed in source and transit zones, and it remains to be seen whether these tactics are much better, but the past record gives cause for some skepticism.
- “Meanwhile, model school-based drug prevention programs can play a role in managing the drug problem, but they cannot by themselves solve the problem.”

ATTACHMENTS

Attachment 1: Family of Services



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Attachment 2 Consumer Matrix

CORE SERVICES	SUB-CONSUMER GROUPS	ESTIMATED PERSONS IN NEED			ESTIMATED UNIVERSE OF POSSIBLE CONSUMERS		
		Description	Number	% of Total Population Families Households	Description	Number	% of Total Population Families Households
Comprehensive Outpatient Substance Abuse Treatment	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 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%.	85,510	6.1% Population	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.	17,102	1.2% Population
Residential Substance Abuse Treatment Programs	Chemically dependent persons 12 and older who require the intensity of an alcohol or drug free day treatment program or twenty-four hour hospital care.	The Cuyahoga County Alcohol and Drug Addiction Services Board estimates that 11,992 persons in addition to the 1,184 served in 2004 needed substance abuse treatment. Thus, totaling these numbers, the estimated number of persons in need in Cuyahoga County is 13,176 in 2004.	13,176	0.9% Population	The Cuyahoga County Alcohol and Drug Addiction Services Board (ADASBCC) estimates that 11,992 persons in addition to the 1,184 served in 2004 needed substance abuse treatment. Thus, totaling these numbers, the estimated number of persons in need in Cuyahoga County is 13,176. ADASBCC also estimates that only 20 percent of those in need actually use the services. This equals 2,636, the estimated universe of possible consumers.	2,635	0.2% Population

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Attachment 2: Consumer Matrix (continued)

CORE SERVICES	SUB-CONSUMER GROUPS	ESTIMATED PERSONS IN NEED			ESTIMATED UNIVERSE OF POSSIBLE CONSUMERS		
		Description	Number	% of Total Population Families Households	Description	Number	% of Total Population Families Households
Substance Abuse Education/ Prevention	Persons ages 5 to 24 years because they are in the most formative and vulnerable years	U.S. Census 2000, SF1 (P1) This report assumes that all persons 5 years and older in Cuyahoga County are in need of substance abuse education/prevention services. However, it strategically targets those ages 5-24 years because they are in the most vulnerable years and because, according to the NSDUH (2004), the highest prevalence of binge and heavy drinking in 2004 was for young adults aged 18 to 25 with the peak rate at age 21. (Note: age 24 was used as the cut-off because of availability of census data.)	366,918	26.3% Population	Estimated universe of possible consumers is the same as estimated persons in need.	366,918	26.3% Population

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Attachment 3: First Call for Help

Persons with or at risk of chemical dependency, including dual diagnosed											
CORE SERVICES	TOTAL REQUESTS					%Change*	MET				
	2000	2001	2002	2003	2004		2000	2001	2002	2003	2004
Comprehensive Outpatient Substance Abuse Treatment	2,141	2,688	2,764	2,129	1,963	(8%)	2,130	2,662	2,735	2,112	1,945
Residential Substance Abuse Treatment Programs	538	746	1,096	1,093	1,175	118%	534	744	1,091	1,090	1,164
Substance Abuse Education/Prevention	39	35	47	43	41	5%	39	35	46	40	41
Total	2,718	3,469	3,907	3,265	3,179	17%	2,703	3,441	3,872	3,242	3,150

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CORE SERVICES	UNMET					TOTALS 00-04			%
	2000	2001	2002	2003	2004	Req.	Met	Unm.	Unmet
Comprehensive Outpatient Substance Abuse Treatment	11	26	29	17	18	24,430	24,214	216	1%
Residential Substance Abuse Treatment Programs	4	2	5	3	11	4,648	4,623	25	1%
Substance Abuse Education/Prevention	0	0	1	3	0	205	201	4	2%
Total	15	28	35	23	29	29,283	29,038	245	1%

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Attachment 4: Revenue Tables

Comprehensive Outpatient Substance Abuse Treatment Revenues Identified as of May 11, 2006					
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 - UWGrCie Support		3,666,920	91.63%	1,732,152	83.80%

Consumer Group Snapshot

Attachment 4: Revenue Tables (continued)

Comprehensive Outpatient Substance Abuse Treatment					
Revenues Identified as of May 11, 2006					
Funder	Period	A		B	
		Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
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 Treatment Programs, Substance Abuse Education and Prevention.

Consumer Group Snapshot

Attachment 4: Revenue Tables (continued)

Residential Substance Abuse Treatment					
Revenues as of May 11, 2006					
Funder	Period	A		B	
		Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Total - Contributions and dues (less UW designations)			0.00%	132,412	2.02%
Abington Foundation, The		40,000			
Bruening Foundation, Eva L. and Joseph M.		75,000		75,000	
Cleveland Foundation, The		95,000		103,191	
Mt. Sinai Health Care Foundation, The				25,000	
Saint Luke's Foundation				50,000	
Woodruff Foundation, The		9,000			
Total - Foundations & Trusts		219,000	11.23%	253,191	3.87%
Total - Special Events - Growth			0.00%	61,005	0.93%
United Black Fund of Greater Cleveland				8,000	
Total - Federated Fundraising Organizations		0	0.00%	8,000	0.12%
Department of Alcohol and Drug Addiction Services				627,774	
Department of Youth Services				78,958	
State Department of Education				31,306	
Subtotal State of Ohio		0	0.00%	738,038	11.28%
Board of Alcohol & Drug Addiction Services (410 Board)	2004	1,500,318		2,876,971	
Cuyahoga Metropolitan Housing Authority (CMHA)				14,600	
Department of Children and Family Services				107,698	
Subtotal Cuyahoga County Funding Sources		1,500,318	76.96%	2,999,269	45.82%
Other City of Cleveland Funders - Not Elsewhere Classified				9,100	
Subtotal City of Cleveland Funding Sources		0	0.00%	9,100	0.14%
Medicaid *				364,097	
Other Private Insurer				316,159	
Other Third Party Billing				7,925	
Subtotal Third Party Payee/Direct Bill		0	0.00%	688,181	10.51%
All Other Funding - Not Elsewhere Classified				558,130	

Consumer Group Snapshot

Attachment 4: Revenue Tables (continued)

Residential Substance Abuse Treatment					
Revenues as of May 11, 2006					
Funder	Period	A		B	
		Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Subtotal Other Govt Funding Sources		0	0.00%	558,130	8.53%
Total - Contracts/grants from government organizations		1,500,318	76.96%	4,992,718	76.28%
Private Pay/Fee for Service				684,360	
Total - Program Service Fees		0	0.00%	684,360	10.46%
Total - Investment Income			0.00%	95,537	1.46%
Total - All Other Revenue			0.00%	87,610	1.34%
Subtotal Non - UWGrCle Support		1,719,318	88.19%	6,314,833	96.48%
Total - UWGrCle designations applied to program		17,694	0.91%	17,694	0.27%
Total - UWGrCle investment committee allocation		212,534	10.90%	212,534	3.25%
Subtotal UWGrCle Support - 4001, 4701 & 4703		230,228	11.81%	230,228	3.52%
Total Support/Revenue		1,949,546	100%	6,545,061	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 Treatment Programs, Substance Abuse Education and Prevention.

Consumer Group Snapshot

Attachment 4: Revenue Tables (continued)

Substance Abuse Education/Prevention					
Revenues as of May 11, 2006					
Funder	Period	A		B	
		Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Total - Contributions and dues (less UW designations)			0.00%	2,601	0.24%
Bruening Foundation, Eva L. and Joseph M.		25,000			
Saint Ann Foundation		25,000			
Woodruff Foundation, The		69,900			
Total - Foundations & Trusts		119,900	0.71%	0	0.00%
State Department of Education	2004	12,594,085			
Other State Funders - Not Elsewhere Classified				32,000	
Subtotal State of Ohio		12,594,085	74.95%	32,000	2.90%
Board of Alcohol & Drug Addiction Services (410 Board)	2004	2,222,304		781,822	
Community Services Block Grant Program				39,999	
County Commissioners	2004	15,000			
Department of Children and Family Services	2004	85,000			
Justice Affairs	2004	1,338,691			
Juvenile Court	2004	336,454			
Subtotal Cuyahoga County Funding Sources		3,997,449	23.79%	821,821	74.60%
Other Board of Education				27,422	
All Other Funding - Not Elsewhere Classified				74,328	
Subtotal Other Govt Funding Sources		0	0.00%	101,750	9.24%
Total - Contracts/grants from government organizations		16,591,534	98.74%	955,571	86.74%
Total - Investment Income			0.00%	50,762	4.61%
Total - All Other Revenue			0.00%	112	0.01%

Consumer Group Snapshot

Attachment 4: Revenue Tables (continued)

Substance Abuse Education/Prevention					
Revenues as of May 11, 2006					
Funder	Period	A		B	
		Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Subtotal Non - UWGrCle Support		16,711,434	99.45%	1,009,046	91.59%
Total - UWGrCle designations applied to program		4,206	0.03%	4,206	0.38%
Total - UWGrCle investment committee allocation		88,400	0.53%	88,400	8.02%
Subtotal UWGrCle Support - 4001, 4701 & 4703		92,606	0.55%	92,606	8.41%
Total Support/Revenue		16,804,040	100%	1,101,652	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 Treatment, and Substance Abuse Education and Prevention.

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Attachment 5: Revenue Checklist

Persons w/or at risk of chemical depend. incl. dual diagnosis							
Category	Administrator of Funding		Comprehensive Outpatient Substance Abuse Treatment	Residential Substance Abuse Treatment Programs	Substance Abuse Education/Prevention		
Private Foundation	Abington Foundation, The		✓				
Private Foundation	Bruening Foundation, Eva L. and Joseph M.		✓	✓			
Private Foundation	Cleveland Foundation, The		✓				
Private Foundation	Reuter Foundation, The	✓					
Private Foundation	Saint Ann Foundation			✓			
Private Foundation	Woodruff Foundation, The	✓	✓	✓			
State of Ohio	Department of Education			✓			
Cuyahoga County	Alcohol & Drug Addiction Services Board	✓	✓	✓			
Cuyahoga County	County Commissioners			✓			
Cuyahoga County	Cuyahoga Metropolitan Housing Authority (CMHA)	✓					
Cuyahoga County	Department of Children and Family Services			✓			
Cuyahoga County	Department of Justice Affairs	✓		✓			
Cuyahoga County	HIV Services Planning Council Ryan White Title I	✓					
Cuyahoga County	Juvenile Court	✓		✓			
3rd Party Payee/Direct Bill	Medicaid	x	x	x			
United Way Greater Cleve	AIDS Funding Collaborative	✓					
United Way Greater Cleve	United Way of Greater Cleveland designations applied to program	✓	✓	✓			
United Way Greater Cleve	United Way of Greater Cleveland investment committee allocation	✓	✓	✓			
✓ = Revenue was identified specifically for this core service and the amount allocated in Cuyahoga County appears in the revenue table of the core service report.							
x = Revenue was identified from these sources, but no dollar amount is available because either it was not possible to obtain data for Cuyahoga County alone, or it was not possible to obtain data specifically for this core service because funding covers multiple core services.							

NOTES

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