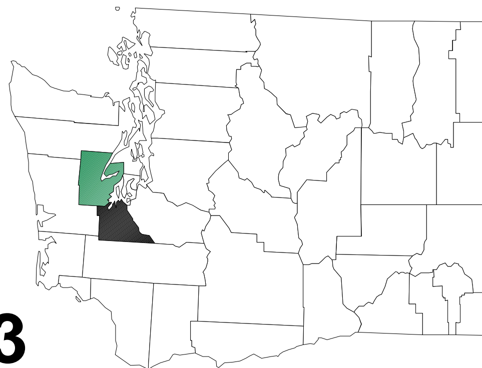
Thurston/Mason County

Strategic Plan for

Substance Abuse
Prevention | Intervention | Treatment | Aftercare
Services

2007-2013



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June, 2007

ACKNOWLEDGEMENTS

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- Donna Bosworth, Chemical Dependency Program Manager
- Erik Landaas, Chemical Dependency Program Specialist
- Kristi Strup, Chemical Dependency Prevention Specialist
- Tina Gehrig, Chemical Dependency Administrative Assistant

THE THURSTON/MASON COUNTIES CHEMICAL DEPENDENCY STRATEGIC PLAN – 2007-2013

CONTENT

- Based upon Washington State Division of Alcohol and Substance Abuse (DASA) six (6) year strategic plan guidelines for prevention, intervention, treatment, and aftercare (PITA)

CONTENT PREPARATION

- Written and edited by Kristi Strup, Erik Landaas, Mary Ann O'Garro, Donna Bosworth, and Tina Gehrig
- Data prepared by Looking Glass Analytics and County staff
- Community Mobilization Against Substance Abuse (CMASA) data and supporting information provided by: Mary Segawa and Chris Zipperer, TOGETHER!, and Julianna Miljour, MCDAP
- Reviewed by Thurston/Mason Chemical Dependency Action Committee

OBJECTIVE

- To provide an overview of Substance Use, Abuse and Addiction in Mason and Thurston Counties using data and associated research, as a means to support the development of plans and strategies that impact Substance Use, Abuse and Addiction.
- To provide a plan that will inform the County and its stakeholders of the direction of PITA services in Thurston and Mason Counties for the next six (6) years.

DEFINITIONS

- Strategic – Merriam Webster's Dictionary defines as:
  a**:** necessary to or important in the initiation, conduct, or completion of a strategic plan

- Plan – Merriam Webster's Dictionary defines as:
  2 a**:** a method for achieving an end b**:** an often customary method of doing something

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B. Thurston/Mason Counties Chemical Dependency Prevention Strategic Plan 2007-2013

C. Thurston County Prevention Programs by Risk Factor

D. Chemical Dependency Treatment Services for the Aging, Blind, and Disabled Populations for Thurston and Mason County Report

E. Key Informant Interview Summaries

F. Prescription Narcotics: It's Effect on a Community – Mason County and Thurston County

G. HIV Prevention and Education – Intervention Summary Report

H. 2007 Homeless Census for Thurston County

CHEMICAL DEPENDENCY PROGRAM OVERVIEW

MISSION

The mission of the Chemical Dependency Program of the Thurston County Public Health and Social Services Department is to operate in a manner that administers efficient and effective use of allocated resources and revenues. This is accomplished through coordination, collaboration, planning, development, implementation, and monitoring of the publicly funded chemical dependency prevention and treatment system.

OVERVIEW (THURSTON/MASON COUNTY SERVICES)

The Thurston County Public Health and Social Services Department, Chemical Dependency Program administers, coordinates and contracts for services for individuals who are chemically dependent. The County contracts with community agencies to provide services that address substance abuse prevention, use, abuse, and addiction. Related services provided through the program include:

- Drug/Alcohol Outpatient Treatment (Adult & Youth)
- ADATSA Assessment and Outpatient Treatment
- Opiate Substitution Treatment
- Medical Detoxification
- Chemical Dependency Involuntary Commitment
- Substance Abuse Prevention
- 24-hour Telephone Crisis Intervention, Information and Referral
- Community Education
- Child Care
- Intensive Case Management
- Nursing Home Services
- Pregnant/Parenting Women's Outpatient
- Transitional Support Services
- WSBIRT
- CJTA – Adult Drug Courts and Adult CJTA Outpatient/Inpatient

Thurston County Public Health and Social Services contracts with the following providers for treatment services in Thurston and Mason County:

- Alternatives Professional Counseling
- BHR Recovery Services
- Damon Counseling Services
- ESD 113 True North Student Assistance Program
- Evergreen Treatment Services – South Sound Clinic
- Northwest Resources
- Providence St. Peter Chemical Dependency Center
- Sea Mar Community Health Centers

Services are available to low income and indigent clients, which includes persons with no income or who receive state assistance for care and support services. Payment for services may include use of a sliding fee scale which matches household income with federal poverty guidelines to determine cost; or no cost to priority populations as determined by the provider and the County.

Thurston County Public Health and Social Services contracts with the following providers for selected prevention services in Thurston and Mason County:

- Big Brothers Big Sisters of Thurston County
- Mason County Drug Abuse Prevention (MCDAP)
- TOGETHER! of Thurston County

PREVENTION PROGRAMS:

- Foster Care Mentoring
- Project Northland
- Strengthening Families
- Parenting Wisely
- Teen Mentoring Program
- Community Organizing
- PACT/ESL Program
- Kids' Place, ROOF Community Center
- Evergreen Villages Neighborhood Center
- Project ALERT

OVERSIGHT AND ACCOUNTABILITY

Thurston and Mason Counties each have an elected three member Board of County Commissioners (BOCC). BOCC members represent particular geographic districts within their county and are elected for four-year terms. The Mason County BOCC has delegated the majority of its administrative authority regarding chemical dependency prevention and treatment services funded through the Washington State Division of Alcohol and Substance Abuse to the Thurston County Board of Commissioners.

In addition, the Thurston/Mason Chemical Dependency Action Committee works in conjunction with staff. The Committee has been involved with the six (6) year plan. They met with staff on April 3, 2007 to review data related to the prevention plan.

RESPONSIBILITIES

The Chemical Dependency Program assumes responsibilities for services by:

- Service planning and coordination; program funding and contractor selection; managing and monitoring contracted providers.
- Analyzing and monitoring chemical dependency subcontractors; working with local providers on systems improvement.
- Researching, developing, and planning social services to maximize service delivery to meet the needs of the identified client population within available resources.
- Maintaining working relationships with State and County agencies across systems.

ORGANIZATIONAL STRUCTURE

The Thurston County Public Health and Social Services Department is organized into three major divisions: Environmental Health, Personal Health, and Social Services. Programmatic planning, budget, contract development, monitoring, and evaluation activities are carried out by each division at the program level. Within the Department, the Chemical Dependency Program also carries out management, coordination and monitoring activities for substance abuse prevention and chemical dependency treatment services in Thurston and Mason Counties.

The Social Services Program consists of the chemical dependency program, regional support network (RSN), and developmental disabilities division. Program managers strive to collaborate and coordinate across systems toward the mutual benefits of patients. In addition, staff works with Public Health to educate staff about the chemical dependency system and provide resources as requested.

Administrative Support Services carries out the Department's responsibilities for fiscal management. The fiscal division is responsible for billing the State, payment to subcontractors, and monitoring program expenditures and revenues against the biennial budget. The fiscal and program managers routinely meet to review the chemical dependency prevention and treatment program budget.

SERVICE DELIVERY

In the substance abuse prevention service area, the Thurston/Mason Chemical Dependency Program contracts with qualified prevention agencies. Treatment services are provided by contracts with state certified chemical dependency agencies for services in both Thurston and Mason County. Chemical Dependency contracts are for specific services to be provided to priority populations which meet federal, state, and local requirements and guidelines.

MORE INFORMATION

For more information about the Chemical Dependency Program or for related questions, please contact:

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REPORT BACKGROUND

PURPOSE

This report derives its purpose from guidelines which are defined by the Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, County Alcohol/Drug Coordinators and Washington State law.

The County Strategic Plan will address county-specific needs, resources, and implementation strategies for community-based substance abuse prevention, intervention, treatment, and aftercare/support services spanning July, 2007 through June 2013.

This five step planning process includes the following:

Step 1: Initial Networking and Community Assessment
Step 2: Mobilize and Capacity Building
Step 3: Comprehensive Strategic Plan and Goal Formation
Step 4: Implementation
Step 5: Evaluation

The Chemical Dependency Prevention and Treatment and Support Services Planning Guidelines call for a Needs and Risk Assessment that incorporates a review of 1) Community Risk related to Substance Use, 2) Needs of Special Populations, 3) Issues affecting Substance Abuse Treatment, 4) Status of Chemical Dependency Service Levels, 5) Criminal Justice System issues related to Substance Abuse or Addiction, and 6) Substance Abuse Prevention Services.

REPORT FOCUS

This report was created to provide data to support strategic plan development and to assist Chemical Dependency Program staff in the assessment process. A broad range of data was reviewed by Chemical Dependency staff over the 2005-07 biennium. A selected series of findings from 05-07 data reviewed have been included in this report. The findings presented here are meant to inform the County in the decision making process that will be undertaken to develop services and service delivery strategies for the 2007-2009, 2009-2011, and 2011-2013 biennia. The focus of this report will cover the 2007-2009 biennium and attempt to identify and describe future biennia. The report could also be utilized by various community stakeholders for prevention and treatment planning between 2007-2013.

REPORT CONTENT

A wide range of data and material could be included in a substance abuse related assessment. For this particular report the content of interest was narrowed down to three major data areas. These three areas are: A) the Population of Mason and Thurston Counties, B) Substance Use and Abuse in Mason and Thurston Counties, and C) HYS Select Data 2004 and 2006.

- Data reviewed regarding the Population of Mason and Thurston Counties are intended to provide an up-to-date description of a chosen set of demographic and other related data indicators.
- Data reviewed regarding Substance Use in each county are intended to provide an up-to-date description of a chosen set of alcohol, tobacco and other drug related data indicators.
- Both the Population and Substance Use sections of this report are intended to provide a broad perspective view of community status/standing and provide insight into service related issues for consideration during the planning process.

Additional data on a set of specific special topic areas was also reviewed. This third report section includes a summary review of data regarding the community environment and specific characteristics of the Mason and Thurston County populations.

DATA DEPTH

Determinations about what data to present in this report were based on expected need for specificity or detail. Some sections of the report may contain several pages of related data and others simply a few paragraphs. A large volume of data was reviewed by Chemical Dependency Program staff, Epidemiology staff and the Thurston/Mason Chemical Dependency Action Committee to assure informed decision making. Findings presented here are considered essential, but not inclusive of all data that may be used during the planning process.

REPORT CONTACT AND ACCESS

To obtain additional copies of this report, please use the following contact information. If an alternative format is needed to help organizations or individuals obtain access to this report, please contact us.

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DATA QUESTIONS

Questions or comments about the data or information presented in this report should be directed to the Chemical Dependency Program staff of the Thurston County Public Health and Social Services Department. If you believe you have found a technical or non-technical error, please contact us.

ORIENTATION TO TOPIC

OVERVIEW OF CHEMICAL DEPENDENCY

Addressing the "Substance Use and Abuse" of an area's population involves the promotion of healthier environments, behaviors, attitudes, and choices that prevent, delay or reduce the harm resulting from the problematic use of tobacco, alcohol, prescription drugs, over-the-counter drugs, and illegal drugs. This report strives to provide data that support a broad perspective into the community status of chemical use and related contributing factors.

Substance abuse is a severe and complex public health problem. Drug and alcohol abuse accounts for approximately 80% of incarcerated individuals in Washington State. Approximately 79% of youth entering juvenile detention facilities have substance abuse problems. More inmates in Washington State Department of Corrections are convicted of drug offenses than any other crime.(1)

There are service gaps in alcohol and drug treatment services in Thurston and Mason County for a variety of reasons. For example, there are patients that over-utilize public services such as hospital emergency rooms, medical detoxification centers, crisis mental health services, local jails and safety net health clinics.

Washington taxpayers pay more than $2 billion each year in medical and criminal justice costs and lost productivity due to untreated substance abuse. Without ongoing specialized care to treat their illnesses, substance abusers frequently rely on emergency medical services, which are costly to provide. (1)

Due to the growing need for alcohol/drug treatment services and shrinking public funds for services, local communities need to address this emerging dilemma. This needs assessment will assist the Chemical Dependency Program and other stakeholders better understand the needs of the community in relation to substance abuse in Thurston and Mason Counties.

The challenge we all face in the field of chemical dependency treatment and prevention is working within fiscal constraints that limit service delivery. In particular, prevention funding has not increased in over ten (10) years.

(1) *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State Report, 2003*

PREVENTION, INTERVENTION, TREATMENT, AND AFTERCARE (PITA) DEFINITIONS

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

Prevention

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

- Alcohol use is acceptable only for those of legal age and only when the risk of adverse consequences is minimal and to not use tobacco, tobacco products and illegal drugs.

- Prescription and over-the-counter drugs are used only for the purposes for and by whom they are intended.
- Other substances, such as gasoline or aerosols, are used only for their intended purposes.
- Pregnant and women who may become pregnant do not use alcohol, tobacco, or other drugs.
- Stopping or delaying the "first use" of chemicals, specifically alcohol, tobacco, and other drugs, is a major goal of the chemical dependency prevention field.

WHAT DOES PREVENTION LOOK LIKE?

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

Universal prevention programs/strategies strive to reach the general population such as all students in a school or all parents of middle school students.

Selective prevention programs target groups at risk or subsets of the population such as children of drug users or poor school achievers.

Indicated prevention programs identify individuals who are exhibiting early signs of problem behavior(s) and target them with special programs to prevent further onset of difficulties.

- Substance use that has not yet begun is known as primary prevention.

- If substance use has begun, intervening early in this stage of "misuse" is an additional priority of substance related work. This is also known as secondary prevention.

- Once dependence or addiction has been determined, providing treatment is the final intervention method available in the substance abuse field. This is also known as tertiary prevention.

INTERVENTION

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

Intervention services include but are not limited to:

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

TREATMENT

The goal of treatment is to improve social functioning through complete abstinence of alcohol and drugs for individuals diagnosed with chemical dependency. Treatment is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual suffering from alcoholism or from another drug dependency designed to enable the affected individual to achieve and maintain sobriety, physical and mental

health and a maximum functional ability. For further information, see the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC) 2-R.

Aftercare

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

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

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

Diagnosis

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

Definitions

Substance *Use*

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

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

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

Substance Use Disorders are separated into two categories (Diagnostic Criteria):

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

Substance *Abuse/Misuse*

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

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

Substance *Dependence*

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

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

MORE INFORMATION

For more information about Substance Abuse Prevention, please contact Kristi Strup at 360-786-5585 ext. 17210#, strupk@co.thurston.wa.us

For more information about Substance Abuse Treatment, please contact Erik Landaas at 360-786-5585 ext. 16955#, landaae@co.thurston.wa.us

DATA SOURCES AND OPTIONS

DATA SOURCES

Numerous research articles were reviewed to provide context for the data in this report. However the majority was accessed through the following organizations:

1) U.S. Census Bureau

The data responsibilities of the U.S. Census Bureau are broad, however the primary purpose for this federal agency's existence is to conduct the U.S. Census. The Census is a national event that is carried out every 10 years. It is required by the U.S. Constitution and has occurred since 1790. The majority of population related data presented in this report comes directly from the 2000 Census and 1990 Census. To view data available from the U.S. Census Bureau directly, visit their website at http://www.census.gov

2) Washington State Office of Financial Management

The Office of Financial Management (OFM) provides population estimates for all years other than Census years. Non-census year population figures (e.g. 1991-1999 and 2001-2004) are developed by OFM and

are released annually. To view data available from the Office of Financial Management directly, visit their website at http://www.ofm.wa.gov

3) **Washington State Department of Health**

The Department of Health (DOH) has the primary responsibility of collecting numerous sources of data that relate to the health and well-being of area residents. Data collected by DOH include births, deaths, hospitalizations, and youth behaviors. To view data available from the Department of Health directly, visit their website at http://www.doh.wa.gov

4) **TARGET and Treatment Analyzer**

The Division of Alcohol and Substance Abuse management information system, TARGET, provides data while the web-based Treatment Analyzer allows for more detailed reports.

5) **Healthy Youth Survey – 2004-2006**

The Healthy Youth Survey (HYS) is a collaborative effort of the Office of the Superintendent of Public Instruction, the Department of Health, the Department of Social and Health Service's Division of Alcohol and Substance Abuse, the Community Trade and Economic Development and the Family Policy Council. The Healthy Youth Survey provides important information about adolescents in Washington. County prevention coordinators, community mobilization coalitions, community public health and safety networks, and others use this information to guide policy and programs that serve youth.

The information from the Healthy Youth Survey can be used to identify trends in the patterns of behavior over time. The state-level data can be used to compare Washington to other states that do similar surveys and to the nation.

Other Key Publication Options

Other substance use related data were available, but not included in this report. The intent of this report was to assemble and summarize a specific set of data to support Chemical Dependency Program planning efforts. Several publications are available with descriptions of county level substance use related data. Including:

- "Risk and Protection Profile for Substance Abuse Prevention Report". Washington State Department of Social and Health Services, Research & Data Analysis Division. http://www1.dshs.wa.gov/rda/research/risk.shtm
- "County Profile of Substance Use and Need for Treatment Services in Thurston and Mason County". Washington State Department of Social and Health Services, Research & Data Analysis Division. http://www1.dshs.wa.gov/rda/research/4/32/default.shtm

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General Note about Data and this Report

Data in tables and graphs found in this report may not add up to total or 100%. For example, due to rounding of numbers during calculation a 100% sum may not occur or missing records/information may impact the calculation of figures.

Step 1
Initial Networking and Community Assessment

The Chemical Dependency Program of the Thurston County Public Health and Social Services Department collaborated with various agencies to effectively evaluate the Counties needs in prevention, intervention, treatment, and aftercare and collaborate on the development of a six (6) year strategic plan. The following is a list of the main collaborating agencies and groups:

A. Thurston County

- The following reports and/agencies contributed towards this community assessment:
  - Thurston County Public Health and Social Service Epidemiological Program
  - Looking Glass Analytics
  - RMC Research Corporation
  - TOGETHER! of Thurston County
- Healthy Youth Survey 2004 and 2006 data
- Thurston/Mason Chemical Dependency County Contracted Treatment and Prevention Providers
- Thurston/Mason Chemical Dependency Action Committee
- Communities That Care® (CTC)
- Key informant interviews from various groups and individuals in Thurston County
- TOGETHER! of Thurston County Board Meetings
- Be the One Mentoring Coalition
- Adult Protective Services – A Team
- Children's Community Consensus (CCCT)
- Coordination and collaboration with mental health services (RSN)

B. Mason County

- The following reports and/agencies contributed towards this community assessment:
  - Thurston County Public Health and Social Service Epidemiological Program
  - Looking Glass Analytics
  - RMC Research Corporation
  - Mason County Drug Abuse Prevention (MCDAP)
- Thurston/Mason Chemical Dependency County Contracted Treatment and Prevention Providers
- Thurston/Mason Chemical Dependency Action Committee

- Mason County Drug Abuse Prevention (MCDAP) Board
- Mason County Interagency
- Be the One Mentoring Coalition
- Children's Community Consensus Team (CCCT)
- Coordination and collaboration with mental health services (RSN)

The Division of Alcohol and Substance Abuse (DASA) requires all counties to complete a (prevention, intervention, treatment and aftercare) P-I-T-A Needs Assessment and six year strategic planning process. Agencies who contract to provide Community Mobilization services also had a requirement to conduct a similar needs assessment to maintain their funding from Washington State Department of Community Trade and Economic Development (CTED).

The following County contracted prevention agencies also contract with CTED for community mobilization and prevention services. These two agencies worked together with the County to minimize redundancies that could have occurred within the community while conducting these required dual needs assessments. This partnership included sharing on particular portions of the planning process.

The two counties have varying demographics and needs. The agencies collaborated in their process where appropriate, but each also conducted their own assessment with various community groups and populations.

*__Mason County – MCDAP__ Board of Directors and Interagency Meetings with numerous providers - provided extended collaboration and insight.

*__Thurston County__ - __TOGETHER! of Thurston County__ Board of Directors, Communities That Care®, and select key informant interviews - provided extended collaboration and insight.

DATA

An assessment of prevention service gaps and barriers was initiated by the County and collected during a Thurston and Mason County Chemical Dependency Provider meeting on September 13, 2006. The participants included Thurston/Mason County Contracted DASA Certified Alcohol/Drug Treatment Providers, and County Contracted Prevention Providers, Public Health and Social Service HIV Education Outreach workers, and the Thurston County Public Health and Social Services Chemical Dependency Program.

The treatment providers serve the following populations:

- Persons with disabilities
- Youth
- Pregnant/postpartum women
- Parents with young children
- Elderly
- Gay, Lesbian, Bisexual, and Transgender persons
- Intravenous drug users

Prevention, intervention, treatment, and aftercare service needs were identified in a brainstorming session where participants identified barriers and gaps in current services.

The group then prioritized each of the issues identified. The following is a summary of those results. The number indicated is the number of participants who prioritized that particular item.

Thurston/Mason County Barriers and Gaps to Prevention Services

Barrier	Priority
Funding	9
Social norms and attitudes	9
Cultural/language	5
Restrictions with funding	4
Engagement with families	3
Community education with professionals	3
Economic	2
Limitations and demands on schools (time constraints and access to students)	1
Access to clients/families in need (maxed out – time constraints)	1
Increased understanding of how prevention and treatment work together	1

Gap	Priority
Funding	9
Stakeholder engagement	9
Volunteer resources	5
Professional training	5
Media support	4
Elementary education	3
Targeted services for adult prevention	3
Early childhood education/support around risk & protective factors	2

Thurston/Mason County Barriers and Gaps to Intervention Services

Barrier	Priority
Lack of funding	8
Education/awareness about intervention	6
Lack of resources for indigent/work poor/uninsured	5
Resistance to harm reduction	5
Medical community awareness/education	5
Eligibility for public funding	4
Cultural/language	3
Attitudes and policies around jail, courts	2
Collaboration missed among stakeholders	2
High case loads among case managers	1

Gap	Priority
Funding (overall)	12
Community agency collaboration (CPS, etc.)	6
Increased case management programs	6
Working with high risk families	3
Structured youth/foster care	3
Subacute social detox	3
Faith based communities	2
Resources for indigent (i.e., housing)	2
Public school intervention specialist	2
Incarcerated population	1

Thurston/Mason County Barriers and Gaps to Treatment Services

Barrier	Priority
Funding restrictions	8
Managed care/legislation parity	8
Access to detox beds	7
Chemical Dependency Professional (CDP) infrastructure and regulations	5
Stigma/denial negative perception of treatment and recovery	5
Reimbursement	4
Maladaptive systems	2
Access to mental health services	2
Community education on diagnosis and perceptions	2
Underserved population	1
Transportation	1
Gap	**Priority**
Detox beds	8
Decreased medical services for low income	8
Co-occurring inpatient and long term residential	8
Working with court systems	5
Rural support services	4
Cultural services (appropriate)	3
Harm reduction gaps	3
Lack of facilities	2
Information and how to access treatment	1
Referrals from jails	1

Thurston/Mason County Barriers to Aftercare Services

Barrier	Priority
Funding	9
Connection/discharge planning (collaboration/follow-up)	6
Legal/court system (lack of knowledge)	6
Environmental challenges	5
Lack of client engagement	4
Lack of agency investment (philosophically)	4
Education around families	3
Client perception/retention	2
Child care	1
Transportation	1
Gap	**Priority**
Recovery housing/clean and sober housing	11
Funds for aftercare, follow-up	8
Vocational training/support	7
Transportation	3
Follow-up survey (i.e., client satisfaction)	3
Culturally appropriate services	2
Mentoring	2
Lack in rural communities	2
Family counseling	2
Agency cooperation among community/health services	1

THURSTON/MASON COUNTY CONTRACTED SERVICES:

TREATMENT PROGRAMS

- Drug/Alcohol Outpatient Treatment (Adult & Youth)
- ADATSA Assessment and Outpatient Treatment
- Opiate Substitution Treatment
- Medical Detoxification
- Chemical Dependency Involuntary Commitment
- Substance Abuse Prevention
- 24-hour Telephone Crisis Intervention, Information and Referral
- Community Education
- Child Care
- Intensive Case Management
- Nursing Home Services
- Pregnant/Parenting Women's Outpatient
- Transitional Support Services
- WSBIRT
- CJTA – Adult Drug Courts and Adult CJTA Outpatient/Inpatient

PREVENTION PROGRAMS:

- Foster Care Mentoring
- Project Northland
- Strengthening Families
- Parenting Wisely
- Teen Mentoring Program
- Community Organizing
- PACT/ESL Program
- Kids' Place, ROOF Community Center
- Evergreen Villages Neighborhood Center
- Project ALERT

Treatment Admission Trends Among Priority Populations

The following section will include data specific to each of these priority populations:

- Overall Outpatient Admissions
- Persons With Disabilities Outpatient Admissions
- Youth Outpatient Admissions
- Pregnant/Parenting Women Outpatient Admissions
- Parents with Kids Outpatient Admissions
- Elderly Population Statistics
- Gay, Lesbian, or Transgender Outpatient Admissions
- IV Drug Users Outpatient Admissions
- Criminal Justice Outpatient Admissions

Assessment of Service Needs for Selected Populations

Thurston/Mason Chemical Dependency Outpatient Admissions ~ 2000-2006

Overall chemical dependency outpatient treatment admissions have steadily increased between 2000 and 2006. There were 586 outpatient admissions in the first half of 2000, and 862 in the first half of 2006, which represents a 47% increase in six years.

There was one six month period that was abnormal. In the first half of 2005 there were 915 outpatient admissions, which was the highest number of admissions and more than the number of outpatient admissions for the first half of 2006.

The increasing trend in overall chemical dependency outpatient treatment admissions (47%) is significantly greater when compared to overall Thurston/Mason County population growth data. There was a 10.7% increase in the Thurston/Mason population between 2000 and 2006.

Change in Population in Thurston and Mason Counties

	2000	2006	% change	2010	2013
Mason	49,405	53,100	↑ 7.5%	58,604	61,809
Thurston	207,355	231,100	↑ 11.5%	258, 687	275,213
Thurston/Mason Combined	256,760	284,200	↑ 10.7%	317,291	337,022

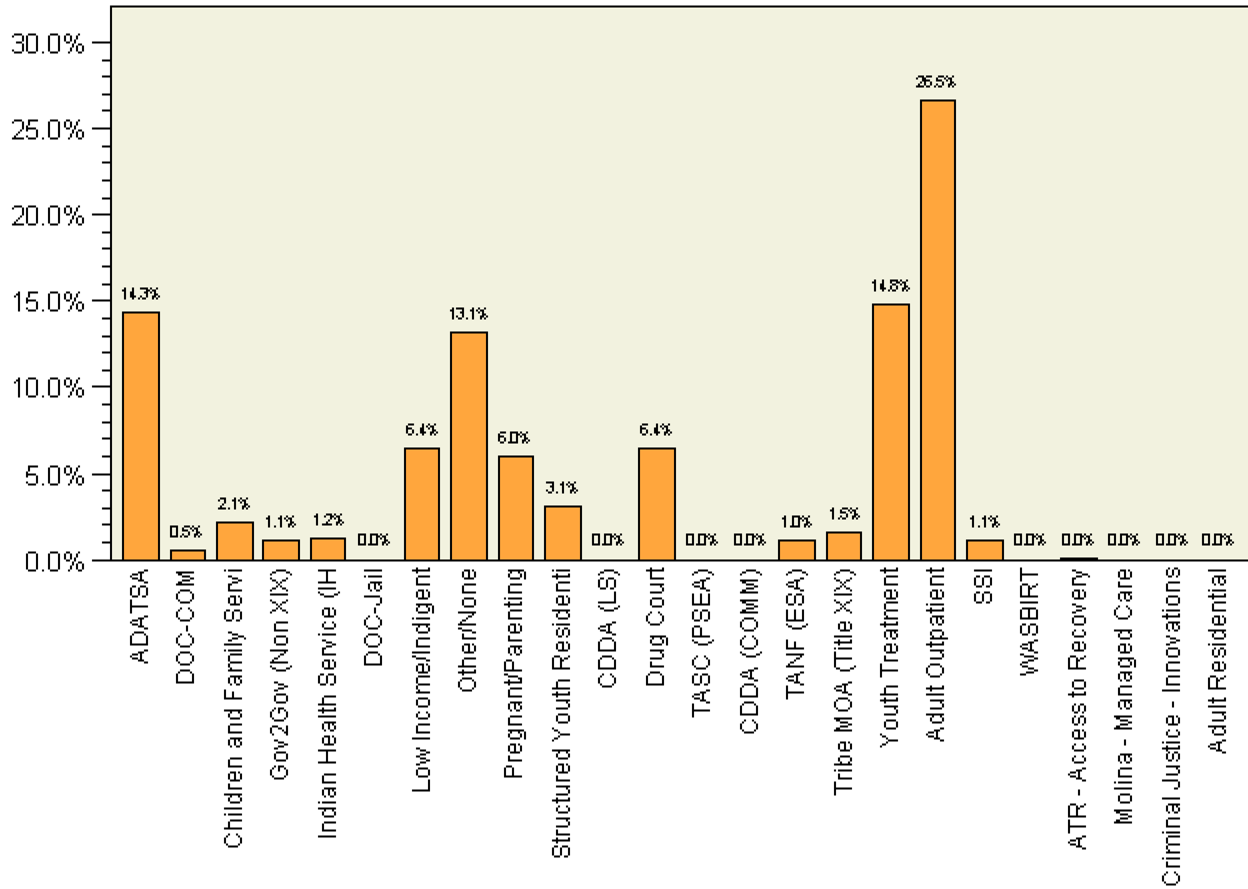
Source: Washington State Office of Financial Management, Census Count and Population Estimates
Projections based on Growth Management Act Intermediate Series

Given the change in population between 2000 and 2006, current projections show that both Mason and Thurston Counties will continue to grow. By 2013, Thurston County is expected to grow to an estimated 275,213 residents and Mason County to 61,809 residents for a Thurston/Mason combined total of 337,022. With these projections and the County's ability to reach deeper into the chemically dependent populations, the Thurston/Mason Chemical Dependency Program will anticipate greater numbers of chemical dependency outpatient treatment admissions. If the increase of outpatient admissions is similar to the period between 2000 and 2006 (47%), the chemical dependency program shall anticipate seeing 1,267 admissions in 2013.

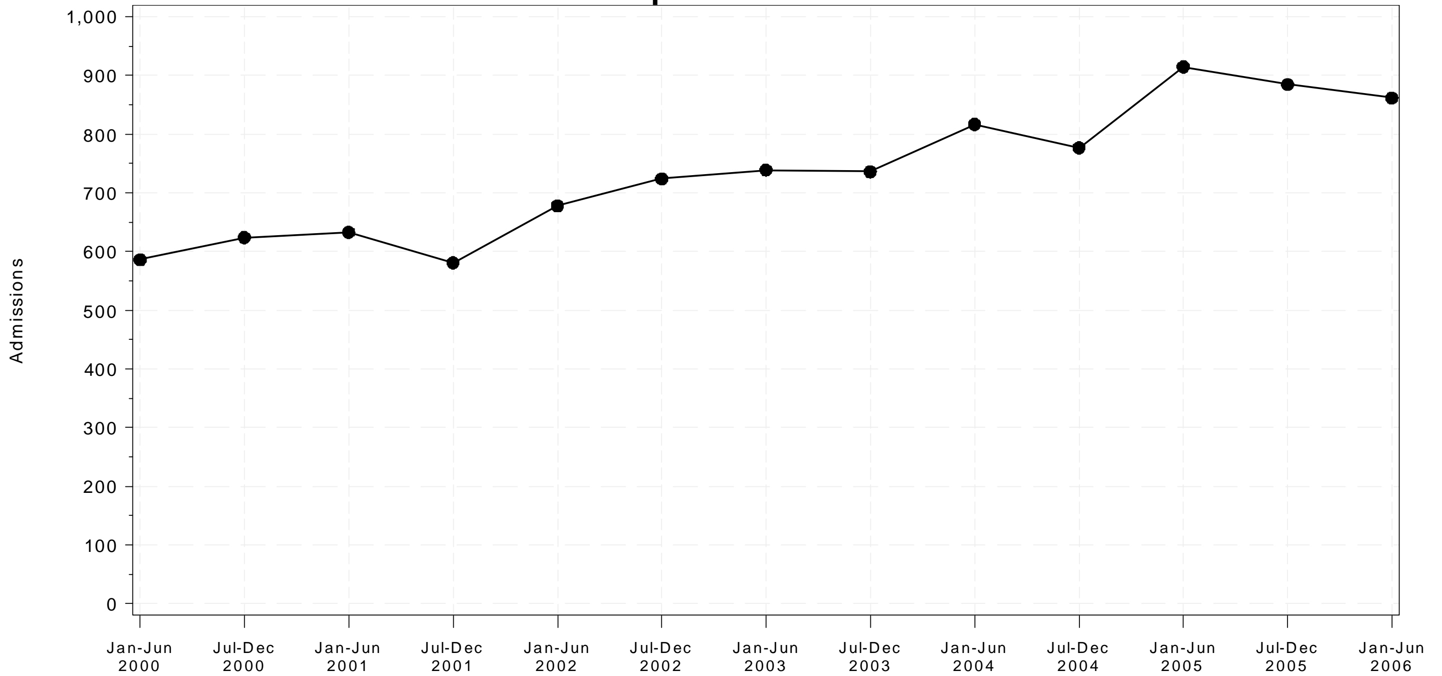
Currently, there are significant demands on the public system to meet the needs of chemically dependent individuals living in Thurston and Mason Counties. Between now and 2013 there will be even greater demands placed on the Division of Alcohol and Substance Abuse (DASA) and Counties to meet the needs of the chemically dependent. The County predicts that treatment services will be in more demand with eligibility requirements and prioritization screening becoming a significant factor if funding and infrastructure do not grow to meet the projected demands.

The following chart illustrates the breakdown of treatment services by contract type. The majority of the services were Adult, Youth, and ADATSA outpatient.

Thurston/Mason County – Overall Admissions by Contract Type
2000 – 2006



Source: DASA Treatment Analyzer
January, 2000 – December, 2006 – Thurston and Mason Counties



Comparison of Admissions Over Time

Jan-Jun 2006 Compared to...	*Change in All Admissions[5]*
Jan-Jun 2005	-5.79% ▼
Jan-Jun 2003	16.64% △
Jan-Jun 2000	47.09% △

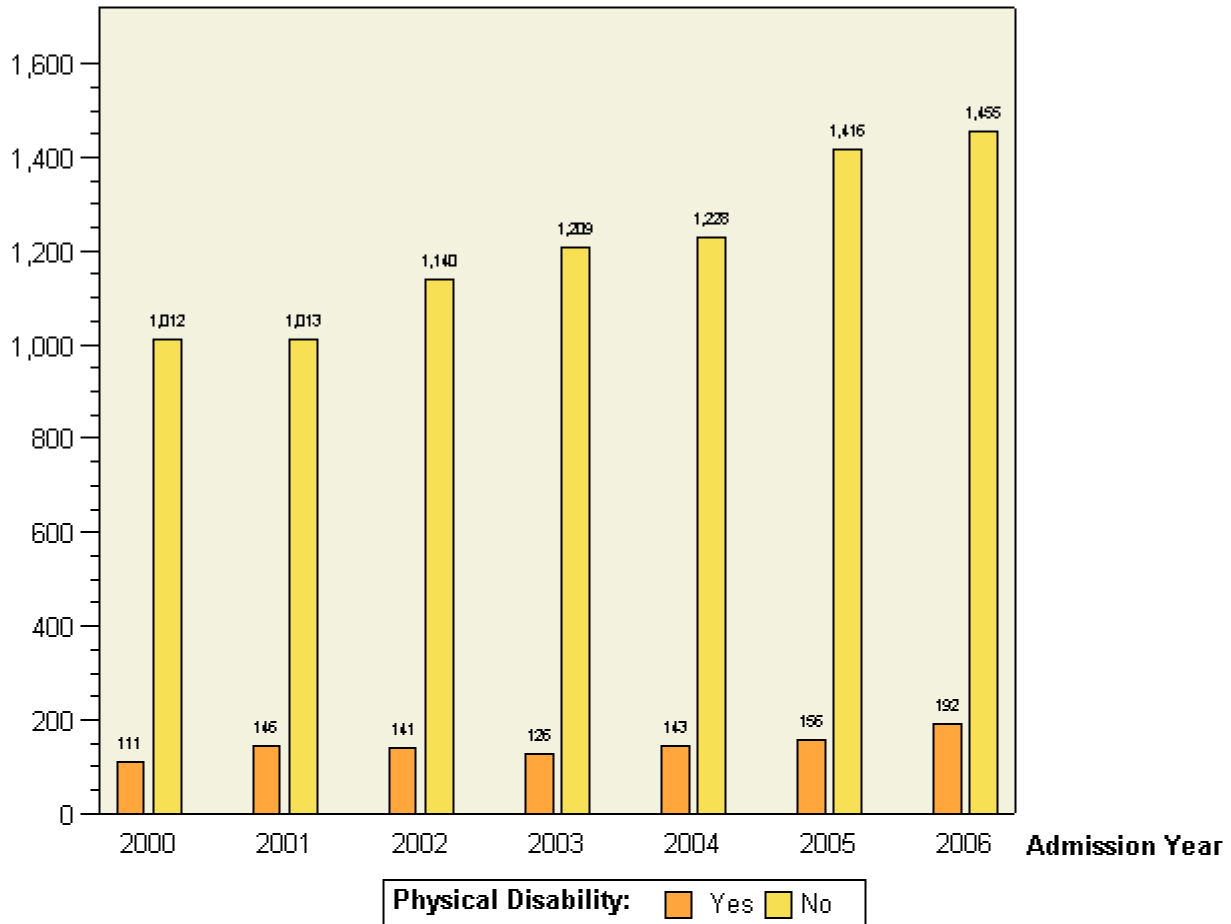
	Admissions[4]
Jan 2000-Jun 2000	586
Jul 2000-Dec 2000	624
Jan 2001-Jun 2001	633
Jul 2001-Dec 2001	581
Jan 2002-Jun 2002	678
Jul 2002-Dec 2002	724
Jan 2003-Jun 2003	739
Jul 2003-Dec 2003	736
Jan 2004-Jun 2004	817
Jul 2004-Dec 2004	777
Jan 2005-Jun 2005	915
Jul 2005-Dec 2005	885
Jan 2006-Jun 2006	862

[1] Defined using the Facility County field in TARGET. Private pay funded admissions are excluded. Contract type = 'DOC-Community' are included.
[2] Includes Intensive Outpatient, Outpatient, MICA Outpatient.
[3] [(Admissions:Jan-Jun06 – Admissions:Previous Period)/Admissions:Previous Period)] * 100.
[4] Counts of admissions for a six month period.
[5] [(Admissions:Jan-Jun 06 – Admissions: Previous Period)/Admissions: Previous Period] * 100.

Persons with Disabilities

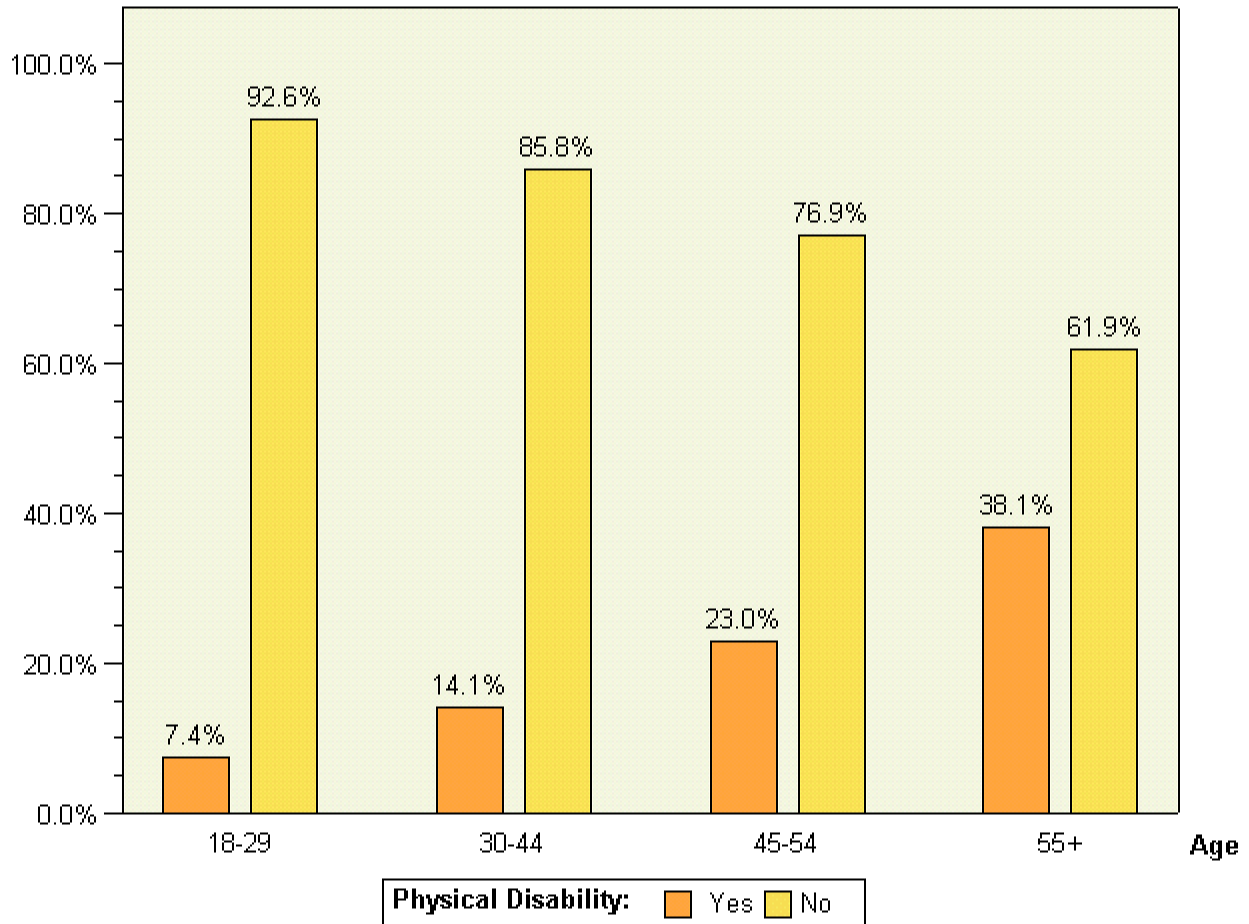
Thurston/Mason Developmental Disabilities and Age ~ 2000-2006

There were 111 persons with disabilities who entered treatment in the year 2000. In 2006, there were 192 persons with disabilities who entered outpatient treatment. The percent change in treatment admissions between 2000 and 2006 is 73%. We can speculate that this trend will continue and between 2007 and 2013, Thurston/Mason County will be serving a growing population of persons with disabilities.



Source: DASA Treatment Analyzer
January, 2000 – December, 2006 – Thurston and Mason Counties

During the period of 2000 through 2006, the proportion of those with physical disabilities increased as people got older. In the 18-29 age category, 7.4% reported having a physical disability. In the 30-44 age category, 14.1% reported having a physical disability. In the 45-54 age category, 23% reported having a physical disability. In the 55+ age category, 38.1% reported having a physical disability.

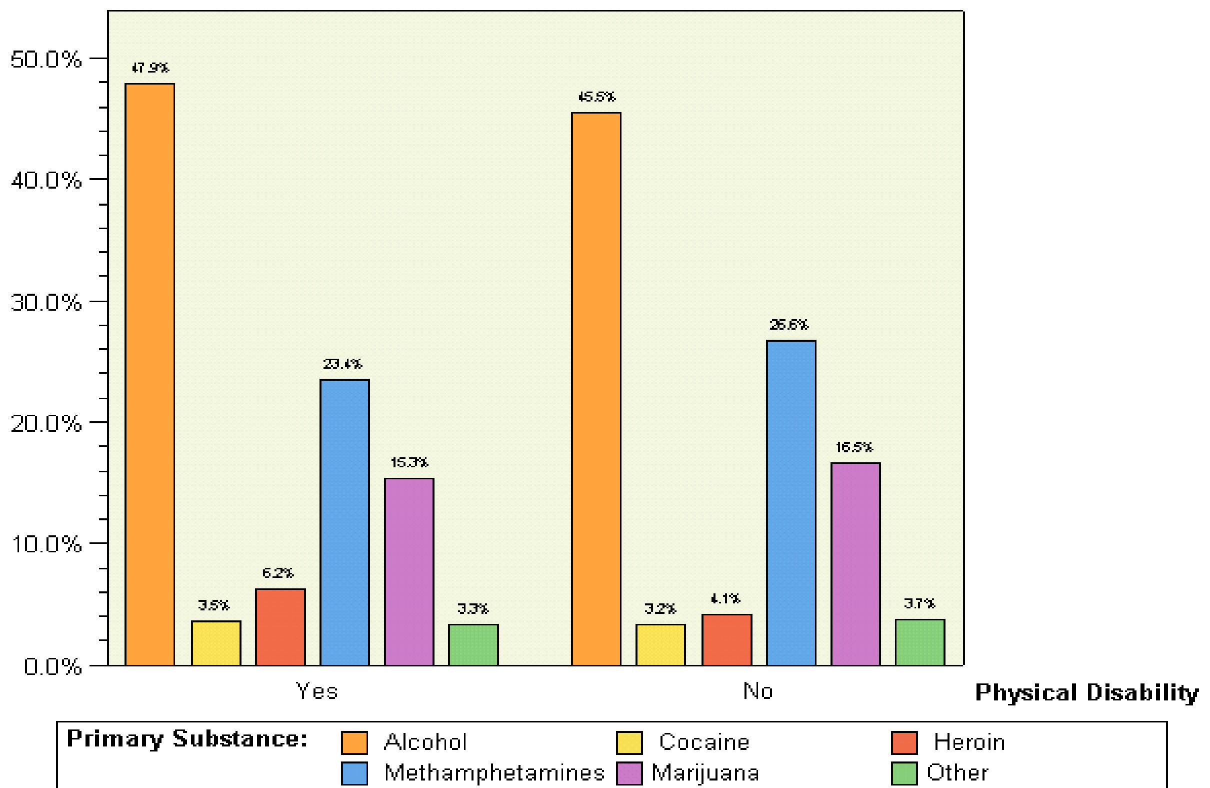


Source: DASA Treatment Analyzer
January, 2000 – December, 2006 – Thurston and Mason Counties

Percent Who Reported Having a Physical Disability by Age Group
Outpatient Treatment Admissions - Thurston and Mason County
January 2000 - December 2006

Age	Physical Disability		
	YES	NO	TOTAL
Less than 18	60	2,299	2,359
18-29	207	2,591	2,798
30-44	464	2,824	3,288
45-54	197	659	856
55-64	49	87	136
65+	7	4	11
Total	984	8,464	9,448
Note: Data in the system is updated monthly and numbers for the most recent months may change slightly over time. Run Date: 05/08/2007 DASA-TA			

Those with disabilities do not use substances differently when compared to those without. People with disabilities have alcohol as their primary substance 47.9% and those without disabilities report alcohol as primary substance 45.5% and correspondingly cocaine – 3.5% with disabilities and 3.2% without; heroin 6.2% and those without is 4.1%; meth is 23.4% for disabilities and 26.6% without disabilities (see chart).



Source: DASA Treatment Analyzer
January, 2000 – December, 2006 – Thurston and Mason Counties

It is difficult to understand what the future chemical dependency needs will be in the next six years for people with disabilities. With overall increase in population in Thurston and Mason Counties, the Chemical Dependency Program will need to better accommodate people with disabilities in the years to come.

Youth

Thurston/Mason Youth Outpatient Admissions ~ 2000–2006

Youth outpatient treatment admissions comprised 24.8% or 2,358 of all outpatient admissions between January 2000 and December 2006 (based on Treatment Analyzer Data). Youth outpatient treatment admissions between 2000 and 2006 increased overall by 83.6%. When comparing youth admission trends to all chemical dependency treatment admissions (percent of all admissions), youth admissions are lower between 2000 and 2004. Between 2004 and 2006 youth admissions climb and grow at a faster rate when compared to overall treatment admissions.

Even though there have been significant increases among youth between 2000 and 2006, there are concerns about youth treatment admissions in 2007. During 2005 and 2006 youth admissions to treatment were on the rise. During the last quarter of 2006, agencies began sharing with the County that they were seeing a downturn in admissions and requests for assessments. During the first quarter of 2007, the downturn trend in admissions and requests for assessments was mirrored.

The County has been investigating the cause of the decrease in admissions. Our findings included all County funded agencies that serve youth. They shared the same challenges of getting and retaining youth in treatment. It appears to be a problem in streamlining referrals from juvenile detention and probation, schools, etc. As the overall youth population increases, chemically dependent youth will increase. Those that work with at risk youth will be stretched to meet the demands (i.e., schools, detention, etc.), as well as street outreach workers.

In the 2007-09 biennium, the County will work to establish a more coordinated referral system. This system would establish a network of those involved with at risk youth to identify and refer appropriate youth earlier to chemical dependency providers. This would enhance and support better referrals and limit the progression of substance abuse among those in need of treatment. Early detection of chemical dependency often supports those at risk in attaining long term sobriety and better living.

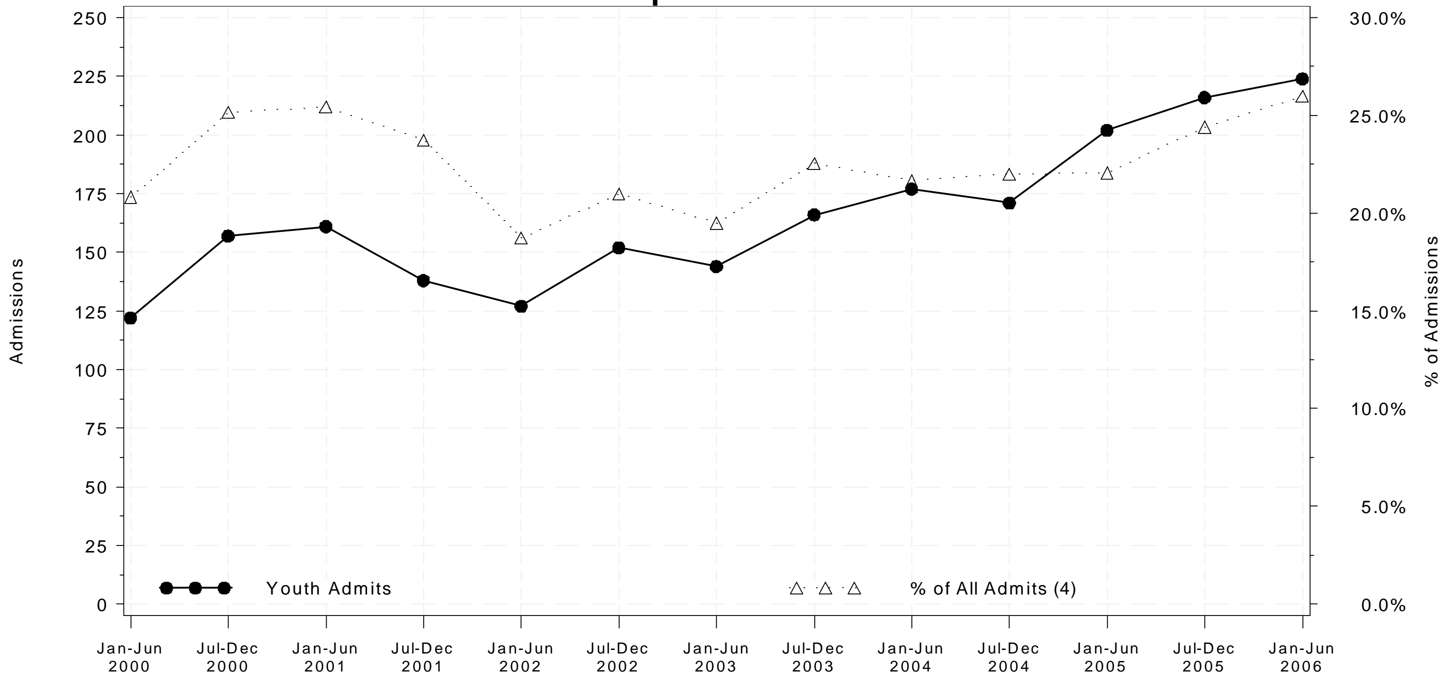
Based on population forecasts, over the next six years, youth will be seeking chemical dependency treatment services at a greater rate as compared to now. Public funds for youth chemical dependency treatment may keep pace with the needs of youth in Thurston/Mason Counties, however, if they don't, eligibility and screening may become more of a factor in the future.

Youth who are abusing or addicted to alcohol, tobacco and other drugs (ATOD's) while in school typically get caught and referred out for an assessment to determine if treatment services are needed. School districts vary on policy and procedures of suspension, expulsion, assessment and treatment follow-up. Follow-up with youth from the school districts regarding the recommendations of the assessment, and re-entry support are challenging due to the complexities of what the school systems deal with on a daily basis. Youth who are solely suspended or expelled for ATOD use/abuse on school property sometimes do not make it back to school or may not be as engaged with school. This lack of school and community bonding has the potential to increase abuse and addiction on an individual basis, as well as community wide. However, studies show that youth who follow through with treatment have a 41% increased likelihood of enrolling in school and a 74% likelihood of staying in school all year (School Youth Outcomes of AOD Treatment, DSHS December, 2005 Report Number 4.54a).

Within the schools there is minimal funding for substance abuse prevention/intervention specialists (P&I's). The ratio of P&I Specialists to students varies among districts but usually is an extremely poor ratio. P&I's are forced to multi-task and balance large caseloads, such as keeping track of youth at risk and their issues, other groups and multiple projects. From counselors to teachers to school administrators, districts are stretched as to how to deal with the complexity of youth at risk, appropriate interventions, referrals/assessments, and adequate funding. Families are forced to navigate and assist their child(ren) through a complex treatment system. Not all youth have a family member able to assist in this process. Often language barriers, single parenting, funding, and laws and norms attribute to youth not being able to access treatment.

Development of a coordinated and collaborative effort with all school districts between chemical dependency treatment providers should be targeted. During the next biennium, the County will look into a cross systems training event that could then be replicated as needed. This technical assistance effort could prove to be invaluable to school districts as well as youth providers who are seeking referrals and which could result in increasing youth outpatient treatment completion rates.

The County recognizes there are many other systems to coordinate with such as: juvenile detention and probation, homeless youth and street outreach workers, the faith community, families, and others. These entities would also benefit from cross systems training efforts.



Comparison of Admissions Over Time

Jan-Jun 2006 Compared to...	Change in Youth Admissions[5]	Change in All Admissions[5]
Jan-Jun 2005	10.89% ▲	-5.79% ▼
Jan-Jun 2003	55.55% ▲	16.64% ▲
Jan-Jun 2000	83.60% ▲	47.09% ▲

Youth

	Yes		No		
	Admits	%[6]	Admits	%	Total
Jan 2000-Jun 2000	122	20.8%	464	79.2%	586
Jul 2000-Dec 2000	157	25.2%	467	74.8%	624
Jan 2001-Jun 2001	161	25.4%	472	74.6%	633
Jul 2001-Dec 2001	138	23.8%	443	76.2%	581
Jan 2002-Jun 2002	127	18.7%	551	81.3%	678
Jul 2002-Dec 2002	152	21.0%	572	79.0%	724
Jan 2003-Jun 2003	144	19.5%	595	80.5%	739
Jul 2003-Dec 2003	166	22.6%	570	77.4%	736
Jan 2004-Jun 2004	177	21.7%	640	78.3%	817
Jul 2004-Dec 2004	171	22.0%	606	78.0%	777
Jan 2005-Jun 2005	202	22.1%	713	77.9%	915
Jul 2005-Dec 2005	216	24.4%	669	75.6%	885
Jan 2006-Jun 2006	224	26.0%	638	74.0%	862

[1] County is defined using the Facility County field in TARGET. Private pay funded admissions are excluded. Contract type = 'DOC-Community' are included.
[2] Under 18 years of age at admission.
[3] Includes Intensive Outpatient, Outpatient, MICA Outpatient.
[4] (Number of Admissions to Youth/Total Outpatient Admissions) * 100. This line shows the trend in Youth admissions relative to overall admissions. It is included on the graph because of the additional information it provides. For example, it is possible for the total number of Youth admissions to be falling over time and still represent an increasing percentage of overall admissions.
[5] [(Admissions:Jan-Jun 06 – Admissions: Previous Period)/Admissions: Previous Period] * 100.
[6] (N/Total)*100. Figures in this column represent the percent of all admissions for youth during a given period of time.

Comments and Explanation of Trends in Healthy Youth Survey Data - Thurston/Mason

Mason County 2007-2009 Risk Factors:

The following risk factors have been identified for Mason County 2007-2009 biennium:

- Poor Family Management (Family domain) {*continuing risk*}
- Favorable Attitudes Towards Substance Use (Peer/Individual domain) {*continuing risk*}
- Laws and Norms Favorable to Substance Use (Community domain) *{new addition}*

Healthy Youth Survey (HYS) data show that all three (3) chosen risk factors for the 2007-2009 biennium have increased following youth from 8th grade to 10th grade (for the period 2004-2006).

The data for these identified risk factors in Mason County revealed that the risk remained the same or had only slight decreases between 2004-2006. The one exception to this is Poor Family Management; 8th grade showed an in county risk increase in 2006.

When comparing these chosen risk factors to the State risk factors for 8th and 10th grades in Mason County, youth reported higher risk in all three (3) areas with one exception (Poor Family Management was about equal to the State in 8th and 10th graders). Youth reported Community Laws and Norms Favorable to Substance Use 14% higher risk than the State.

Other Mason County areas of higher risk than the State were: Early Initiation of Substance Use at 6% above the State's reported risk and Favorable Attitudes Towards Substance Use at 3% above the State.

Mason County 2007-2009 Protective Factors:

The following protective factors have been identified for Mason County:

- Opportunities for Pro-Social Involvement (Community and School domain) *{new addition}*

Targeting increasing Bonding by Providing Opportunities, Skills, and Recognition in these two domains.

Mason County youth in 8th and 10th grade reported a decrease in protective factors in Opportunities for Pro-Social Involvement in School and Family with one exception. In 2006, 10th graders reported 5% more Opportunities for Prosocial Involvement than in 2004. However, following 8th graders (2004) into 10th grade (2006), there was still a 4% decrease of opportunities. This protective factor is still below the State.

Alcohol/Tobacco/Other Drugs

- Smoking cigarettes, drinking alcohol, and using marijuana within the past 30 days is higher in all areas than Statewide use for both 8th and 10th graders.

- Females reported drinking more in the past 30 days than males in both 8th and 10th grade. Although males report more binge drinking in the 10th grade than females.

- Forty percent (40%) of 8th graders, 63% of 10th graders, and 75% of 12th graders report easy access to alcohol.

- Twenty-six percent (26%) of 8th graders, 60% of 10th graders, and 71% of 12 graders report easy access to marijuana.

- Twenty-five percent (25%) of 12th graders, 16% of 10 graders and 11% of 8th graders have been drunk or high at school in the past year.

For more detailed information, see the complete 2007-2013 prevention plan in Appendix B.

Thurston County 2007-2009 Risk Factors:

The following risk factors have been identified for Thurston County 2007-2009 biennium:

- Laws and Norms Favorable to Substance Use (Community domain) {*continuing risk*}
- Early Initiation of Substance Use (Peer/Individual domain) {*continuing risk*}
- Poor Family Management (Family domain) {*continuing risk*}

When comparing 2004 HYS data to 2006 HYS data, all three (3) chosen risk factors for the 2007-2009 biennium remained the same or slightly decreased with 8th grade to 10th graders.

However, when following 8th graders into 10th grade, Thurston County youth reported at 9% risk increase in Laws and Norms Favorable Towards Substance Use and a 3% risk increase in Poor Family Management.

Early Initiation of Substance Use showed the greatest decrease of the risk factors for 8th and 10th graders. However, Thurston County youth still report a higher risk than youth Statewide.

Thurston County 2007-2009 Protective Factors:

Protective factors were not identified for the 2005-2007 biennium. For the 2007-2009 biennium, the following protective factors were identified as a priority:

- Pro-social Involvement (Peer/Individual domain)
- Opportunities for Pro-social Involvement (Family, School, and Community domains in order of priority)
- Rewards for Pro-social Involvement (Family, School, and Community domains in order of priority)

Therefore, focusing or increasing Bonding by Providing Opportunities, Skills, and Recognition in these four domains (peer/individual, family, school, and community) are priority when addressing protective factors for Thurston County.

Individual/Peer Pro-social Involvement in the 8th grade should be focused on, as well as 10th grade Rewards for Pro-social Involvement in the Family domain should be a focus to increase. Eighth (8th) graders report less for Rewards for Pro-social Involvement in the School and Community domains than 10th graders.

Tenth (10th) graders report less Opportunities for Pro-social Involvement in Family, School, and Community domains (in order) than 8th graders in 2006. Eighth (8th) graders reported a decrease in Opportunities for Pro-social Involvement in the Community domain and no 2004 Opportunities in the Family domain data was available. Following 8th graders into the 10th grade from 2004-2006 youth reported decreases in both School and Community domains. Opportunities in the Family domain 2004 data was not available.

A positive finding when compared to the State, all Thurston County 8th and 10th grade Opportunities for Pro-social Involvement in all three domains were equal to or higher than the State protective factors, except 8th grade Family Opportunities which was 5% less than State.

Alcohol/Tobacco/Other Drugs

- Past 30 day use HYS data showed that 8th graders in Thurston County are drinking more than youth Statewide, using slightly less marijuana, and are about equal to State for smoking cigarettes. Whereas, all 10th graders report less 30 day use of marijuana, cigarettes, and alcohol than youth Statewide.
- Thurston County females are smoking cigarettes more in 8th and 10th grade than youth Statewide.
- Females are drinking more than males in 8th and 10th grade than youth Statewide.
- More 8th graders binge drink in Thurston County than youth Statewide; female binge drinking is higher than males.
- Youth in 10th grade are reporting less binge drinking than youth Statewide. However, Thurston County 10th males binge drink more than females.
- Thirty-three (33%) percent of 8th graders said they would NOT be caught by parents if they were drinking.
- Ten percent (10%) of 8th graders (youth ages 11-13) reported that they had begun drinking regularly (1-2 times per month).
- Only 31% of 12th graders and 46% of 10th graders think they would be caught by their parents if they drank.
- Thirty-six percent (36%) of 8th graders think it's easy to get alcohol.
- Twenty-three percent (23%) of 8th graders, 49% of 10th graders, and 64% of 12th graders report it is easy to get marijuana.

For more detailed information, see the complete 2007-2013 prevention plan in Appendix B.

Emerging Issue

Thurston County Youth Suicide

Recently a Child Death Review team was convened by the Thurston County Health Officer to address seven or eight possible youth suicides ages 13-19 between 2006 and early 2007. Agencies and departments that are involved are Thurston County Public Health and Social Services which include: Mental Health, and Chemical Dependency Prevention, Epidemiology, and the Health Officer; Thurston County Coroners Office; Lacey Police Department; Providence St. Peter Hospital; 211 and Crisis Clinic line staff; North Thurston School District Support Services; and the non-profit agency Community Youth Services. The Child Death Review team is an ongoing group that will look at child deaths and identify issues that can be acted on to prevent the unintended deaths. It was a natural to review these deaths as a cohort of cases.

Over three meetings the team reviewed details of each death. The issues identified are: 1) mental health awareness, recognition, and access; 2) access to a method; and 3) drug/alcohol use.

Questions of possible themes were a focus. The group determined that there were various gaps in details and future suggestions may be made to include psychological autopsies on youth in this age group (pending permission, staff availability, and funding), as to be able to review this age group in the future for prevention strategies within systems and the community.

This team also identified other areas where data can be obtained that is relevant to the issue of suicide or attempted suicide. Other agencies that are currently researching data for this group are the Thurston County Public Health and Social Services Chemical Dependency Prevention Program and Epidemiology Program, Emergency Management Services, 211 and the Crisis Clinic crisis line, along with Lacey Police Department calls for attempted or completed suicides. Resources that are currently available in the community were identified, as well as resource gaps.

The group will continue to meet regularly and will also bring in a Best Practice Youth Suicide consultant to educate and guide the team in the possible next steps, which could include a community action plan and targeted prevention strategies.

Pregnant/Post Partum/Parenting Women

Thurston/Mason Pregnant/Post Partum/Parenting Outpatient Admissions ~ 2000-2006

Pregnant women comprised 1.8% or 172 of all outpatient treatment admissions between January 2000 and December 2006. Pregnant/Post Partum/Parenting (PPPW) outpatient admissions combined were 509 or about 7.5% of the overall admissions. PPPW trends between the years 2000 and 2006 display extreme change. Each six month period shows the volatility of admissions among this population. This population is vulnerable to proportionate change because the numbers are small and because many gate keeping entities such as the Washington State DSHS Children Administrations and dependency and custody courts influence admission rates.

The lowest period was between July and December 2000 where there were only 12 (twelve) admissions or two per month on average. The highest point was the last time period or January through June 2006, where there were 65 (sixty-five) total pregnant and parenting chemical dependency outpatient treatment admissions (261% increase from January – June 2000).

We project the outpatient chemical dependency needs of this population in the next six years to increase as well. Due to the system's limitations and other factors that may influence chemical dependency treatment admissions, it is very difficult to predict what services will be needed in the future. Furthermore, the squeeze of financial limitations from categorical funding streams for pregnant/parenting populations will play a major role in how many of these clients will be served in the coming six years.

Unique to Thurston County is the Family Treatment Court (FTC) program which is funneled via federal Methamphetamine Initiative funds and approved in Thurston County. Each year the funding is vulnerable to other lobbying efforts in Congress. The first two years the funds were stable; year three and year four funds have decreased. The overall funding for Family Treatment Court has been renewed for the next federal fiscal year (FY October 2007)

The FTC runs on a Federal fiscal year, which starts in October and runs through September.

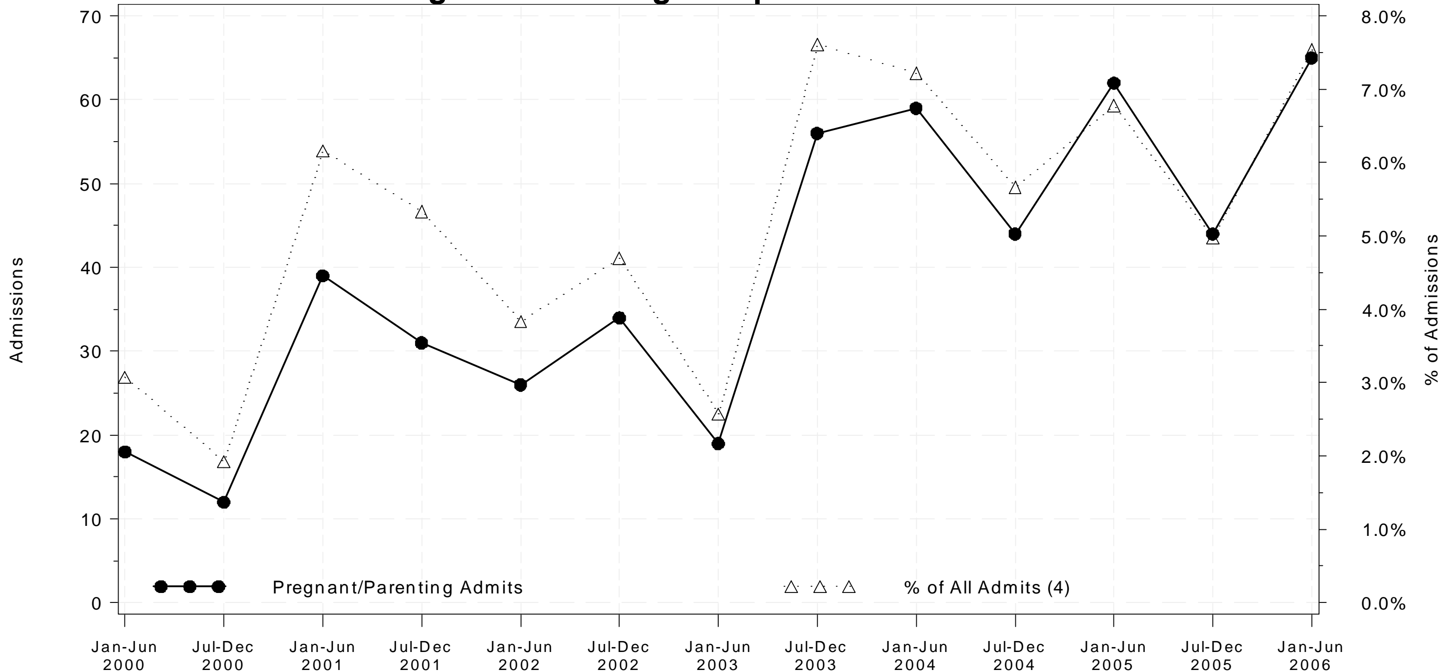
Thurston County Family Treatment Court

	FY2003	FY2004	FY2005	FY2006 (Only for 6 month period)
# of Participants	229	187	137	96
# Clients	83	62	48	35
# Family Members	146	125	89	58
# of Persons Assessed for Chemical Dependency	47	70	72	56
# of Persons Admitted to Treatment	21	22	15	13
# of Persons Completing Treatment	13	11	10	3

Source: Behavioral Health Resources Recovery Services
(Chemical Dependency provider for Family Treatment Court)

The total number of participants in FY03 was greater than those in FY04 and FY05 due in part to the decrease in Federal funding. In addition, referrals from DCFS have been reduced over the last six months which impacts the number of participants in the program. Ironically, the number of persons assessed for chemical dependency has gone up significantly when comparing FY03 to FY04 or FY05. When looking at the number of persons admitted to treatment and those completing treatment, there is not a significant change between FY03, FY04, and FY05.

The County predicts the Methamphetamine funds will sunset and the Thurston County Family Treatment Court (FTC) will need to identify and attain other funds in order to continue. The success and community support for the FTC in Thurston County will likely influence efforts to retain the program. The County will support all efforts to maintain the program and will look to the Division of Alcohol and Substance Abuse (DASA) to assist in acquiring needed ongoing funding.



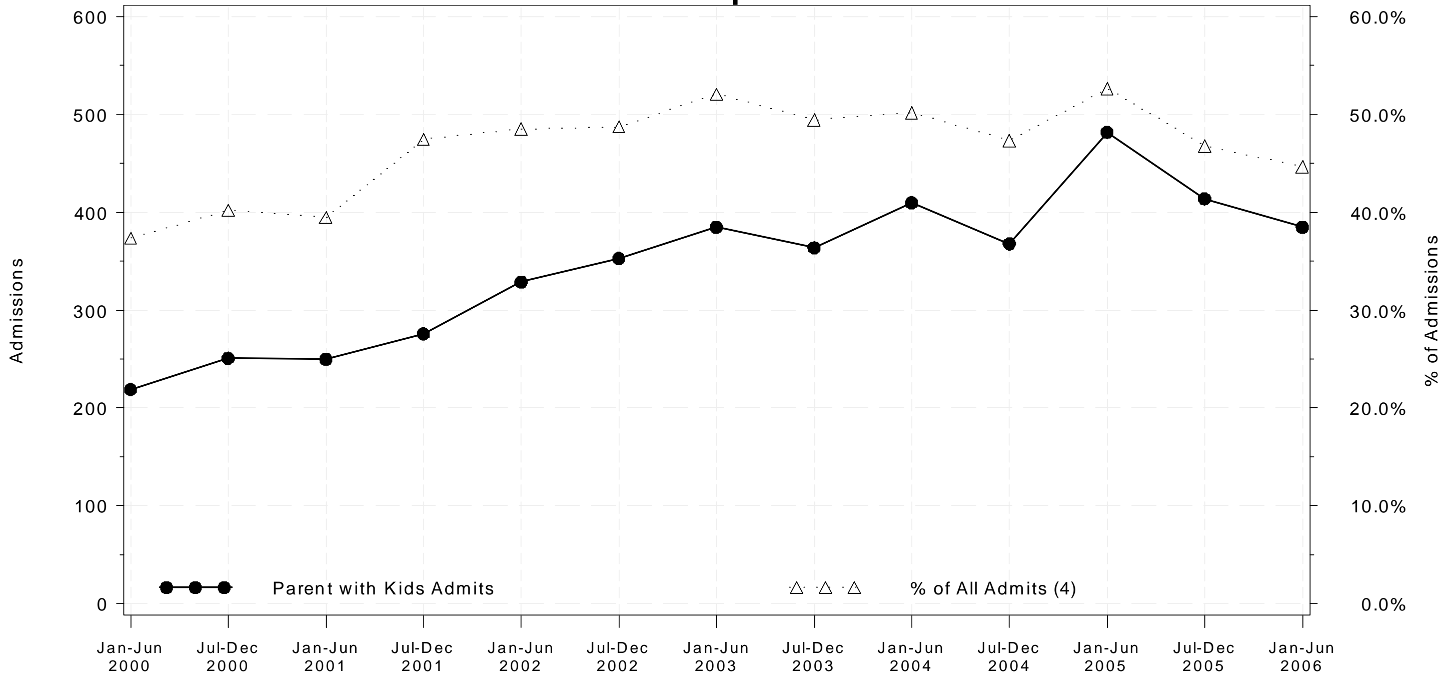
Comparison of Admissions Over Time

Jan-Jun 2006 Compared to...	Change in Pregnant/Parenting Admissions[5]	Change in All Admissions[5]
Jan-Jun 2005	4.83% △	-5.79% ▼
Jan-Jun 2003	242.10% △	16.64% △
Jan-Jun 2000	261.11% △	47.09% △

Pregnant/Parenting

	Yes		No		
	Admits	%[6]	Admits	%	Total
Jan 2000-Jun 2000	18	3.1%	568	96.9%	586
Jul 2000-Dec 2000	12	1.9%	612	98.1%	624
Jan 2001-Jun 2001	39	6.2%	594	93.8%	633
Jul 2001-Dec 2001	31	5.3%	550	94.7%	581
Jan 2002-Jun 2002	26	3.8%	652	96.2%	678
Jul 2002-Dec 2002	34	4.7%	690	95.3%	724
Jan 2003-Jun 2003	19	2.6%	720	97.4%	739
Jul 2003-Dec 2003	56	7.6%	680	92.4%	736
Jan 2004-Jun 2004	59	7.2%	758	92.8%	817
Jul 2004-Dec 2004	44	5.7%	733	94.3%	777
Jan 2005-Jun 2005	62	6.8%	853	93.2%	915
Jul 2005-Dec 2005	44	5.0%	841	95.0%	885
Jan 2006-Jun 2006	65	7.5%	797	92.5%	862

[1] County is defined using the Facility County field in TARGET. Private pay funded admissions are excluded. Contract type = 'DOC-Community' are included.
[2] Identified using the contract type field in TARGET. Value of Pregnant/Parenting.
[3] Includes Intensive Outpatient, Outpatient, MICA Outpatient.
[4] (Number of Admissions to PPW/Total Outpatient Admissions) * 100. This line shows the trend in PPW admissions relative to overall admissions. It is included on the graph because of the additional information it provides. For example, it is possible for the total number of PPW admissions to be falling over time and still represent an increasing percentage of overall admissions.
[5] [(Admissions:Jan-Jun 06 – Admissions: Previous Period)/Admissions: Previous Period] * 100.
[6] (N/Total)*100. Figures in this column represent the percent of all admissions for PPW during a given period of time.



Comparison of Admissions Over Time

Jan-Jun 2006 Compared to...	*Change in Parent with Kids Admissions*[5]	*Change in All Admissions*[5]
Jan-Jun 2005	-20.12%	-5.79%
Jan-Jun 2003	0.00%	16.64%
Jan-Jun 2000	75.79%	47.09%

Parent with Kids

	Yes		*No*		
	Admits	*%*[6]	*Admits*	*%*	*Total*
Jan 2000-Jun 2000	219	37.4%	367	62.6%	586
Jul 2000-Dec 2000	251	40.2%	373	59.8%	624
Jan 2001-Jun 2001	250	39.5%	383	60.5%	633
Jul 2001-Dec 2001	276	47.5%	305	52.5%	581
Jan 2002-Jun 2002	329	48.5%	349	51.5%	678
Jul 2002-Dec 2002	353	48.8%	371	51.2%	724
Jan 2003-Jun 2003	385	52.1%	354	47.9%	739
Jul 2003-Dec 2003	364	49.5%	372	50.5%	736
Jan 2004-Jun 2004	410	50.2%	407	49.8%	817
Jul 2004-Dec 2004	368	47.4%	409	52.6%	777
Jan 2005-Jun 2005	482	52.7%	433	47.3%	915
Jul 2005-Dec 2005	414	46.8%	471	53.2%	885
Jan 2006-Jun 2006	385	44.7%	477	55.3%	862

[1] County is defined using the Facility County field in TARGET. Private pay funded admissions are excluded. Contract type = 'DOC-Community' are included.
[2] Identified using two fields from TARGET. The first field indicates the client's children (under 18) that are living with them and the second indicates other children living with the client. If the client has either their own or other children living with them they are counted as parents with children for this analysis.
[3] Includes Intensive Outpatient, Outpatient, MICA Outpatient.
[4] (Number of Admissions to Parents with children/Total Outpatient Admissions) * 100. This line shows the trend in admissions for parents with children relative to overall admissions. It is included on the graph because of the additional information it provides. For example, it is possible for the total number of PPW admissions to be falling over time and still represent an increasing percentage of overall admissions.
[5] [(Admissions:Jan-Jun 06 – Admissions: Previous Period)/Admissions: Previous Period] * 100.
[6] (N/Total)*100. Figures in this column represent the percent of all admissions for parents with children in the home during a given period of time.

Elderly

Thurston/Mason Elderly Outpatient Admissions ~ 2000-2006

The elderly or those 65 years and older comprised .2% or 26 among all outpatient treatment admissions between 2000 and 2006. There are a significant number of aging people in Mason and Thurston County, and their numbers are growing steadily. The aging populations of Thurston and Mason County are expected to at least double in 15 years.

The tables below illustrate how the older adult population is rapidly increasing. This data is broken down by age categories. Also included in the tables are total populations of Thurston and Mason Counties, as well as the percentages of those populations that are over 65 years of age.

Mason County Population Age 65+, 1990-2020

Age	# in 1990	# in 2000	# in 2005	# in 2010	# in 2020
65-69	2,361	2,451	2,731	3,276	5,098
70-74	1,765	2,253	2,204	2,904	4,316
75-79	1,056	1,684	1,591	2,298	3,166
80-84	623	1,003	1,103	1,705	2,289
85+	446	758	923	1,457	2,423
Adults 65+	6,251	8,149	8,552	11,640	17,292
Total (All Ages)	38,341	49,405	51,900	58,604	69,635
Adults 65+ as Percent of Total	16%	16%	16%	20%	25%

Source: Washington State Office of Financial Management, Census Counts and Population Estimates
Projections based on Growth Management Act Intermediate Series

Thurston County Population Age 65+, 1990-2020

Age	# in 1990	# in 2000	# in 2005	# in 2010	# in 2020
65-69	6,064	6,258	7,219	11,771	20,194
70-74	4,884	5,764	5,826	7,710	16,944
75-79	3,653	5,065	4,942	5,490	10,339
80-84	2,313	3,589	4,093	4,140	5,579
85+	1,788	2,953	3,718	4,624	5,781
Adults 65+	18,707	23,629	25,798	33,735	58,837
Total (All Ages)	161,238	207,355	224,100	258,687	312,029
Adults 65+ as Percent of Total	12%	11%	12%	13%	19%

Source: Washington State Office of Financial Management, Census Counts and Population Estimates
Projections based on Growth Management Act Intermediate Series

One of the remarkable changes in Thurston and Mason County's aging population is its projected rapid increase.

This table illustrates the number of clients served in aging and adult services in Thurston and Mason County from July 2003 through June 2004.

Aging and Adult Services - DSHS Human Services, July, 2003 –June, 2004

Facility	Mason County Clients	Thurston County Clients
Adult Family Homes	30	164
Adult Residential Care	8	111
Assisted Living	33	189
In-Home Services	314	896
Nursing Homes	221	617
Total for Aging and Adult Services	551	1,804

Across the United States, a growing number of older adults are chemically dependent. There were 66,500 admissions of clients aged 55 or older into substance abuse treatment facilities in 2002 alone. Alcohol was the most frequently reported substance of abuse among older adults in treatment for all years from 1995 to 2002 (SAMHSA 2005). According to the journal American Family Physician, ten percent of the country's population abuses drugs or alcohol (2003). Applying that statistic to the populations of this area, there are roughly 2,600 older adults in Thurston County and 1,200 older adults in Mason County who abuse drugs or alcohol.

Admissions into drug treatment are on the rise, nationwide. Primary drug admissions among older adults increased by 106% for men and 119% for women between 1995 and 2002 (SAMHSA 2005). There is consensus among national and statewide publications on substance abuse that the aging population is an emerging problem for chemical dependency treatment centers and older adult care facilities. This population was and is a priority for treatment expansion funds.

In March of 2006 the Thurston/Mason Chemical Dependency Program published a report entitled, "Chemical Dependency Treatment Services for the Aging, Blind and Disabled Populations of Thurston and Mason Counties." Please find this report in Appendix D. The Chemical Dependency program hired a project staff to research the chemical dependency treatment needs for aging, blind and disabled. The purpose of the project was to identify:

1) the chemical dependency (CD) treatment needs among the aging;
2) what barriers to CD treatment exist among the aging;
3) trends among the aging;
4) and how to better reach and serve the aging that are chemically dependent.

Staff established a directory listing all the nursing homes, assisted living facilities, group homes and other health care facilities/agencies that serve this population in Thurston and Mason Counties. A questionnaire was designed in collaboration with key informants and other professionals working in various fields of caring for this population.

The survey was implemented and an analysis was conducted. The results of the report were insightful and helpful in understanding the complexities with identifying and serving these populations. Some of the conclusions included:

- Seek out National and/or State models that have proven results identifying chemically dependent older adults, in accurately assessing chemical dependency among older adults and in serving and treating this population.

- Develop an "older adult chemical dependency treatment" pilot program design for Thurston/Mason Counties and Statewide.

- Describe the design of the pilot program in a format that would enable Thurston County Public Health and Social Services to submit a proposal to DASA and other agencies for funding.

- More studies need to be conducted to further explore the complexities of older adults and chemical dependency.

When the County submitted an aging, blind, disabled proposal to DASA to fund a pilot project to address the issues identified in the report, DASA responded favorably. In July of 2006, the County established a contract with DASA and sub-contracted with NW Resources (DASA certified chemical dependency treatment facility) to provide outreach, brief screening and brief interventions, and case management for the aging, blind, disabled in Thurston and Mason Counties.

Since July of 2006, there have been 42 (forty two) aged, blind, or disabled clients admitted to chemical dependency treatment. Examples of alternative approaches may include, but are not limited to: more onsite services at nursing homes and adult group homes; complex discharge plans worked out by every system involved with a patient; and in home individual counseling.

Much work has gone into training and educating hospital discharge planners, Home and Community Services social workers, nursing homes, assisted living facilities, Area Agency on Aging (AAA), and many others.

The County projects that chemical dependency treatment admissions will continue to increase; however, like other populations served by public dollars, this population will continue to demand more service capacity. Between now and 2013, service needs for the aged, blind and disabled will surpass funding and treatment service capacity. Alternative approaches are needed and health care facilities will be required to become more involved in the service structure of chemical dependency services for these populations. NW Resources CDP/Case Manager provide direct interventions to these clients. For more details in the Aging report, please see Appendix D.

Gay, Lesbian and Transgender Persons

Thurston/Mason Gay, Lesbian, and Transgender Outpatient Admissions ~ 2000-2006

Gay, lesbian, and transgender persons comprised 3.2% or 306 among all outpatient treatment admissions between January 2000 and December 2006. The data trends from outpatient treatment admissions among gay, lesbian, transgender in Thurston/Mason Counties during the years 2000 and 2006 show an increased awareness about acknowledging this population in the field of chemical dependency. During 2000 and 2001, there were no reported treatment admissions among this population. However, when this population was initially identified and reported in Target (2002), there was a sharp representation in the first six months.

From January – June 2002, there were 25 admissions and each six month period following, the number of admissions were greater than 25. The first half of 2004 represented the highest recorded GLT chemical dependency outpatient treatment admissions: 39. Numbers would be significantly higher if the admission question included bisexual and questioning persons. These numbers only reflect individuals who indicate gay, lesbian or transgender.

In 2006, TOGETHER!, a youth violence and substance abuse prevention agency conducted a focus group of GLBTQ (gay, lesbian, bisexual, transgendered, and questioning) Youth from Stonewall Youth. Stonewall Youth supports, informs, and advocates for bisexual, lesbian, gay, transgendered, queer and questioning youth up to 21 years old. The findings included the following:

- A majority of the youth seen at Stonewall have substance abuse problems including alcohol, drugs, and nicotine. If they are not chemically dependent, they are actively experimenting.
- Risk factors include not feeling like they belong, feeling socially outcast, lack of good family connections, and homelessness/transitions.
- About 30% of homeless youth in Olympia identify as GLBTQ; so the risk factors applying to homeless youth also apply to these youth.
- A lot of GLBTQ youth are in a lot of pain, i.e., they are regularly harassed at school, both verbally and physically. Many have a history of sexual abuse in their families, both males and females.
- Most youth avoid discussing substance abuse issues since smoking and use of drugs/alcohol are coping mechanisms for them. Their primary issues are: family, assaults, and relationship issues as they try to sort out their emerging identity.
- Harm reduction strategies such as: helping them identify their overdose signals and knowing what drugs can't be mixed are the most effective. Abstinence approaches are not effective.
- Tobacco companies often target GLBTQ youth in their advertising. Appealing to the social justice issue seems to work best as an approach for prevention with nicotine.
- There is a lot of glamorization of alcohol and drug use. For example, one youth who has a minor in possession (MIP) charge used her mug shot on her my-space page.

- A high percentage of youth have been diagnosed with mental health issues, i.e., depression, bi-polar, attention deficit disorder and have been medicated since a fairly early age. They have high levels of social anxiety, and many use drugs to self-medicate that anxiety.

- A lot of GLBTQ youth are into the rave scene; it's very accepting of make-up, clothes, dancing, and sexual liberation. But it's also infused with a "tripper" culture and drugs and kids get offered ecstasy, psychedelics, and other street drugs.

Youth who are not using tend to fall into two categories:

- They have really hit rock-bottom with traumatic experiences of drugs that scared them off using and they have found other coping mechanisms; or

- They have found other positive community and sports involvement that keep them from being "partiers". Several youth have cut back on partying as they got into community college classes. Their commitment to a different set of goals is bolstered by a new sense of self-esteem. One youth who previously used a lot and has cut back is being isolated by other GLBTQ youth and is having a really hard time with that.

SYSTEM RESPONSE

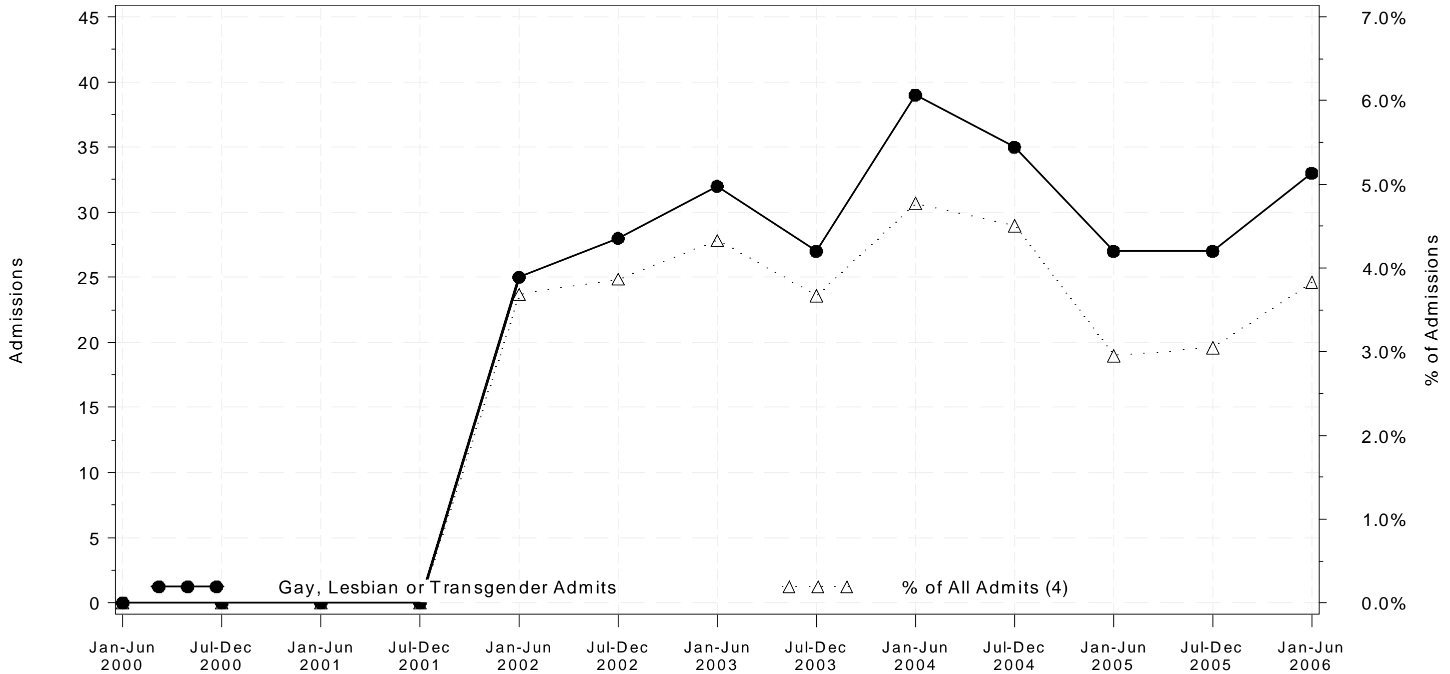
There is no GLBTQ youth-specific treatment facilities in the area. Local programs may need more training in this area of GLBTQ competence. Youth will avoid detox and treatment at all costs, because they feel vulnerable and are fearful of institutionalization. Many of these youth are low-income and lack health insurance which presents another system barrier.

Stonewall has a grant from the Human Services Review Council (HSRC) to pay for gay/lesbian and gay/lesbian friendly therapists, and that's been really helpful. There's an GLBTQ AA meeting in town, and some youth have attended. However, they find that AA has a religious overtone, and many meet in churches, which is hard for youth who have been rejected by their families due to their families' religious beliefs.

For most of the youth seen by Stonewall, substance abuse is a symptom of a larger problem, i.e., shame, guilt, stress, poor self image, and bombardment with stereotypes. Drinking is mostly for self-medication.

Stonewall itself is working on developing real guidelines for older youth to not glamorize their use in front of younger youth, since they serve an age range from 13-21.

This population is the most difficult sub-population to predict future needs. The outpatient treatment trends do not follow a pattern that is definable or predictable. The one trend that is clear is that overall the number of outpatient chemical dependency treatment admissions among GLBTQ in the future will be inconsistent. Despite the apparent inconsistency among this population, we can forecast that in general, the treatment needs for the GLBTQ will increase between now and 2013.



NOTE: During 2000 and 2001, there were no reported treatment admissions among this population, because it was not a question in the assessment, therefore it was not reflected in the database.

Comparison of Admissions Over Time

Jan-Jun 2006 Compared to...	*Change in Gay, Lesbian or Transgender Admissions[5]*	*Change in All Admissions[5]*
Jan-Jun 2005	22.22%	-5.79%
Jan-Jun 2003	3.12%	16.64%
Jan-Jun 2000	undefined	47.09%

Gay, Lesbian or Transgender

	Yes		No		
	Admits	*%[6]*	*Admits*	*%*	*Total*
Jan 2000-Jun 2000	N/A	N/A	586	100.0%	586
Jul 2000-Dec 2000	N/A	N/A	624	100.0%	624
Jan 2001-Jun 2001	N/A	N/A	633	100.0%	633
Jul 2001-Dec 2001	N/A	N/A	581	100.0%	581
Jan 2002-Jun 2002	25	3.7%	653	96.3%	678
Jul 2002-Dec 2002	28	3.9%	696	96.1%	724
Jan 2003-Jun 2003	32	4.3%	707	95.7%	739
Jul 2003-Dec 2003	27	3.7%	709	96.3%	736
Jan 2004-Jun 2004	39	4.8%	778	95.2%	817
Jul 2004-Dec 2004	35	4.5%	742	95.5%	777
Jan 2005-Jun 2005	27	3.0%	888	97.0%	915
Jul 2005-Dec 2005	27	3.1%	858	96.9%	885
Jan 2006-Jun 2006	33	3.8%	829	96.2%	862

[1] County is defined using the Facility County field in TARGET. Private pay funded admissions are excluded. Contract type = 'DOC-Community' are included.
[2] Identified using the sexual orientation field in TARGET.
[3] Includes Intensive Outpatient, Outpatient, MICA Outpatient.
[4] (Number of Admissions to gay, lesbian and transgender clients/Total Outpatient Admissions) * 100. This line shows the trend in gay, lesbian and transgender admissions relative to overall admissions. It is included on the graph because of the additional information it provides. For example, it is possible for the total number of gay, lesbian and transgender admissions to be falling over time and still represent an increasing percentage of overall admissions.
[5] [(Admissions:Jan-Jun 06 – Admissions: Previous Period)/Admissions: Previous Period] * 100.
[6] (N/Total)*100. Figures in this column represent the percent of all admissions for gay, lesbian and transgender clients during a given period of time.

IV Drug Users

Thurston/Mason IV Drug Users Outpatient Admissions ~ 2000-2006

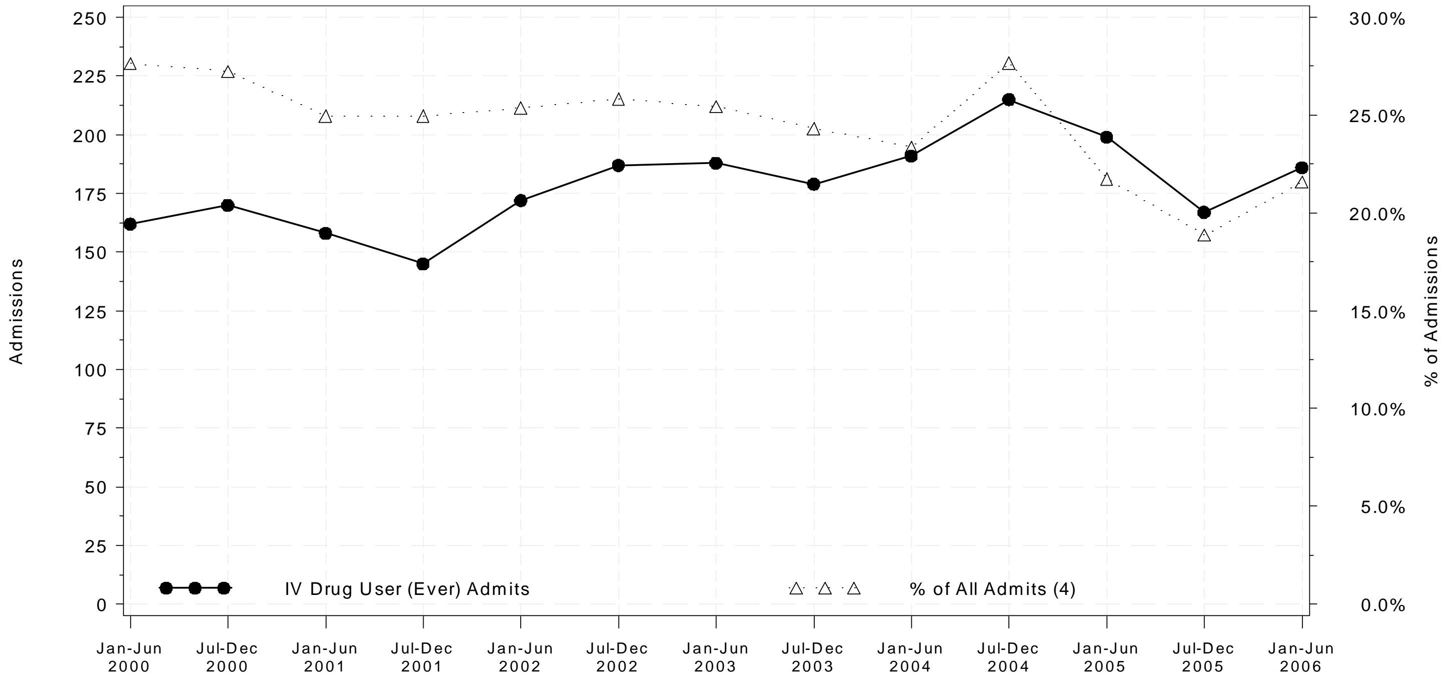
Recent IV drug users (used within the last 30 days) comprised 9.3% or 891 of all outpatient treatment admissions between January 2000 and December 2006. Chemical dependency outpatient treatment admissions among IV drug users have not increased significantly between 2000 and 2006. There are many factors that are associated with outpatient treatment admissions for this population. One of these factors is that many IV drug users seek residential/inpatient treatment. Another factor is that many heroin IV drug users are more appropriate for Opiate Replacement Treatment (OTP) or Methadone Treatment services and admission data is not represented. Those admitted into OTP's typically stay in treatment an average of two years.

The Thurston County Public Health and Social Services Department operates a full time Syringe Exchange Program. The program was initiated in March of 1994. The report comes from locally entered data that is put into a Washington State HIV/AIDS data base.

In 2000 there were 119 clinic days and 2,230 clients served. There were 13,644 condoms distributed, and 233,164 syringes exchanged. During 2000, there were a total of 123 drug treatment referrals from the syringe exchange. In 2006 there were 103 clinic days and 1,184 clients served. There were 3,194 condoms distributed, and 198,757 syringes exchanged. During 2006, there were a total of 39 drug treatment referrals from the syringe exchange.

Over the last six years the Thurston County Syringe Exchange Program has not seen significant changes with regards to numbers of clients, condoms distributed and syringes exchanged. After speaking with program staff at Thurston County, some insights were gathered. One of the limiting factors to the program is funding and program capacity. The County has not been able to keep up with the increase in demand for this program. Therefore, services have not increased because of less demand, but from financial barriers. Please see attached 2006 Thurston County Syringe Exchange report in Appendix G.

It is difficult to know what to predict for service needs among IV drug users in the next six years. One influential component is that the opiate replacement treatment program (OTP) in Thurston County is growing and expanding services. Every year that it is open we are seeing increases in admissions.



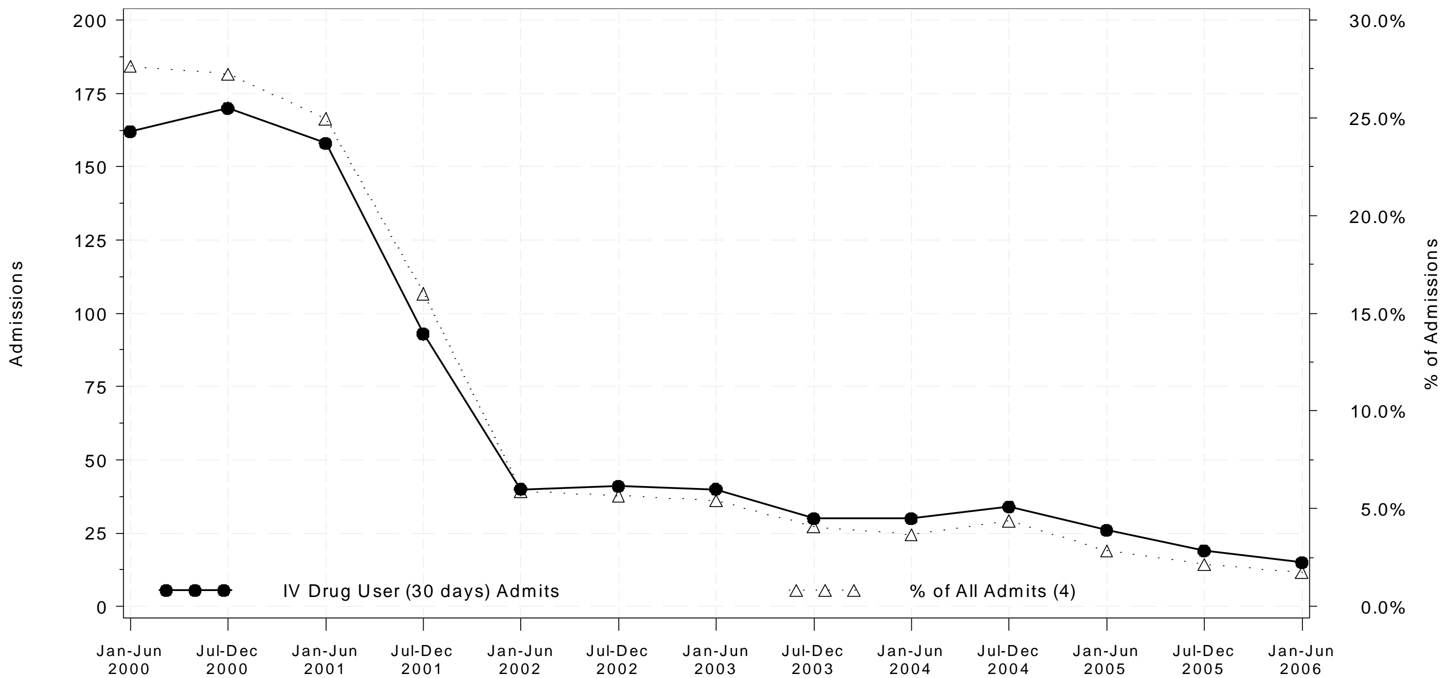
Comparison of Admissions Over Time

Jan-Jun 2006 Compared to...	*Change in IV Drug User (Ever) Admissions[5]*	*Change in All Admissions[5]*
Jan-Jun 2005	-6.53% ▼	-5.79% ▼
Jan-Jun 2003	-1.06% ▼	16.64% △
Jan-Jun 2000	14.81% △	47.09% △

IV Drug User (Ever)

	Yes		No		
	Admits	*%[6]*	*Admits*	*%*	*Total*
Jan 2000-Jun 2000	162	27.6%	424	72.4%	586
Jul 2000-Dec 2000	170	27.2%	454	72.8%	624
Jan 2001-Jun 2001	158	25.0%	475	75.0%	633
Jul 2001-Dec 2001	145	25.0%	436	75.0%	581
Jan 2002-Jun 2002	172	25.4%	506	74.6%	678
Jul 2002-Dec 2002	187	25.8%	537	74.2%	724
Jan 2003-Jun 2003	188	25.4%	551	74.6%	739
Jul 2003-Dec 2003	179	24.3%	557	75.7%	736
Jan 2004-Jun 2004	191	23.4%	626	76.6%	817
Jul 2004-Dec 2004	215	27.7%	562	72.3%	777
Jan 2005-Jun 2005	199	21.7%	716	78.3%	915
Jul 2005-Dec 2005	167	18.9%	718	81.1%	885
Jan 2006-Jun 2006	186	21.6%	676	78.4%	862

[1] County is defined using the Facility County field in TARGET. Private pay funded admissions are excluded. Contract type = 'DOC-Community' are included.
[2] Identified using the needle use field in TARGET.
[3] Includes Intensive Outpatient, Outpatient, MICA Outpatient.
[4] (Number of Admissions to IV Drug Users/Total Outpatient Admissions) * 100. This line shows the trend in IV Drug Use admissions relative to overall admissions. It is included on the graph because of the additional information it provides. For example, it is possible for the total number of IV Drug Use admissions to be falling over time and still represent an increasing percentage of overall admissions.
[5] [(Admissions:Jan-Jun 06 – Admissions: Previous Period)/Admissions: Previous Period] * 100.
[6] (N/Total)*100. Figures in this column represent the percent of all admissions for clients that every used needles to inject drugs.



Comparison of Admissions Over Time

Jan-Jun 2006 Compared to...	*Change in IV Drug User (30 days) Admissions[5]*	*Change in All Admissions[5]*
Jan-Jun 2005	-42.30% ▼	-5.79% ▼
Jan-Jun 2003	-62.50% ▼	16.64% △
Jan-Jun 2000	-90.74% ▼	47.09% △

IV Drug User (30 days)

	Yes		No		
	Admits	*%[6]*	*Admits*	*%*	*Total*
Jan 2000-Jun 2000	162	27.6%	424	72.4%	586
Jul 2000-Dec 2000	170	27.2%	454	72.8%	624
Jan 2001-Jun 2001	158	25.0%	475	75.0%	633
Jul 2001-Dec 2001	93	16.0%	488	84.0%	581
Jan 2002-Jun 2002	40	5.9%	638	94.1%	678
Jul 2002-Dec 2002	41	5.7%	683	94.3%	724
Jan 2003-Jun 2003	40	5.4%	699	94.6%	739
Jul 2003-Dec 2003	30	4.1%	706	95.9%	736
Jan 2004-Jun 2004	30	3.7%	787	96.3%	817
Jul 2004-Dec 2004	34	4.4%	743	95.6%	777
Jan 2005-Jun 2005	26	2.8%	889	97.2%	915
Jul 2005-Dec 2005	19	2.1%	866	97.9%	885
Jan 2006-Jun 2006	15	1.7%	847	98.3%	862

[1] County is defined using the Facility County field in TARGET. Private pay funded admissions are excluded. Contract type = 'DOC-Community' are included.
[2] Identified using the used needle recently field or the method_ID field in TARGET.
[3] Includes Intensive Outpatient, Outpatient, MICA Outpatient.
[4] (Number of Admissions to IV Drug Users/Total Outpatient Admissions) * 100. This line shows the trend in IV Drug Use admissions relative to overall admissions. It is included on the graph because of the additional information it provides. For example, it is possible for the total number of IV Drug Use admissions to be falling over time and still represent an increasing percentage of overall admissions.
[5] [(Admissions:Jan-Jun 06 – Admissions: Previous Period)/Admissions: Previous Period] * 100.
[6] (N/Total)*100. Figures in this column represent the percent of all admissions for recent IV drug users during a given period of time.

Treatment Expansion Assessment of Expanded Services for SSI, GA-U, TANF and Youth - Thurston/Mason

To meet the projections of serving new clients in the 2005-2007 biennium, the following changes were made to the Thurston/Mason Chemical Dependency Program:

Within the current County provider system, additional funds and targets have been added to:

- PSCPDC (adult and youth)
- BHR Recovery Services (adult and youth)
- SeaMar (adult)
- Alternatives (youth)
- South Sound Clinic (adult)
- ESD 113 – True North (youth)

In addition, the County has added the following providers and programs:

- NW Resources (aging project)
- Damon Counseling (adult)
- BHR Recovery Services (youth co-occurring and intensive case management)
- PSCPDC (intensive case management)

The County monitors agencies on a monthly basis to assure new clients are coming into the system. Current adult providers will be able to further expand the number of Title XIX clients served while preserving some ability to continue to meet demand for low-income, sliding fee scale clients.

Strategies to assist new providers included adding some local funds to the Damon Counseling contract to assist with start-up costs and providing technical assistance. The County assisted with agency training to understand Title XIX billing, TARGET, outreach, and other activities as needed.

The County sent out a memo to the broad community in Thurston and Mason County announcing treatment expansion. Included in the mailing was agencies who serve clients through: the Area Agency on Aging, Senior Center, nursing and retirement homes, mental health providers, youth serving agencies, health care organization(s), to name a few. A listing of County providers was included for referral purposes.

Other efforts have and will continue to be made to coordinate with local Community Service Offices (CSO's) to streamline eligibility for publicly funded chemical dependency services.

The following tables illustrate treatment expansion outcomes for the period July 1, 2005 to June 30, 2006 and July 1, 2006 to March 30, 2007.

TREATMENT EXPANSION – 2005-2007

Mason County - July 1, 2005 – June 30, 2006

	GAU	TANF	Blind/Disabled/GAX
Expected	10.7	98.4	85.9
New Clients Served	16	100	63
Percentage of Goal	149%	101.6%	73.3%

Mason County July 1, 2006 – March 30, 2007

(please note this is for only a nine (9) month period)

	GAU	TANF	Blind/Disabled/GAX
Expected	17	86.9	59.3
New Clients Served	12	79	51
Percentage of Goal	70.7%	90.9%	86%

Thurston County - July 1, 2005 – June 30, 2006

	GAU	TANF	Blind/Disabled/GAX
Expected	29	280.7	396.3
New Clients Served	35	287	254
Percentage of Goal	120.9%	102.2%	64.1%

Thurston County July 1, 2006 – March 30, 2007

(please note this is for only a nine (9) month period)

	GAU	TANF	Blind/Disabled/GAX
Expected	38.5	248.2	297.7
New Clients Served	46	288	237
Percentage of Goal	119.4%	116%	79.6%

Source: DASA Treatment Analyzer
Thurston and Mason Counties

The following describes the Thurston/Mason County request for treatment expansion funds for July 1, 2006 – June 30, 2007. This includes the additional providers, services, and proposed expenses.

Youth Outpatient Services

(1) Add a new youth outpatient treatment provider to the county system.

BHR/Recovery Services proposes to hire a Master's Level Chemical Dependency Professional (CDP @ 1.0 FTE) to work in conjunction with BHR's Mental Health Children's Services Team to provide outreach, screening, assessment, individualized youth and families outpatient counseling in support of co-occurring youth who are served by BHR Mental Health Services. The focus of this program will be on individual sessions with some group outpatient. These youth seldom receive any youth chemical dependency services.

Provide funds for recruitment/start-up May – June 2006; funds for treatment for the period July 1, 2006 – June 30, 2007.

Estimated number of youth who would be ***eligible*** for this model = 200 clients.

Estimated number of youth ***served***: 40 – 50 clients; 1125 hours of treatment; 375 hours of outreach.

Youth Outpatient Services
BHR/Recovery Services

Item	Amount
Recruitment/Start-Up/Training	5,000
Outreach & Treatment Services	84,000
Total Request	89,000
Provider Match	9,000
Total Budget	$98,000

(2) Provide funds to our contract with **ESD 113, True North Student Assistance Program** to support additional service expansion to South Thurston County (Rainier, Tenino, and Rochester) and to the newly established on-site services at ESD 113's headquarters on McPhee Road.

Estimated number of youth ***served***: 25 – 30 clients; 3744 hours of treatment; 300 outreach hours.

Youth Outpatient Services
ESD 113, True North

Item	Amount
Outreach Services	10,500
Treatment Services	73,850
Total Request	84,350
Provider Match	8,500
Total Budget	$92,850

Total new Youth Treatment Expansion fund request: $173,350

Adult Outpatient Services

(1) Add another adult outpatient treatment provider to the Thurston/Mason County system, **Northwest Resources**, with a targeted program in Mason County at their branch site. They are currently averaging about 7 referrals per month to County funded providers. They have a Title XIX contract in place.

Provide funds for recruitment/start-up May – June 2006; funds for treatment for the period July 1, 2006 – June 30, 2007.

Estimated number of adults ***served***: 16 – 20

Adult Outpatient Services
Northwest Resources

Item	Amount
Recruitment/Start Up	5,000
Treatment Services	50,000
Total Request	55,000
Provider Match	5,500
Total Budget	$60,500

(2) Provide additional adult opiate treatment funds to **South Sound Clinic** to reduce the waiting list.

Provide funds for treatment for the period July 1, 2006 – June 30, 2007.

Estimated number of adults ***served***:
20 GAU clients; **30** Title XIX clients

Adult Opiate Treatment Services
South Sound Clinic

Item	Amount
Total Request	130,536
Provider Match	13,053
Total Budget	$143,589

Total new Adult Treatment expansion request: $185,536

Total Treatment Expansion Fund Request

Item	Amount
Youth Outpatient Treatment	173,350
Adult Outpatient Treatment	185,536
Total Thurston/Mason Treatment Expansion Request	**$358,886**

DASA-TA
Treatment Expansion[1] Report - Progress by Adult Subgroup[2]
Adult Clients - Mason County[3]
June 2006

Aged

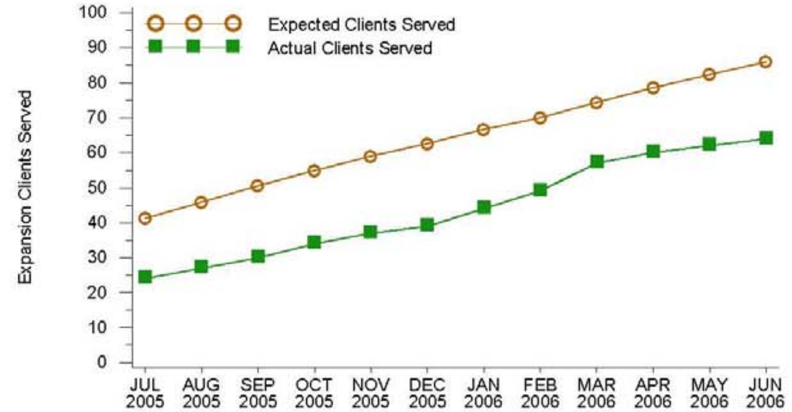
Through June 2006, 1 new adult expansion population clients were served in Mason county. Based on the pattern of clients served in FY 2005, we expected to serve 2.4. ***Thus, the cumulative count of 1 through April represents 41.8% of what was expected by this point in time.***

Cumulative

	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected[5]*
Jul 2005	1.5	1	66.1%
Aug 2005	1.6	1	63.0%
Sep 2005	1.7	1	58.2%
Oct 2005	1.8	1	55.8%
Nov 2005	1.9	1	52.5%
Dec 2005	2.0	1	50.5%
Jan 2006	2.0	1	49.1%
Feb 2006	2.1	1	47.4%
Mar 2006	2.2	1	46.2%
Apr 2006	2.2	1	45.0%
May 2006	2.3	1	43.2%
Jun 2006	**2.4**	**1**	**41.8%**

Blind/Disabled/GAX

Through June 2006, 64 new adult expansion population clients were served in Mason county. Based on the pattern of clients served in FY 2005, we expected to serve 85.9. ***Thus, the cumulative count of 64 through April represents 74.5% of what was expected by this point in time.***



Cumulative

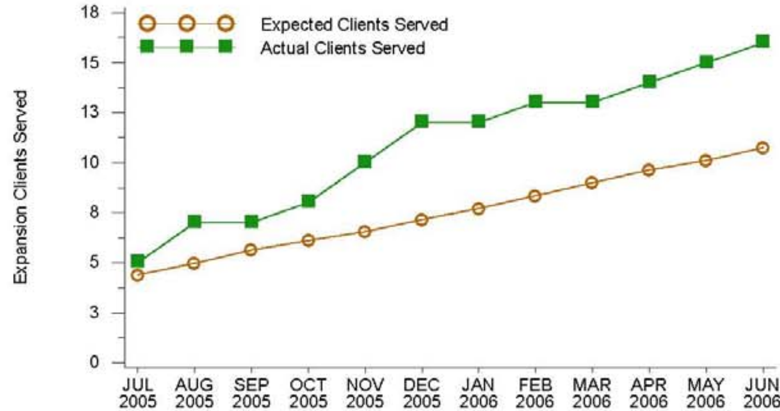
	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected[5]*
Jul 2005	41.2	24	58.2%
Aug 2005	45.9	27	58.8%
Sep 2005	50.6	30	59.3%
Oct 2005	55.0	34	61.8%
Nov 2005	59.0	37	62.7%
Dec 2005	62.6	39	62.3%
Jan 2006	66.7	44	66.0%
Feb 2006	70.0	49	70.0%
Mar 2006	74.3	57	76.7%
Apr 2006	78.6	60	76.4%
May 2006	82.4	62	75.2%
Jun 2006	**85.9**	**64**	**74.5%**

DASA-TA
Treatment Expansion[1] Report - Progress by Subgroup[2]
Adult Clients - Mason County[3]

June 2006

GAU

Through June 2006, 16 new adult expansion population clients were served in Mason county. Based on the pattern of clients served in FY 2005, we expected to serve 10.7. ***Thus, the cumulative count of 16 through April represents 149.0% of what was expected by this point in time.***

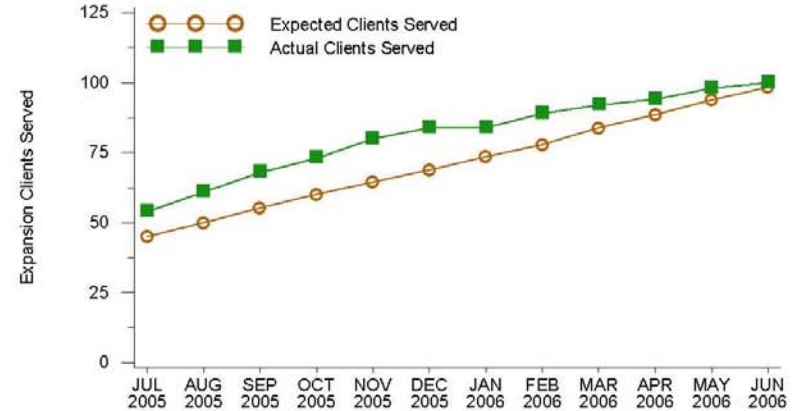


Cumulative

	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected*[5]
Jul 2005	4.4	5	113.8%
Aug 2005	5.0	7	140.4%
Sep 2005	5.6	7	124.2%
Oct 2005	6.1	8	131.2%
Nov 2005	6.6	10	152.4%
Dec 2005	7.2	12	167.8%
Jan 2006	7.7	12	155.5%
Feb 2006	8.3	13	155.7%
Mar 2006	9.0	13	144.3%
Apr 2006	9.6	14	145.2%
May 2006	10.1	15	148.2%
Jun 2006	**10.7**	**16**	**149.0%**

TANF/Other Medicaid

Through June 2006, 100 new adult expansion population clients were served in Mason county. Based on the pattern of clients served in FY 2005, we expected to serve 98.4. ***Thus, the cumulative count of 100 through April represents 101.6% of what was expected by this point in time.***



Cumulative

	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected*[5]
Jul 2005	45.1	54	119.7%
Aug 2005	50.1	61	121.7%
Sep 2005	55.3	68	123.0%
Oct 2005	60.2	73	121.2%
Nov 2005	64.5	80	124.1%
Dec 2005	68.8	84	122.1%
Jan 2006	73.6	84	114.1%
Feb 2006	77.9	89	114.3%
Mar 2006	83.8	92	109.8%
Apr 2006	88.6	94	106.1%
May 2006	93.8	98	104.4%
Jun 2006	**98.4**	**100**	**101.6%**

DASA-TA

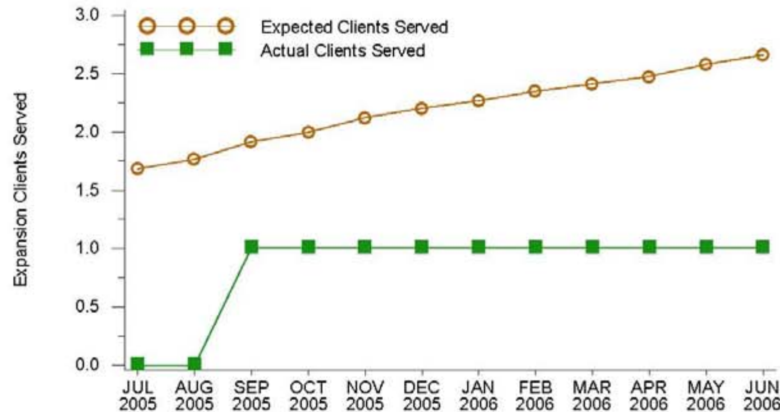
Treatment Expansion[1] Report - Progress by Adult Subgroup[2]

Adult Clients - Thurston County[3]

June 2006

Aged

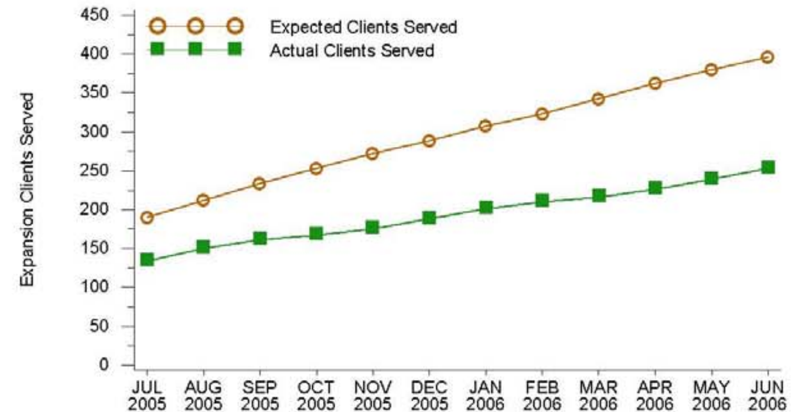
Through June 2006, 1 new adult expansion population clients were served in Thurston county. Based on the pattern of clients served in FY 2005, we expected to serve 2.7. ***Thus, the cumulative count of 1 through April represents 37.6% of what was expected by this point in time.***



	Cumulative		
	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected*[5]
Jul 2005	1.7	0	0.0%
Aug 2005	1.8	0	0.0%
Sep 2005	1.9	1	52.3%
Oct 2005	2.0	1	50.1%
Nov 2005	2.1	1	47.1%
Dec 2005	2.2	1	45.4%
Jan 2006	2.3	1	44.1%
Feb 2006	2.3	1	42.6%
Mar 2006	2.4	1	41.5%
Apr 2006	2.5	1	40.4%
May 2006	2.6	1	38.8%
Jun 2006	**2.7**	**1**	**37.6%**

Blind/Disabled/GAX

Through June 2006, 253 new adult expansion population clients were served in Thurston county. Based on the pattern of clients served in FY 2005, we expected to serve 396.3. ***Thus, the cumulative count of 253 through April represents 63.8% of what was expected by this point in time.***



	Cumulative		
	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected*[5]
Jul 2005	190.1	134	70.5%
Aug 2005	211.7	150	70.8%
Sep 2005	233.4	161	69.0%
Oct 2005	253.6	167	65.9%
Nov 2005	272.0	175	64.3%
Dec 2005	288.7	188	65.1%
Jan 2006	307.5	201	65.4%
Feb 2006	322.9	210	65.0%
Mar 2006	342.7	216	63.0%
Apr 2006	362.2	226	62.4%
May 2006	380.0	239	62.9%
Jun 2006	**396.3**	**253**	**63.8%**

DASA-TA
Treatment Expansion[1] Report - Progress by Subgroup[2]
Adult Clients - Thurston County[3]
June 2006

GAU

Through June 2006, 35 new adult expansion population clients were served in Thurston county. Based on the pattern of clients served in FY 2005, we expected to serve 29.0. ***Thus, the cumulative count of 35 through April represents 120.9% of what was expected by this point in time.***

Cumulative

	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected*[5]
Jul 2005	11.8	15	126.6%
Aug 2005	13.4	16	119.1%
Sep 2005	15.2	17	111.9%
Oct 2005	16.4	20	121.7%
Nov 2005	17.7	20	113.0%
Dec 2005	19.3	20	103.7%
Jan 2006	20.8	20	96.2%
Feb 2006	22.5	22	97.8%
Mar 2006	24.3	29	119.4%
Apr 2006	26.0	31	119.3%
May 2006	27.3	33	121.0%
Jun 2006	**29.0**	**35**	**120.9%**

TANF/Other Medicaid

Through June 2006, 287 new adult expansion population clients were served in Thurston county. Based on the pattern of clients served in FY 2005, we expected to serve 280.7. ***Thus, the cumulative count of 287 through April represents 102.2% of what was expected by this point in time.***

Cumulative

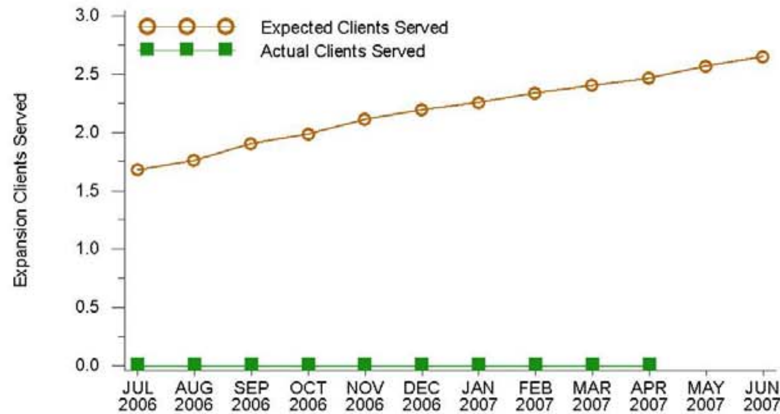
	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected*[5]
Jul 2005	128.7	116	90.1%
Aug 2005	142.9	121	84.7%
Sep 2005	157.7	138	87.5%
Oct 2005	171.8	150	87.3%
Nov 2005	183.9	167	90.8%
Dec 2005	196.3	183	93.2%
Jan 2006	210.0	200	95.3%
Feb 2006	222.1	216	97.2%
Mar 2006	239.1	234	97.9%
Apr 2006	252.7	248	98.2%
May 2006	267.7	271	101.2%
Jun 2006	**280.7**	**287**	**102.2%**

DASA-TA
Treatment Expansion[1] Report - Progress by Adult Subgroup[2]
Adult Clients - Mason County[3]

April 2007

Aged

Through April 2007, 0 new adult expansion population clients were served in Mason county. Based on the pattern of clients served in FY 2005, we expected to serve 2.5. ***Thus, the cumulative count of 0 through April represents 0.0% of what was expected by this point in time.***

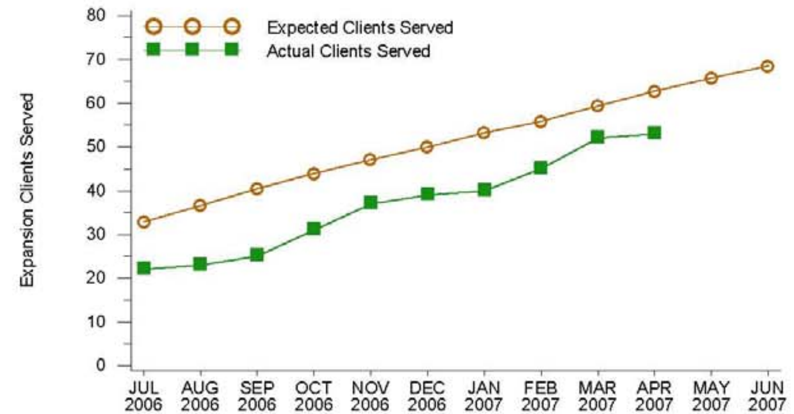


Cumulative

	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected[5]*
Jul 2006	1.7	0	0.0%
Aug 2006	1.8	0	0.0%
Sep 2006	1.9	0	0.0%
Oct 2006	2.0	0	0.0%
Nov 2006	2.1	0	0.0%
Dec 2006	2.2	0	0.0%
Jan 2007	2.3	0	0.0%
Feb 2007	2.3	0	0.0%
Mar 2007	2.4	0	0.0%
Apr 2007	**2.5**	**0**	**0.0%**
May 2007	2.6		
Jun 2007	2.7		

Blind/Disabled/GAX

Through April 2007, 53 new adult expansion population clients were served in Mason county. Based on the pattern of clients served in FY 2005, we expected to serve 62.7. ***Thus, the cumulative count of 53 through April represents 84.5% of what was expected by this point in time.***



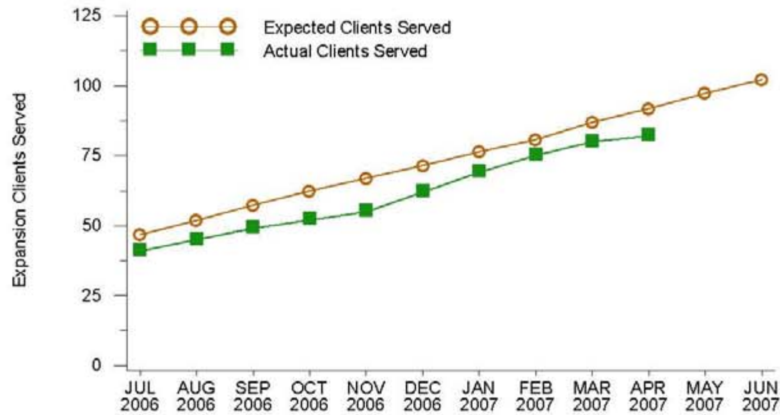
Cumulative

	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected[5]*
Jul 2006	32.9	22	66.8%
Aug 2006	36.6	23	62.8%
Sep 2006	40.4	25	61.9%
Oct 2006	43.9	31	70.6%
Nov 2006	47.1	37	78.6%
Dec 2006	50.0	39	78.0%
Jan 2007	53.2	40	75.2%
Feb 2007	55.9	45	80.5%
Mar 2007	59.3	52	87.7%
Apr 2007	**62.7**	**53**	**84.5%**
May 2007	65.8		
Jun 2007	68.6		

DASA-TA
Treatment Expansion[1] Report - Progress by Subgroup[2]
Adult Clients - Mason County[3]
April 2007

TANF/Other Medicaid

Through April 2007, 82 new adult expansion population clients were served in Mason county. Based on the pattern of clients served in FY 2005, we expected to serve 91.9. ***Thus, the cumulative count of 82 through April represents 89.2% of what was expected by this point in time.***

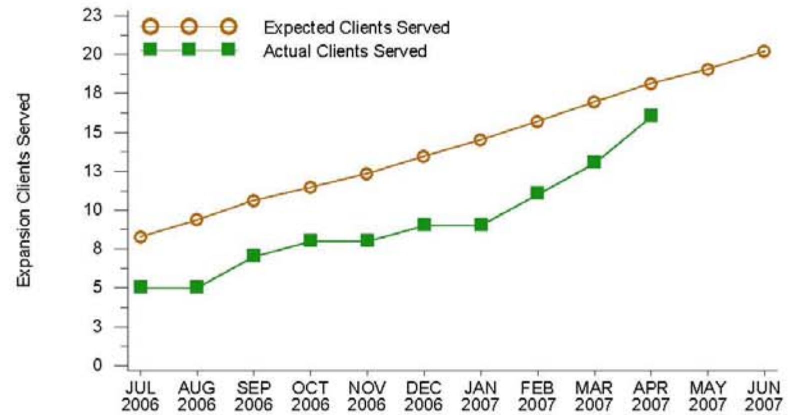


Cumulative

	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected[5]*
Jul 2006	46.8	41	87.6%
Aug 2006	52.0	45	86.6%
Sep 2006	57.4	49	85.4%
Oct 2006	62.5	52	83.2%
Nov 2006	66.9	55	82.2%
Dec 2006	71.4	62	86.8%
Jan 2007	76.4	69	90.4%
Feb 2007	80.8	75	92.8%
Mar 2007	86.9	80	92.0%
Apr 2007	**91.9**	**82**	**89.2%**
May 2007	97.3		
Jun 2007	102.1		

GAU

Through April 2007, 16 new adult expansion population clients were served in Mason county. Based on the pattern of clients served in FY 2005, we expected to serve 18.2. ***Thus, the cumulative count of 16 through April represents 88.1% of what was expected by this point in time.***



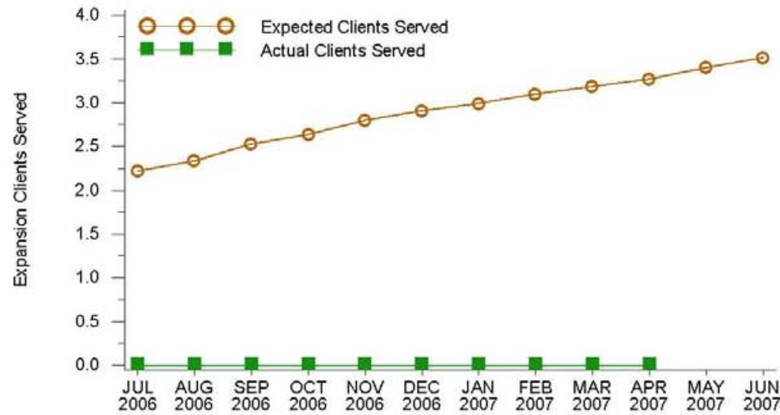
Cumulative

	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected[5]*
Jul 2006	8.3	5	60.4%
Aug 2006	9.4	5	53.3%
Sep 2006	10.6	7	65.9%
Oct 2006	11.5	8	69.7%
Nov 2006	12.4	8	64.7%
Dec 2006	13.5	9	66.8%
Jan 2007	14.5	9	61.9%
Feb 2007	15.7	11	69.9%
Mar 2007	17.0	13	76.6%
Apr 2007	**18.2**	**16**	**88.1%**
May 2007	19.1		
Jun 2007	20.2		

DASA-TA
Treatment Expansion[1] Report - Progress by Adult Subgroup[2]
Adult Clients - Thurston County[3]
April 2007

Aged

Through April 2007, 0 new adult expansion population clients were served in Thurston county. Based on the pattern of clients served in FY 2005, we expected to serve 3.3. ***Thus, the cumulative count of 0 through April represents 0.0% of what was expected by this point in time.***



Cumulative

	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected[5]*
Jul 2006	2.2	0	0.0%
Aug 2006	2.3	0	0.0%
Sep 2006	2.5	0	0.0%
Oct 2006	2.6	0	0.0%
Nov 2006	2.8	0	0.0%
Dec 2006	2.9	0	0.0%
Jan 2007	3.0	0	0.0%
Feb 2007	3.1	0	0.0%
Mar 2007	3.2	0	0.0%
Apr 2007	**3.3**	**0**	**0.0%**
May 2007	3.4		
Jun 2007	3.5		

Blind/Disabled/GAX

Through April 2007, 251 new adult expansion population clients were served in Thurston county. Based on the pattern of clients served in FY 2005, we expected to serve 314.6. ***Thus, the cumulative count of 251 through April represents 79.8% of what was expected by this point in time.***

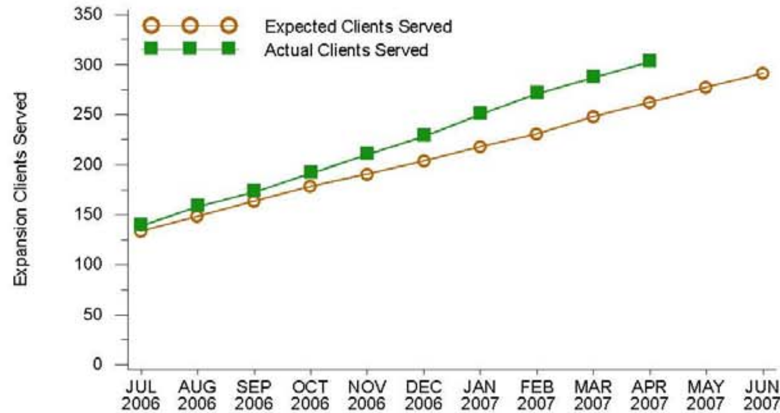
Cumulative

	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected[5]*
Jul 2006	165.2	126	76.3%
Aug 2006	183.9	151	82.1%
Sep 2006	202.7	163	80.4%
Oct 2006	220.3	189	85.8%
Nov 2006	236.3	203	85.9%
Dec 2006	250.8	211	84.1%
Jan 2007	267.1	220	82.4%
Feb 2007	280.5	229	81.6%
Mar 2007	297.7	239	80.3%
Apr 2007	**314.6**	**251**	**79.8%**
May 2007	330.1		
Jun 2007	344.2		

DASA-TA
Treatment Expansion[1] Report - Progress by Subgroup[2]
Adult Clients - Thurston County[3]
April 2007

TANF/Other Medicaid

Through April 2007, 303 new adult expansion population clients were served in Thurston county. Based on the pattern of clients served in FY 2005, we expected to serve 262.3. ***Thus, the cumulative count of 303 through April represents 115.5% of what was expected by this point in time.***

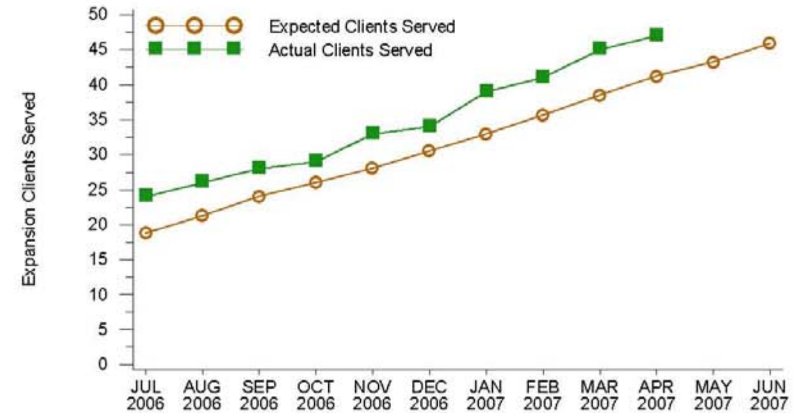


Cumulative

	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected[5]*
Jul 2006	133.6	139	104.0%
Aug 2006	148.4	158	106.5%
Sep 2006	163.7	173	105.7%
Oct 2006	178.3	191	107.1%
Nov 2006	190.9	210	110.0%
Dec 2006	203.8	228	111.9%
Jan 2007	218.0	250	114.7%
Feb 2007	230.6	271	117.5%
Mar 2007	248.2	287	115.6%
Apr 2007	**262.3**	**303**	**115.5%**
May 2007	277.9		
Jun 2007	291.4		

GAU

Through April 2007, 47 new adult expansion population clients were served in Thurston county. Based on the pattern of clients served in FY 2005, we expected to serve 41.2. ***Thus, the cumulative count of 47 through April represents 114.0% of what was expected by this point in time.***



Cumulative

	Expected Clients Served[4]	*New Clients Served*	*Percent of Expected[5]*
Jul 2006	18.8	24	127.7%
Aug 2006	21.3	26	122.0%
Sep 2006	24.1	28	116.2%
Oct 2006	26.1	29	111.3%
Nov 2006	28.1	33	117.6%
Dec 2006	30.6	34	111.2%
Jan 2007	33.0	39	118.2%
Feb 2007	35.7	41	114.9%
Mar 2007	38.5	45	116.8%
Apr 2007	**41.2**	**47**	**114.0%**
May 2007	43.3		
Jun 2007	45.9		

Criminal Justice System

Thurston/Mason Criminal Justice System ~ 2000-2006

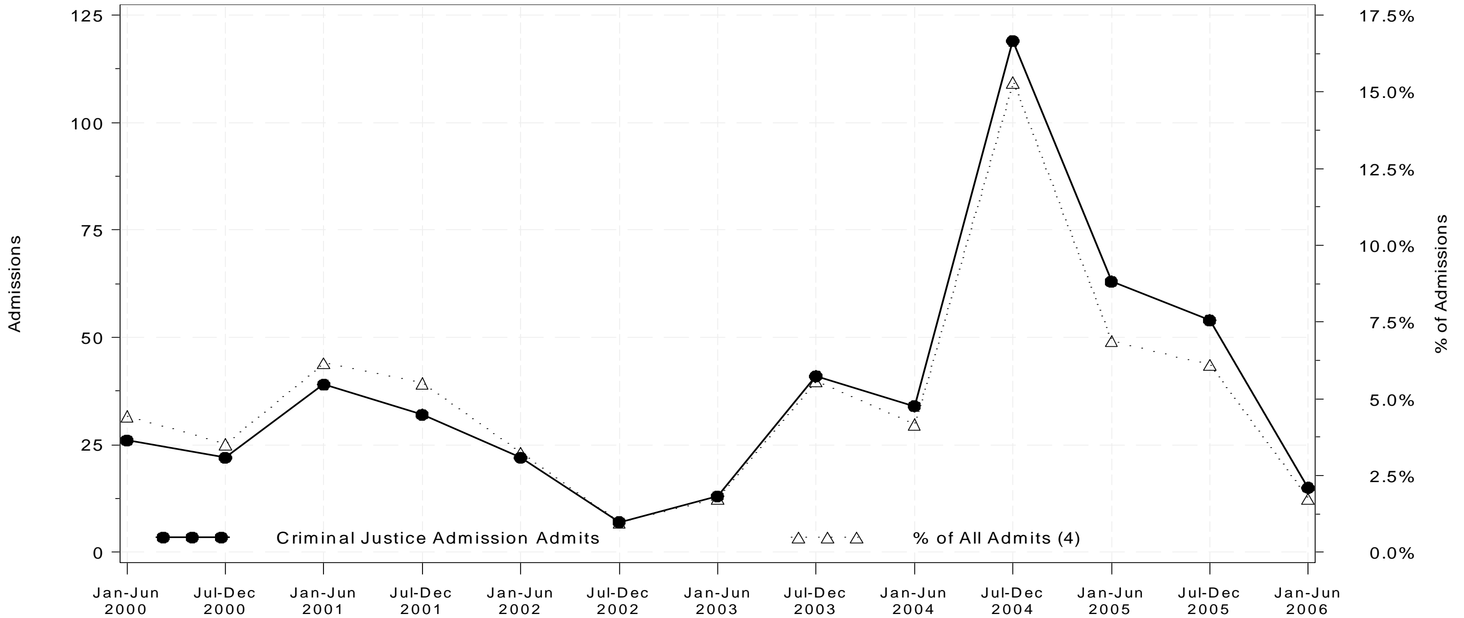
The first Criminal Justice (CJ) chart displays chemical dependency outpatient treatment admissions during January of 2000 through June, 2006. The graph illustrates that for the first few years (January 2004) CJ admissions were limited and did not exceed 41 admissions within a six month period. January - June of 2000 there were only 26 admissions. In the period January – June 2004 there were 34, which only showed a 4.2% increase.

In the 2003 – 2005 biennium, the Criminal Justice Treatment Account (CJTA) was implemented and provided increased funding for drug courts and criminal justice. In the period of July – December 2004 there was a sharp spike or increase in admissions. For that period there were 119 admissions, which accounted for a 15.3% increase (which was the greatest increase among all the six month periods in the six year analysis). With the advent of CJTA, there was a significant increase in admissions. One of the peculiarities with this chart is that the numbers go up and down. One of the explanations for this is that individuals who enter drug court stay in treatment for nine to eighteen months (see footnote #4 on chart).

Ironically, during the last period of the six years (January – June 2006) there were only 15 admissions. It's hard to speculate what the needs will be in 2013, but the County does expect an increase in treatment needs. Jail treatment funding and other factors, including drug court, influence CJ admissions. The County will be prepared for an increase in treatment admissions because the Mason County treatment cycle fluctuates based on the 9-18 month length of stay required in drug court.

Therefore, CJ treatment admissions will experience punctuated admission trends. These trends will have short term increases in admissions and then decrease until there are a significant number of participants graduate and make space for new admissions.

Thurston-Mason County[1] Strategic Plan
Criminal Justice Admission[2] Outpatient[3] Admissions



Comparison of Admissions Over Time

Jan-Jun 2006 Compared to...	*Change in Criminal Justice Admission Admissions[5]*	*Change in All Admissions[5]*
Jan-Jun 2005	-76.19% ▼	-5.79% ▼
Jan-Jun 2003	15.38% △	16.64% △
Jan-Jun 2000	-42.30% ▼	47.09% △

Criminal Justice Admission

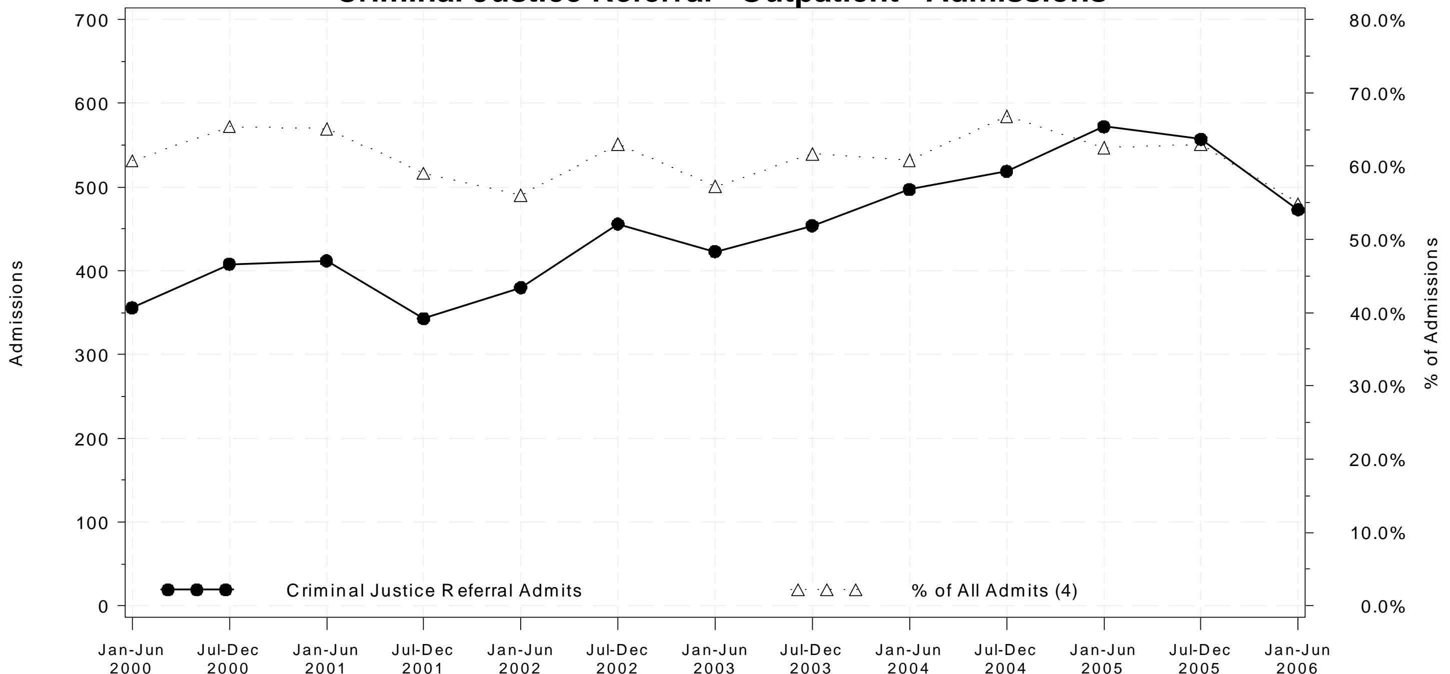
	Yes		*No*		
	Admits	*%[6]*	*Admits*	*%*	*Total*
Jan 2000-Jun 2000	26	4.4%	560	95.6%	586
Jul 2000-Dec 2000	22	3.5%	602	96.5%	624
Jan 2001-Jun 2001	39	6.2%	594	93.8%	633
Jul 2001-Dec 2001	32	5.5%	549	94.5%	581
Jan 2002-Jun 2002	22	3.2%	656	96.8%	678
Jul 2002-Dec 2002	7	1.0%	717	99.0%	724
Jan 2003-Jun 2003	13	1.8%	726	98.2%	739
Jul 2003-Dec 2003	41	5.6%	695	94.4%	736
Jan 2004-Jun 2004	34	4.2%	783	95.8%	817
Jul 2004-Dec 2004	119	15.3%	658	84.7%	777
Jan 2005-Jun 2005	63	6.9%	852	93.1%	915
Jul 2005-Dec 2005	54	6.1%	831	93.9%	885
Jan 2006-Jun 2006	15	1.7%	847	98.3%	862

[1] County is defined using the Facility County field in TARGET. Private pay funded admissions are excluded. Contract type = 'DOC-Community' are included.
[2] Identified using the contract type field in TARGET. Values of 1) Criminal Justice or 2) Criminal Justice - Innovations.
[3] Includes Intensive Outpatient, Outpatient, MICA Outpatient.
[4] (Number of CJTA Admissions/Total Outpatient Admissions) * 100. This line shows the trend in CJTA admissions relative to overall admissions. It is included on the graph because of the additional information it provides. For example, it is possible for the total number of CJTA admissions to be falling over time and still represent an increasing percentage of overall admissions.
[5] [(Admissions: Jan-Jun 06 – Admissions: Previous Period)/Admissions: Previous Period] * 100.
[6] (N/Total)*100. Figures in this column represent the percent of all admissions funded by the CJTA during a given period of time.

The second Criminal Justice (CJ) chart describes all the chemical dependency outpatient admissions that were tagged in TARGET for being referred by a CJ source. The CJ referral sources include 1) Court/Probation, 2) Department of Corrections, 3) Diversion, 4) Police, or 5) JRA. This chart shows a six year term for both Thurston and Mason Counties. The first six month term (January – June 2000) reports 356 (lowest) and the highest was in January – June 2005, which had 572 admissions. During this period there was a 62.5% increase in admissions between 2000 and 2005 (advent of CJTA).

The overall trend among outpatient admissions that were referred by a criminal justice source displays a consistent increase. It is expected that over the next six years this trend will continue. Therefore, the County will continue to work with local chemical dependency providers, community service office staff, and the criminal justice system to better serve this population.

One of the barriers to serving this population is the stigma associated with individuals that are "sent" to treatment as opposed to those that come "willingly." Research has shown that those coerced or sent to treatment actually have better outcomes than those that are driven to treatment on their own volition. The County has and will continue to attempt to change this myth by sharing these facts and educating chemical dependency professionals and community service office staff regarding these outcome data.



Comparison of Admissions Over Time

Jan-Jun 2006 Compared to...	*Change in Criminal Justice Referral Admissions[5]*	*Change in All Admissions[5]*
Jan-Jun 2005	-17.30% ▼	-5.79% ▼
Jan-Jun 2003	11.82% △	16.64% △
Jan-Jun 2000	32.86% △	47.09% △

Criminal Justice Referral

	Yes		No		
	Admits	*%[6]*	*Admits*	*%*	*Total*
Jan 2000-Jun 2000	356	60.8%	230	39.2%	586
Jul 2000-Dec 2000	408	65.4%	216	34.6%	624
Jan 2001-Jun 2001	412	65.1%	221	34.9%	633
Jul 2001-Dec 2001	343	59.0%	238	41.0%	581
Jan 2002-Jun 2002	380	56.0%	298	44.0%	678
Jul 2002-Dec 2002	456	63.0%	268	37.0%	724
Jan 2003-Jun 2003	423	57.2%	316	42.8%	739
Jul 2003-Dec 2003	454	61.7%	282	38.3%	736
Jan 2004-Jun 2004	497	60.8%	320	39.2%	817
Jul 2004-Dec 2004	519	66.8%	258	33.2%	777
Jan 2005-Jun 2005	572	62.5%	343	37.5%	915
Jul 2005-Dec 2005	557	62.9%	328	37.1%	885
Jan 2006-Jun 2006	473	54.9%	389	45.1%	862

[1] County is defined using the Facility County field in TARGET. Private pay funded admissions are excluded. Contract type = 'DOC-Community' are included.
[2] Identified using the entry referral field in TARGET. Values of 1) Court/Probation, 2) Department of Corrections, 3) Diversion, 4) Police or 5) JRA.
[3] Includes Intensive Outpatient, Outpatient, MICA Outpatient.
[4] (Number of CJ referral Admissions/Total Outpatient Admissions) * 100. This line shows the trend in CJ referral admissions relative to overall admissions. It is included on the graph because of the additional information it provides. For example, it is possible for the total number of CJ referral admissions to be falling over time and still represent an increasing percentage of overall admissions.
[5] [(Admissions: Jan-Jun 06 – Admissions: Previous Period)/Admissions: Previous Period] * 100.
[6] (N/Total)*100. Figures in this column represent the percent of all admissions whose entry referral source was related to the criminal justice system during a given period of time.

Mason County Criminal Justice Treatment Account & Services 2007-2013

This plan has been prepared in response to DSHS, Division of Alcohol & Substance Abuse (DASA) and County guidelines for submittal of Criminal Justice Treatment Account (CJTA) plans and services. Additionally, the Statewide Criminal Justice Treatment Account Panel has some oversight of the plans and sets the funding formula for counties.

The CJTA funding formula takes into account a number of variables utilizing data from the U.S. Census Bureau; annual caseload reports by the Administrative Office of the Courts; criminal cases filed by Superior Court and published by the Administrative Office of the Courts; and Substance Abuse Treatment Need Rates from the 1999 DASA/RDA report entitled: "Profile of Substance Use & Need for Treatment Services in Washington State."

Based on these data sources there were a total of 1,206 non-traffic misdemeanor filings and 326 felony filings for a total of 1,532. Of the total number of offenders the estimated number with an addiction is 613 offenders or 40%. *Reference source is DASA literature review, state comparison and Research and Data Analysis.

Best Practice Plan 2007-2013:

1. Mason County will utilize its best practice grant funds to provide inpatient substance abuse treatment services to clients participating in Adult Felony Drug Court. Client inpatient substance abuse treatment services will meet the definition of evidence-based practice. American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) will be used to determine the appropriate level of care and length of stay.

   The following is a description of the evidence-based treatment modality, drug problem, and population to be served:

Title	Drug Problem	Population
Inpatient treatment with cognitive behavioral therapies incorporated into program	Applicable to most alcohol & other drug problems	Drug Court participants: Men Women

   With specific funds available for inpatient substance abuse treatment, many drug court clients will benefit from the structure and intensity of inpatient treatment. For most clients, inpatient treatment helps to stabilize them and provides a foundation for successful completion of the three (3) phases of treatment required by the Adult Felony Drug Court.

2. For fiscal years 2007-2009, Mason County may explore the development of a Family Dependency Treatment Court. An implementation goal may be set for the 2009-2011 biennium.

   The correlation between parental substance abuse and child maltreatment is well-documented. A number of courts across the nation are successfully applying the drug

court model to child welfare cases that involve an allegation of child abuse or neglect related to substance abuse. "Family Drug Courts" or "Family Dependency Treatment Courts" (FDTC) seek to do what is in the best interest of the family by providing a safe and secure environment for the child(ren) while intensively intervening and treating the parent's substance abuse and other co-morbidity issues. The FDTC approach has resulted in better collaboration between agencies and better compliance with treatment and other court orders necessary to improve child protection case outcomes.

I. CJTA Funds for 2007-2013

These funds will be used to continue providing Adult Felony Drug Court services. The rationale for providing drug court services is based on the recommendation of the Mason County Drug Court Team. The Team has been working together for six (6) years and has established an effective process that ensures that the operational accountability and treatment structure is sound.

II. Local Funds: (Anticipated)

The annual County General and Tribal Funds will be used to pay for child care in order for participants to attend treatment, transportation for participants to and from treatment activities, additional screening tests, and training for the Drug Court Team. This allows all CJTA funds to be used for the costs associated with treatment. Community support for the Adult Felony Drug Court program is evident, and the local match funds garnered in support of it signify the commitment of elected officials as well as the local tribal governments.

III. Drug Court Services

The Mason County Adult Felony Drug Court will continue to provide the same services that are currently operating, as described in the following section.

IV. Drug Court Program Description

The Mason County Adult Felony Drug Court program is a post-plea, court-supervised, comprehensive treatment program for non-violent, adult felony drug and drug addicted offenders. It is a voluntary program. Successful completion of graduation from the program results in having the felony charge(s) dismissed.

This program includes regular court appearances before the Drug Court Judge and the Drug Court Team members. Treatment services include: residential and outpatient care, individual and group counseling sessions, substance abuse education, cognitive behavioral therapies, family program, relapse prevention, individual needs workbooks, relationships, referral to community resources/services, regular attendance at 12-step meetings and/or other recovery support groups or meeting and random urinalysis/breathalyzer testing, or other drug testing as required.

Providence St. Peter Chemical Dependency Center provides treatment services.

The primary counselor assigned to the drug court participant provides individual and group counseling, case management, and monitoring of participant progress. Progress reports are submitted to the court prior to every court appearance and include the following:

- Current address/living arrangements
- Employment status
- Progress made on the treatment plan
- Attendance and participation in treatment services
- Results of urinalysis/breathalyzer testing
- Number of clean and sober days
- Record of fee payments
- Comment/recommendations

Failure to appear in court or attend any other program sessions may result in sanctions being imposed. Bench warrants may be issued for arrest and in some cases participants may be terminated from the program. Other violations that could result in termination from the program could include, but are not limited to:

- Missing urinalysis/breathalyzer tests
- Refusing or unable to submit to tests
- Getting positive test results or having diluted test results
- Tampering with urine samples or drug testing devised
- Failing to cooperate with the counseling staff
- Not actively participating in program services
- Being late for appointment/sessions/activities/court reviews
- Forging 12-step service forms
- Failing to complete imposed sanctions
- Being violent or making any threats of violence directed at program staff or participants
- Violating any conditions of the drug court program contract, the treatment participant contract, or any other conditions that you must follow.

Treatment Procedures

Treatment Services: Treatment services are comprised of five (5) separate parts:
1) individual counseling; 2) group counseling; 3) substance abuse education; 4) 12-step support meetings and; 5) referral(s) for services in the community.

Moral Reconation Therapy (MRT): MRT is a highly structured cognitive-behavioral treatment strategy that focuses on changing the thinking (beliefs) and behaviors that lead to problems of drug abuse, relationship difficulties, and negative (crime-related) lifestyles. MRT significantly raises moral reasoning levels, helps the participant set goals, and develops positive personal qualities. MRT helps redirect decision-making to "do the right thing because it is the right thing to do."

Access to services in the community: Ancillary services that may be needed for participants are obtained with the assistance of the participant's counselor. Some of these services may include, but are not limited to:

- Education and employment information and assistance
- Mental health services
- Medical and dental care
- Transportation and housing needs
- Ethnic/gender/cultural services

- Anger management and/or domestic violence classes
- Legal assistance and support

Treatment Phases (The following 3 Phases describe the program in more detail)

Phase I: Orientation, Intake, and Stabilization is 3-4 months in length. This requires cognitive behavioral therapy 1½ hours twice a week; individual counseling 1 hour each week at a minimum; substance abuse education 1 hour each week; 12-step self-help groups 1 hour three times per week; and one Drug Court hearing each week at a minimum.

Phase II: Intensive counseling, therapy, and treatment services are 5-8 months in length. This requires cognitive behavioral therapy 1½ hours twice a week; individual counseling up to 1 hour each week; specialized groups (e.g. anger management, domestic violence, parenting) 1 hour each week (minimum of 16 sessions); relapse prevention 1½ hours twice a week (minimum of 16 sessions); 12-step self help groups 1 hour three times per week; and Drug Court hearings twice a month at a minimum.

Phase III: Referral/Monitoring is 4-6 months in length. This requires Aftercare group 1½ hours each week (minimum of 12 sessions); individual/group counseling 1 hour each week; 12-step self help groups 1 hour three times per week; and Drug Court hearings once a month at a minimum. Graduation to Phase II and III will depend on clear measures of progress in the previous phase to the satisfaction of the treatment agency, Drug Court Team, and Judge.

Screening Tests

Drug and alcohol testing occurs on a random basis throughout the Drug Court Program. All samples are directly observed and monitored by a same-gender employee or treatment designee.

The Drug Court Judge is informed of all screening test results. Any refusals or participant inability to test, no shows/missed tests or tampered with/diluted test results are considered to be positive UA results. When the test is positive, the participant is contacted immediately to appear at the next court review. This occurs whether or not the participant is scheduled for that particular court appearance.

Medications (Prescriptions/Over-The-Counter)

If the drug court participant is taking medication(s) provided by their doctor, they must strictly follow the Medication Policy. This includes:

1. Telling the healthcare provider that they are in a recovery program for drug addiction/alcoholism. They must tell their health care provider all the drugs that they have used in their life and if they have ever used needles.

2. They must inform all health care providers that they are participating in the Drug Court Program. They must provide their doctor with a release of information form and have the provider fill out the form and return it to their counselor.

3. If the health care provider determines that the participant must take any medications, they must sign a release for their counselor and the health care professional to

communicate with one another, bring written documentation about their health care condition to the court, provide the name and phone number of their health care provider(s), and bring all medication(s) in their original bottles each and every time they must submit a urinalysis sample.

12-Step Recovery/Support Groups

All participants are required to attend a minimum number of 12-step support groups/meetings each week. These must be done on different days within a seven day period of time.

When attending a meeting where another Drug Court member may be chairing, the participant must have someone else sign the attendance slip. If another participant signs the slip, that meeting will not count towards their required number of weekly meetings. The participants must use the approved blue attendance slip for all meetings. Signatures on any other pieces of paper will not be accepted and the participant will not be awarded credit for attendance. These will all be counted as missed meetings and could result in sanctions.

Participants are also required to find a 12-step sponsor of the same gender. This is the person who will support the participant and help them "work the steps" of the 12-step program. A sponsor is also the one to help the participant develop a level of trust and how to create healthy social bonds with other recovering individuals.

Program and Court Fees

All participants agree to a $15.00 per week treatment services fee. All fees will be made directly to the treatment provider. These fees are documented in the participant's progress reports that are brought to their court reviews. If a participant is unable to make payment of these fees, it is their responsibility to make arrangements with the treatment program. If program fees are not paid and the participant has not made financial arrangements for payment, they may be referred to the court with a recommendation for a sanction up to and/or including termination.

If the felony charge(s) was the result of a property offense, participants may be required to pay restitution to the victim(s). They may also be required to pay some or all of their Defense Attorney's fees.

Courtroom Behavior

Appropriate behavior must be maintained at all times during Drug Court Reviews and while in the courthouse. All participants must be in the courtroom when court convenes and they must remain until their case is called. Arriving late without prior approval from the counselor or Program Coordinator may result in a sanction.

Program Compliance, Accountability, and Confidentiality

1. **Compliance**
   Attendance is mandatory for all program services, activities, and court appearances. Documentation must be presented for missed appointments no later than the next business day. Arriving late to any scheduled appointment is considered a "no show" and sanctions may be imposed.

   All program services require active participation and self-disclosure. Attendance alone is not sufficient. Also, failure to work on and complete exercises in any event will result in a Special Treatment/Behavior Contract being developed between the participant and their counselor.

   Participants must pay close attention to complying with all terms of all program contracts that have been signed. All violations are reported to the other jurisdictions and to the Judge who determines the consequences in the program no later than the next business day.

   All program and contract violations and any illegal behavior must be reported to the participant's counselor or Coordinator no later than the next business day. The Drug Court Team makes sanction recommendations and the Judge makes all final decisions.

2. **Program Accountability**
   Accountability and honesty are the two most important elements to successful completion of chemical addiction treatment. Chemically dependent people tend to operate with many "thinking errors" about themselves and the world. Therefore, it is required that participants be intellectually, morally, and behaviorally responsible.

3. **Program Confidentiality**
   Participants are required to sign irrevocable "Consents to Release Information" to the Drug Court Judge, Program Coordinator, Public Defender, Prosecuting Attorney, Treatment Provider, and any other agencies/persons providing program services.

   An ongoing flow of information passes between the Drug Court Team and counseling professionals. The participant must agree to allow the Team members to receive information from other treatment agencies and medical/mental health professionals. There must be an agreement to extend this flow of information to all other criminal justice and law enforcement agencies, and the medical/mental health professionals who are providing services and have jurisdiction over the participant.

   In order for treatment to be effective, it is critical for the participants that absolute confidentiality be maintained. Participants must not talk about anything that has been said in groups to others. Violation of this requirement could result in termination from the program.

   From the date that participants graduate or are terminated from the Drug Court Program, their criminal history and program records are released to the Drug Court Program for 10 years to track their arrest and conviction record. They will be, when possible, contacted on a random basis for the purpose of gathering other relevant

information, such as drug/alcohol relapse, employment and education status, and changes in family/living arrangements.

Sanctions/Incentives

Progress is closely monitored by the participant's counselor and the Program Coordinator. The Judge also receives written progress reports from the counselor regarding client progress. During each Drug Court Team review, participant progress, or that lack thereof, is discussed. As a result, certain sanctions or incentives are recommended throughout the program.

Examples of incentives for positive behavior and/or progress with program goals:

- Coins for sober days
- Praise and appreciation from the Drug Court Judge
- Small gifts or tokens that are donated by the community
- Other members of the Drug Court Team may share encouragement, support and appreciation for the participant's commitment

Examples of sanctions for failing to comply with any aspects of the Drug Court.

- Face peers in court and describe thoughts, feelings, and actions that lead to violation
- Write a paper on a specific topic assigned by the Judge
- Complete other written/verbal assignments
- Increase frequency of court reviews
- Increase attendance at 12-step meetings
- Remain in a treatment phase for a specified period of time
- Return to a previous treatment phase for a specified period of time
- Attend other court proceedings for a specified number of days
- Complete 24 hours (or more) per week of community service work assigned by the Program Coordinator

Detoxification/Inpatient Treatment

A counselor makes a referral if a participant is in need of detoxification services. If the participant is pregnant, special arrangements are made to address both needs. The counselor also determines if the participant could benefit from going to an inpatient treatment program.

Ancillary Services/Community Resources

When admitted, the counselor determines the status of the participant's physical, mental, emotional, and basic living needs in order to effectively write the Initial Treatment Plan.

There may be a need for different services to maintain stability and/or to continue making progress in treatment, and the counselor will assist the participant in acquiring these services. Some examples of such services include, but are not limited to:

- Financial assistance (food stamps, medical coupons, childcare)
- Mental health evaluation and treatment services
- Family services, counseling, and parenting classes
- Health, wellness, and nutritional assistance
- Emergency shelter, transitional, and other housing
- Transportation assistance
- Domestic violence, trauma treatment, and anger/stress management
- Services for special needs: gender-specific, cultural and ethnic considerations
- Medical and dental services
- Educational/vocational/employment assistance.

Educational Requirement

As a condition of graduation from the Drug Court, all participants must show proof of meaningful work on their GED or High School Diploma to the court.

Family Support System Program

Providence St. Peter Chemical Dependency Center offers a family program at no cost to Drug Court participants and/or their family members, significant others and/or closes friends. The goal of the program is to provide those people with information that will help them to better understand some of the things that the Drug Court participants will be learning.

It will also help them to better understand and to more effectively cope with problems in their relationships. The model used in the family program follows the cognitive behavioral format and the focus is also on treatment and education of the addict/alcoholic.

Law Enforcement/Drug Court Program Partnership

Partnership in Mason County has been made between the Drug Court Program and all of the law enforcement agencies based upon the concepts and philosophies of "Community-Oriented Policing." Law enforcement participation plays an important role in how the court handles each Drug Court case. Law enforcement provides feedback to the Judge in determining the appropriateness of placing participants in the program. They also provide information about participant progress once they have entered the program and/or how to respond to their behavior. Officers and Deputies assist the court by enforcing Drug Court Bench Warrants and by monitoring participant activity when they are not engaged in treatment services. Their professional observations, opinions, and written reports, as experienced community policing officers, plays an important role in determining how well the participant is doing in the program.

Graduation

Once the participant has successfully completed Phase III of the program, written documentation must confirm that all of the goals in their treatment plan and phase requirements have been accomplished. Then the Judge, with the recommendations from the other Drug Court Team members, determines if all other conditions of graduation have been met.

V. Measurable Goals and Objectives:

- Demonstrate the cost-efficiency of drug court program (mean cost for 12 months of service, per client, from date of admission to date of discharge). Cost efficiency is measured by comparing the mean cost referenced above with the cost of maintaining an offender who is incarcerated and/or on extended supervision who has not experienced drug court.
- Maximize the use of the drug court program by maintaining an 80% utilization rate in the program
- Identify eligible offenders suitable for drug court
- Reduce recidivism of criminal offenses by 20%
- Reduce relapse
- Increase jail space for more serious offenders
- Reduce incidence and prevalence of drug use
- Use resources effectively and efficiently
- Provide judicial oversight services to drug court participants

- Treatment retention/completion – treatment completion rates are projected to be 60%.

VII. Evaluation Strategy

- Use TARGET data and Treatment Analyzer data to document treatment retention rates
- Use client satisfaction surveys
- Measure criminal activity involvement through the number of arrests reported through county law enforcement
- Determine cost per participant, utilizing fiscal monitoring for both program and court costs

Thurston County Criminal Justice Treatment Account & Services 2007-2013

This plan has been prepared in response to DSHS, Division of Alcohol & Substance Abuse (DASA) and County guidelines for submittal of Criminal Justice Treatment Account (CJTA) plans and services. Additionally, the Statewide Criminal Justice Treatment Account Panel has some oversight of the plans and set the funding formula for counties.

The CJTA funding formula takes into account a number of variables utilizing data from the US Census Bureau; annual caseload reports by the Administrative Office of the Courts; criminal cases filed by Superior Court and published by the Administrative Office of the Courts; and Substance Abuse Treatment Need Rates from the 1999 DASA/RDA report entitled: "Profile of Substance Use & Need for Treatment Services in Washington State."

For Thurston County, there are a reported <u>2,022 non-traffic misdemeanor filings, 2,014 felony filings, for a total of 4,036 offenders. Of the total, 40% or an estimated 1,614 offenders have an addiction. *(These figures are annual estimates)</u>. *Reference source is DASA literature review, state comparisons and Research and Data Analysis.

These funds will be used to serve nonviolent drug offenders in a Drug Court Program.

<u>Strategic Plan 2007-2013:</u>

The Thurston County Drug Court team, in conjunction with the Community Drug Court Support Foundation (their non-profit foundation) has submitted the following ideas and plans for the improvement and enhancement of their drug court:

1. Increase program capacity by 50%.

2. Include the following curriculum for drug court participants within their existing treatment system:
   - Life skills - finances/budgeting, nutrition, exercise, and personal hygiene
   - Parenting skills education
   - Employment readiness - career exploration, job search techniques, application and resume writing, salary negotiations, successful interviewing, and job survival skills

3. Expand the capacity of drug court assistance to include medical and mental health services which will address:
   - Medical and dental services for participants
   - Evaluations and counseling services to be provided by a licensed mental health specialist
   - Contracted access to a physician for diagnosing and prescribing medication

4. Implement a Family Treatment Program to include family members of drug court participants. A consequence of an individual's addiction is often confusion, anger and alienation of family members and loved ones. Creating a family treatment program provides the extended family members education about addiction and the opportunity to work in therapy to repair and restore their relationships with the participant and one another.

5. Add a full-time Case Manager to the drug court staff. Currently, participant case management is performed by several staff. This process is in need of a more specific, formalized approach to ensure optimum participant care.

6. Thurston County may also explore the development of either a stand-alone DUI court or a hybrid program built from critical components of a full DUI court program.

   A DUI court is designed to utilize the drug court model with impaired drivers. To date, it has been left to the traditional courts and criminal justice system to deal with DUI cases; and it has become clear that the traditional process is not working for repeat offenders. Punishment unaccompanied by treatment and accountability is an ineffective deterrent for the repeat DUI offender.

   The goal of the DUI court is to protect public safety by using the drug court model to address the root cause of impaired driving, alcohol, and other substance abuse. With the repeat offender as its primary target population, DUI courts follow the Ten Key Components of Drug Court and the Ten Guiding Principles of DUI Courts, as established by the National Association of Drug Court Professionals and their training branch, the National Drug Court Institute.

7. Add a full-time "Case Aide" for home visits. This position would be utilized if/when the drug court develops a DUI court. The position would be responsible for regular home and community monitoring with random alcohol and drug tests and ongoing support for this population.

I. CJTA Funds for 2007-2013

These funds will be used to continue providing Thurston County Drug Court program services for nonviolent drug offenders. The rationale for providing drug court services is based on the recommendation of the Thurston County Executive Drug Court Team. The team has been working together for nine years and has established an effective process that ensures that the operational accountability and treatment structure is sound.

II. Local Funds: (Anticipated)

- Annual County general and local funds will be used to pay for targeted personnel and program lease costs.
- Federal funds (minimal and not guaranteed) to be used to supplement the cost of supplies, extra urinalysis tests, equipment, materials, training and trauma treatment services. "Seeking Safety," is a present-focused therapy to help people recover from trauma/PTSD and substance abuse.
- A $100 fee assessed on all drug convictions is dedicated to the drug court. All program participation fees paid are allocated by the Board of County Commissioners.

According to the Thurston County Drug Court, the only program gaps (and associated costs) are listed in the Strategic Plan above.

III. Drug Court Services

The Thurston County Drug Court will continue to provide the same services that are currently operating, as described in the following section. This decision correlates with the need for more funding to allow the Drug Court to continue to grow.

In addition to the following programmatic outline, the Thurston County Drug Court partners with the Chemical Dependency Program in the Thurston County Corrections Facility (TCCF). The corrections program was developed in July 1995 to address the law enforcement, prosecution, incarceration, and other community

challenges presented by the manufacture, distribution, and use of methamphetamine, heroin, cocaine, marijuana, and alcohol in the community.

This model program has significantly reduced recidivism by addressing both the antisocial personality traits and the chemical dependency relapse issues of offenders. The program has developed solid linkages with critical ancillary services to provide "wrap around" services for all clients.

A complimentary relationship with the Thurston County Drug Court provides a vital continuum of care option that reflects the clinical needs of the drug court participants. Graduated sanctions set forth by the Drug Court could require a participant be incarcerated for a period of time with compulsory involvement in the chemical dependency program. This not only protects the safety of the community and holds the participant accountable for an infraction, but allows clinical care to continue uninterrupted.

IV. Drug Court Program Description

The Thurston County Drug Court Program is a court-supervised, comprehensive drug treatment program available to eligible non-violent drug and property felony offenders whose crimes are related to or caused by drug and/or alcohol addiction.

The Thurston County Drug Court has been in existence since 1998. Pierce County Alliance is the drug court treatment provider.

Drug Court Program Mission

The mission is to break the "revolving door" cycle of drugs and crime and to support participants to achieve total abstinence from drugs and alcohol, by promoting responsibility and accountability, and by teaching participants to become productive members in the community.

The Drug Court Program is an alternative to jail and/or prison and integrates chemical dependency treatment and community resources/ancillary services with the criminal justice system.

Overview

The Thurston County Drug Court Program is a voluntary program and includes regular court appearances before the Drug Court Judge and the other Drug Court Team members (Program Administrator, Prosecuting Attorney, Defense Attorney, and Counseling Staff).
Total abstinence from drugs and alcohol is mandatory and participants are monitored by random urinalysis and breathalyzer testing throughout the entire program. Upon admission the participant is assigned a primary counselor who, with the input of the participant, develops an individualized treatment plan, reviews the participant handbook and answers any questions. The counselor conducts individual counseling sessions, assists with obtaining community resources and services needed, helps with obtaining educational, vocational, and/or job readiness skills by providing referrals into the community. The counselor continually monitors compliance, the treatment plan, and all contract requirements. They also provide detailed progress and compliance reports to the Drug Court Judge prior to each court review.

Successful completion and graduation from the program will result in having the felony charge(s) dismissed, with prejudice.

Drug Court participants must appear in court on a regular basis. Prior to each court appearance, the Judge and team members review progress reports that contain the following information:

- Progress made on the treatment plan

- Attendance and participation in treatment services
- Urinalysis and breathalyzer test results
- Number of clean and sober days
- Record of fee payments
- Current address and living arrangements
- Employment
- Comments and/or recommendations by the participant's counselor

Failure to appear in court or attend any other required appointments on the date and time that they are scheduled will result in sanctions being imposed, which could include a bench warrant for the participant's arrest.

Bench warrants that are issued by the Judge could result in termination from the program. Other violations that could result in termination include, but are not limited to:

- Positive drug/alcohol tests, missing tests, refusing and/or tampering with a test
- Not following through with counselor recommendations and/or not actively participating in program services
- Failing to complete all assigned work on time
- Forging 12-step service forms
- Failing to complete sanctions
- Being violent or making any threats of violence directed at program staff or participants
- Failure to comply with **any** requirement of the Drug Court Program Contract

Treatment Procedures

The Drug Court Program continues to provide three phases of treatment to a caseload of 72 clients in the program. Grant funding will increase the program by up to 22 participants in 2008.

Phase I: Orientation, Intake, Assessment, and IOP (3-4 months):

During Phase I, an assessment is completed that is based on the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC). This illuminates problem
areas for the participant in six life dimensions: intoxication/withdrawal; medical conditions/complications; emotional/behavioral conditions/complications; treatment readiness; relapse potential; and recovery environment. In turn, this determines the level of treatment and the initial focus of that treatment the participant should receive. At this point, a treatment plan is developed and the participant is placed into an appropriate level of care.

Services required for this phase are:

- Drug & alcohol education
- Moral Reconation Therapy (MRT) – MRT is a highly structured cognitive-behavioral treatment strategy that focuses on changing thinking and behaviors that lead to problems of drug abuse, relationship difficulties, and negative lifestyles. It is a treatment process designed to develop higher levels of moral reasoning and positive personal qualities
- Individual & group counseling
- Seeking Safety group (if applicable) – Seeking Safety is present-focused therapy to help people attain safety from trauma/PTSD (Post Traumatic Stress Disorder) and substance abuse. It can be used in a variety of settings: individually or in groups, with women, men or mixed-gender, and in either outpatient or inpatient settings. The key principles of the program are: safety in relationships, integrated treatment (treating both trauma and substance abuse at the same time), and a focus on ideals
- Urinalysis/breathalyzer testing
- Drug court process reviews

- Recovery/support group attendance- participants must attend meetings a minimum of four times per week or as recommended by the team

Advancement to Phase II is contingent upon a set of criteria that establishes participant stabilization, e.g. clean and sober days, payment of program fees, stable address, no program violations, etc.

Phase II – Intensive Counseling: 5-8 months:

During Phase II, the intensity of the program changes and counseling sessions focus on more in-depth problem areas and skill-building.

Services begun in Phase I continue with an updated treatment plan and goal revision (individual counseling, Seeking Safety, Moral Reconation, 12-step attendance, drug testing, court appearances, etc.) with the addition of vocational/educational services added. It is a requirement that all participants obtain either a GED or a high school diploma prior to advancing to Phase III. Verification of employment, the acquisition of a 12-step sponsor, and written assignments will be required prior to advancement. Ancillary services may be required that could include mental health counseling, housing assistance, medical/dental care, etc.

Phase III: Referral/Monitoring (4-6 months):

During Phase III, the participant will focus on applying and enhancing their recovery and relapse prevention skills. This phase is designed to support the participant as a contributing, productive, and responsible person in the community. Requirements include:

- Updating the individualized treatment plan
- Continue with group counseling (Cognitive Self Change)
- Individual counseling
- Enhancement groups: Relapse Prevention Process and MRT assignment "Untangling Relationships"
- Complete a personal recovery plan, "Life Map and Calendar", MRT "Mentoring" assignment, and "Giving back to the community" and present these in group
- Continue with drug/alcohol testing, drug court appearances, 12-step group attendance, payment of fees, employment and other ancillary service requirements

Graduation

Participants who successfully complete Phase III and all goals in their individualized treatment plan will be eligible for graduation. Examples of requirements for graduation could include:

- Maintaining sober support through ongoing utilization of a 12-step sponsor
- 180 days minimum, clean and sober
- All program fees paid
- Submission of all assignments and proof of education, employment, safe housing, and graduation application
- No violations for a minimum of 45 days prior to graduation

Drug Court Benefits to the Community

- Reduces the revolving door of crime and drugs by providing treatment to drug-addicted criminal offenders
- Requires strict accountability from program participants through frequent in-person court hearings and intensive monitoring
- Requires total abstinence from illicit and illegal drugs and alcohol
- Reduces emergency room, hospital, and medical costs
- Reduces domestic violence
- Reduces felony and misdemeanor crimes

- Requires completion of education and/or vocational training
- Requires employment in a "W-2" tax-paying job
- Decreases use of public assistance
- Eases court, jail, and prison overcrowding and costs

Drug Court Benefits to the Participant

- Stops criminal and other self-defeating behaviors
- Breaks the cycle of addiction
- Gains control of life patterns and decisions
- Requires accountability and responsibility for choices and actions
- Completes education (GED or high school diploma)
- Obtains a job/learns a skill
- Changes health and life skills
- Improves family and other relationships
- Changes thinking (beliefs) and behaviors
- Stays out of jail and/or prison

V. Measurable Goals and Objectives

- Demonstrate the cost-efficiency of drug court program (mean cost for 12 months of service, per client, from the date of admission to the date of discharge) in comparison to incarceration costs
- Maximize the use of the drug court program by increasing utilization and completion rates in the program
- Reduce recidivism of criminal offenses. Currently the Thurston County Drug Court has a low 12% recidivism rate for felony re-convictions after graduation
- Reductions in drug/alcohol relapse rates while in the program and post graduation.
- Improve participant medical and mental health, specifically trauma, PTSD, depression, and self-esteem
- Maximize quality of life measurements for drug court participants which include, but are not limited to: social, emotional, familial, environmental, and economic factors

VI. Evaluation Strategy

- Use drug court-specific Access MIS system to determine performance measures
- Utilize Statistical Programs for the Social Science (SPSS) to evaluate assessment and treatment/outcome data
- Submitted Process Evaluation to the Department of Justice in 2002 and revision is in process
- Utilize data reports re: recidivism, demographics, graduates, terminations, cost savings, following graduates and terminations after five years
- 8-year Outcome/Impact Evaluation is in the final phases of completion
- Enhancement Grant Evaluation (for Integrated Trauma Treatment Program) is in the final stages of completion. Dr. Robert Kirchner, Director of Glacier Consulting, is program evaluator

VII. Other Services Provided with CJTA Funds

Alternatives Professional Counseling provides the community-based adult outpatient treatment services for offenders who have begun their treatment in the Thurston County Corrections Facility (TCCF) treatment program. **Phase I** services are provided by the correctional facility for these incarcerated offenders. The following two phases are governed by the clinical progress of the client and are not necessarily connected to the requirements of the correctional system.

Phase II:
These participants may have transitioned from full-time incarceration to work release status in the Thurston County Correctional Facility (TCCF) site. However, due to the individualized correctional requirements of some participants, their treatment may take place while they are still in custody. This transitional phase includes the following clinical focus:

- Weekly recovery support groups – 10 weeks of two-hour sessions. Random, weekly, or higher frequency drug level testing is required for all participants and at least two individual sessions are provided during this phase.

Phase III:
This phase takes place with offenders who may still be constrained by correctional requirements or they may be eligible for and taking advantage of work release status and/or are on Electronic Home Monitoring through TCCF. This phase has the following clinical focus:

- Weekly group sessions that focus on Relapse Prevention and Moral Reconation Therapy steps 13 through 16 are mandated. Phase III lasts for a minimum of eight weeks and may be longer, depending on the participant's sentence and individual needs. Random drug testing will also occur during this phase.

- Case management services to inmates to secure clean and sober housing, referrals for vocational and educational enhancement, other psychosocial issues, and the brokerage of available community-based services that connect the participant and/or family members to the appropriate resources.

Step 2
Mobilization and Capacity Building

All steps have been described in Appendix B, as well as within this document's narrative and data.

Step 3
Comprehensive Strategic Plan and Goal Formation

Goals and Expanded Services: The Treatment Expansion Population

Over the next six years the Thurston/Mason Chemical Dependency Program will continue to serve all designated priority populations. Most of the identified populations are treatment expansion clients. The only constraints that we foresee are funding limitations by the Division of Alcohol and Substance Abuse (DASA).

In light of recent reductions in the treatment expansion funding for 2007-2009, it is difficult to project treatment expansion outcomes. We will continue to make efforts to reach and serve these populations, thereby improving access for these priority populations.

Once our 2007-09 allocations, unit rates, and 2007-09 contracts are received, we'll be able to reassess and plan for the future. It's possible given the fluid nature of County fund reallocations, special projects or other needed services that may arise, there may be some changes.

In addition, the chemical dependency program staff and PHSS Fiscal Manager will be closely monitoring the increased workload that will impact us. The level of monitoring and accountability from the State, while important, has the potential to significantly impact our administrative functions.

Prevention Goals

This section is addressed in the Thurston/Mason Counties Chemical Dependency Prevention Strategic Plan 2007-2013 which is included as Appendix B.

List of Priority Risk and Protective Factors

This section is addressed in the Thurston/Mason Counties Chemical Dependency Prevention Strategic Plan 2007-2013 which is included as Appendix B.

Goals: Increases of Decreases in Risk/Protective Factors

This section is addressed in the Thurston/Mason Counties Chemical Dependency Prevention Strategic Plan 2007-2013 which is included as Appendix B.

Objectives, Identifying Target Population

This section is addressed in the Thurston/Mason Counties Chemical Dependency Prevention Strategic Plan 2007-2013 which is included as Appendix B.

Dates for Accomplishing Goals

This section is addressed in the Thurston/Mason Counties Chemical Dependency Prevention Strategic Plan 2007-2013 which is included as Appendix B.

Prevention Programs: Descriptions and Implementation Plans

This section is addressed in the Thurston/Mason Counties Chemical Dependency Prevention Strategic Plan 2007-2013 which is included as Appendix B.

Monitoring Prevention Activities

This section is addressed in the Thurston/Mason Counties Chemical Dependency Prevention Strategic Plan 2007-2013 which is included as Appendix B.

Monitoring Prevention Programs for Fidelity

This section is addressed in the Thurston/Mason Counties Chemical Dependency Prevention Strategic Plan 2007-2013 which is included as Appendix B.

Plan to Gather Prevention Services Data

This section is addressed in the Thurston/Mason Counties Chemical Dependency Prevention Strategic Plan 2007-2013 which is included as Appendix B.

Step 4
Implementation

The implementation plan for prevention can be found in Appendix B. The implementation plan for criminal justice can be found in the criminal justice supplemental report. The criminal justice report will be submitted to DASA in June 2007.

Treatment Implementation

Chemical dependency treatment funded services for 2007-09 will continue based on available funding. Services may be expanded in the future through more DASA funds and/or grants. The County chemical dependency program will be flexible and plan for fluctuating funding streams.

As a means to implement chemical dependency (CD) treatment services in Thurston/Mason Counties, the chemical dependency program will support increased funding through collaboration with DASA and other funding resources. Over the next six years, greater capacity for CD treatment services will be needed. After reviewing each of the admission trends among all priority populations, there has been an overall increase in admissions (between 2000 and 2006), therefore we anticipate growth in all services. DASA will be involved in dialogue with the Thurston/Mason Chemical Dependency program staff to be proactive in implementing CD services that meet the growing needs among those with severe chemical dependency within our governing county.

Step 5
Evaluation

Evaluation of Substance Abuse Services

Monitoring

i. Agencies demonstrate they function according to statement of works and contract requirements and produce desired results.
ii. Programs and services identify, reach and serve those populations with the greatest need (priority populations) and contracted agencies produce reports indicating their outcomes in these efforts.
iii. Agencies are successful in making CD treatment services accessible to all priority populations and make services open to all those in need, thereby producing desired outcome data in TARGET for County and DASA's review and analysis.