

Core Service Report

Residential Substance Abuse Treatment Programs

Consumer Category:
Behavioral Health Conditions

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



February 2007

TABLE OF CONTENTS

Companion Reports	ii
Acknowledgements	ii
Snapshot	iii
I. Foreword	1
Introduction	1
Methodology	1
II. The Core Service Environment	3
Core Service Environment.....	3
Public Policy Issues	5
III. The Core Service Consumers	8
Definition Of Target Population.....	8
Demographic Characteristics.....	8
Realized Access To Service	14
IV. Core Service Delivery	15
Core Service Definition	15
Background On Core Service	15
Funding Of Core Services.....	19
Identified Revenues	23
Reimbursement/Cost	24
V. What Works; What Doesn't	25
Impact On Individuals/Families	25
Impact On Community	26
Accreditations/Standards/Certifications	27
VI. Gap Analysis	28
VII. Summary	31
References	32
Attachments	35
Attachment 1: Researcher List	35
Attachment 2: Technical Notes	36
Attachment 3: Actual Consumer Demographics.....	44
Attachment 4: Actual Consumer Zip Codes.....	46
Attachment 5: Profile Of Core Service Providers – 2005	48
Attachment 6: Providers And Functions – 2005	50
Attachment 7: United Way - First Call For Help Requests – 2000-2004	51
Attachment 8: United Way - First Call For Help Requests 2000-2004: Unmet Need.....	52
Attachment 9: Service Site Index.....	53
Attachment 10: Map.....	54

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

We are grateful to the multiple public and private funders, provider agencies, experts in the various fields of interest, and staff of United Way of Greater Cleveland for their assistance, support, information, and insight. We would specifically like to acknowledge the substantial contributions of the Alcohol and Drug Addiction Services Board of Cuyahoga County.

This report was written by a team under contract with MCS Consulting Service, LLC including the following in alphabetical order:

- Renée Aten, Aten Enterprises
- Carey Wiant Nyberg
- Jeremy Shapiro, IntelliSolve, Inc.
- Jennifer Slusser, IntelliSolve, Inc.
- Marlene C. Stoiber, MCS Consulting Service, LLC.
- Jacqueline Kirby Wilkins, IntelliSolve, Inc.

This report reflects the comments from reviewers and United Way Community Investment Committee cluster volunteers.

Suggested Citation: MCS Consulting Service. (2007). Core service report: Residential substance abuse treatment. United Way of Greater Cleveland. Available at <http://uws.org>.

SNAPSHOT

AIRS Code Level I: Health Care

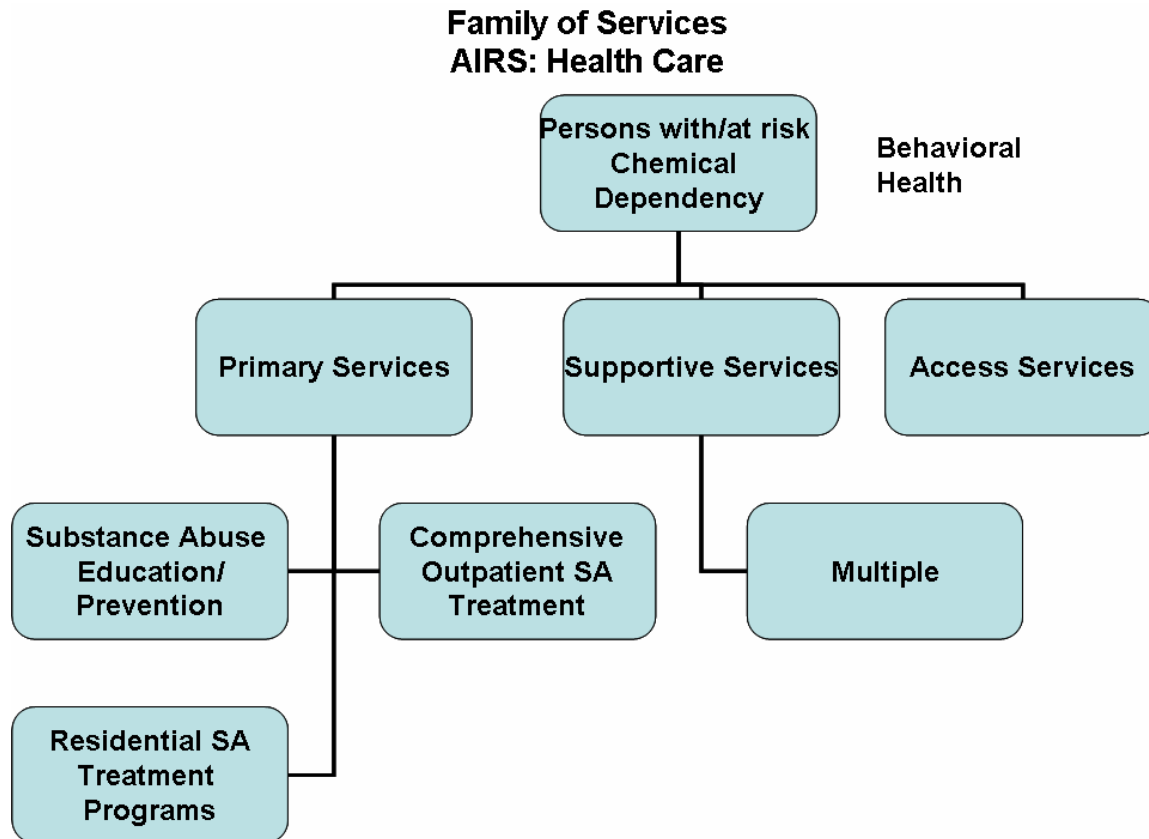
AIRS Code Level II: Substance Abuse Services

Name of Core Service with Complete AIRS Code: Residential Substance Abuse Treatment LX-845.700

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

AIRS Definition: Community-based residential facilities that provide long- or short-term treatment in the context of a 24-hour supervised drug- and alcohol-free environment for people who have problems related to substance abuse.

The Residential Substance Abuse Treatment Program 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

Residential treatment for drug abuse and addiction has existed for approximately 40 years. The main advantage of a residential treatment setting is that individuals are removed from their usual environment, which generally includes strong social pressures and cues supporting substance abuse, and allows them to live in an environment free of drugs and alcohol. It provides 24-hour 7-days-a-week support among others with the same addiction recovery goal, and clients both give and receive peer support for abstinence. As time progresses, individuals acquire more responsibility for helping other residents recover from substance abuse problems.

As it is nationally, funding is Cuyahoga County's major local policy issue. Treatment programs are perceived to be expensive, however, less costly than hospitalization or incarceration. 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.

The Core Service Consumers

The target population addressed in this core service report is 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.

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

- 121 million Americans aged 12 or older were current drinkers of alcohol in 2004. 55 million participated in binge drinking, and 16.7 million were heavy drinkers. 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.
- Among pregnant women aged 15 to 44, 11.2 percent reported past month alcohol use and 4.5 percent reported past month binge drinking.
- Young adults aged 18 to 22 enrolled full time in college were more likely than their peers not enrolled full time to use alcohol, binge drink, and drink heavily in 2004.
- In 2004, 19.1 million Americans aged 12 or older, were current illicit drug users.
- Among youths aged 12 to 17, rates of current illicit drug were 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 were employed either full or part time.

In 2004, the Alcohol and Drug Addiction Services Board of Cuyahoga County (ADASBCC) estimated that 13,176 Cuyahoga County persons 12 and older have a chemical dependency disorder and need residential treatment. This number is projected to increase slightly to 13,272 by 2015 because of population shifts.

Core Service Delivery

The definition of residential substance abuse treatment for this report is consistent with the AIRS definition: community-based alcohol and drug free residential facilities that provide long or short-term treatment in the context of a 24-hour, supervised drug and alcohol-free environment.

Residential substance abuse treatment programs are provided by different organizations including hospitals, social service agencies, and religious institutions. Most consumers are referred individually by health care providers or through the criminal justice system. Most treatment centers offer specialized chemical dependency treatment programs that focus on personal responsibility. They address multiple aspects of the disease: physical, psychological, behavioral, social, family and spiritual. Patients are generally treated in residential centers for a variety of substance addictions. Treatment often includes education, group therapy, multi-family groups, relapse prevention plans, individual counseling, and appropriate 12-step programs. Each patient is urged to participate fully in the treatment process. Since addiction is often seen as a family disease, the entire family is generally encouraged to participate in treatment whenever possible.

Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 9 comprehensive outpatient substance abuse treatment program providers operating from 13 different sites; all are nonprofit. United Way funded 4 of the providers in FY2004. FCFH call data shows an increase in the number of total requests for residential substance abuse treatment programs in the county: from 538 in 2000 to 1,175 in 2004. Over the same five-year period, FCFH had 4,648 requests for information regarding residential substance abuse programs. Of these requests, they were able to make referrals to 99 percent of callers.

Between calendar years 2003 and 2005, government funding for residential substance abuse treatment has increased from \$1.5 million to close to \$1.8 million in Cuyahoga County. In 2004, there was a total of \$8.5 million Medicaid dollars for CADAS (Community Alcohol and Drug Addiction Services) in Cuyahoga County. CADAS funding covers more than residential services.

As of May 11, 2006, more than \$1.9 million in revenues for residential substance abuse treatment programs has been identified countywide, excluding Medicaid dollars. Note that other funding sources such as private insurance and individual fees are not included. Nearly 77 percent of the revenues are from contracts or grants from government organizations. United Way of Greater Cleveland's funds account for almost 12 percent of the total from Investment Committee allocations and designations.

The range of cost for residential days is approximately \$99-\$200, depending on whether it is a half-way house or residential program. Clients pay for the service(s) on a sliding scale fee.

What Works; What Doesn't

Because residential treatment is much more intensive, restrictive, and expensive compared to outpatient therapy and even day treatment, outcome research on residential intervention has generally examined the question of whether it is more effective than alternative interventions rather than whether it is more effective than no treatment. Below are selected findings regarding adult-focused residential substance abuse treatment.

Fridell (2003) conducted several meta-analyses of outcome studies on residential treatment of substance abuse and addiction. The studies suggest that it is not generally cost effective to extend residential treatment beyond 6 months.

Burnam et al. (1995) compared residential and outpatient drug treatment for homeless substance abusers with co-morbid mental illness. In a short-term follow-up assessment, they found that residential treatment produced larger reductions in substance abuse and also improved housing conditions for the clients, but the interventions had similar effects on psychiatric symptomatology.

According to former ODADAS Director Lucille Fleming, \$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."

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 2,635 including both realized (1,184) and unrealized (1,451) 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 are 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.

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.

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, diabetes, and asthma—sobriety can be maintained through a prescribed treatment regimen administered throughout a person's lifetime.

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. In 2003, 21.3 percent of adults with SMI were dependent on or abusing 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)

The greatest single drug abuse threat in Ohio seems to be cocaine. Estimates from the 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 an increase in club drug availability.

ADASBCC (2004) reported that in its experience 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 use of crack cocaine 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, the availability of methamphetamine in Cleveland is limited, which should have the effect of curtailing use.

Residential treatment for drug abuse and addiction has existed for approximately 40 years. The main advantage of a residential treatment setting is that individuals are removed from their usual environment, which generally includes strong social pressures and cues supporting substance abuse, and allows them to live in an environment free of drugs and alcohol. It provides 24-hour 7-days-a-week support among others with the same addiction recovery goal,

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.

and clients both give and receive peer support for abstinence. As time progresses, individuals acquire more responsibility for helping other residents recover from substance abuse problems.

Until the mid 1980s, interventions for drug abuse consisted largely of the residential treatment approach, which established therapeutic communities and provided institutional milieu therapy (Fridell, 2003). Since that time, increased concern about health care costs in general—and drug treatment costs in particular—has resulted in a substantial decrease in residential treatment because it is generally much more expensive than outpatient or day treatment. The question of whether these high costs are justified by correspondingly positive results is addressed in the “What Works” section of this report.

As noted by a local agency expert, a continuum of seamless care between detoxification services, residential substance abuse treatment, and outpatient substance treatment is necessary. Essentially treatment for chemical dependence is centered on achieving sobriety through abstinence from mood altering chemicals.

PUBLIC POLICY ISSUES

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 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.

DEMOGRAPHIC CHARACTERISTICS

According to the U.S. Department of Labor (n.d.), inpatient treatment offers several advantages over less intensive programs for specific types of consumers:

- Hospital settings offer a high level of medical supervision for individuals who require intensive physical and/or psychiatric monitoring.
- The intensity of inpatient treatment may be helpful to patients who do not respond to lesser measures. For example, hospital treatment may benefit those who are too discouraged or unmotivated to attend outpatient treatment meetings regularly.
- Inpatient treatment may benefit some individuals by increasing their awareness of the internal triggers that place them at risk to return to drug abuse.
- Inpatient treatment can help to interrupt a cycle of drug use even in the absence of dangerous withdrawal symptoms.

NATIONAL

Within the estimated 22.5 million Americans who met 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.

Cuyahoga County

Table 1 describes Cuyahoga County hospital utilization grouped by diagnosis, the avenue of admission and the mean length of stay for 2003. The largest number of patients (1,245) was admitted for alcohol/drug use and alcohol/drug induced organic mental disorders. More than one-third was admitted through emergency rooms, a high cost option. Large proportions of patients admitted for other substance-related issues were also admitted through emergency rooms.

Table 1: Cuyahoga County Hospital Utilization by Major Diagnostic Category, Non-Government Patients, 2003

TOTAL patients admitted for alcohol/drug use & alcohol/drug induced organic mental disorders	1,245
% Emergency Room Admissions	38.39%
% Hospital Transfer Admissions	1.93%
% Other Admissions	59.68%
Mean length of stay	3.34
TOTAL patients admitted for cirrhosis & alcoholic hepatitis	151
% Emergency Room Admissions	71.52%
% Hospital Transfer Admissions	5.96%
% Other Admissions	22.52%
Mean length of stay	12
TOTAL patients admitted for alcohol/drug abuse or dependence, left AMA	67
% Emergency Room Admissions	40.30%
% Hospital Transfer Admissions	0%
% Other Admissions	59.70%
Mean length of stay	1.95
TOTAL patients admitted for alcohol/drug abuse or dependence with complications	442
% Emergency Room Admissions	51.81%
% Hospital Transfer Admissions	2.71%
% Other Admissions	45.48%
Mean length of stay	3.82
TOTAL patients admitted for alcohol/drug abuse or dependence without complications, without rehab therapy	736
% Emergency Room Admissions	30.16%
% Hospital Transfer Admissions	1.63%
% Other Admissions	68.21%
Mean length of stay	3.18

Source: *Annual Hospital Disclosure*. Non-Government Patients, Most Frequently Treated Diagnosis Related Groups (DRGs) survey, Ohio Department of Health

Estimated Persons in Need

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.)

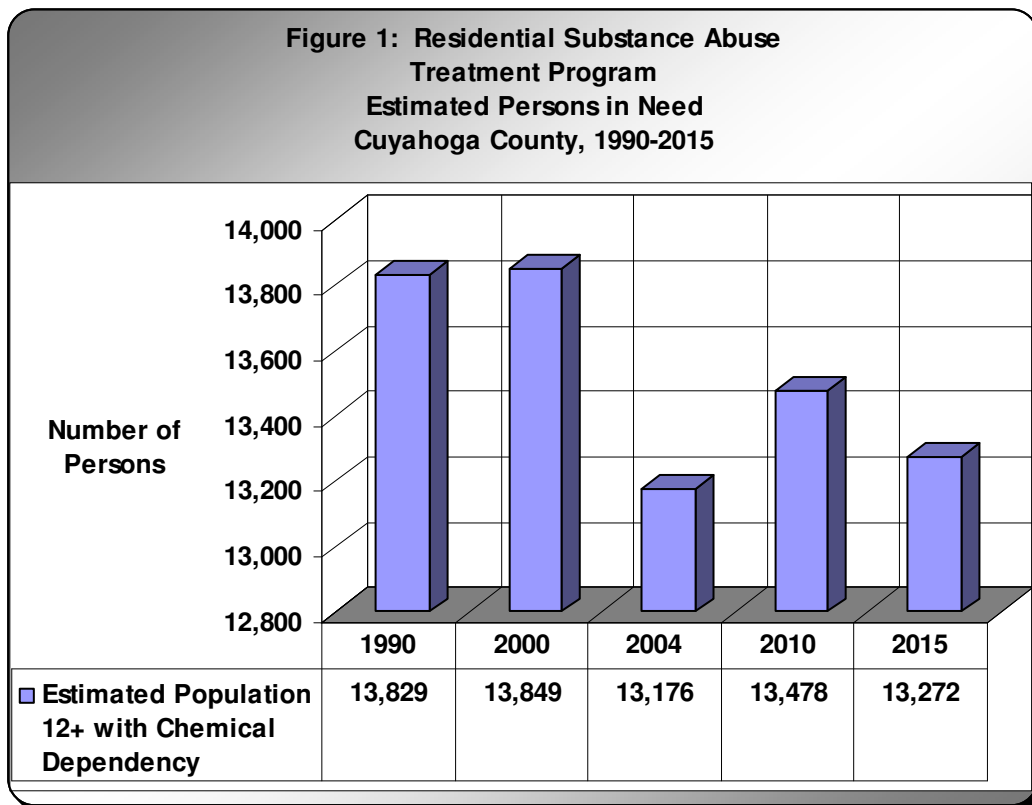
- Persons dependent on or abusing a substance in the past 12 months, or who received specialty treatment for a substance use problem within the past 12 months, are classified as needing treatment by a qualified chemical dependency counselor. In 2004, the number of persons aged 12 or older needing treatment for an alcohol or illicit drug use problem was 23.48 million (9.8 percent). Of these, 2.33 million received treatment at a specialty facility in the past year. Thus, 21.15 million people 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

There are a large number of individuals with significant drug or alcohol problems who 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).

Cuyahoga County

In 2004, the Alcohol and Drug Addiction Services Board of Cuyahoga County (ADASBCC) estimated that in addition to the 1,184 persons who received residential treatment services in the county, there were 11,992 persons who needed but did not receive treatment, or were receiving it through the non-public service system. Totaling these numbers results in an estimated 13,176 Cuyahoga County persons 12 and older with a chemical dependency disorder and need residential treatment. This represents 1.1 percent of the population 12 years and older (1,160,037). The number of individuals 12 and older in need of residential substance abuse treatment is projected to increase slightly to 13,272 by 2015 because of population shifts. (See Figure 1.)



Sources:

* US Census: 1990, STF3 (P11); 2000 SF3 (P8); 2004, American Community Survey; 2010 & 2015, Ohio Department of Development, (July, 2003).

** The Cuyahoga County Alcohol and Drug Addiction Services Board estimates that 11,992 persons in addition to the 1,184 served in 2004 needed residential substance abuse treatment. Thus, totaling these numbers, the estimated number of persons in need in Cuyahoga County was 13,176 in 2004.

It is recognized that this is a conservative estimate of persons in need of residential substance abuse treatment 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 be underestimating 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. It includes the actual number of consumers reported by United Way funded agencies and by government funders from which it was possible to obtain data. Thus, it is an underestimate of actual numbers of consumers receiving service.

In FY 2004, United Way funded 962 Cuyahoga County residents ages 12 and older for residential substance abuse programs. (See Attachment 3.) In CY 2004, the Alcohol and Drug Addiction Services Board funded 1,184 actual annual consumers. It is assumed that these numbers are duplicated.

While 46.5 percent of the county's total 12 and older population is male and 53.5 percent female, United Way funded agencies served close to the same percentages of males (45 percent) and females (55 percent). ADASBCC did not provide demographic data.

In 2000, according to the U.S. Census, 69 percent of the county's total 12+ population was Caucasian, 26 percent African American, and 2 percent Asian. Consumers funded by United Way for residential substance abuse treatment were 33 percent Caucasian and 64 percent African American. No Asians were reported.

Three percent of both the county's 12+ population and United Way funded consumers are Hispanics.

Eighty percent of those funded by United Way reported annual household income below \$9,999.

Twenty-nine percent of the county's 12 years and older population resided in the City of Cleveland in 2000 and 71 percent in the suburbs. (See Attachment 4.) Nearly one half of persons funded by United Way (48 percent) resided in Cleveland, with approximately a third (32 percent) residing in the suburbs and the remainder unknown. United Way funded consumers for whom zip code data was provided were distributed across most zip codes.

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

The definition of residential substance abuse treatment for this report is consistent with the AIRS definition: community-based alcohol and drug free residential facilities that provide long or short-term treatment in the context of a 24-hour, supervised drug and alcohol-free environment.

BACKGROUND ON CORE SERVICE

The best-known residential treatment model is the therapeutic community (TC). Therapeutic communities focus on the “resocialization” of the individual and use the program's entire “community” as active components of treatment. Residential treatment may also employ other models, such as cognitive-behavioral therapy or medical model. Models for youth and for adults are also very different.

According to the U.S. Department of Labor (n.d.) *residential or inpatient* refers to:

...a variety of treatments that take place in one of a number of different settings. The treatment may take place either in a medical or general psychiatric setting or in a specialized chemical dependency unit. Therapeutic communities (TCs), for example, are a special type of inpatient program. TCs are highly structured programs in which patients stay at a residence, typically for 6 to 12 months. Patients in TCs include those with relatively long histories of drug dependence, involvement in serious criminal activities, and seriously impaired social functioning. The TC views drug abuse as a deviant behavior. Thus, the principal aim of the TC is a global change in lifestyle: abstinence, elimination of antisocial behavior, and the development of employability and pro-social attitudes and values.

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.

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 that are based mostly on the potential for (or existence and severity of) withdrawal symptoms and the required intensity of care. Residential treatment is a Level II service. (Level I is outpatient treatment, Level III is sub-acute care, and Level IV is acute care). ODADAS defines residential treatment as the following:

Residential treatment provides services in a residential environment a minimum of 30 hours per week and may include medical or non-medical, transitional, and/or long term residential treatment, a halfway house environment, a women's recovery center, etc. (ODADAS, 2002). Residential Treatment for adolescents requires 20 hours a week of programming due to school taking at least 20 other hours. Minimum treatment services required by ODADAS certification standards and defined by ODADAS taxonomy for Level II include: Assessment, Individual Counseling, Group Counseling, Family Counseling, Crisis Intervention, and Case Management. (ODADAS, 2002)

The Ohio Department of Alcohol and Drug Addiction Services outlines specific services that are required to be provided in residential treatment programs:

- *Assessment* refers to the evaluation of an individual to determine the nature and extent of his or her addiction to alcohol and other drugs.
- *Individual counseling* involves a face-to-face encounter between a client and a counselor. Individual counseling assists an individual in achieving treatment objectives through the exploration of alcohol and other drug problems and/or addiction and their ramifications, including an examination of attitudes and feelings, consideration of alternative solutions and decision making and/or discussing didactic materials with regard to alcohol and other drug problems.
- *Group counseling* assists two or more individuals in achieving treatment objectives. This occurs through the exploration of alcohol and other drug problems and/or addiction and their ramifications, including an examination of attitudes and feelings, consideration of alternative solutions and decision making and/or discussing information related to alcohol and other drug related problems. Such group sessions can consist of lectures, videos, or a structured discussion session.
- *Case management* refers to the activities provided to assist and support individuals and groups in gaining access to needed medical, social, educational, and other services essential to meeting basic human needs. Case management services may include interactions with family members, significant others, and/or other individuals or entities.
- *Crisis intervention* refers to a face-to-face or telephone response to a crisis or emergency situation experienced by a client, family member, or significant other. (ODADAS, n.d.)

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.

Residential substance abuse treatment programs are provided by different organizations including hospitals, social service agencies, and religious institutions. Programs also have a multitude of staffing, collaboration, and reimbursement/payment structures. Most consumers are referred individually by health care providers or through the criminal justice system.

Most treatment centers offer specialized chemical dependency treatment programs that focus on personal responsibility. They address multiple aspects of the disease: physical, psychological, behavioral, social, family, and spiritual. Patients are generally treated in residential centers for a variety of substance addictions, including: alcoholism, cocaine, crack, methamphetamine, Ecstasy, inhalants, heroin, and other harmful drug and chemical dependencies. Treatment often includes education, group therapy, multi-family groups, relapse prevention plans, individual counseling, and appropriate 12-step programs. Each patient is urged to participate fully in the treatment process. Since addiction is often seen as a family disease, the entire family is generally encouraged to participate in treatment whenever possible.

Many residential substance abuse treatment centers are staffed by physicians, psychiatrists, psychologists, masters and Ph.D. level lecturers, workshop facilitators, counselors, nurses, and other treatment personnel. Doctors and nurses often provide the initial psychiatric evaluation and monitor levels of medication. Case managers develop a treatment plan to help guide the client and other staff in treatment.

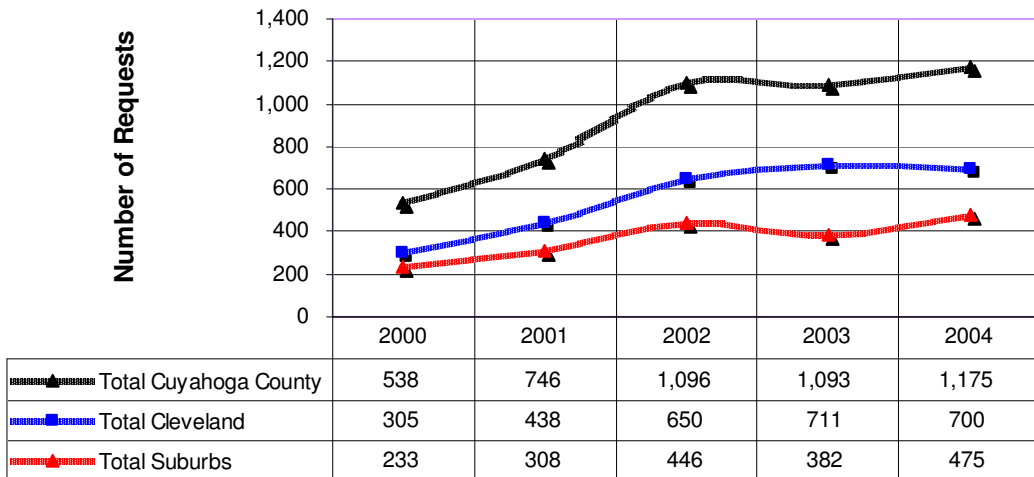
United Way - First Call for Help Call Data

Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 9 residential substance abuse treatment program providers operating from 13 different sites, all of which are nonprofit. In FY 2004 (July 2003 to June 2004), United Way funded four of the providers. (See Attachments 5 and 6.) Note that ADASBCC has funding contracts with 11 providers of residential treatment centers for a total of 16 sites. Not all of these are included in the United Way-First Call for Help database.

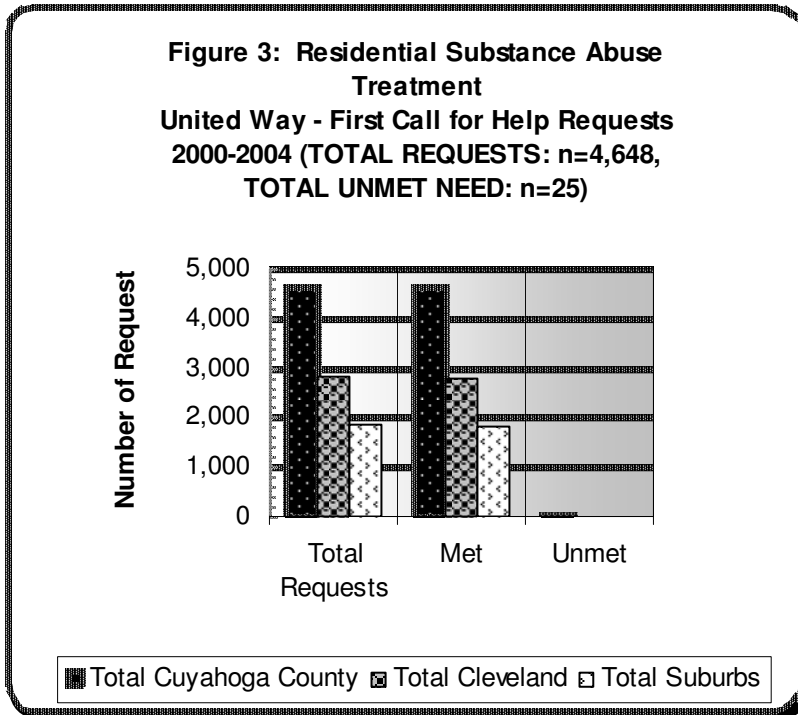
United Way - First Call for Help call data shows an increase in the number of total requests for residential substance abuse treatment programs in the county: from 538 in 2000 to 1,175 in 2004 (118 percent), with a 130 percent increase in Cleveland (305 to 700 requests) and a 104 percent in the suburbs (233 to 475 requests). (See Figure 2 and Attachment 7.) Calls came from approximately a third of Cuyahoga County zip codes with the following experiencing the highest average number of calls from 2000-2004:

- 44105 (Cleveland/NewburghHts/GarfieldHts), 79 average calls;
- 44102 (Cleveland/Brooklyn), 55 average calls;
- 44103 (Cleveland), 50 average calls;
- 44109 (Cleveland/Brooklyn Heights), 40 average calls; and
- 44106 (Cleveland/Cleveland Heights), 37 average calls.

**Figure 2: Residential Substance Abuse Treatment
United Way - First Call for Help Requests 2000-2004
Greatest Increase/(Greatest Decrease)**



Over the same five-year period, United Way - First Call for Help had 4,648 requests for information about residential substance abuse programs. Of these requests, they were able to make referrals to 99 percent of callers; however, 1 percent of all Cuyahoga County callers (25) had an unmet need, meaning there was no agency to which to refer the caller. Callers from the City of Cleveland had a less than 1 percent unmet need rate and from the suburbs, 1 percent. (See Figure 3 and Attachment 8.)



FUNDING OF CORE SERVICES

Major Government Funders

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

- Medicaid;
- Substance Abuse Prevention and Treatment Block Grant (SAPT);
- Temporary Assistance to Needy Families (TANF);
- Ohio General Revenue Funds and Ohio Special Revenue Funds; and
- Cuyahoga County General Revenue Fund.

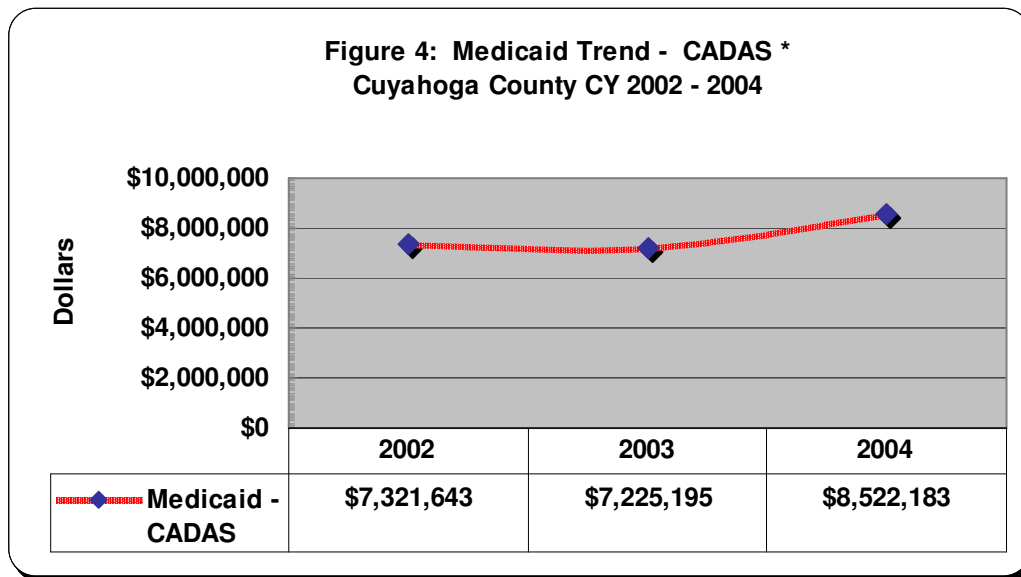
Funding of the public service system for substance abuse prevention and treatment is from federal, state, and county sources, the majority of which is passed through to the Alcohol and Drug Addiction Board of Cuyahoga County. Below is further explanation of these various major government sources.

NATIONAL

Medicaid

Medicaid is a federal entitlement program available to alcohol and other drug services clients since 1993. In 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 (Ohio Department of Alcohol and Drug Addiction Services 2004 Annual Report). In CY 2004, \$8.5 million Medicaid dollars were

available to Alcohol and Drug Addiction Board of Cuyahoga County (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.

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.

The Alcohol and Drug Addictions Services Board of Cuyahoga County (ADASBCC) is the primary funder of local services and was created through Authorization H.B.317 to reduce the incidence and prevalence of chemical abuse and dependency in Cuyahoga County. ADADSBCC funds 93 programs and projects administered by 54 agencies. Providers must focus on client retention and treatment completion. Medicaid reimburses on a fee-for-service methodology. The ADASBCC reimbursement process has shifted from a grant-based to a fee-for-service and 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.

Temporary Assistance to Needy Families (TANF)

Created by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, TANF is administered at the federal level by the Department of Health and Human Services. TANF ended individual federal entitlement to welfare and replaced it with block grants to states, and states decide how funds will be spent within TANF guidelines. TANF funding has the flexibility to provide assistance to needy families for a range of services, including substance abuse treatment and prevention. Each year since 1999, the State of Ohio receives \$728 million in TANF funds. Ohio previously used its TANF grant to fund substance abuse treatment at about \$4 million in FY 2002 and FY 2003; however, only \$1,370 was allocated in FY 2004, and nothing has been allocated from this source since FY 2005.

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

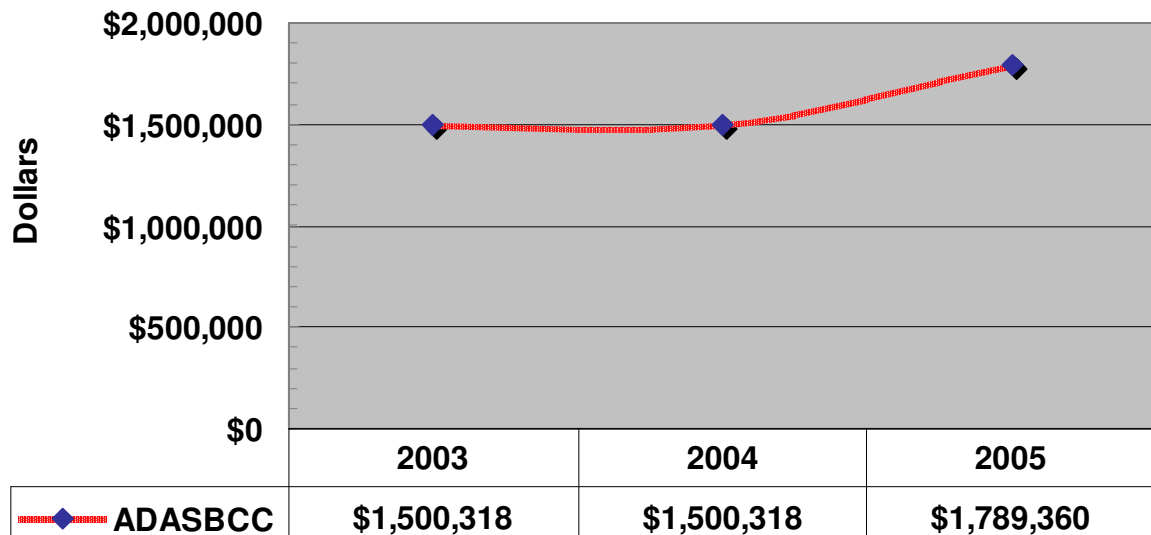
County General Revenue Fund

The county funds the Alcohol and Drug Addiction Services Board of Cuyahoga County (ADASBCC) out of its general revenue fund (GRF) to provide 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 Government Funders

Between calendar years 2003 and 2005, government funding for residential substance abuse treatment has increased in Cuyahoga County from \$1.5 million to close to \$1.8 million. (See Figure 5.) This increase, however, is related to one-time SAMHSA grants.

Figure 5: Identified Government Funding for Residential Substance Abuse Treatment Cuyahoga County, CY 2003-2005



Source: Alcohol and Drug Addiction Services Bureau of Cuyahoga County, 2005

Table 2 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 2: Alcohol and Drug Addiction Services Board of Cuyahoga County Historical Funding: Residential Services CY 2003 TO CY 2005, Cuyahoga County

Funding Level	CY 2003		CY 2004		CY 2005	
	\$	%	\$	%	\$	%
Federal	\$938,149	62.5%	\$962,154	64.1%	\$1,205,850	67.4%
State	\$474,701	31.6%	\$247,402	16.5%	\$6,263	0.4%
County	\$87,469	5.8%	\$290,762	19.4%	\$577,248	32.3%
TOTAL	\$1,500,319	100.0%	\$1,500,318	100.0%	\$1,789,361	100.0%

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

Other Funders

Since 2002, local foundation contributions also have increased. In 2002, foundation funding was \$100,500. The funded amount had increased by 2004, when total contributions were \$259,000.

IDENTIFIED REVENUES

As of May 11, 2006, more than \$1.9 million in revenues for residential substance abuse treatment programs has been identified countywide, excluding Medicaid dollars. (See Table 3.) 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.

Nearly 77 percent of the revenues are from contracts or grants from government organizations. ADASBCC is a primary funder of the service through county, state, and federal funds. United Way of Greater Cleveland's funds account for almost 12 percent of the total from Investment Committee allocations and designations.

Table 3: Annual Identified Revenue for Core Services: Countywide and United Way of Greater Cleveland Residential Substance Abuse Programs, 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)
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	
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.

REIMBURSEMENT/COST

According to ADASBCC, the cost for residential units of service varies by service offered and by provider. Typically, ADASBCC pays the provider the amount listed on the budget for residential services. If it is a facility with fewer than 17 beds, the room and board cost is split from the treatment services, as Medicaid will reimburse the services for Medicaid-eligible clients. This applies to all public funds administered by the board that consist of federal, state, and local dollars (Substance Abuse Block Grant dollars, ODADAS Women's Set-Aside, county levy dollars, Corrections Planning Board, ODADAS Therapeutic Community, and SAMHSA grants). Generally, "paid services" are determined by what funds the payer requests through a request for proposal process. Depending on whether it is a halfway house or residential program, range of cost for residential days is approximately \$99-\$200. Clients pay for the service on a sliding-scale fee based on the poverty guidelines (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 (outpatient and inpatient are not distinguished) in the Cleveland area. 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 its website at <http://csat.samhsa.gov/publications.aspx>.

Because residential treatment is much more intensive, restrictive, and expensive compared to outpatient therapy and even day treatment, outcome research on residential intervention has generally examined the question of whether it is more effective than alternative interventions, rather than whether it is more effective than no treatment. This is a more stringent criterion of effectiveness than that used in outcome research on outpatient therapy, and there is a valid reason for the stringency.

Fridell (2003) conducted several meta-analyses of outcome studies on residential treatment of substance abuse and addiction. The meta-analysis for studies of treatment of opiate dependence involved 6 studies that conducted 15 comparisons between treatment groups; a total of 1,492 clients were included in these studies. The average effect size was .10. This difference between groups receiving residential and non-residential treatment was statistically significant, but very small. When sample size is large, as is the case here, findings of statistical significance can be misleading, because experimental effects that are small or even negligible in magnitude can emerge as significant in this technical extent.

Fridell's (2003) meta-analysis of outcome studies on residential treatment for cocaine abuse included 4 studies that reported 6 comparisons between treatment groups. A total of 723 clients participated in these studies. This meta-analysis produced an average effect size of .15. This difference between groups receiving residential and non-residential intervention only bordered on being statistically significant, and was very small. (Although this effect size was larger than that for opiate dependence, it was not significant and the latter was because smaller effect sizes emerge as statistically significant in larger sample sizes.)

In the studies included in Fridell's meta-analysis review, time in treatment varied from 3 months to 2 years. The studies generally found that greater length of treatment produced more improvement on outcome measures. A careful series of studies that, unlike most research on treatment length, had random assignment to groups found that the benefits of residential intervention increase up to 3 months and, possibly, at the most 6 months before leveling off (McCusker et al., 1995; McCusker, Bigelow, Vickers-Lahti et al., 1997; McCusker, Bigelow,

Frost et al., 1997; Vickers-Lahti et al., 1995). These results suggest that it is not generally cost effective to extend residential treatment beyond 6 months.

There is a significant group of people within the substance abusing population who also contend with mental illness and homelessness. This subpopulation's needs are complex and severe; it presents major challenges for treatment that make the option of residential treatment especially salient. Burnam et al. (1995) compared residential and outpatient drug treatment for homeless substance abusers with co-morbid mental illness. In a short-term follow-up assessment, they found that residential treatment produced larger reductions in substance abuse and it also improved housing conditions for the clients, but the interventions had similar effects on psychiatric symptomatology. In a study that compared two types of residential treatment for this population, Nuttbrock, Rahav, Rivera, Ng-Mak, and Lnik (1998) found that therapeutic communities produced better outcomes than regular supportive housing in general community settings.

Finally, the opioid-agonist approach for treating chronic opiate (such as heroine) addicts has proven to be effective. Opioid addiction treatment is the generic term for the various treatment modalities employed to treat opioid-dependent individuals. Therapeutic communities; abstinence-based programs (both residential and outpatient); and opioid addiction treatment programs that use a pharmacotherapeutic approach are experienced in treating patients who are addicted to heroin or another opiate derivative such as morphine or synthetic opioids. To date, treatment using methadone or LAAM has demonstrated effectiveness with patients who have a history of opiate dependence for more than one year. Medication modalities include maintenance, short-term detoxification and long-term detoxification. The most researched treatment modality for substance abuse treatment, methadone is delivered within a comprehensive treatment program that includes a complete physical examination and individual and group counseling. Treatment providers also make available HIV risk reduction counseling and treatment or referral for ongoing health issues. Patients are usually referred to other agencies for vocational, legal, or other human services. CSAT has published several documents in its "Treatment Improvement Protocol" series (TIPs) that cover topics related to policy and clinical issues of narcotic or opioid treatment (SAMSHA, 2006).

IMPACT ON COMMUNITY

The Ohio Department of Alcohol and Drug Addiction Services SFY 2004 Annual Report outlined specific cost savings for investment in prevention and treatment programs. Below are the findings.

- In 2003, 27,948 children were removed from homes where substance abuse was a contributing factor. Thanks to interventions that included treatment and family drug courts, 12,576 children were reunited with caregivers = \$118 million saved in out-of-home care.
- Of those Ohioans in a drug court or diversion program in 2003, only 8 percent of the adult offenders were rearrested and only 3 percent of the youthful offenders were committed to juvenile state institutions = \$91 million saved in prison and jail costs.
- Ohio's women in treatment gave birth to 588 drug-free babies in 2004 = \$29.5 million saved in healthcare for drug-affected infants.
- In Ohio's family drug court programs, 15 drug-free babies were delivered = \$750,000 saved.

- 70 percent of persons with alcohol and other drug abuse or addiction are employed. One of every ten employees suffers from substance abuse, costing the employer about \$7,000 per year per employee in lost productivity.
- Of Ohio's 6.7 million workers, approximately 670,000 have a substance abuse problem that costs Ohio employers \$4.7 billion in lost productivity annually.
- For every 4 cents spent in Ohio on prevention, treatment and recovery services, 96 cents is spent on healthcare, justice services, education, child abuse, and homelessness impacted by substance abuse.
- Of unemployed Ohioans in treatment in 2004, approximately 1,000 obtained employment during treatment = \$16.6 million in earnings (at \$8 per hour) and a combined state and local tax gain (at \$2,869 per person) of \$2.9 million.
- Alcohol and other drug prevention services, which reached more than 1,000,000 Ohioans in SFY 2004, cost \$27,553,893. At a modest return of \$7 saved for every \$1 spent, Ohio's prevention benefit was \$165,323,358.

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 residential treatment programs are required to 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:

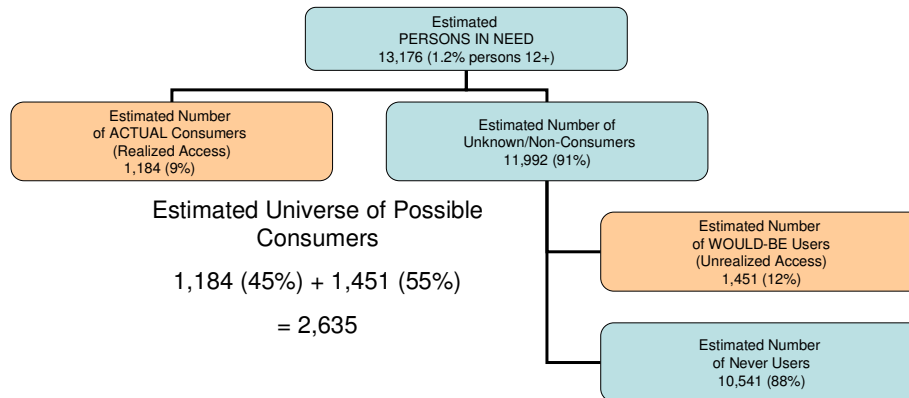
- A *chemical dependency counselor assistant* must be employed in a paid or volunteer position in an appropriate organization, must have 40 hours of approved education in chemical dependency, and must work under supervision.
- A *licensed chemical dependency counselor* must have an associate's degree in a behavioral science or a bachelor's degree in any field, 5,000 hours of relevant paid or volunteer work experience, 270 hours of chemical dependency education, and must pass written and oral examinations.
- A *licensed chemical dependency counselor* must have a bachelor's degree in a behavioral science, 4,000 hours of professional experience as a chemical dependency counselor, 270 hours of professional training, and must pass written and oral examinations.
- A *licensed independent chemical dependency counselor* must have a master's degree in a behavioral science, 6,000 hours of professional chemical dependency counseling experience, 270 hours of professional education, and must pass two written and one oral examinations.

VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for Residential Substance Abuse Treatment:

- A conservative estimate of 13,176 Cuyahoga County persons need residential substance abuse treatment programs.
- The Alcohol and Drug Addiction Services Board of Cuyahoga County places the actual number of consumers served in 2004 at 1,184 (unduplicated count), realized access. This number reflects only the consumers who accessed treatment using public funds administered by the board (ADSABCC, 2005). It assumes that the 962 consumers funded by United Way are duplicated with ADASBCC.
- The estimated number of persons in need (13,176) less the actual consumers (1,184) equals the estimated number of unknown or non-consumers (11,992). ADASBCC estimates that 11,992 individuals who need alcohol and other residential drug treatment in Cuyahoga County and are either not receiving services or are receiving it from unaccounted-for sources. The primary reasons services are not obtained include:
 - Some of the 11,992 may be accessing services in the private sector through insurance benefits utilizing private centers, hospitals and employee assistance programs.
 - There is lack of available funding and other resources to meet the need.
 - Some populations, such as women, are funded more readily than others. Because women are a priority population, more funding is allocated for these services.
 - Consumers may not be seeking services. Only about 20 percent of individuals in need of service may actually seek service (ADASBCC, 2004).
- Applying the ADASBCC figure of 20 percent actual seekers to the estimated persons in need (13,176) equals 2,635, the estimated universe of possible consumers.
- Subtracting the actual consumers (1,184) from the estimated universe of possible consumers (2,635) equals the would-be consumers (1,451). 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 (1,184) and unrealized (1,451) access, the estimated universe of possible consumers for residential substance abuse treatment programs is 2,635 persons 12+. (See Figure 6.)

Figure 6: Consumer Estimates
Residential Substance Abuse Treatment Program



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 13 service sites for residential substance abuse treatment programs. This is a ratio of 203 possible consumers (estimated 2,635 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 capacity of providers to offer the service, for example, the number of days of service. 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 9:1 in zip code 44107 (Lakewood/Cleveland) to a low of 0:1 in zip code 44040 (Gates Mills/Mayfield Village). (Gates Mills/Mayfield Village). In addition to zip code 44107, two other zip codes have ratios greater than 7 consumers to one service site:

- 44130 (Parma/Cleveland, 8:1); and
- 44105 (Cleveland/NewburghHts/ GarfieldHts, 8:1) (high minority area).

(See Map in Attachment 10.) Since most residential substance abuse treatment facilities 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

Capacity is defined as the number of beds and the length of the stay for each client in a residential program. This definition varies between agencies and has changed as agencies move from program-based services to client-focused services. A residential stay typically is classified as short term or long term. Short term is 30 days or less. Long term is 31 to 90 days. Halfway house programs could be 6 months. Agencies are transitioning from program-based length of stays to length of stays based on client need. Currently, there are 308 residential beds and 159 halfway house beds in Cuyahoga County. Although this capacity is available, there may not be funding available to support all the identified capacity. Contract limits and grant payments actually determine the level of available capacity. Thirteen ADASBCC certified agencies in Cuyahoga County provide residential services for persons with substance abuse disorders. The board contracts with 11 agencies with a combined 1.7 sites offering residential services. This number does not include private providers (ADASBCC, 2005).

The number of clients providers are able to serve varies by agency and by population. For example, adolescents in Cuyahoga County who need residential services are less likely to have immediate access as there is only one residential agency for them, and it operates at full capacity. Juvenile Court and the Department of Children and Family Services refer these adolescents to out-of-county facilities for treatment. In addition, there are residential agencies that will take children as well as the parent, but space is limited in those facilities. The Cuyahoga County Department of Criminal Justice often contracts with private facilities to reserve a number of beds. Other populations will be able to access services quickly once an assessment is completed (ADASBCC, 2005).

The primary reasons for the difference between community capacity and actual clients served are (ADASBCC, 2005):

- Lack of funding: funding has remained flat over the last 10 years, but the cost of providing service has increased, therefore, the number of clients served has decreased.
- Lack of capacity in terms of physical environment: 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, Department of Criminal Justice consumers are seen only at a few facilities.

VII. SUMMARY

These are the major findings in this report:

- Residential treatment for drug abuse and addiction has existed for approximately 40 years. The main advantage of a residential treatment setting is that individuals are removed from their usual environment, which generally includes strong social pressures and cues supporting substance abuse, and allows them to live in an environment free of drugs and alcohol.
- As it is nationally, funding is Cuyahoga County's major local policy issue. Treatment programs are perceived to be expensive, however, less costly than hospitalization or incarceration. Public funding resources are limited.
- 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 2004 there was a total of \$8.5 million Medicaid dollars for CADAS (Community Alcohol and Drug Addiction Services) in Cuyahoga County. CADAS funding covers more than residential services.
- Between calendar years 2003 and 2005, government funding for residential substance abuse treatment increased from \$1.5 million to close to \$1.8 million in Cuyahoga County.
- As of May 11, 2006, more than \$1.9 million in revenues for residential substance abuse treatment programs has been identified countywide, excluding Medicaid dollars.
- Burnam et al. (1995) found that residential treatment produced larger reductions in substance abuse and also improved housing conditions for homeless substance abusers with co-morbid mental illness, but the interventions had similar effects on psychiatric symptomatology.
- Studies suggest that it is not generally cost effective to extend residential treatment beyond 6 months.
- The estimated universe of possible consumers is 2,635 including both realized (1,184) and unrealized (1,451) access.
- Countywide, according to United Way - First Call for Help (February 2005), there are 13 service sites for residential substance abuse treatment services. This is a ratio of 203 possible consumers (estimated 2,635 total) to one service site countywide.

REFERENCES

- Alcohol and Drug Addiction Services Board of Cuyahoga County (ADASBCC). (n.d). Website. Available from <http://www.adasbcc.org/>
- Anderson, R.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.
- Burnam, M.A., Morton, S.C., McGlynn, E.A., Petersen, L.P., Stecher, B.M., Hayes, C., et al. (1995). An experimental evaluation of residential and nonresidential treatment for dually diagnosed homeless adults. *Journal of Addictive Disorders*, 14:111-134.
- Center for Substance Abuse Treatment. (2005). Substance abuse treatment for persons with co-occurring disorders. Treatment improvement protocol (TIP) series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved on May 11, 2006 from <http://ncadi.samhsa.gov/media/prevline/pdfs/bkd515.pdf>
- The Cleveland Plain Dealer. (2007). Taft signs mental health parity bill. Retrieved on January 8, 2006 from <http://www.cleveland.com/news/plaindealer/index.ssf?/base/news/1167652567178730.xml&coll=2#continue>
- Fridell, M. (2003). Psychosocial treatment for drug dependence. In M. Berglund, S. Thelander, & E. Jonsson (Eds.) *Treating alcohol and drug abuse: An evidence based review*. Weinheim, Germany: Wiley-VCH.
- McCusker, J., Bigelow, C., Frost, R., Garfield, F., Hindin, R., Vickers-Lahti, M., et al. (1997). The effects of planned duration of residential drug abuse treatment on recovery and HIV risk behavior. *American Journal of Public Health*, 87:1637-1644.
- McCusker, J., Bigelow, C., Vickers-Lahti, M., Spotts, D., Garfield, F., & Frost, R. (1997). Planned duration of residential drug abuse treatment: Efficacy versus effectiveness. *Addiction*, 92:1467-1478.
- McCusker, J., Vickers-Lahti, M., Stoddard, A., Hindin, R., Bigelow, C., Zorn, M., et al. (1995). The effectiveness of alternative planned durations for residential drug abuse treatment. *American Journal of Public Health*, 85:1426-1429.
- McLellan AT, Lewis D, O'Brien CP, Kleber HD. (2000, October 4). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA*, 4(13): 1689-1695.
- Nuttbrock, L., Rahav, M., Rivera, J., Ng-Mak, D., & Lnik, B. G. (1998). Outcomes of homeless mentally ill chemical abusers in community residences and a therapeutic community. *Psychiatric Services*, 49:68-76.

- Ohio Department of Alcohol and Drug Addiction Services (2002). ODADAS adult protocol for levels of care. Retrieved September 16, 2006 from <http://www.odadas.state.oh.us/GD/Templates/Pages/ODADAS/ODADASPrimary.aspx?page=4&TopicRelationID=220&Content=1623>
- Ohio Department of Alcohol and Drug Addiction Services (2004). SFY 2004 annual report. Columbus, OH.
- Ohio Department of Alcohol and Drug Addiction Services (2006). Strategic plan update. Retrieved on May 14, 2006 from <http://www.odadas.state.oh.us/GD/Templates/Pages/ODADAS/ODADASPrimary.aspx?page=4&TopicRelationID=115&Content=1241>
- Ohio Department of Alcohol and Drug Addiction Services (n.d). Continuum of care service taxonomy treatment and recovery support. Retrieved December 20, 2006 from <http://www.odadas.state.oh.us/GD/Templates/Pages/ODADAS/ODADASPrimary.aspx?page=4&TopicRelationID=221&Content=2535>
- The Ohio State University Medical Center. (n.d.) Substance abuse/chemical dependency. Retrieved on May 7, 2006 from <http://medicalcenter.osu.edu/patientcare/healthinformation/diseasesandconditions/mentalhealth/substance/>
- Ohio Substance Abuse Monitoring Network. (OSAM). (2002, January-June). *Patterns and trends of drug use in Cuyahoga County/Cleveland, Ohio*. Columbus, OH: Ohio Department of Alcohol and Drug Addiction Services.
- Ohio Substance Abuse Monitoring Network (2005). *Surveillance of drug abuse trends in the state of Ohio*. Columbus, OH: Ohio Department of Alcohol and Drug Addiction Services.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2003). Overview of findings from the 2003 national survey on drug use and health. Office of Applied Studies, NSDUH Series H-24, DHHS Publication No. SMA 04-3963. Rockville, MD.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2004). Overview of findings from the 2004 national survey on drug use and health. Office of Applied Studies, NSDUH Series H-24, DHHS Publication No. SMA 04-3963. Rockville, MD.
- Substance Abuse and Mental Health Services Administration (2006). Opioid agonist therapy (OAT) with methedone or LAAM. Retrieved September 16, 2006 from <http://dpt.samhsa.gov/001025optx.htm>
- U.S. Department of Labor, Office of the Assistant Secretary for Policy. (n.d.). Treatment. Retrieved on May 11, 2006 from <http://www.dol.gov/asp/programs/drugs/workingpartners/sab/treatment.asp#q1>
- Vickers-Lahti, M., Garfield, F., McCusker, J., Hindin, R., Bigelow, C., Love, C., et al. (1995). The relationship between legal factors and attrition from a residential drug abuse treatment program. *Journal of Psychoactive Drugs*, 27:17-25.



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

ATTACHMENTS

Attachment 1: Researcher List

MCS

CONSULTING SERVICE

CORE SERVICE RESEARCH TEAM

Co-Lead Consultants

Marlene C. Stoiber, Ph.D. President, MCS Consulting Service, LLC
Bette S. Meyer, M.A.

Research Team

Renee Aten, CFRE, Aten Enterprises, Associate, MCS Consulting Service, LLC
Edwin A. Balcerzak, Ph.D., Associate, MCS Consulting Service, LLC
Louis B. Burroughs, M.S.U.S., Associate, MCS Consulting Service, LLC
Elsie Day, J.D., Associate, MCS Consulting Service, LLC
Jennifer M. Forshey, M.P.P., IntelliSolve, Inc.

Karen Gillooly, M.Ed., IntelliSolve, Inc.
Sue E. Grant, Ella & Associates, IntelliSolve, Inc.
Gary Harris, B.A., M.B.A., IntelliSolve, Inc.
Jeffry D. Harris, M.P.A., J.D., IntelliSolve, Inc.
Kristen Haskell, M.A., Associate, MCS Consulting Service, LLC

Dion Lau, B.A., Associate, MCS Consulting Service, LLC
Kitty Leung, M.S.S.A., Associate, MCS Consulting Service, LLC
Marcy Hunt- Morse Ph.D., Ella & Associates, IntelliSolve, Inc.
Carey Wiant Nyberg, M.U.P., Associate, MCS Consulting Service, LLC
RNR Consulting, Inc.

Jeremy Shapiro, Ph.D., IntelliSolve, Inc.
Jennifer Slusser, J.D., IntelliSolve, Inc.
Sarah Stilgenbauer, M.N.O., Associate, MCS Consulting Service, LLC
Kola Sunmonu, Ph.D., Associate, MCS Consulting Service, LLC
Jamie Watkins, B.A., IntelliSolve, Inc.

Jacqueline Kirby Wilkins, Ph.D., CFLE - President/Director, IntelliSolve, Inc.
Debra Zanglin, Ella & Associates, IntelliSolve, Inc.

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: Residential Substance Abuse Treatment Program - Adult LX-845.700					
PERIOD	Total Population (%)*	Total Population 12+ (%)**	Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source****	
				Estimated Population 12+ with Chemical Dependency in Need of Residential Treatment (%)***	UW Program Report Data (94.2%)
	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2004-12/31/2004	7/1/2003-6/30/2004	
TOTAL	1,393,978	1,160,037	13,176	962	1,184
Percent		83.2%	1.1%		
GENDER					
Male	47.2%	46.5%	N/A	44.8%	0.0%
Female	52.8%	53.5%	N/A	55.2%	0.0%
Unknown Data*****				0.0%	0.0%
Missing Data*****					100.0%
RACE*****					
White alone	67.1%	69.2%	N/A	32.6%	0.0%
Black or African American alone/combination	27.9%	26.0%	N/A	63.5%	0.0%
Asian alone/combination	2.1%	2.1%	N/A	0.0%	0.0%
American Indian and Alaska Native alone/combination	0.7%	0.7%	N/A	0.2%	0.0%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	0.1%	N/A	0.0%	0.0%
Some other race alone/combination	2.1%	1.9%	N/A	2.6%	0.0%
Unknown Data*****				1.1%	0.0%
Missing Data*****				0.0%	100.0%
HISPANIC*****					
	3.3%	2.9%	N/A	2.9%	0.0%
AGE					
0-4				0.0%	0.0%
5-9				0.0%	0.0%
10-14	4.1%	5.0%	N/A	1.7%	0.0%
15-19	6.4%	7.7%	N/A	19.2%	0.0%
20-34	19.1%	22.9%	N/A	33.6%	0.0%
35-54	29.3%	35.2%	N/A	38.1%	0.0%
55-64	8.7%	10.5%	N/A	7.4%	0.0%
65-74	7.8%	9.3%	N/A	0.0%	0.0%
75+	7.8%	9.4%	N/A	0.0%	0.0%
Unknown Data*****				0.0%	0.0%
Missing Data*****				0.0%	100.0%
INCOME*****					
Average Household Size	2.4	N/A	N/A	N/A	N/A
\$0-\$9,999	11.3%	N/A	N/A	79.6%	0.0%
\$10,000-\$14,999	6.9%	N/A	N/A	4.2%	0.0%
\$15,000-\$19,999	6.7%	N/A	N/A	4.0%	0.0%
\$20,000-\$29,999	13.6%	N/A	N/A	7.3%	0.0%
\$30,000 and above	61.5%	N/A	N/A	4.3%	0.0%
Unknown Data*****				0.5%	0.0%
Missing Data*****				0.0%	100.0%
Totals	100.0%	N/A	N/A	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 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.
**** Note: Consumers could be funded by more than one funding source; thus the columns are not 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 - For United Way Data - represents computational errors or incorrect completion of online report. For all other data - represents data funder was unable to provide.
***** 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: Residential Substance Abuse Treatment LX-845.700						
Period	City/Town (% Cleveland)	Total Population (%) [*] 1/1/2000-12/31/2000	Total Population 12+ (%) ^{**} 1/1/2000-12/31/2000	Estimated Persons in Need Estimated Population 12+ with Chemical Dependency in Need of Residential Treatment (%) ^{***} 1/1/2004-12/31/2004	Actual Number/Percent of Consumers by Funding Source <small>****</small>	
					UW Program Report Data (%) 7/1/2003-6/30/2004	ADASBCC (%) 7/1/2003-6/30/2004
TOTAL		1,393,978	1,160,037	13,176	962	1,184
Percent			83.2%	1.1%		
44017	Berea	1.4%	1.4%	N/A	0.3%	0.0%
44022	Bentleyville	1.3%	0.8%	N/A	0.2%	0.0%
44040	Gates Mills/Mayfield Village	0.2%	0.2%	N/A	0.0%	0.0%
44070	North Olmsted	2.4%	2.5%	N/A	0.9%	0.0%
44101	Cleveland (100%)	0.0%	0.0%	N/A	0.1%	0.0%
44102	Cleveland/Brooklyn (95%)	3.7%	3.6%	N/A	3.6%	0.0%
44103	Cleveland (100%)	1.8%	1.7%	N/A	4.7%	0.0%
44104	Cleveland (100%)	2.1%	1.8%	N/A	3.8%	0.0%
44105	Cleveland/NewburghHts/GarfieldHts	3.9%	3.7%	N/A	4.0%	0.0%
44106	Cleveland/Cleveland Hts (60%)	2.3%	2.4%	N/A	2.9%	0.0%
44107	Lakewood/Cleveland	4.0%	4.2%	N/A	2.5%	0.0%
44108	Cleveland/Bratenahl (90%)	2.6%	2.5%	N/A	11.7%	0.0%
44109	Cleveland/Brooklyn Hts (98%)	3.3%	3.2%	N/A	2.9%	0.0%
44110	Cleveland/East Cleveland (98%)	1.9%	1.8%	N/A	3.2%	0.0%
44111	Cleveland (100%)	3.1%	3.0%	N/A	2.0%	0.0%
44112	East Cleveland/Cleveland	2.4%	2.3%	N/A	4.6%	0.0%
44113	Cleveland (100%)	1.4%	1.4%	N/A	3.7%	0.0%
44114	Cleveland (100%)	0.3%	0.3%	N/A	0.5%	0.0%
44115	Cleveland (100%)	0.6%	0.5%	N/A	1.8%	0.0%
44116	Rocky River	1.5%	1.6%	N/A	0.2%	0.0%
44117	Euclid/Cleveland	0.9%	0.9%	N/A	0.5%	0.0%
44118	ClevelandHts/UniversityHts/ShakerH	3.2%	3.3%	N/A	1.1%	0.0%
44119	Cleveland/Euclid (50%)	1.0%	1.0%	N/A	0.5%	0.0%
44120	Shaker Hts/Cleveland	3.4%	3.3%	N/A	4.9%	0.0%
44121	University Hts/South Euclid	2.5%	2.5%	N/A	1.4%	0.0%
44122	Beachwood/Highland	2.5%	2.6%	N/A	1.1%	0.0%
44123	Euclid	1.3%	1.3%	N/A	0.4%	0.0%
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	3.1%	N/A	0.4%	0.0%
44125	Valley View/Garfield Hts	2.1%	2.2%	N/A	0.9%	0.0%
44126	Fairview Park/Cleveland	1.2%	1.3%	N/A	0.3%	0.0%
44127	Cleveland (100%)	0.6%	0.6%	N/A	0.7%	0.0%
44128	Warrensville Hts/Cleveland	2.4%	2.4%	N/A	3.5%	0.0%
44129	Brooklyn/Parma/Cleveland	2.1%	2.2%	N/A	0.7%	0.0%
44130	Parma/Cleveland	3.8%	4.0%	N/A	1.4%	0.0%
44131	Independence/Seven	1.5%	1.6%	N/A	0.0%	0.0%
44132	Euclid	1.1%	1.1%	N/A	0.2%	0.0%
44133	North Royalton	2.0%	2.1%	N/A	0.6%	0.0%
44134	Parma/Cleveland	2.9%	3.0%	N/A	0.9%	0.0%
44135	Cleveland/Lindale (90%)	2.0%	2.0%	N/A	1.5%	0.0%
44136	Strongsville	3.1%	3.1%	N/A	0.3%	0.0%
44137	Maple Hts/Cleveland	1.9%	1.9%	N/A	1.4%	0.0%
44138	Olmsted Twp/Olmsted Falls	1.3%	1.3%	N/A	0.4%	0.0%
44139	Bentleyville/Glenwillow/Solon	1.6%	1.6%	N/A	0.0%	0.0%
44140	Bay Village	1.1%	1.2%	N/A	0.0%	0.0%
44141	Brecksville	1.0%	1.0%	N/A	0.1%	0.0%
44142	Brookpark/Cleveland	1.5%	1.6%	N/A	0.4%	0.0%
44143	Highland Hts/Richmond Heights	1.7%	1.8%	N/A	0.3%	0.0%
44144	Brooklyn/Cleveland	1.6%	1.6%	N/A	0.4%	0.0%
44145	Westlake	2.3%	2.4%	N/A	0.3%	0.0%
44146	Walton Hills/Oakwood/Bedford	2.3%	2.4%	N/A	0.8%	0.0%
44147	Broadview Hts	1.1%	1.1%	N/A	0.3%	0.0%
44149	Strongsville				0.1%	0.0%
	Unknown Cuyahoga County Zip Codes ^{*****}				20.2%	0.0%
	Missing ^{*****}				0.0%	100.0%
	Unknown ^{*****}				6.1%	0.0%
	Total Cuyahoga County^{*****}	100.0%	100.0%	N/A	100.0%	0.0%
	Total Known Cleveland	30.5%	29.5%	N/A	47.7%	0.0%
	Total Known Suburbs	69.5%	70.5%	N/A	32.1%	0.0%
	Unknown & Missing				6.1%	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 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.
****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 zip codes because some zip codes 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	9	4
Number of Providers by Type		
Nonprofit	9	4
For-profit	-	-
Government	-	-
Other	-	-
Total Number of Sites	13	-
Number of Service Sites per Provider		
1	5	-
2 – 5	4	-
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	1	-
44102 – Brooklyn/Cleveland	-	-
44103 – Cleveland	3	-
44104 – Cleveland	2	-
44105 – Newburgh Hts/Garfield Hts	-	-
44106 – Cleveland Hts/Cleveland	2	-
44107 – Cleveland/Lakewood	-	-
44108 – Cleveland/East Cleveland	1	-
44109 – Cleveland/Brooklyn Hts	1	-
44110 – Cleveland/Bratenahl	-	-
44111 – Cleveland	-	-
44112 – Cleveland/East Cleveland	-	-
44113 – Cleveland	1	-
44114 – Cleveland	-	-
44115 – Cleveland	1	-
44116 – Rocky River	-	-
44117 – Cleveland/Euclid	-	-
44118 – Euclid/University Hts	-	-
44119 – Cleveland/Euclid	-	-
44120 – Cleveland/Shaker Hts	-	-
44121 – University Hts/South Euclid	-	-
44122 – Orange/Warrensville Hts	-	-
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	-	-
44131 – Seven Hills/Brooklyn Hts	-	-
44132 – Euclid	-	-
44133 – North Royalton	-	-
44134 – Parma/Cleveland	-	-
44135 – Cleveland/Linndale	-	-
44136 – Strongsville	-	-
44137 – Maple Hts/Cleveland	-	-
44138 – Olmsted Twp/Olmsted Falls	-	-
44139 – Bentleyville/Glenwillow/Solon	-	-
44140 – Bay Village	-	-
44141 – Brecksville	-	-
44142 – Cleveland/Brookpark	-	-
44143 – Highland Hts/South Euclid	-	-
44144 – Brooklyn/Cleveland	-	-
44145 – Westlake	-	-
44146 – Walton Hills/Oakwood/Bedford	-	-
44147 – Broadview Hts	-	-
44149 – Strongsville	-	-

Attachment 6: Providers and Functions – 2005

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	Services
Catholic Charities Services of Cuyahoga County	Residential Substance Abuse Program for Adult Males, Residential Substance Abuse Program for Adult Females
Cleveland Restoration Church	Christian Home for Substance Abusers
East Side Catholic Center and Shelter	Alcohol/Drug – Residential Treatment- Women, Residential Chem. Dependency Treatment- Women With Children
Fresh Start	Primary Residential Treatment – Men – Fresh Start VI, Primary Residential Treatment – Women – Fresh Start I
Hitchcock Center for Women	Substance Abuse – Residential Treatment – Women
HUMADAOP	Residential Substance Abuse Treatment
New Directions Inc	Residential Treatment – Chemical Dependency – Youth
Orca House	Residential Substance Abuse Program for Women, Residential Substance Abuse Program for Men
The Salvation Army	Substance Abuse – Inpatient Treatment for Men

Bold represents agencies funded by United Way for this service.

In addition, refer to the Alcohol and Drug Addiction Services Board of Cuyahoga County's publication "The Road to Wellness: Taking the Next Step—Services Directory 2005" for more information. An on-line directory is available from the board's website at <http://www.adasbcc.org/findinghelp/provider.htm> The Alcohol and Drug Addiction Services Board of Cuyahoga County has funding contracts with 11 providers of residential treatment, for a total of 16 treatment sites.

For Men:

- Matt Talbot Inn
- Community Assessment & Treatment Therapeutic Community
- Fresh Start II
- Orca Men's Program
- Stella Maris Community for Men

For Women:

- Matt Talbot for Women
- Community Assessment Treatment -S.E. Women's Center
- East Side Catholic Center & Shelter -Miracle Village
- -Iwo San
- Fresh Start, Inc. -Fresh Start IV

- Hitchcock Center for Women
- Orca Women's Program

Detox:

- Salvation Army Harbor Light
- Huron Road Hospital (private)
- Cleveland Clinic (private)
- Stella Maris
- St. Vincent Charity Hospital – Rosary Hall

Adolescent:

- New Directions, Inc. -Dual Diagnosis Treatment & Applewood Centers (boys)
- -CCS/Parmadale (boys)

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

LX-845.700 Residential 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		
44105	Cleveland/NewburghHts/GarfieldHts	45	69	99	80	100	122%	79
44102	Cleveland/Brooklyn	26	55	61	67	64	146%	55
44103	Cleveland	25	44	54	62	65	160%	50
44109	Cleveland/Brooklyn Hts	18	30	44	52	56	211%	40
44106	Cleveland/Cleveland Hts	16	22	53	39	54	238%	37
44114	Cleveland	2	7	17	43	53	2550%	24
44107	Lakewood/Cleveland	14	18	25	18	39	179%	23
44111	Cleveland	11	13	36	29	27	145%	23
44135	Cleveland/Linndale	6	22	24	22	26	333%	20
44118	ClevelandHts/UniversityHts/ShakerHts	6	6	17	20	17	183%	13
44130	Parma/Cleveland	8	10	4	21	22	175%	13
44125	Valley View/Garfield Hts	4	4	20	10	15	275%	11
44129	Brooklyn/Parma/Cleveland	2	4	6	14	14	600%	8
44123	Euclid	1	5	9	10	8	700%	7
44132	Euclid	4	1	9	7	16	300%	7
44142	Brookpark/Cleveland	3	3	12	8	7	133%	7
44144	Brooklyn/Cleveland	1	7	10	9	5	400%	6
44119	Cleveland/Euclid	3	7	3	3	8	167%	5
44133	North Royalton	1	7	5	1	11	1000%	5
44136	Strongsville	1	4	7	6	8	700%	5
44017	Berea	2	8	4	1	7	250%	4
44126	Fairview Park/Cleveland	1	8	6	3	4	300%	4
44147	Broadview Hts	2	2	2	3	6	200%	3
44101	Cleveland	5	0	0	2	1	(80%)	2
44139	Bentleyville/Glenwillow/Solon	1	0	3	1	7	600%	2
44141	Brecksville	1	3	1	3	0	(100%)	2
	**Total Cuyahoga County	538	746	1,096	1,093	1,175	118%	930
	**Total Cleveland	305	438	650	711	700	130%	561
	**Total Suburbs	233	308	446	382	475	104%	369

* 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 2000-2004: Unmet Need

LX-845.700 Residential Substance Abuse Treatment					
United Way - First Call for Help Requests 2000-2004					
Unmet Need					
Zip Code		TOTALS 00-04			% Unmet
		Requests	Met	Unmet	
44139	Bentleyville/Glenwillow/Solon	12	11	1	8%
44136	Strongsville	26	24	2	8%
44129	Brooklyn/Parma/Cleveland	40	38	2	5%
44144	Brooklyn/Cleveland	32	31	1	3%
44132	Euclid	37	36	1	3%
44125	Valley View/Garfield Hts	53	52	1	2%
44137	Maple Hts/Cleveland	63	62	1	2%
44107	Lakewood/Cleveland	114	113	1	1%
44111	Cleveland	116	115	1	1%
44103	Cleveland	250	248	2	1%
44102	Cleveland/Brooklyn	273	271	2	1%
44120	Shaker Hts/Cleveland	287	285	2	1%
44112	East Cleveland/Cleveland	317	315	2	1%
44115	Cleveland	175	174	1	1%
44110	Cleveland/East Cleveland	183	182	1	1%
44109	Cleveland/Brooklyn Hts	200	199	1	1%
44104	Cleveland	233	232	1	0%
44108	Cleveland/Bratenahl	332	331	1	0%
44105	Cleveland/NewburghHts/GarfieldHts	393	392	1	0%
* Total Cuyahoga County		4,648	4,623	25	1%
* Total Cleveland		2,804	2,793	11	0%
* Total Suburbs		1,844	1,830	14	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.

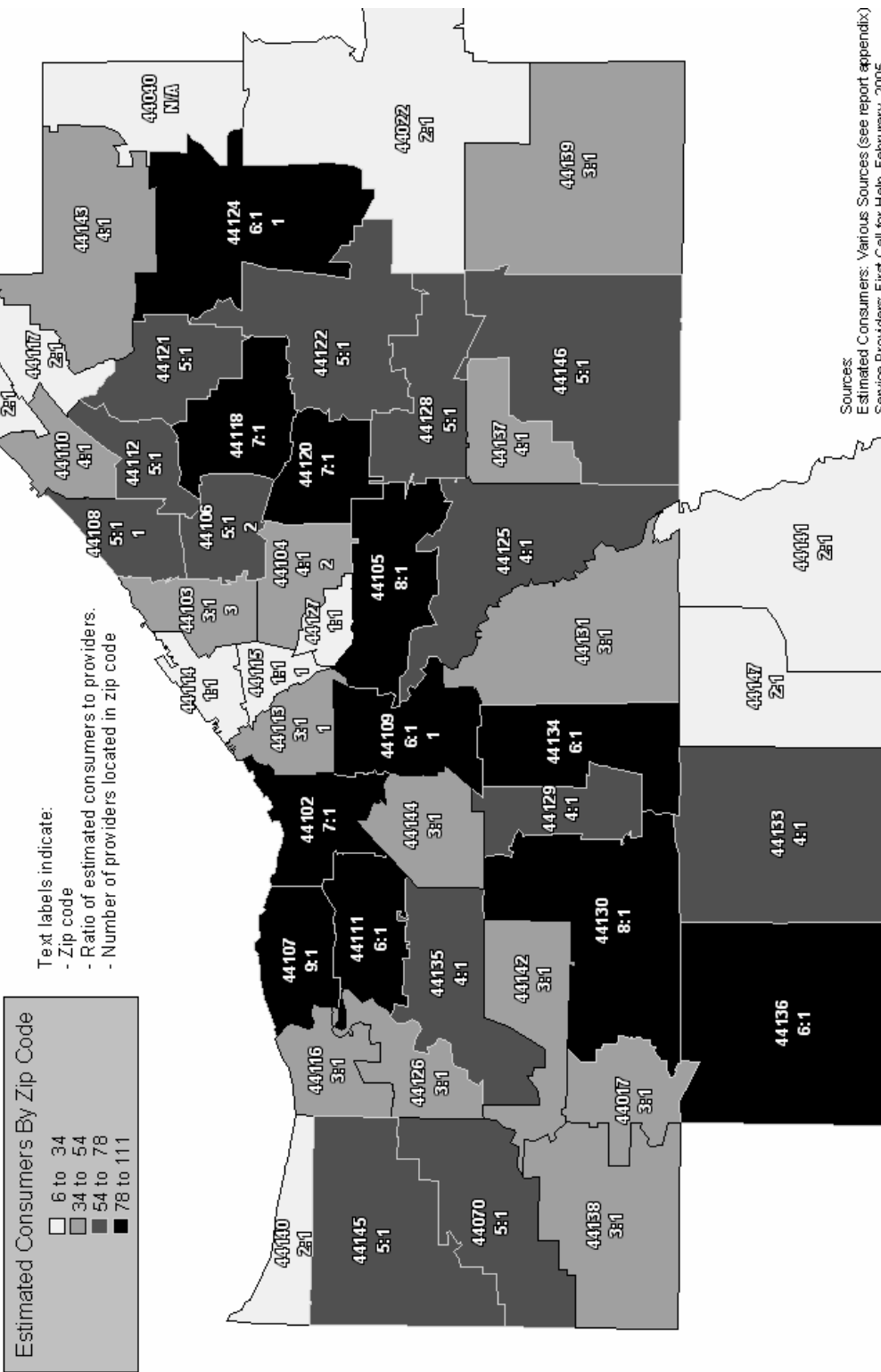
Attachment 9: Service Site Index

Core Service: Residential Substance Abuse Treatment Programs LX-845.700								
Service Site Index								
Zip	Number of Sites****	City/Town (% Cleveland)	Proportion of Minorities in Geographical Area	Total Population (#)*	Total Population 12+ (#)**	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
Period				1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/2005	Ratio of CONSUMERS to Service SITES
TOTAL	13			1,393,978	1,160,037	2,635	13	203:1
Percent					83.2%	0.2%		
44117		Euclid/Cleveland	African Am 53.1%	12,078	10,564	24	13	2:1
44105		Cleveland/NewburghHts/ GarfieldHts (75%)	African Am 61.9%	54,834	43,067	98	13	8:1
44106	2	Cleveland/Cleveland Hts (60%)	African Am 62.2%	32,417	27,700	63	13	5:1
44110		Cleveland/East Cleveland (98%)	African Am 74.7%	26,536	20,769	47	13	4:1
44120		Shaker Hts/Cleveland	African Am 76.7%	47,349	38,006	86	13	7:1
44103	3	Cleveland (100%)	African Am 80.2%	25,348	19,990	45	13	3:1
44108	1	Cleveland/Bratenahl (90%)	African Am 94.9%	36,456	28,796	65	13	5:1
44112		East Cleveland/Cleveland	African Am 95.2%	33,222	26,225	60	13	5:1
44128		Warrensville Hts/Cleveland	African Am 95.8%	33,612	27,885	63	13	5:1
44104	2	Cleveland (100%)	African Am 97.5%	28,904	21,034	48	13	4:1
44115	1	Cleveland (100%)	African Am 98.4%	8,186	5,820	13	13	1:1
44114		Cleveland (100%)	Asian 20.3%	3,891	3,363	8	13	1:1
44109	1	Cleveland/Brooklyn Hts (98%)	Hispanic 20.3%	45,783	36,696	83	13	6:1
44102		Cleveland/Brooklyn (95%)	Hispanic 20.4%	52,108	41,318	94	13	7:1
44113	1	Cleveland (100%)	Hispanic 23.5%	19,466	16,205	37	13	3:1
44017		Berea		19,005	16,606	38	13	3:1
44022		Bentleyville		17,720	9,438	21	13	2:1
44040		Gates Mills/Mayfield Village		2,883	2,483	6	13	N/A
44070		North Olmsted		34,081	28,950	66	13	5:1
44101	1	Cleveland (100%)		-	0	-	5	N/A
44107		Lakewood/Cleveland		56,710	48,957	111	13	9:1
44111		Cleveland (100%)		42,967	35,276	80	13	6:1
44116		Rocky River		21,122	18,105	41	13	3:1
44118		ClevelandHts/UniversityHts/ ShakerHts		45,279	37,910	86	13	7:1
44119		Cleveland/Euclid (50%)		13,493	11,512	26	13	2:1
44121		University Hts/South Euclid		35,185	29,460	67	13	5:1
44122		Beachwood/Highland Hills/ShakerHts		34,883	30,192	69	13	5:1
44123		Euclid		18,363	15,258	35	13	3:1
44124	1	Pepper Pike/MayfieldHts/Lyndhurst		40,334	35,461	81	13	6:1
44125		Valley View/Garfield Hts		29,876	25,301	57	13	4:1
44126		Fairview Park/Cleveland		17,196	14,798	34	13	3:1
44127		Cleveland (100%)		8,403	6,462	15	13	1:1
44129		Brooklyn/Parma/Cleveland		29,658	25,107	57	13	4:1
44130		Parma/Cleveland		53,615	46,873	106	13	8:1
44131		Independence/Seven Hills/BrooklynHts		20,666	18,189	41	13	3:1
44132		Euclid		15,322	12,783	29	13	2:1
44133		North Royalton		28,685	24,182	55	13	4:1
44134		Parma/Cleveland		40,396	34,516	78	13	6:1
44135		Cleveland/Linddale (90%)		28,561	23,656	54	13	4:1
44136		Strongsville		43,858	36,284	82	13	6:1
44137		Maple Hts/Cleveland		26,107	21,566	49	13	4:1
44138		Olmsted Twp/Olmsted Falls		18,046	15,223	35	13	3:1
44139		Bentleyville/Glenwillow/Solon		22,231	18,078	41	13	3:1
44140		Bay Village		16,076	13,378	30	13	2:1
44141		Brecksville		13,676	11,461	26	13	2:1
44142		Brookpark/Cleveland		21,132	18,110	41	13	3:1
44143		Highland Hts/Richmond Heights		23,730	20,302	46	13	4:1
44144		Brooklyn/Cleveland		21,805	18,710	42	13	3:1
44145		Westlake		31,972	27,407	62	13	5:1
44146		Walton Hills/Oakwood/Bedford		31,648	27,316	62	13	5:1
44147		Broadview Hts		15,954	13,289	30	13	2:1

* U.S. Census 2000, SF1 (P1)
 ** U.S. Census 2000, SF3 (P8)
 *** 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.
 **** United Way - First Call for Help, February 2005

Attachment 10: Map

United Way of Greater Cleveland, Core Service Research
Estimated Universe of Possible Consumers:
Residential Substance Abuse





**United Way of
Greater Cleveland**

1331 Euclid Avenue

Cleveland, Ohio 44115

uws.org/CoreServicesPlanning