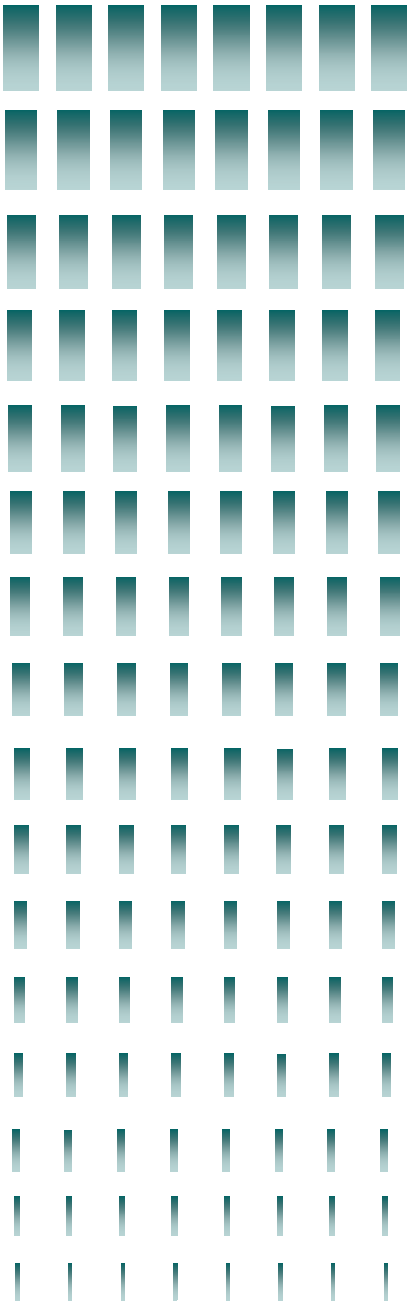

Gravely Disabled Pilot Project

Client Characteristics and Initial Indicators of Change

March 2004

Washington State Department of Social and Health Services
Management Services Administration
Research and Data Analysis Division

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Gravely Disabled Pilot Project

Client Characteristics and Initial Indicators of Change

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March 2004

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This study represents the efforts of chemical dependency treatment providers at project sites across Washington State who attempted to serve the needs of clients with serious conditions emanating from their use of alcohol and other drugs. Without their efforts and dedication the needs of these clients could not be met.

Finally, we acknowledge the clients who participated in this program and the difficult paths many of them had to pursue in attempting to overcome the pervasive effects of drug and alcohol use. The importance of this project in helping individuals reach the potential in their lives was summed up by one client, who said: "***You guys seemed to see something in me that I couldn't see anymore. You didn't give up on me...***"

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Executive Summary

Gravely Disabled Pilot Project

Between July 2002 and mid-April 2003, 323 clients entered the Gravely Disabled Pilot Project (GDPP) which provided integrated case management and treatment for chemical dependency. The project was implemented in seven counties: Clallam, Clark, Columbia, Snohomish, Spokane, Stevens, and Thurston. According to the legislation that established this pilot project, the GDPP was to serve clients whose chemical dependency problems had resulted in serious physical or mental health problems or exceptionally high use of treatment services or other community resources. Clients were selected to participate in this project based on a range of characteristics, including prior unsuccessful treatment attempts, a history of arrests, homelessness, lack of employment, high rate of hospital emergency department use, and untreated medical or mental health problems. Some counties specifically selected clients who were users of methamphetamines due to attendant physical and behavioral health problems associated with the use of this drug.

Although the counties differed somewhat in the exact mix of services provided, they commonly used an intensive form of case management to support the clients and to help them remain motivated and develop skills needed to remain abstinent. All of the programs attempted to help clients achieve a greater degree of stability in their lives by dealing with problems of homelessness and criminal justice involvement. Clients were supported and encouraged to get much needed community resources to treat medical and mental health problems, to find housing, and to become more financially stable.

To create a profile of clients served by the GDPP, this report relies almost exclusively on data from automated information systems regarding chemical dependency treatment, social services, arrests, and convictions. In addition, these data were used to assess whether clients' conditions appeared to change once they entered the GDPP. The assessment of change was limited to only three months after a client entered the program since this evaluation was completed with very limited follow-up information available.

Demographic Characteristics

The demographic characteristics of clients varied somewhat by county, reflecting differences in client selection criteria and related program characteristics. Three of the counties—Snohomish, Clark, and Clallam—selected more women than men and concentrated some of their efforts on helping women who had Child Protective Services' involvement. In those counties, between 57 and 63 percent of their clients were women. In Spokane, Thurston, and Columbia Counties, however, males comprised between 61 and 74 percent of their clients. Only in Stevens County were the number of males and females nearly equal. Since Spokane and Thurston served over half of the clients in the GDPP, males constituted 59 percent of project participants overall.

Sixty percent of the clients were under the age of 40, with a few women under the age of 18 in one county that focused on the problems of methamphetamine use. Clients who were under 30 years of age were much more likely to be women, while those 30 or older were more likely to be men. For clients aged 50 or older, males outnumbered females three to one.

Chemical Dependency

GDPP focused on trying to help clients who had a history of repeated unsuccessful chemical dependency treatment attempts or detoxifications. A portion—but not all—GDPP clients met these criteria, as shown by the following percentages:

- 68% of the clients had entered publicly funded chemical dependency (CD) treatment at least once since the late 1980s
- 16% percent had been admitted to CD treatment four or more times
- 36% had received detoxification services from a free-standing detoxification center since the late 1980s [1]
- 7% had received detoxification six or more times in that period

Thirty-two percent of the clients, however, had no prior record of publicly funded CD treatment, and 31% did not appear to enter either residential or outpatient CD treatment as a result of GDPP. Most of the clients with no prior CD treatment history or who did not get CD treatment as part of the GDPP program participated in Spokane County, where the emphasis was placed on clients with co-occurring mental illness and substance abuse disorders and the project was administered by the county's mental health program.

In many counties, the program administrators indicated that the GDPP was intended to reduce the use of detoxification and increase the completion rates for CD treatment. Both outcomes appear to have occurred, at least in the near term based on outcomes in the first 90 days after clients entered the program:

- The completion rate for CD residential treatment rose from 67% for GDPP clients prior to the program to 84% in the 90-day period afterwards and only a few clients appeared to still be in residential programs when data were drawn in late April 2003, so this increase appears to be real
- The completion rate for CD outpatient treatment was 27% before GDPP and 28% in the 90-day post period, but over 50% of the admissions records appeared to be active so the final completion rate is not known
- Detoxification comprised 36% of all admissions (CD treatment plus detoxification) prior to GDPP and only 18% of admissions in the 90 days after entry into GDPP entry, indicating a drop in the use of detoxification

[1] Detoxification is based on data from the Treatment and Assessment Report Generation Tool (TARGET) which records detoxification services in free-standing centers but does not include such services rendered in hospital settings. Therefore, these percentages under-represent the use of such services.

Mental Health Problems

A number of counties focused their GDPP services on clients who had co-occurring mental health and substance abuse disorders. Available data suggested that fairly high proportions of GDPP clients had recently been treated for mental health problems, particularly depression, anxiety, and psychosis or bipolar disorder. Specifically, based on prescription drug records for 140 clients who were supported through medical programs for the disabled (e.g., General Assistance-Unemployable (GA-U), Supplemental Security Income (SSI)), the percentage treated for various mental health problems included:

- 74% for depression or anxiety within the two fiscal years preceding the GDPP
- 37% for psychotic illness or bipolar disorder
- 31% for seizure disorders

Medical Problems

Gravely disabled clients also had a high incidence of chronic medical conditions and infections, based on recent treatment records for SSI or GA-U clients, including:

- 31% treated for cardiac illness
- 24% had received medication for asthma or chronic obstructive pulmonary disease
- 14% had received prescriptions for moderately serious infections and 70% for less serious ones

Receipt of Social Services

Entering the GDPP was associated with an increase in the proportion of clients getting public assistance. This increase may reflect the successful efforts of GDPP case managers in helping clients to apply for benefits for which they were eligible. Comparisons between the average percent of clients receiving benefits during the eight quarters before entry into GDPP and the first quarter after entry into GDPP revealed the following increases:

- Receipt of cash assistance (through such programs as Temporary Aid for Needy Families (TANF)) rose 71% (from 25% on average in the eight prior quarters to 44% in the quarter following GDPP)
- Clients receiving Supplemental Security Benefits (SSI) rose 28% (from 15% on average to 19%)
- Receipt of food assistance (formerly called food stamps) doubled (from 28% on average to 55%)
- Receipt of medical assistance increased 45% (from 57% on average to 82%)

Homelessness

Clients who were homeless were likely candidates for the GDPP in a number of the participating counties. According to available indicators of homelessness contained in publicly funded chemical dependency treatment records, 52% of the GDPP clients who received CD treatment in the two years before being entering the GDPP were homeless.[2] The percentage of clients in CD treatment who were listed as homeless in the three-month period immediately preceding entrance into the GDPP was 40% compared to 28% of those in CD treatment in the quarter after entrance into GDPP. Thus, the likelihood of being homeless among those in CD treatment programs may have declined once clients entered GDPP. Assistance from GDPP case managers in finding suitable housing could have contributed to such a decline.

Criminal Involvement

The GDPP program was intended to serve clients with prior histories of criminal behavior, in part, because such behavior is not only costly and disruptive to the individual but also to the society. The GDPP administrators successfully selected clients who had criminal histories, as shown by the fact that nearly three-fourths of the clients had been arrested or convicted at least once since the mid-1970s. Indeed, one-third had six or more prior arrests or convictions. Felonies accounted for about one in four of the arrests and convictions.

Several county projects cited measurable success at reducing client criminal involvement. However, due to the small absolute number of clients arrested in a 90-day period, it was not possible to reliably determine if criminal activity in the quarter following GDPP entry was less than prior levels of arrests or convictions. Data would be needed over a longer time period to determine if GDPP reduced the likelihood of criminal activity.

[2] This estimate is limited to 84 of the 323 GDPP clients who were in CD treatment in the two years before entering this pilot project and may not be representative of GDPP clients who did not enter treatment during that period.

1 Introduction

Overview

The Gravely Disabled Pilot Project (GDPP) was implemented in seven counties: Clallam, Clark, Columbia, Snohomish, Spokane, Stevens, and Thurston. Between July 2002 and mid-April 2003, 323 clients entered the GDPP, and more could be admitted through June 2003, when funding for the project ended.

This report provides a profile of the 323 clients admitted through mid-April and a preliminary assessment of the project's effects on the clients' use of detoxification as well as chemical dependency and mental health treatment, receipt of social services, incidence of homelessness, and arrest patterns following project involvement. Client profiles and assessment of potential project effects are derived from data contained in automated information systems about publicly funded chemical dependency detoxification and treatment, mental health services, other social services, arrests, and convictions.

Preliminary analyses of outcomes were limited to the first three months after a client was admitted to the program using the subset of clients who entered the program between July 1 and December 31, 2002 so that there would be sufficient administrative data to examine possible outcomes in a three-month follow-up period. Since this report was prepared concurrently with the implementation of the pilot project, a longer follow-up period was not possible.

Background

The GDPP was established to serve chemically dependent clients with complex physical, behavioral, and social problems. Many of the clients had co-occurring mental illness and substance abuse disorders. The law that established this pilot project indicated that it was to serve people who were "…in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognition or volitional control over his or her actions and is not receiving care as essential for his or her health or safety; or is a high utilizer of treatment services and other resources, including the chronic public inebriate."[3]

Due to the complexity and seriousness of each client's problems, the counties' programs were designed to use a full complement of available methods to address these clients' needs. These included assessment and treatment planning, intensive outpatient programs, chemical dependency and mental health counseling in both individual and group settings, and integrated case management to help clients obtain available community resources. In

[3] Definition, as stated in memorandum to County Alcohol and Drug Coordinators from Kenneth D. Stark, August 28, 2001, Request for Proposal, Gravely Disabled Pilot Project.

some cases, clients were referred to and placed in appropriate residential treatment programs for chemical dependency. Further information about the county projects is presented in Appendices A – C which provide detailed information by county on client selection criteria, types of programs and services provided, and project goals and initial outcomes.

Client Profile

The 323 clients participating in the GDPP by mid-April 2003 have a history of detoxification and chemical dependency treatment, mental and physical health problems, homelessness, arrests, and convictions that reflect the high-risk population that was targeted by this program. In the years before entering the GDPP, these clients had experienced the following:

- **Chemical dependency (CD) treatment**
  - 68% of the clients had been admitted to at least one CD treatment program since the mid-1980s[4]
  - 16% had been admitted to treatment 4 or more times since the mid-1980s
  - Of the 235 clients who had received CD treatment or detoxification at least once before entering the GDPP, alcohol was listed as the primary substance for 60%, methamphetamines or other stimulants for 40%, marijuana for 19%, cocaine or crack for 18%, and heroin for 17%

- **Detoxification**
  - 36% had received detoxification services at a free-standing detoxification center at least once before entering the program; others may have received detoxification in hospital settings which is not recorded in TARGET
  - 7% had received detoxification six or more times

- **Mental health problems**
  - 74% of the 140 clients who were supported through medical programs for the disabled (e.g., General Assistance-Unemployable (GA-U), Supplemental Security Income (SSI)) received prescription drugs to treat depression or anxiety within the two fiscal years preceding the GDPP[5]
  - 37% of these clients received prescription drugs to treat psychotic illness or bipolar disorder
  - 31% had been treated for seizure disorders

[4] Source: DSHS Division of Alcohol and Substance Abuse, TARGET treatment records, 1987-2003.
[5] Source: Washington Medicaid Integration Partnership database on aged, blind, and disabled clients for FY 1999-2002 created by the DSHS Research and Data Analysis Division.

- **Medical problems**
  - 31% of the GA-U or SSI clients had been treated for cardiac illness
  - 24% had received medication for asthma or chronic obstructive pulmonary disease
  - 14% had received prescriptions for moderately serious infections and 70% for less serious ones

- **Homelessness**
  - In the two years before entering the GDPP, 52% had been identified as being homeless at least once in records for those receiving chemical dependency treatment.[6]

- **Arrests**
  - 74% had been arrested at least once for any type of crime between 1974 and their entrance into the GDPP7
  - 53% had been arrested for a felony before entering the GDPP
  - 33% were arrested six or more times before entering the GDPP

- **Convictions**
  - 72% were convicted of one or more offenses since 1987 and prior to GDPP admission[8]
  - 42% were convicted of at least one felony prior to GDPP admission
  - 33% were convicted on six or more separate occasions prior to GDPP admission

Initial Indicators of Change

The goals of the county's programs (as shown in detail in Appendix C) were to help clients achieve progress toward recovery from serious substance abuse and mental health problems, to stabilize clients living conditions and reduce homelessness, to assist them in obtaining appropriate social and medical services, and to reduce criminal activity and unnecessary contact with the criminal justice system. Goals were often stated in such concrete terms as: to reduce repeat admissions to detoxification, emergency rooms, and jail.

To determine whether the GDPP had any effect, a preliminary assessment was made in the clients' use of detoxification, admission to CD or mental health treatment, receipt of social services, incidence of homelessness, and arrest patterns following project

[6] Information about living arrangements is not consistently available in any other database for clients who did not receive chemical dependency treatment.
[7] Source: Washington State Patrol, arrest records in which arrestee was fingerprinted, 1974-2003.
[8] Source: Washington State Institute for Public Policy, Criminal Recidivism Database, 1987-2002.

involvement. A minimum three-month follow-up period was chosen so that each client would be compared based on a comparable period once they entered the program. Due to different lags in the availability of up-to-date data in the various administrative information systems used in this evaluation, analyses were performed for 124 clients who had entered the GDPP by October 31, 2002 or 202 clients who had entered by December 31, 2002. For most comparisons, change was based on an increase or decrease in the proportion of clients in the three-month post period (one quarter of the year) compared to the trends over the prior eight quarters (two-year pre-period).

Chemical Dependency Treatment

The proportion of clients receiving CD treatment rose in the three-month period following entry into GDPP compared to the rates over the eight prior quarters. In contrast the percent receiving detoxification declined after the clients entered the pilot project. In particular:

- The percent of clients receiving outpatient treatment doubled during the 90 days following entry to the GDPP.
- Percent of admissions to CD treatment or detoxification that were for detoxification services declined from 36% of all admissions prior to the GDPP to 18% of admissions following GDPP entry.

Residential treatment completion rates improved following GDPP entry:

- Completion rates for those admitted to residential treatment programs following GDPP entry rose from 67% to 84%.

Receipt of Social Services

The receipt of social services increased among GDPP clients following entry into the pilot project, as follows:

- Receipt of cash assistance (through such programs as Temporary Aid for Needy Families-TANF) rose 71% (from an average of 25% in the prior eight quarters to 44% in first quarter following entry into GDPP)
- Receipt of SSI rose 28% (from 15% on average to 19%)
- Receipt of food assistance doubled (from 28% on average to 55%)
- Clients on medical assistance increased 45% (from 57% on average to 82%)

Homelessness

Homelessness among clients in CD treatment increased before they entered the GDPP and then declined afterwards based on the following average quarterly rates of homelessness:

- 20% two years before entrance to GDPP
- 34% one year before entrance to GDPP
- 28% one quarter after entrance to GDPP

Criminal Involvement

Several county projects cited measurable success at reducing client criminal involvement. However, data limitations for arrest and conviction samples, as well as small sample sizes of criminal activity during the 90 days following GDPP admission make it unfeasible to compare overall changes in criminal activity following GDPP entry to prior criminal involvement. In particular Washington State Patrol data on arrests for 54 clients admitted to GDPP during October 2002 are probably not complete for the full 90 day follow-up period. Since convictions are based on adjudication of crimes that may have occurred six or more months before the court's decision, conviction data was not considered suitable for examining outcomes in the short follow-up period.

2 Methods

Study Population

This report presents information about adult clients admitted to the Gravely Disabled Pilot Project (GDPP).[9] Gravely disabled clients are defined as those who are "in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognition or volitional control over his or her actions and is not receiving care as essential for his or her health or safety; or is a high utilizer of treatment services and other resources, including the chronic public inebriate."[10]

Between July 1, 2002 and April 15, 2003, 323 clients were admitted to the GDPP in the seven counties participating in this pilot project. Information about these clients was gathered from a number of administrative record-keeping systems listed below to describe their demographic characteristics, use of chemical dependency treatment and detoxification, recent history of mental health and physical health treatment, receipt of social services, rate of homelessness, and prior patterns of arrest and conviction.

Initial Follow-up Period

This report examines outcomes for a subset of clients to assess whether or not GDPP participation had an effect on their use of chemical dependency treatment, detoxification, or mental health treatment; receipt of social services; the likelihood of being homeless; or the tendency to be arrested. Since these analyses were conducted at the same time that the project was underway, the follow-up period was limited to only three months (one quarter) immediately following client entry into GDPP. Thus, the "post" period occurs concurrently with case management, treatment or other interventions that are used to address the complex set of issues facing each client.

Use of such a brief follow-up period which is concurrent with the intervention being attempted is subject to a number of limitations. Some changes may be transitory but difficult to sustain in the long run, while other changes may be underway but difficult to measure in such a short time. Any indication of favorable outcomes during this brief period could be used to indicate the *potential* for positive effects associated with the intervention.

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[9] A small number of individuals (14) identified by the Thurston County project as referred but not admitted to treatment were not included in this report.

[10] Definition, as stated in memorandum to County Alcohol and Drug Coordinators from Kenneth D. Stark, August 28, 2001, Request for Proposal, Gravely Disabled Pilot Project.

Data Sources

County Gravely Disabled Pilot Project Client Participation – County GDPP project staff submitted information on each client admitted to their programs between July 1, 2002 and April 15, 2003. Personal identifiers (names, date of birth, aliases, gender, and Social Security Number) were provided so that the clients' administrative records could be found. Providers also were to report the death of any client since admission to the project.[11]

Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse – TARGET data was used to investigate client CD treatment history and their use of detoxification in non-hospital detoxification centers, from 1987 through late April 2003. TARGET data was also used to identify the type of substances used by clients, recent homelessness history, type of CD treatment, and discharge status.

Client Services Database (CSDB), Research and Data Analysis Division – CSDB was used to identify types of services received from DSHS programs in FY 2000, FY 2001 and FY2002. CSDB data is also the basis for estimates of costs for services for FY 2001-2002 and client race or ethnicity.

Washington Medicaid Integration Project Database, Research and Data Analysis Division – Medical and mental health diagnoses were derived from prescription drug data obtained from the Medicaid Management Information System using algorithms developed by the University of California at San Diego.[12]

Automated Client Eligibility System (ACES), Economic Services Administration – ACES data was used to identify recent use of cash assistance, food assistance (formerly called food stamps), and medical eligibility, July 2001 – March 2003.

Criminal Recidivism Database, Washington State Institute for Public Policy (WSIPP) – The WSIPP Criminal Recidivism data was used to identify convictions for GDPP clients. These data represent adjudications from information systems of the Washington State Administrative Office of the Courts, 1975 – early 2003.

Arrest Database, Washington State Patrol (WSP) – The WSP data represents arrests in which an arrestee is fingerprinted. Felonies tend to be more consistently reported in this database than less serious offenses, and completeness of reporting may vary by local jurisdiction. The arrest data covers 1975 through December 31, 2002. Data reporting for non-felonies may decline somewhat in the most recent months.

[11] Two deaths were reported by mid-April 2003.

[12] T. Gilmer, R. Kronick, P. Fishman, and T.G. Ganiats. 2001. "The Medicaid Rx Model: Pharmacy-Based Risk Adjustment for Public Programs." *Medical Care*. Vol 39 (No.11), pp.1188-1202.

Clients Found in Administrative Records

Using the personal identifiers provided by the county GDPP staff, clients were matched to records in the automated information systems described above. The percent of clients for whom records were found that were used in analyses in this report ranged from 73-74% in the criminal recidivism and arrest databases to 89% in CSDB, the system that contains a comprehensive record of all DSHS services.

The TARGET system, which records publicly funded CD treatment and detoxification, had information for 270 of the 323 GDPP clients, or 84% of all clients. Most of the GDPP clients who did not have a record of CD treatment in TARGET were served in the Spokane County project that focused on clients with co-occurring disorders and provided mental health treatment to many of the clients before referring them to CD treatment[13]

Table 2.1. Clients in Gravely Disabled Pilot Project, July 1, 2002 – April 15, 2003 Found in Administrative Databases

Administrative Databases	Clients	Percent Found[a]
Total Clients	323	
DSHS Client Services Database (CSDB)	270	84%
Chemical Dependency Treatment and Detoxification (TARGET)	289	89%
Arrests	235	73%
Convictions	240	74%

[a]Percent of GDPP clients who were found in the administrative database and for whom records were used in analyses in this report.

Initial Indicators of Change

As described above, a three-month follow-up period was used to examine the early indications of change for each client. The three-month period was defined uniquely for each client to be the consecutive 90-day period that started with his or her date of admission to GDPP.

Analyses were limited to subsets of GDPP clients for whom at least three months of up-to-date information could be extracted from one or more of the administrative databases. Two groups were defined as followed:

- Clients who entered GDPP between July 1 and October 31, 2002.[14]
- Clients who entered GDPP between July 1 and December 31, 2002.[15]

[13] Spokane County project staff, personal communication.
[14] A client who entered GDPP on October 31st could be followed with administrative data recorded for the months of November through January.

Clients who entered the program by the end of October were used for follow-up analyses on several types of DSHS services obtained from CSDB and felony arrest data.

Clients who entered the program by the end of December were used for analyses in which data were considered to be relatively complete through the end of March 2003. These included analyses of potential changes in admissions to CD treatment and detoxification recorded in TARGET and receipt of cash assistance, Supplemental Security Income (SSI) benefits, food assistance, and medical eligibility since these came from ACES which was very up to date at the time of data extraction in early May 2003.

The degree of change was measured in three basic ways:

1. Change in monthly trends – This approach was used to represent changes in the proportion of GDPP clients who were receiving social services. These were calculated for the 24 months preceding admission to GDPP, and for three months (90 days) from admission to GDPP forward.
2. Change in quarterly averages – Differences were examined between rates in the four or eight quarters that preceded the GDPP admission date which represented the one- or two-year pre-period. Frequently, a pre-quarterly average was computed so that it could be compared with the likelihood of an event occurring in the one quarter following GDPP admission. Using quarters rather than months was particularly useful for more rare events, like arrests, which do not occur in sufficiently high numbers in a given month to produce a reliable monthly trend. By combining three months, a more stable measure was created.
3. Change in status before and after admission to GDPP – A client's status prior to entering the GDPP (typically their 2 years prior) was compared to his or her status in the three months after entering GDPP. This approach allowed us to see if entering GDPP resulted in a shift away from one condition to another. For example, this method can be used to answer the question: Was the average rate of treatment completion improved by involvement in the GDPP?

[15] A client who entered GDPP on December 31st could be followed from January through March 2003.

3 Demographic Characteristics of Clients

County of Enrollment

Spokane enrolled over a third of all GDPP clients (117 out of 323). Thurston and Snohomish counties admitted about 50 clients each, which represented 15 to 16% of GDPP participants. The other four counties—Clark, Stevens, Clallam, and Columbia—enrolled the remainder of the GDPP clients, with each county accounting for 6 to 11% of the GDPP clients.

Table 3.1. County of Participation

County	Clients	Percent
Total	323	100%
Clallam	23	7%
Clark	35	11%
Columbia	18	6%
Snohomish	50	15%
Spokane	117	36%
Stevens	27 [a]	8%
Thurston	53	16%

Source: County Gravely Disabled Pilot Project Records, July 1, 2002 - April 15, 2003

[a]Excludes one client who was enrolled originally in Spokane County and later enrolled in

County and Gender

The proportion of males and females varied among the counties. Men outnumbered women in Spokane, Thurston, and Columbia with proportions ranging from 61 to 74% of their clients. Other counties—Clark, Snohomish, Clallam, and Stevens—enrolled somewhat higher proportions of women (52 to 63%).

The majority of GDPP clients were males (59%) due in part to the particularly high concentration of males in Spokane and Thurston Counties, which served over half of all GDPP clients.

Table 3.2. County of Participation by Gender of Clients

County	Total	Female	Male
Total	**323**	**41%**	**59%**
Clallam	23	57%	43%
Clark	35	63%	37%
Columbia	18	39%	61%
Snohomish	50	58%	42%
Spokane	117	26%	74%
Stevens	27	52%	48%
Thurston	53	32%	68%

Source: County Gravely Disabled Pilot Project Records, April 15, 2003

Age and Gender

GDPP clients were relatively young given the seriousness of their health conditions and personal histories: 60% were under 40 years of age and 27% were less than 30 years old. Only 14% were 50 years of age or older.

Table 3.3. Age of Clients

Age	Clients	Percent
Total	**323**	**100%**
Under 20 yrs	10	3%
20 - 29 yrs	78	24%
30 - 39 yrs	105	33%
40 - 49 yrs	85	26%
50 yrs +	45	14%

Source: County Gravely Disabled Pilot Project Records, April 15, 2003

Female participants tended to be younger; males older. Indeed, the percentage of men increased from 40% among clients under 20 years of age to 76% among those aged 50 years or older. This progression reflects differences between the counties in the types of clients they tended to enroll. Snohomish County, for example, concentrated much of their effort on young women who were users of methamphetamines and at risk of losing custody of their children. Other counties, like Spokane, tended to serve an older male population, who, in that particular county, had serious co-occurring mental health and chemical dependency problems.

Table 3.4. Age and Gender of Clients

Age	Total	Female	Male
Total	323	41%	59%
Under 20 yrs	10	70%	40%
20-29 yrs	78	54%	45%
30-39 yrs	105	42%	58%
40-49 yrs	85	33%	67%
50 yrs +	45	24%	76%

Source: County Gravely Disabled Pilot Project Records, April 15, 2003

Race and Ethnicity

The majority (84%) of GDPP participants were white. American Indians comprised 8%, and African Americans 5%. Hispanics, who can be of any race, equaled 7% of the clients. These percentages cannot be compared directly to the state's population since persons with more than one race were counted in only one category in the Client Services Database for FY2000 – 2002 which was used to examine the race and ethnicity of GDPP clients, while U.S. Census data for 2000 gathered information about more than one race.

Table 3.5. Race and Ethnicity of Clients

Race/Ethnicity[a]	Number	Percent
Total	289	100%
American Indian and Alaska Native	23	8%
Asian/Pacific Islander	4	1%
Black or African American	15	5%
White	243	84%
Not reported	4	1%
Hispanic Origin[b]	21	7%

Source: Research and Data Analysis Division, Client Services Database, FY2000-2002

[a] Only one racial group reported for each client, even if a client is of more than one race.

[b] Persons of Hispanic Origin may be of any race.

4 Chemical Dependency Treatment

Chemical Dependency Treatment and Detoxification

Over two-thirds (68%) of the clients who participated in GDPP had entered publicly funded CD treatment at least once since 1987. About half (49%) of the GDPP participants had done so in the two years before entering the pilot project.

One-third had not received CD treatment before entering the pilot project: 27% had no record at all in TARGET and 4% had only received detoxification (see Table 4.1). Most of the clients with no previous history of publicly funded CD treatment entered the GDPP through the mental health treatment system. Roughly three-fourths of those with no prior CD treatment record in TARGET participated in the GDPP program in Spokane County that placed a strong emphasis on choosing clients with co-occurring substance abuse and mental health disorders.

Table 4.1. Chemical Dependency Treatment Episodes Prior to GDPP Entry

CD Treatment Episodes per Client	Number	Percent
Total	323	100%
No Prior CD Treatment	102	32%
No TARGET record	88	27%
Detox Only	14	4%
1 or more	221	68%
1	80	25%
2 to 3	88	27%
4 or more	53	16%

Source: TARGET, 1987 to entry into GDPP by April 15, 2003

In total, 221 clients accounted for 814 separate admissions to CD treatment. Of the 814 admissions to CD treatment before entry into GDPP, 381 (47%) were for residential treatment, 420 (52%) were for outpatient treatment, and 13 (2%) were for methadone treatment. The average number of admissions to CD treatment per client was 3.7.

CD Treatment and Detoxification Episodes

Separate admissions to CD treatment can be grouped into sequential periods of relatively uninterrupted treatment, called episodes.[16] The average number of episodes of treatment per client was 2.6, somewhat lower than the 3.7 average number of admissions per client since multiple admissions can occur as part of a single episode of treatment.

Analyses of prior episodes of treatment revealed that 25% of the clients had a single episode of treatment before entering the GDPP, 27% had two or three prior episodes, and the remaining 16% had between four and eight prior treatment episodes.

About one-third (31%) of all episodes of CD treatment involved only outpatient treatment (see Table 4.3). Another 16% of the episodes involved residential and outpatient treatment regimens, 4% included residential, outpatient, and detoxification, and 2% involved outpatient and detoxification. As a result, over half (53%) of all episodes of treatment that began prior to the clients' entry into GDPP involved outpatient treatment either alone or in combination with residential treatment programs.

Table 4.2. Episodes by Types of Admissions Prior to GDPP Entry

Types of Admission	Episodes	Percent
Total	783	100%
Outpatient Only	242	31%
Residential Only	99	13%
Residential and Outpatient	124	16%
Residential, Outpatient, and Detoxification	34	4%
Residential and Detoxification	42	5%
Outpatient and Detoxification	16	2%
Detoxification Only	226	29%

Source: TARGET, April 26, 2003

Thirty-eight percent of the episodes involved residential CD treatment programs either alone (13%) or in combination with outpatient and/or detoxification. Slightly less than one-third (29%) of the episodes of care involved only detoxification.

Detoxification

One of the major goals of the GDPP program identified by several counties was to reduce the subsequent need for detoxification. Of the clients in GDPP, 36% had received publicly funded detoxification at least once in the 16 years before entering GDPP and

[16] Episodes were defined as a sequence of admissions with gaps of no more than 30 days between the date of discharge or last recorded activity for one admission record and the beginning of the next.

27% in the two years immediately preceding GDPP, as recorded in TARGET. Since TARGET only records detoxification that occurs at free-standing clinics and does not contain records of detoxification that occurs in hospitals, these percentages underestimate the actual rates of detoxification.

Table 4.3. Detoxification Admissions Prior to GDPP Entry

Detox Admissions per Client	Number	Percent
Total	323	100%
No Detox	208	64%
No TARGET record	88	27%
CD Treatment Only	120	37%
1 or more	115	36%
1	50	15%
2 to 3	31	10%
4 to 5	12	4%
6 to 10	9	3%
11+	13	4%

Source: TARGET, 1987 to entry into GDPP by April 15, 2003.

Clients who were homeless were especially likely to have received detoxification in the two years before entering GDPP. Over two-thirds (69%) of clients who were identified as homeless in an admission record in TARGET during this two-year period received detoxification services compared to only 19% of those who were not homeless.

From 1987 until entry into the GDPP, 15% of the clients had received detoxification (as recorded in TARGET) only once, 10% two or three times, 4% four or five times, 3% six to eight times, and 4% 11 or more times.

Substances Used

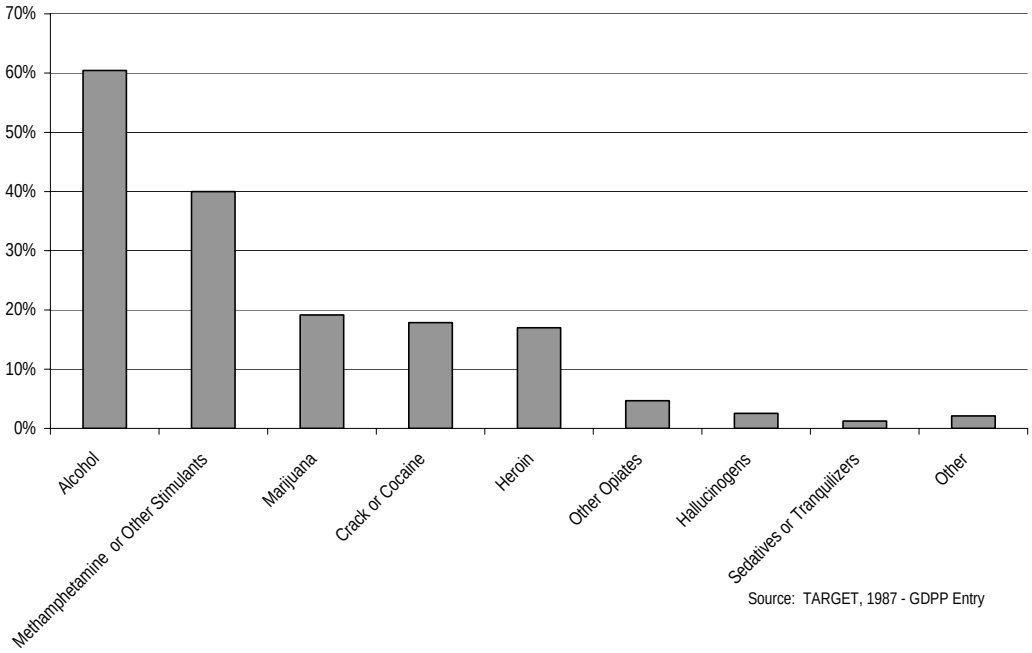
Alcohol was listed as the primary substance used by 60% of the 235 clients who had been admitted to CD treatment or detoxification between 1987 and entrance into GDPP. Methamphetamines or other stimulants were listed as the primary substance for 40% of the GDPP clients. Marijuana was listed as the primary substance for 19% of the clients, crack or cocaine for 18%, and heroin for 17%.[17]

A number of clients were admitted to treatment or detoxification for multiple primary substances over time. For example, in the two years before entrance into GDPP, 72 clients were admitted to AOD treatment for methamphetamines (listed as their primary

[17] The total of the percentages for primary substances is greater than 100% since clients are counted each time a different substance is listed as the primary substance in separate admission records.

substance). During the same two-year period about one-fourth of these clients were also admitted to treatment on a separate occasion in which alcohol was listed as the primary substance.

Figure 4.1. Primary Substance Used by GDPP Clients Admitted to Chemical Dependency Treatment or Detoxification Prior to GDPP

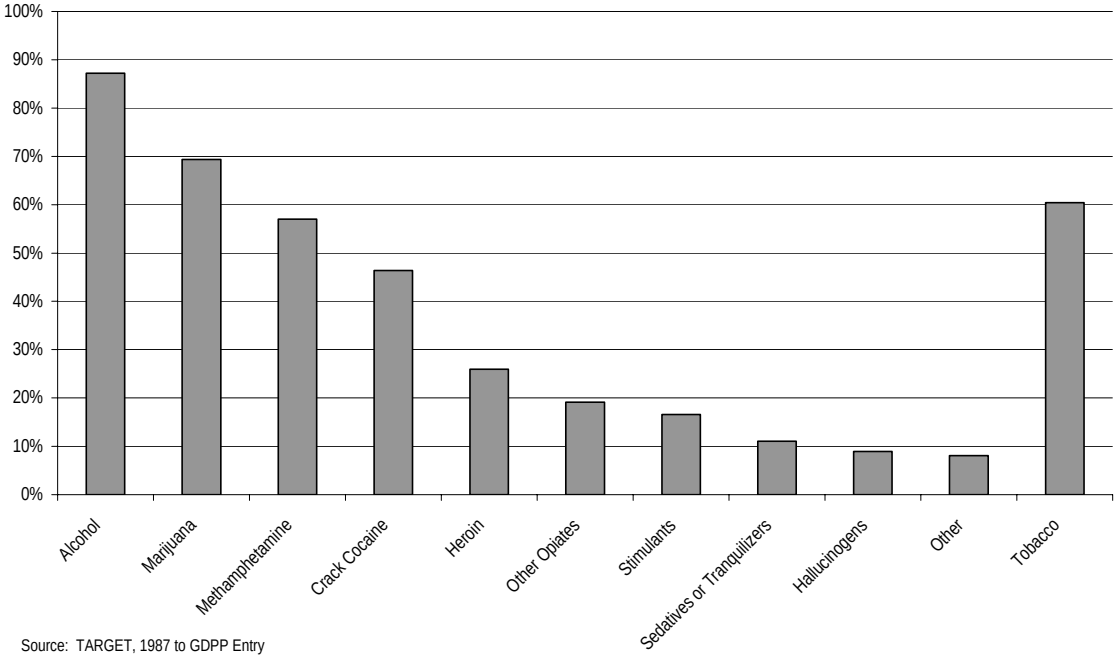


Since CD treatment and detoxification admission records contain up to three different substances that the client was using, it was possible to consider the use rates of clients for substances beyond those listed as "primary." Based on these analyses, the use rates for each type of drug are considerably higher than the rates based on primary drug (shown in the preceding figure). Of the 235 clients with a prior admission to treatment or detoxification, 87% had reported using alcohol, 57% methamphetamines, 46% cocaine or crack, and 26% heroin (Figure 4.2). These percentages reflect the substances recorded in clients' admission records in TARGET as primary, secondary, or tertiary substances used.[18] To differentiate methamphetamine use relative to other stimulants rates for these are shown separately and indicate that 17% of the clients used other stimulants (compared to 57% who used methamphetamines).

Marijuana was identified as one of the substances used by 69% of the clients. Although clients do not receive CD treatment for tobacco use, 60% of the clients who had been admitted to CD treatment or detoxification before GDPP reported tobacco products under other substances used.

[18] TARGET records up to three substances used by clients prior to admission to detoxification or CD treatment. The substance listed as primary is assumed to be the principal object of treatment or detoxification.

Figure 4.2. Substances Used by GDPP Clients Admitted to Chemical Dependency Treatment or Detoxification Prior to GDPP



Source: TARGET, 1987 to GDPP Entry

Completion Rates for CD Treatment and Detoxification

The completion rate for those admitted to CD treatment programs before entering GDPP was 48% overall. The completion rate was higher for residential treatment programs (67%) than for outpatient treatment (27%).

Table 4.4. Completion Rates and Discharge Status Prior to GDPP Entry

Type of Admission	Admissions[a]	Completed	Not Completed[b]	Other Outcomes[c]	Missing 11/25/02[d]	Completion Rate[e]
Total Admissions	814	312	337	160	5	48%
Residential	381	234	116	31	0	67%
Outpatient	420	78	211	126	5	27%
Methadone	13	0	10	3	0	NA

[a]Based on TARGET records of 241 clients with discharge dates prior to GDPP entry.

[b]"Not Completed" includes the following TARGET discharge categories: quit, no contact/abort, and broke rules.

[c]"Other" includes the following TARGET discharge categories: transferred, funds exhausted, inappropriate admission, incarceration, withdrawal advised, administrative discharge, and other.

[d]Missing outcomes: treatment assumed to be in progress; all admissions with missing outcome status began in CY2002-03.

[e]Completion rate equals number discharged as treatment "Completed" out of the total "Completed" plus "Not Completed" (excluding discharges under "Other" and "Missing)."

Costs for CD Treatment and Detoxification

Total costs for publicly funded CD services to GDPP clients increased by 71% from FY 2001 to FY 2002, due to an increase in the number of GDPP clients who received CD services from 90 to 136 and to an increase in the average costs per client from $2,669 to $3,018. Total costs for CD services for GDPP clients were $240,209 in FY 2001 and $410,405 in FY 2002.

Residential treatment services which made up the largest share of expenses in both years cost $4,186 per client in FY 2001 and $4,396 per client in FY 2002. Clients in residential programs include some women in long-term residential treatment programs for pregnant women, which tends to increase the overall average somewhat. For example, the average residential treatment expenses were only $1,272 in FY 2001 when the costs for one client who was in a residential treatment program for pregnant women were excluded.

Outpatient treatment expenditures rose from $53,234 in FY 2001 to $101,428 in FY 2002 due to a rise in both the number of clients receiving this form of treatment (from 44 to 62, 41% increase) and an increase in per client costs (from $1,210 to $1,636, 35% increase).

Table 4.5. Division of Alcohol and Substance Abuse Services and Costs, FY2001-2002

	FY 2001			FY 2002		
Type of Services	Clients	Total Costs	Cost per Client	Clients	Total Costs	Cost per Client
Total	90	$240,209	$2,669	136	$410,405	$3,018
Residential Treatment	34	$142,326	$4,186	55	$241,756	$4,396
Outpatient Treatment	44	$53,234	$1,210	62	$101,428	$1,636
Alcohol/Drug Detoxification	30	$29,265	$976	48	$42,683	$889
Outpatient Assessment	33	$7,003	$212	51	$10,232	$201
ADATSA Assessments & Stipends	42	$6,905	$164	59	$10,994	$186
Miscellaneous	20	$1,475	$74	36	$3,312	$92

Source: Research and Data Analysis, Client Services Database, May 8, 2003

Initial Indicators of Change

Chemical Dependency Treatment

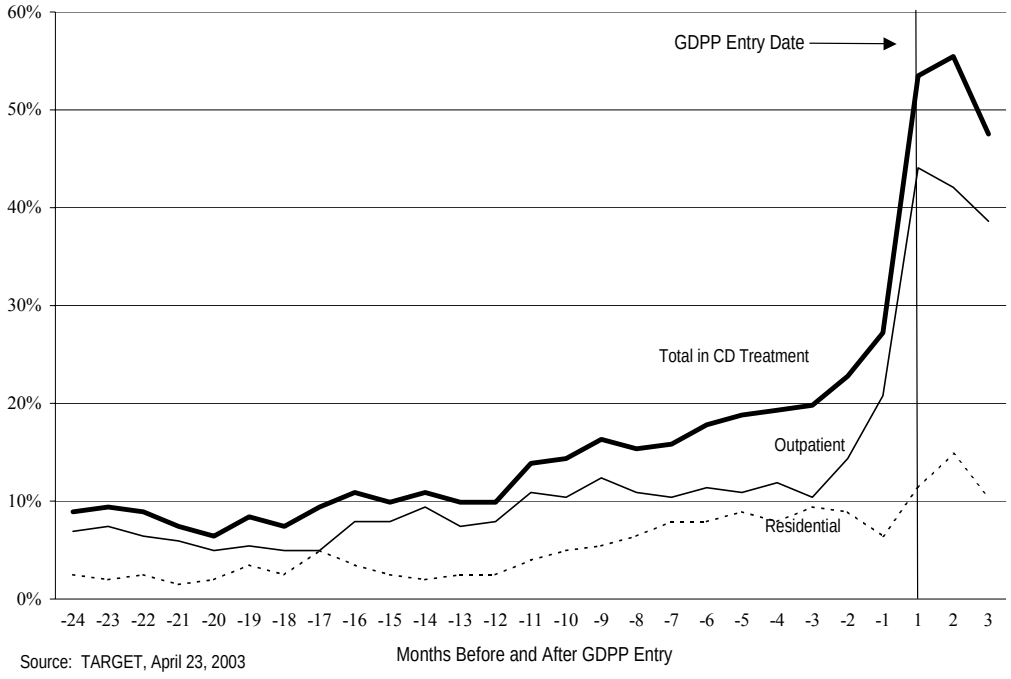
The monthly CD treatment penetration rate rose immediately before clients entered the GDPP and continued upwards once the program began.[19] During the 12 months immediately preceding each client's entrance into GDPP, the percent of clients receiving CD treatment rose gradually reaching 27% in the month just before entry, suggesting that

[19] Months were defined as the 30-day increments before and after the date on which each client entered the GDPP. Thus, the monthly increments are client specific and do not correspond to calendar months.

a number of clients entered the GDPP while they were in a CD treatment program. Increases occurred for both residential and outpatient CD treatment programs.[20] In contrast, in the one- to two-year period prior to entrance into GDPP the percent of clients who were in treatment in any given month remained near the 10% level between one and two years before entrance into GDPP (pre months 12 to 24 in Figure 4.2).

In the 90-day period following entrance into GDPP, 53% of the clients were in residential or outpatient CD treatment in the first month, 55% in the second month, and 48% in the third. Most of the increase was due to a doubling of clients in outpatient treatment, which rose from 21% in the month before entrance into GDPP to 44% in the first month after entrance into GDPP. Residential treatment participation rates also rose during the first 90 days of GDPP involvement, from 6% in the month prior to GDPP to 11% in the following month.

Figure 4.3. Chemical Dependency Treatment Before and After GDPP Entry, Clients who Entered GDPP in July – December 2002 (n=202)



Source: TARGET, April 23, 2003

Overall, 69% of the 202 clients who entered GDPP between July and December 2002 received CD treatment while they were in GDPP. Among the clients who entered GDPP between July and December 2002, 19% were already in CD treatment when they entered GDPP, 21% were admitted to CD treatment on the day they entered GDPP, and 29% were admitted to CD treatment after entering GDPP (see Table 4.6).

[20] Treatment activity records from TARGET were selected for 202 clients who entered GDPP between July 1, 2003 and December 31, 2003 to determine whether or not a client appeared to be in CD treatment in 30-day increments prior to their date of entry into GDPP. This subset of GDPP participants was chosen for analyses so that three months of follow-up data from TARGET were available for analyses of initial indicators of potential outcomes.

Of the 202 clients who entered GDPP from July through December 2002, 63 of them (31%) did not receive publicly funded CD treatment in the three months following their entrance into GDPP. Of the 63 clients who were not admitted to CD treatment after entering the GDPP program, 31 of them had no record in TARGET of ever having received publicly funded CD treatment (either before or after their GDPP admission date). Ninety-four percent of the clients who had no record of CD treatment in TARGET participated in the county GDPP run by the Spokane County Mental Health Department which focused on treating clients with co-occurring disorders.

Table 4.6. Receipt of Chemical Dependency Treatment Relative to Entry into GDPP
Clients who Entered GDPP in July - December 2002 (n=202)

CD Treatment in Relation to Entry into GDPP	Number	Percent
Clients who Entered GDPP July - December 2003	202	100%
Received CD Tx During GDPP Participation		
In CD Tx at time of GDPP Entry	38	19%
Entered CD Tx on day of GDPP Entry	42	21%
Entered CD Tx after GDPP Entry	59	29%
Subtotal	139	69%
No CD Tx on or after Entry into GDPP		
Discharged from CD Tx before GDPP Entry	32	16%
No Record of CD Tx in TARGET Ever	31	15%
Subtotal	63	31%

Source: County Gravely Disabled Pilot Project Records; TARGET as of April 15, 2003.

Use of Detoxification Services

Several counties identified the reduction in the use of detoxification services as one of the main outcomes they hoped to achieve with the GDPP. Preliminary data for the relatively brief 90-day period following entrance into the project suggests that this goal was fulfilled, at least during this initial period of program implementation. Prior to entry into GDPP entry 36% of the admission records in TARGET for CD treatment and detoxification were for detoxification for the 202 clients who entered GDPP from July through December 2002. The rate of detoxification admissions out of all CD treatment and detoxification admissions fell to 18% in the 90-day period following entrance into GDPP among this group of clients.

Residential Treatment Completion Rates

Table 4.7. Completion Rates Following GDPP Entry[a]
Clients who Entered GDPP in July 1 - December 31, 2002 (n=202)

Type of Admission	Admissions[a]	Completed	Not Completed[b]	Other Outcomes[c]	Missing or in process[d]	Completion Rate[e]
Total Admissions	199	57	38	26	78	60%
CD Treatment						
Residential	66	46	9	4	7	84%
Outpatient	133	11	29	22	71	28%

Source: TARGET, April 26, 2003

[a] Data includes records for chemical dependency treatment following GDPP entry.

[b]Not Completed" includes the following TARGET discharge categories: quit, no contact/abort, and broke rules.

[c]Other" includes the following TARGET discharge categories: transferred, funds exhausted, inappropriate admission, incarceration, withdrawal advised, administrative discharge, and other.

[d]Missing outcomes --treatment assumed to be in progress; all admissions with missing outcome status began during CY2002-3.

[e]Completion rate equals number discharged as treatment "Completed" out of the total "Completed" plus "Not Completed" (excluding discharges under "Other" and "Missing)."

A key goal of the GDPP, reported by local projects, was to create conditions in which clients could more successfully complete CD treatment. Local programs reported considerable success, and actual completion rates from TARGET data demonstrate this success. For clients who participated in GDPP, their CD treatment completion rate before entering GDPP was 48% overall, 67% for residential treatment programs, and 27% for outpatient CD treatment (see preceding Table 4.4). Among the 202 clients who entered the GDPP between July and December, there were a total of 199 CD treatment admission record following the clients' entrance into the program. By the time that TARGET data were extracted in late April 2003, these admissions had resulted in a completion rates of 60% overall, 84% for residential treatment programs, and 28% for outpatient treatment. Thus, the completion rate for those in residential programs was much higher than the rates previously recorded for these clients.

A number of clients were still in CD treatment programs by late April 2003 when TARGET data was examined. Discharges were not yet recorded for seven out of 66 admissions to residential programs and 71 out 133 outpatient admissions, and this treatment was assumed to still be underway for most if not all of these clients. It is too early to draw any conclusion about the outpatient treatment completion rates since over half of the outpatient admissions were still in process by the time we were able to examine the TARGET data.

For residential treatment the completion rate under GDPP would still be well above the prior rate observed for these clients even if all seven of the clients who were still in residential treatment late in April 2003 failed to successfully complete their residential program.[21] Thus, while benefiting from the intensive case management and other support offered through the GDPP, the gravely disabled clients experienced much better residential treatment outcomes than they had previously experienced.

[21] The resulting residential completion rate would be 74%.

5 Mental and Physical Health

Health Conditions

Mental and physical health issues were important challenges for the majority of GDPP clients. Medical conditions often had to be stabilized in order for CD treatment to be viable. Some clients received mental health treatment upon entering the GDPP and then received CD treatment while in the program.

Type of Illness based on Prescription Drug Use

Table 5.1. Type of Illness with Prevalence of 5% or More Based on Prescription Drug Use GDPP Clients, FY2001-2002

Type of Illness	Prevalence Rates FY 2001-2002 (n=140)
Depression/Anxiety	74%
Infections, low	70%
Pain	61%
Psychotic Illness/Bipolar	37%
Cardiac	31%
Siezure Disorders	31%
Nausea	24%
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	24%
Gastric Acid Disorder	23%
Eye, Ear, Nose & Throat	22%
Infections, medium	14%
Inflammatory /Autoimmune	16%
Insomnia	12%
Attention Deficit	6%

Source: Research and Data Analysis, Medicaid Integration Partnership database derived from Medicaid Management Information System (MMIS)

Physical and mental health problems were examined using detailed medical records for clients receiving Medicaid benefits under Supplemental Security Income (SSI) or other programs.[22] These clients comprise about half of the GDPP participants. Using an algorithm that classifies illness based on prescription drugs,[23] we found that 74% were treated for depression or anxiety and 37% were treated for psychoses or bipolar disorders in the last two years.

Sixty-one percent of the clients had received prescription drugs ordinarily used to treat pain. Nearly one-third have been treated for seizure disorders, and 12% were treated for insomnia.

Treatment for infections ranked high on the list of illnesses for which these clients have received prescription medication. Seventy percent have recently been treated for low-grade infections, and 14% have been treated for medium-level infections. These clients have also recently received medical care for such chronic conditions as cardiac illness (31%) and asthma or chronic obstructive pulmonary disorders (COPD) (24%).

Other types of conditions that were treated with medications in the last two fiscal years before the beginning of the GDPP project included nausea (24%); gastric acid disorder (23%); problems of the eye, ear, nose or throat (22%), and inflammatory or autoimmune problems (16%). Six percent of the clients have also received treatment for attention deficit disorder.

Chronic Illness and Disability Based on Diagnoses

The types of illnesses for which SSI clients have been treated were also examined using the diagnoses recorded in their Medicaid claims in the prior fiscal years by hospitals, emergency departments, clinics, physician's offices, or other health care providers. These diagnoses were grouped using an algorithm that has been developed to help health care planners anticipate costs for clients in future years based on current patterns of diagnoses, called the Chronic Illness and Disability Payment System (CDPS).[24] In the next table, the categories with a prevalence of 5% or more among GDPP clients who received Medicaid benefits through SSI or other programs are shown.

The chronic illness categories in Table 5.2 all represent illnesses associated with higher than average medical costs predicted in the near future based on patterns of diagnoses in the current year. The predicted costs are based on medical costs for treating chronically ill and disabled clients. Sub-categories for certain diagnoses (e.g., psychiatric) have been ranked from one to five in which a rank of one represents diagnoses that are likely to result in the highest subsequent medical costs. It is important to note, however, that **all of**

[22] Includes clients who receive Medicaid on a fee-for-service basis under programs like SSI and General Assistance-Unemployable (GA-U). Medicaid payments for these services are recorded for all paid medical care and prescription drug claims in the Medicaid Management Information System (MMIS).
[23] T. Gilmer *et al*., *op cit.*
[24] R. Kronick, T. Gilmer, T. Dreyfus, and L Lee. 2000. "Improving Health-Based Payment for Medicaid Beneficiaries: CDPS," *Health Care Financing Review*, Vol. 21 (No.3), pp. 29-64.

the diagnosis categories listed in Table 5.2 are associated with **higher than average** medical costs among the chronically ill and disabled population (and much higher than the general population). Therefore, an illness category with a rank of four or five still represents an exceptionally costly group. A list of the diagnoses for each category shown in Table 5.2 is shown in Appendix D.

Table 5.2. Chronic Illness Categories with Prevalence of 5% or More Based on Diagnoses GDPP Clients, FY2001-2002

Chronic Illness Categories[a]	Prevalence Rates FY 2001-2002 (n=160)
Psychiatric - Rank 3	36%
Substance Abuse - Rank 3	36%
Pulmonary - Rank 3	24%
Central Nervous System - Rank 3	22%
Substance Abuse - Rank 4	19%
Skin - Rank 4	17%
Psychiatric - Rank 2	16%
Gastro-Intestinal - Rank 3	15%
Cardiovascular - Rank 5	12%
Psychiatric - Rank 1	9%
Skeletal - Rank 4	7%
Genital - Rank 5	7%
Diabetes, type 2 - Rank 3	7%
Skeletal - Rank 5	6%
Cardiovascular - Rank 3	6%
Gastro-Intestinal - Rank 2	6%
Diabetes and Other Metabolic - Rank 4	5%

Source: Research and Data Analysis, Medicaid Integration Partnership database derived from Medicaid Management Information System (MMIS)

[a]Based on Chronic Illness and Disability Payment System, as described in Kronick *et al.*, 2000, *op cit* . The categories of illness represent clients with higher than average medical costs rank ordered from 1(highest predicted medical costs) to 5 (relatively lower costs but still expensive). See Appendix D for examples of diagnoses in each category.

Substance abuse or dependence (rank 3) was recorded in the Medicaid records for 36% of the clients over the two fiscal years before the GDPP was implemented. Substance abuse diagnoses (rank 4 level), which included such diagnoses as alcohol withdrawal and nondependent alcohol abuse, were found for 19% of the clients in the last two years.

The most frequent diagnoses among GDPP clients in recent years were for psychiatric disorders. The category of mental illness associated with the third highest level of anticipated medical costs (rank 3) that includes such diagnoses as depression, unspecified psychosis, and panic disorder was recorded for 36% of the clients in the last two years. Psychiatric diagnoses like bipolar affective disorder with rank of 2 in anticipated medical costs were recorded for 16% of the clients. Psychiatric problems like paranoid schizophrenia that were associated with the highest predicted medical costs (rank 1) were diagnosed for 9% of the GDPP clients in SSI, GA-U or other fee-for-service Medicaid programs.

Other chronic diseases that were diagnosed among these clients in the last two years included pulmonary disorders like asthma or COPD (24%), problems with the central nervous system like epilepsy and migraine (22%), problems associated with the skin such as burns (17%), gastro-intestinal problems (15%), cardiovascular illness (6%), and diabetes (7%).

Mental Health Services

Mental Health Services Received Before GDPP

In the two fiscal years before the start of the GDPP, 28% of the clients received mental health services each year. The percent of clients who required community psychiatric hospitalization held steady across the two-year period. Between July 1999 and June 2002, 49 clients (15%) were treated at least once in either a community psychiatric hospital or a state institution. Thus, before the start of GDPP, slightly over a fourth of the clients received treatment for a mental health problem annually through any form of mental health treatment.

Table 5.3. Mental Health Division Services, FY2001 - FY2002

	FY 2001		FY 2002	
Total Project Clients (n = 323)				
Clients with Services	90	28%	89	28%
State Hospitalizations	7	2%	11	3%
Com.Psych.Hospitalizations[a]	20	6%	18	6%
Community Outpatient Services	88	27%	84	26%

Source: Research and Data Analysis, Client Services Database, May 8, 2003

[a]Includes involuntary and voluntary treatment

Cost of Mental Health Services

The cost for providing mental health treatment was between $4,400 and $5,500 per person per year for those clients who received such treatment. Annual per capita costs for state hospitalizations ranged from $10,650 to $15,200, community psychiatric hospitalizations from $3,900 to $5,400, and community outpatient from $2,050 to $3,600.

Table 5.4. Mental Health Division Services and Costs, FY2001-2002

	FY 2001			FY 2002		
Type of Services	Clients	Total Costs	Average Costs	Clients	Total Costs	Average Costs
Total	90	$393,658	$4,374	89	$487,809	$5,481
State Hospitalizations	7	$106,220	$15,174	11	$117,140	$10,649
Com. Psych. Hospitalizations[a]	20	$107,104	$5,355	18	$69,893	$3,883
Community Outpatient Services	88	$180,333	$2,049	84	$300,776	$3,581

Source: Research and Data Analysis, Client Services Database, May 8, 2003

[a]Includes involuntary and voluntary treatment

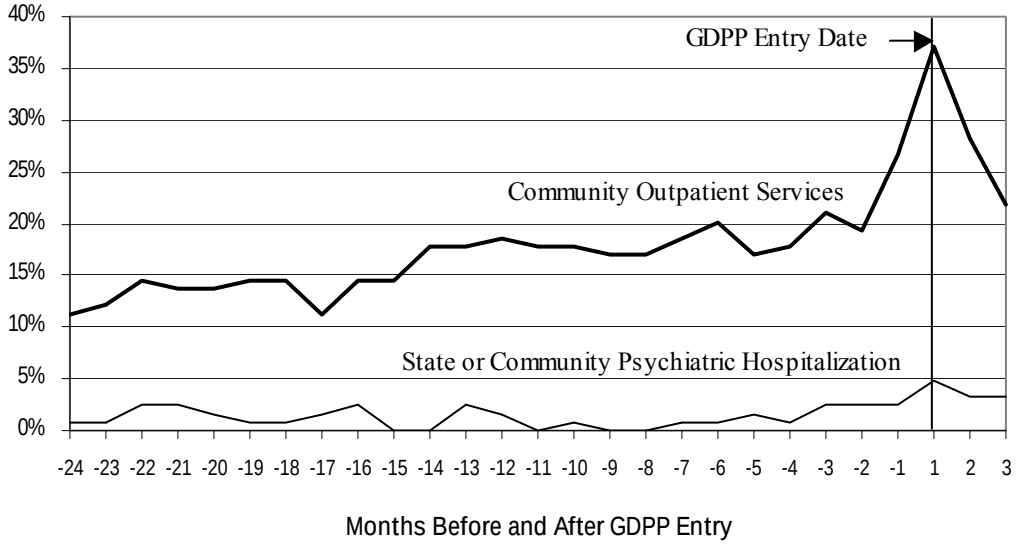
The annual per person costs for either type of hospitalization were lower in FY 2002 than in FY 2001, while annual per capita costs for community outpatient services rose over the two-year period.

Receipt of Mental Health Services After Entry into GDPP

Use of community outpatient mental health services appeared to rise gradually in the two-year period preceding entry into GDPP with a sharp increase in the month just before clients were enrolled in GDPP, culminating in the highest rate of service in the month in which the clients actually entered the project which equaled 37% of the 124 clients who entered GDPP by October 2002.

The fact that use of outpatient mental health services rose sharply in the month before clients entered GDPP (the month labeled as "−1" in Figure 5.1) may reflect the fact that a number of clients could have been selected for this program because of needs that had become apparent as they were in treatment. In addition, a peak in use of outpatient services during the month of entry to GDPP (labeled month "1") may reflect the goal of some counties, notably Spokane, to provide mental health services to clients with co-occurring disorders. It is also noteworthy that the percent of clients receiving outpatient mental health services appeared to decline in months after enrollment in GDPP. Month "2" in the above figure represents the 31 to 60 days following entry into GDPP and month "3" is 61 to 90 day after entry. By the 3rd month in the follow-up period, the rate of use dropped to 22%.

Figure 5.1. Mental Health Services Before and After GDPP Entry, Clients who Entered GDPP in July – October 2002 (n=124)



Outpatient mental health services were in many cases an essential first step to treatment. In the following case described by one county, therapy was helpful in getting the client into the chemical dependency treatment she needed but had previously resisted:

> *"…one female with an extensive history of IV heroin use, depression, trauma, and incarceration that initially refused our services re-contacted Project staff within four weeks of her refusal of assistance. By using the principles of Harm Reduction and Motivational Interviewing/ Enhancement Therapy, Project staff were able to engage her in a therapeutic relationship and begin resolving her treatment ambivalence. Staff also assisted her attorney in accessing drug court as an alternative to returning to prison for outstanding drug charges, and helped her reconnect with her family for housing and support. Ultimately, the client was successfully transitioned into a Methadone Maintenance program."*

In the 24 months before entry into GDPP, between zero and three of the 124 clients who entered the program by the end of October were in either the state institution or a community psychiatric hospital in any given month. In the 30-day period after the clients entered GDPP (month "1"), six of the 124 clients received this type of mental health treatment. In each of the two subsequent months, four clients were in these more intensive types of settings. Given the small numbers of clients in any month, these fluctuations may be due to chance. The slightly higher numbers in the 90-day period following the entrance of clients into GDPP could also reflect attempts to use these more intensive forms of treatment to help clients become stabilized so that they might benefit from case management and other GDPP services.

Medical Assistance

Medical Services Received Before GDPP

Between FY 2001 and FY2002, the proportion of the clients eligible for medical assistance increased under both Medicaid (Title 19) and other programs such as the state-funded General Assistance – Unemployable (GA-U). By FY 2002, nearly two-thirds of the GDPP clients were eligible for medical coverage under these programs.

Table 5.5. Medical Assistance Administration Services, FY2001 - FY2002

	FY 2001		FY 2002	
Total Project Clients (n = 323)				
Clients with Medical Assistance[a]	177	55%	205	63%
Eligible under Medicaid (Title 19)	129	40%	137	42%
Eligible under other programs	58	18%	95	29%
Types of Medical Care Received				
Managed Care	60	19%	46	14%
Claims paid based on fee for service				
Hospital Inpatient	54	17%	71	22%
Hospital Outpatient	65	20%	80	25%
Prescription Drugs	121	37%	146	45%
Physicians Services	121	37%	152	47%
Dental Services	54	17%	51	16%
Other Services	85	26%	103	32%

Source: RDA, Client Services Database, May 8, 2003

[a]A client may be counted in more than one eligibility category during a year, so subcategories add to more than the total number of clients.

GDPP clients' use of medical care increased between FY 2001 and FY 2002 for those whose medical claims were paid on a fee-for-service basis.[25] In FY 2002, for example, 22% of these clients were hospitalized compared to 17% in the prior year. Similarly, the percent of clients getting other types of medical care also increased, including use of hospital outpatient facilities (from 20 to 25%), prescription drugs (from 37 to 45%), and physician services (from 37 to 47%). These increases may reflect a combination of factors, including, the clients' increased medical coverage to pay for care that they have put off due to lack of insurance and potentially their worsening health prior to entering the GDPP program.

Cost of Medical Services

Despite the increased number and percent of GDPP clients who sought medical care in FY 2002, their total medical costs and average annual costs (per person receiving services) declined. This drop was due to one or two exceptionally expensive hospitalizations in FY 2001 and the absence of such outliers in FY 2002. When examining hospital costs for a small group of clients such as this, the effects of one or two clients with extremely expensive hospital stays can be pronounced.

Table 5.6. Medical Assistance Administration Services and Costs, FY2001-2002

	FY 2001			FY 2002		
Type of Services	Clients	Total Costs	Average Costs	Clients	Total Costs	Average Costs
Total	177	$752,655	$4,252	205	$594,859	$2,902
Managed Care	60	$119,288	$1,988	46	$99,400	$2,161
Fee-for-Service						
Hospital Inpatient	54	$306,229	$5,671	71	$101,401	$1,428
Hospital Outpatient	65	$57,157	$879	80	$76,262	$953
Prescription Drugs	121	$139,215	$1,151	146	$174,123	$1,193
Physicians Services	121	$84,905	$702	152	$97,834	$644
Dental Services	54	$22,757	$421	51	$17,943	$352
Other Services	85	$23,103	$272	103	$27,896	$271

Source: RDA, Client Services Database, May 8, 2003

Annual average costs for hospital outpatient care and prescription drugs among those who received these services increased slightly in FY 2002, while average costs for physician and dental services declined slightly.

[25] The Client Services Database maintained by Research and Data Analysis began capturing information about fee-for-service medical claims in FY 2001, thus allowing a description of the types of medical care received for clients whose care is paid this way. These are mostly SSI and GA-U clients, not TANF.

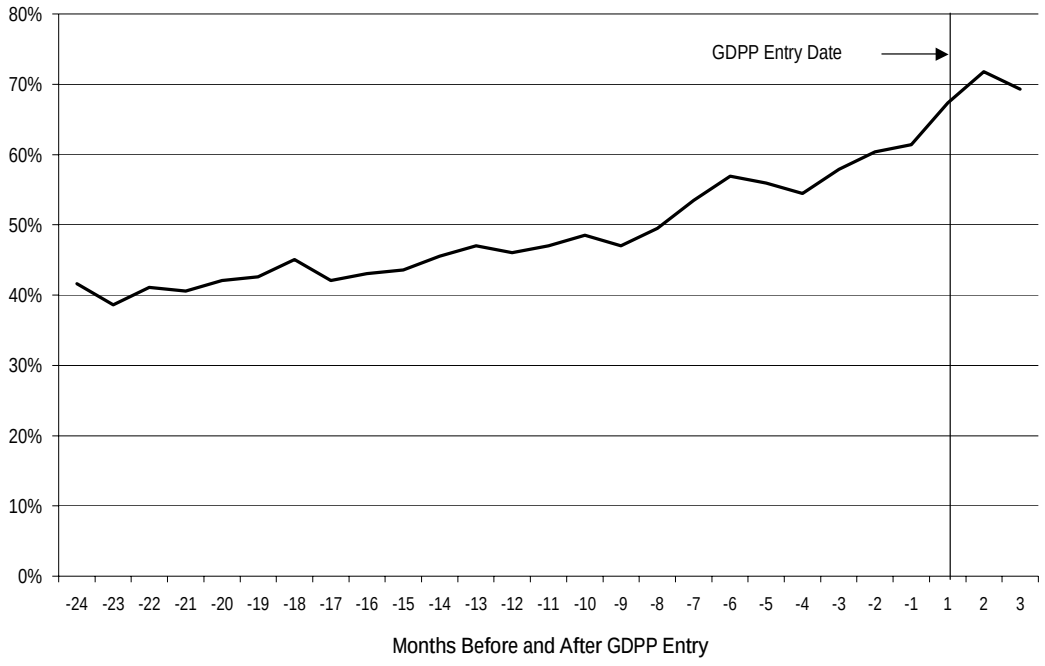
Medical Assistance After Entry into GDPP

A number of counties identified case management as a means to help clients achieve greater stability in their lives. Given the medical problems facing these clients, getting clients enrolled in publicly funded medical assistance programs was one way to help them achieve such stability. The need to address health issues in order to develop a successful CD treatment regimen is indicated by the following GDPP case history:

> *"A 55 year old diabetic, homeless man that has a history of meth, cocaine and heroin dependence. [This client] had been hospitalized a few times in the previous 6 months. He initially requested detox, but after meeting with him and assessing his situation, which includes chronic pain due to diabetic complications, we discussed and he agreed to methadone treatment. He continued to visit the emergency room for the next month as he had abscesses from intra-muscular drug injection, but through establishing him with a primary care provider, and assisting him with obtaining housing, he has stabilized in the community and is successful with both better self care and with his methadone program."*

The percent of clients who were covered by publicly funded medical assistance programs, usually Medicaid, was gradually increasing even before clients entered GDPP. Out of the 202 clients who entered by December 2002, about 40% were on Medicaid or a similar form of medical assistance 24 months before they entered the project, 60% in the month before GDPP, and 72% in the second month after GDPP. Thus, GDPP may have helped more clients get enrolled into a program to help cover their medical expenses.

Figure 5.2. Medical Assistance Before and After GDPP Entry, Clients who Entered GDPP in July – December 2002 (n=202)



6 Economic and Social Services

Economic Assistance

Economic Assistance Received Before GDPP

Between FY 2001 and FY2002, the percent of GDPP clients getting some form of assistance through Economic Services Administration increased from 56% to 61%. The percent getting financial help through the GA-U program or the presumptively disabled program (called GA-X) rose from 14% to 18% over the two-year period, while the percent on SSI was 12% and 13% in the two years. Recipients of cash grants under Temporary Aid to Needy Families or the State Family Assistance Program (TANF/SFA) increased from 14 to 17%. WorkFirst, which is designed to help TANF/SFA recipients find jobs, was 20% and 19% in the two years. By FY 2002, 56% were getting Basic Food assistance, one of the major forms of support.

Table 6.1. Economic Services Administration Services, FY2001-2002

	FY 2001		FY 2002	
Total Project Clients (n = 323)				
Clients with Services[a]	182	56%	196	61%
Cash Grant Assistance				
TANF/SFA Grants[b]	45	14%	55	17%
GA-U & GA-X[c]	45	14%	57	18%
SSI (State Supplement)[d]	40	12%	43	13%
WorkFirst				
WorkFirst Participants	64	20%	62	19%
Other Forms of Assistance				
Basic Food Assistance[e]	152	47%	180	56%
ESA Child Care	19	6%	18	6%
Diversion	2	1%	1	0%
Misc - Not Reported Separately	39	12%	56	17%

Source: RDA, Client Services Database, May 8, 2003

[a]Clients may get assistance from more than one program during the year and, therefore, are counted in more than one category.

[b]TANF/SFA Grants = Temporary Assistance to Needy Families & State Family Assistance

[c]GA-U & GA-X = General Assistance-Unemployable and Presumed Disabled, Aged, or Blind

[d]SSI = SSI State Supplement, CPI, and Additional Requirements

[e]Formerly called "Food Stamps."

Cost of Economic Assistance

Total costs for economic assistance to GDPP clients increased from $300,311 in FY 2001 to $341,916 due mostly to increases in the number of clients receiving assistance under the state-funded GA-U and GA-X programs, TANF, and federally funded basic food assistance.

The average costs (per person receiving assistance) also increased in this two-year period, from $1,650 to $1,744. Increases occurred in per person costs for cash assistance under GA-U and GA-X ($2,097 to $2,280), food assistance ($608 to $762 per person per year), and child care ($959 to $1,204).

The annual averages translate into rather low monthly allotments. For example, if one assumes that each person who received food assistance did so for all 12 months of the year, than the average of $762 per person in FY 2002 translates into a monthly food allotment of $63.49. For those on GA-U or GA-X, the annual amount of $2,280 would be equal to $190 per month for each person who received this form of support to cover rent and other living expenses.[26]

Table 6.2. Economic Services Administration Services and Costs, FY2001-2002

	FY 2001			FY 2002		
Type of Services	Clients	Total Costs	Average Costs	Clients	Total Costs	Average Costs
Total[a]	182	$300,311	$1,650	196	$341,916	$1,744
Cash Grant Assistance						
TANF/SFA Grants	45	$60,039	$1,334	55	$59,254	$1,077
GA-U and GA-X	40	$83,867	$2,097	43	$98,029	$2,280
SSI (State Supplement)[b]	45	$8,924	$198	57	$6,319	$111
WorkFirst						
WorkFirst	64	$30,741	$480	62	$20,499	$331
Other Forms of Assistance						
Basic Food Assistance	152	$92,412	$608	180	$137,140	$762
ESA Child Care	19	$18,230	$959	18	$21,679	$1,204
Diversion	2	$750	$375	1	$361	$361
Miscellaneous	39	$5,346	$137	56	$11,121	$199

Source: RDA, Client Services Database, May 8, 2003

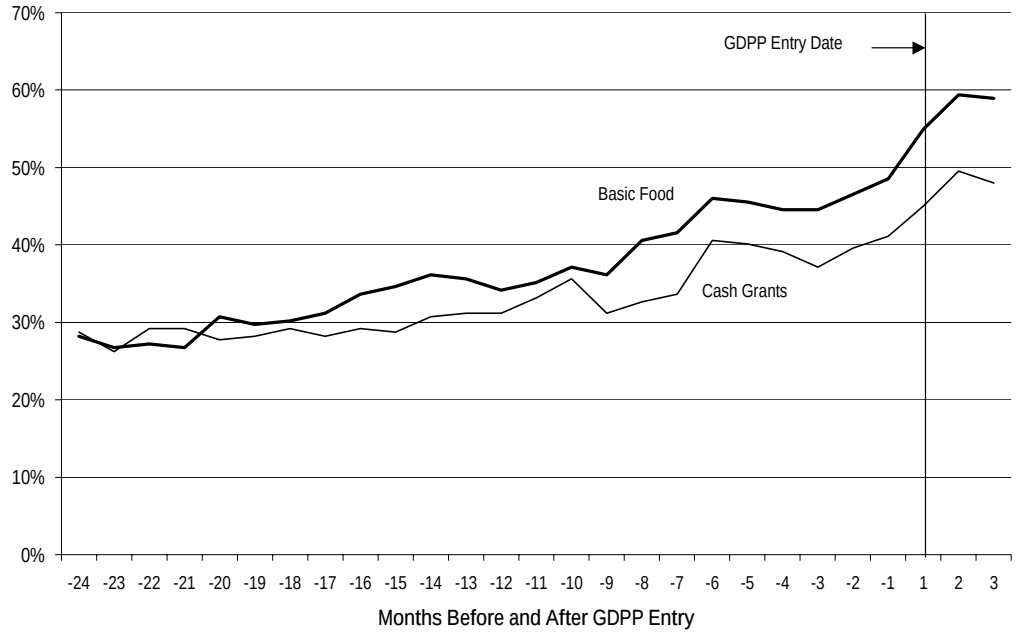
[a]Clients may get assistance from more than one program during the year.

[b]The State Supplement to SSI represents only a small share of the total cash amount paid to SSI clients; the larger amount which is paid for by the federal government is not captured in the CSDB database used for these analyses.

Economic Assistance After Entry into GDPP

Twenty-four months before clients entered GDPP, less than 30% of the clients were getting food assistance or receiving cash grants from programs like TANF/SFA, GA-U, GA-X, or SSI. In the month before they entered GDPP, however, these percentages had risen to 49% for basic food (formerly called "food stamps") and 41% for cash grants. Thus, over the intervening months, the proportion of clients getting some form of economic support was increasing gradually. Entering GDPP appeared to further increase the likelihood that a client would be getting these forms of support. The percent getting basic food rose to nearly 60%, and the percent getting cash grants increased to 50% in the second month following entry into GDPP and declined slightly in the next month.

Figure 6.1. Cash Grants or Basic Food Assistance Before and After GDPP Entry
Clients who Entered GDPP in July – December 2002 (n=202)



Children's Administration Services

Several counties provided services to young mothers, particularly those using methamphetamines who faced child custody issues through the intervention of Child Protective Services (CPS). Of the 132 women participating in GDPP, 38% had been involved with CPS at some point in the three fiscal years before the GDPP program was implemented.

[26] Actual monthly allotments may be somewhat higher since clients may have been receiving GA-U or GA-X for a portion of the year. Therefore, these calculations are only rough approximations of actual monthly support.

As the following GDPP case illustrates, helping to reunite parents with their children was one of the goals of the GDPP program in some counties:

> *"A 30-year old single mother of four children, all of whom had been removed to foster care by CPS because of her methamphetamine use. She had lost her spouse to a drug overdose with the previous year of admittance to the program and came with enormous loss and grief issues, including a great deal of anger….She became a participating and appropriate group member….applied for housing, and is residing in a new apartment. Two of her children have been returned to her…"*

Table 6.3. Children's Administration Services, FY2001-2002

	FY 2001		FY 2002	
Total Project Clients (n = 323)				
Clients with Services	45	14%	60	19%
Case Management				
Child Protective Services	37	11%	45	14%
Family Reconciliation Services	3	1%	4	1%
Child Welfare Services	8	2%	21	7%
Other Services				
Home-Based Services	8	2%	16	5%
Foster Care Support Services	5	2%	14	4%
Child Care Services	1	0%	2	1%

Source: RDA, Client Services Database, May 8, 2003

Involvement with CPS increased over the two-year period from 11% in FY 2001 for GDPP clients overall (including males) to 14% in FY 2002. Child welfare services, another form of case management provided under the DSHS Children's Administration also increased during this period (from 2% to 7%). Home-based services and foster care support also appeared to rise slightly (from around 2% for each type of service to 4 or 5%). Thus, by the time the GDPP program was implemented in FY 2003, a number of clients had had recent experience with Children's Administration.

Cost of Children's Administration Services

Both total and average costs for Children's Administration services rose in the two years before the GDPP program started. Overall costs reached $46,195 in FY 2002 to serve 60 GDPP clients with an average cost of $770 per person served. CPS and child welfare services made up most of the FY 2002 costs.

Table 6.4. Children's Administration Services and Costs, FY2001-2002

	FY 2001			FY 2002		
Type of Services	Clients	Total Costs	Average Costs	Clients	Total Costs	Average Costs
Total	45	$25,787	$573	60	$46,195	$770
Case Management						
Child Protective Services	37	$12,516	$338	45	$19,267	$428
Family Reconciliation Services	3	$975	$325	4	$2,608	$652
Child Welfare Services	8	$4,013	$502	21	$12,552	$598
Other Services						
Home Based Services	8	$6,052	$757	16	$7,654	$478
Foster Care Support Services	5	$500	$100	14	$3,364	$240
Child Care Services	1	$1,590	$1,590	2	$750	$375

Source: RDA, Client Services Database, May 8, 2003

Effects of GDPP participation on use of CPS or other Children's Administration services could not be assessed since up-to-date data for FY 2003 was not yet available in CSDB.

Other Social Services

A small number of clients received several other forms of services administered through DSHS. Vocational rehabilitation case management was the most common form of other service, received by 11 (3%) of GDPP clients in FY 2001 and FY 2002. In FY 2002 three clients were in Juvenile Rehabilitation Administration institutions or youth camps or on parole. Five received services provided by Aging and Adult Services and two by the Division of Developmental Disabilities, both parts of the Aging and Disabilities Services Administration.

The total number of clients served by these DSHS programs—Vocational Rehabilitation, Juvenile Rehabilitation, Aging and Adult Services, or Developmental Disabilities Division—did not change much from FY 2001 to FY 2002. Total costs for services provided by these programs dropped from about $174,000 to less than $90,000 over this two-year period. Since so few clients received services from these DSHS programs, however, the change in overall costs may simply reflect services provided to one or two clients and should be used with caution. The changes from one year to the next does not

necessarily reflect a shift in client needs for such services or in the degree to which these needs are met. Effects of GDPP participation on use of these DSHS services could not be assessed since up-to-date data for FY 2003 was not yet available in CSDB.

Table 6.5. Other DSHS Programs Services and Costs, FY 2001-2002

	FY 2001			FY 2002		
Type of Services	Clients	Total Costs	Average Costs	Clients	Total Costs	Average Costs
Total Costs		$173,700			$89,656	
Division of Vocational Rehabilitation	11	$26,812	$2,437	11	$10,162	$924
Juvenile Rehabilitation Administration	1	$51,612	$51,612	3	$49,437	$16,479
Aging and Adult Services	2	$14,262	$7,131	5	$21,631	$4,326
Developmental Disabilities Division	2	$81,014	$40,507	2	$8,427	$4,213

Source: RDA, Client Services Database, May 8, 2002

Homelessness

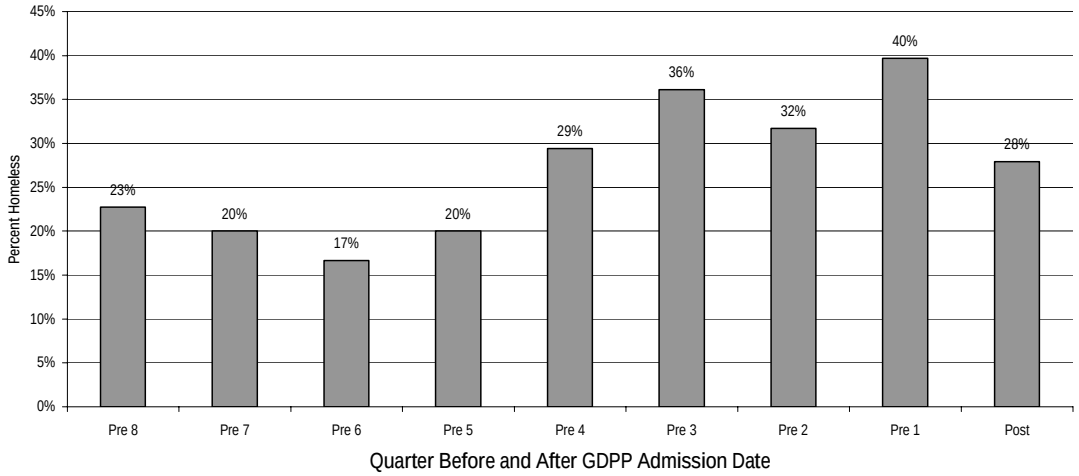
Although available information on one's housing history is rather limited, there are indicators in the Department of Social and Health Services' chemical dependency treatment records. Based on this information 52% of the 157 clients who had received chemical dependency treatment or detoxification services in the two years before being admitted to the GDPP had also been homeless at some point during that period. Information about the living arrangement for other clients is not available.

Homelessness was also strongly related to treatment patterns. Those identified as homeless at least once during their treatment records were more likely to be admitted to residential and detoxification, and less likely to receive outpatient treatment than those not homeless. 54% of the admission records for those identified as homeless at some point prior to GDPP entry were for detoxifications, compared to 36% for the overall GDPP set of clients. Those identified as homeless at least once entered residential CD treatment for 79% of their admission prior to GDPP entry (compared to 48% for the entire set of GDPP clients).

During the two years prior to their GDPP entry, 69% of those with TARGET records for that period who were also homeless during that period experienced detoxifications, 63% were admitted for residential treatment and 53% for outpatient treatment. The corresponding percentages for those not listed in TARGET records as homeless during the two years prior to their GDPP entry: 19% of those not homeless were given detoxification, 47% received residential treatment, and 80% received outpatient treatment.

Figure 6.2 shows the percent per quarter who entered treatment and were identified as homeless during the 8 quarters prior to GDPP entry and the 90 days following GDPP entry. The percentage entering treatment identified as homeless rose over the eight quarters prior to GDPP entry from 23% to 40% in the quarter preceding entry, and declined to 28% during the 90-day period following GDPP entry.

Figure 6.2. Homelessness of Clients Admitted to Chemical Dependency Treatment Before and After GDPP Entry, Clients who Entered GDPP in July – December 2002 (n=202)



Note: Homelessness is based on information recorded in TARGET for clients in chemical dependency treatment in each quarter.
Source: TARGET, April 26, 2003

Homelessness was one of the issues case managers had to resolve to help GDPP clients maintain abstinence. In the following example from one county, homelessness was one of several underlying difficulties the client was attempting to address:

> *"One of our male clients had spent approximately half his lifetime in prison.…He had experienced numerous treatments both during and in between his incarcerations. He came to the program recently released.…He was residing in the homeless shelter, was unemployed, and presented with great difficulty in sleeping due to constant nightmares. The mental health counselor was able to work effectively with him on his sleep issues, which gave him a great deal of release.…He has maintained abstinence, has proven to be a caring and supportive group member and is actively involved in 12-Step recovery. He recently was denied Section 8 housing due to his past felony history, appealed it with staff support and currently resides in his own apartment."*

7 Arrests and Convictions

Criminal History

Many of the clients selected for the GDPP program had prior criminal histories. Before entering the program, 74% of these clients had been arrested and 72% had been convicted at least once in their lives. Many clients had a history of multiple arrests with 20% of the clients accounting for two-thirds of all prior arrests.

Annual Arrest and Conviction Rates

Table 7.1. Annual Arrest and Conviction Rates, CY 1993 - 2002

	Arrests		Convictions	
Year	Number	Rate per 100 (n= 323)	Number	Rate per 100 (n= 323)
1993	72	22%	82	25%
1994	97	30%	105	33%
1995	123	38%	116	36%
1996	146	45%	164	51%
1997	151	47%	158	49%
1998	150	46%	141	44%
1999	130	40%	141	44%
2000	161	50%	161	50%
2001	193	60%	183	57%
2002	222	69%	228	71%

Sources: Washington State Patrol, Arrest data, March 2003; Washington State Institute for Public Policy, Criminal Recidivism database, May 2003.

The annual arrest rate among GDPP clients increased gradually in the last ten years from 22% in 1993 to 69% in 2002. Conviction rates also rose during this period from 25% to 71%. Since the arrest data used in this report is based on crimes for which a fingerprint was taken and a record was sent to the Washington State Patrol, the arrest rates tend to represent felonies and more serious misdemeanors. The conviction data, however, includes convictions for all crimes since this data incorporates information from Superior Courts, which adjudicate more serious crimes, as well as Courts of Limited Jurisdiction, which handle most misdemeanors. Therefore, the conviction rates are slightly higher than the arrest rates in several years and merely reflect differences in the level of offenses included in the different databases.

Felony Arrests and Convictions

Table 7.2. Arrests and Convictions for Any Offense and for Felonies, CY1975 - 2003

	Arrests (n=240 Clients)			Convictions (n=235 Clients)		
Year	All Arrests	Felony Arrests	Percent Felony	All Convictions[a]	Felony Convictions	Percent Felony
Total	2,037	449	27%	1,785	399	22%
1975-1979	54	11	20%	6	6	100%
1980-1984	108	20	19%	13	12	92%
1985-1989	225	45	20%	83	52	63%
1990-1994	374	78	21%	331	63	19%
1995-1999	700	151	22%	720	138	19%
2000-2003[b]	576	144	25%	632	128	20%

Sources: Washington State Patrol, Arrest data, March 2003; Washington State Institute for Public Policy, Criminal Recidivism database, May 2003.

[a]Excludes 7 felony convictions recorded in the recidivism database for 1967-1974.

[b]Arrests were reported through December 2002. Arrest data for 2002 and conviction data for 2002 and 2003 may have been incomplete at the time of data extraction and, therefore, may underestimate the actual number of arrests or convictions in the last 4-year period.

Felonies accounted for 27% of the arrests and 22% of the convictions recorded by the Washington State Patrol and courts statewide since the mid-1970s. The proportion of arrests that were felonies remained relatively constant throughout the 27 years covered by this data. Convictions recorded in the 1970s and 1980s include only data from the Superior Court system which handles mostly felonies. Data for convictions for lesser offenses handled by lower courts are not included until the early 1990s. Therefore, the proportion of felony convictions among GDPP clients stabilized around 20% once convictions from all court levels are included in the early 1990s. Therefore, it appears that about one in five arrests or convictions among GDPP clients has been for felonies.

Type of Offense

The four most common types of arrests among GDPP clients before entering the pilot project were: failure to comply with prior conditions of convictions or probation violations (22%), property crimes (22%), assaults (18%), and drug-or alcohol-related offenses (16%). Of the 322 arrests for drug- or alcohol-related crimes, 37% were for driving while under influence of alcohol. An additional 194 arrests, which comprised 10% of all prior arrests, were for driver's license violations such as driving with a suspended license or traffic offenses such as hit and run.

Minor vagrancy and petty street crimes, which included such charges as malicious mischief, criminal trespass, attempt to elude, disorderly conduct, public disturbance, vehicle prowling and prostitution, comprised 7% of previous arrests. Violations of Domestic Violence Court Orders, robbery, and sex offenses each constituted about 1% of prior arrests. One person had been arrested for homicide.

Prior Arrests per Client

Nearly three-fourths of the clients had been arrested at least once in their lives before entering the GDPP program. Out of 323 clients, 26% had no prior arrests recorded in the Washington State Patrol's database.. Forty-one percent had been arrested between one and five times, 13% between six and ten times, and 20% eleven or more times over the last 27 years. As a result of the multiple arrests experienced by a select group of clients, 20% of the GDPP clients (who had been arrested 11 or more times) accounted for 67% of all arrests.

Table 7.4. Number of Arrests per Client Before Entry into GDPP[a]

	# of Clients		# of Arrests[b]	
# of Arrests	Number	Percent	Number	Percent
Total	323	100%	2,013	100%
No Prior Arrests	84	26%	n.a.	n.a.
1 to 5	132	41%	342	17%
1	37	11%	37	2%
2	37	11%	74	4%
3	20	6%	60	3%
4	19	6%	76	4%
5	19	6%	95	5%
6 to 10	43	13%	332	16%
6	11	3%	66	3%
7	10	3%	70	3%
8	8	2%	64	3%
9	8	2%	72	4%
10	6	2%	60	3%
11 to 15	25	8%	324	16%
16 to 20	11	3%	197	10%
21+	28	9%	818	41%

Source: Washington Sate Patrol, 1975 - 2002, March 2003

[a]Based on arrest records for 239 clients.

[b]Charges filed on the same day for a given client are counted as a single arrest.

Prior Convictions per Client

Seventy-two percent of GDPP clients had been convicted at least once based on Washington court records dating back to the mid-1970s that are contained in the Washington Institute for Public Policy's criminal recidivism database. Since this database contains sparse records for the Courts of Limited Jurisdiction that handle most misdemeanors until the early 1990s, these conviction records are likely to underestimate the full extent of convictions among these clients.

Between one and five convictions had been recorded for 39% of the clients and between six and ten convictions for 15% of them. Seventeen percent had eleven or more prior convictions. Thus, this relatively small group of clients accounted for well over half (58%) of all convictions recorded.

Table 7.5. Number of Convictions per Client Before Entry into GDPP[a]

	# of Clients		# of Convictions	
# of Convictions	Number	Percent	Number	Percent
Total	323	100%	1,727	100%
No prior convictions	90	28%	na	na
1 to 5	126	39%	334	19%
1	37	11%	37	2%
2	31	10%	62	4%
3	19	6%	57	3%
4	17	5%	68	4%
5	22	7%	110	6%
6 to 10	50	15%	387	22%
6	15	5%	90	5%
7	7	2%	49	3%
8	11	3%	88	5%
9	10	3%	90	5%
10	8	2%	70	4%
11 to 15	20	6%	256	15%
16+	35	11%	750	43%

Source: Washington State Institute for Public Policy, May, 2003

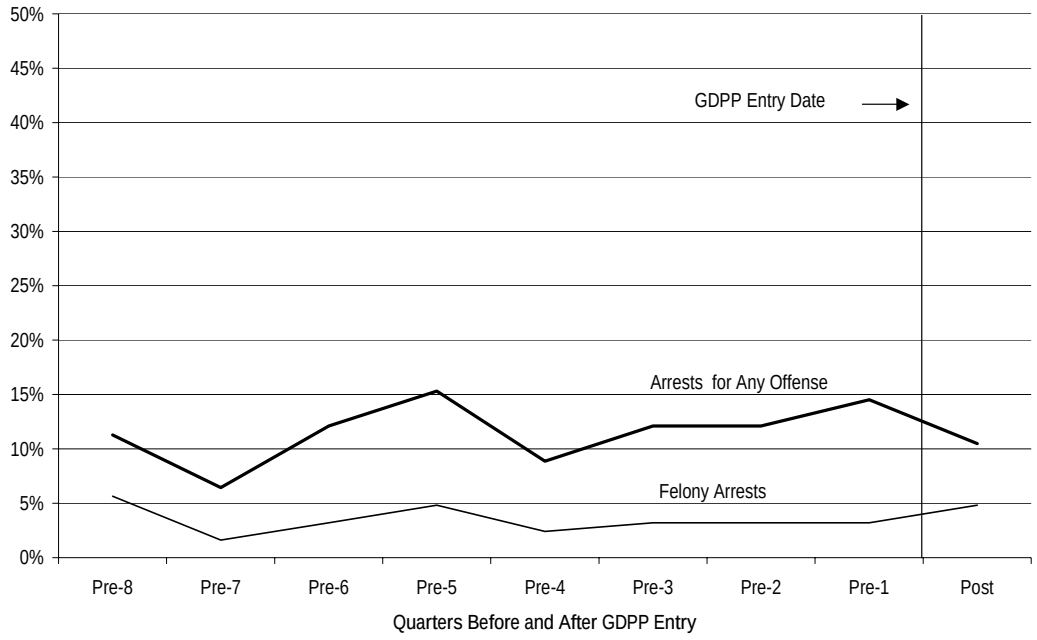
[a]Based on records for 233 clients who had been convicted at least once from 1975 until entry into GDPP in FY 2003.

Arrests Before and After GDPP Entry

Several counties cited their own success at reducing client criminal involvement through the GDPP program. Given our limited 90-day follow-up period and the small number of clients arrested in any given 90-day period, an analysis of changes in criminal activity after GDPP entry must be considered with extreme caution.[27]

Since the Washington State Patrol data on arrests only goes through December 31, 2002, arrests among the clients admitted in October are only available for 60 rather than 90 days.[28] As a result, the quarterly arrest rates shown in Figure 7.1 may underestimate the actual number of arrests in the post period. This graph suggests that arrest rates tend to fluctuate on a quarterly basis.

Figure 7.1. Arrests Before and After GDPP Entry,
Clients who Entered GDPP in July - October 2002 (n=124)



Quarterly arrest rates fluctuated in the two year period (8 quarters prior to GDPP entry) from a low of 6% in the seventh quarter preceding GDPP to a high of about 15% recorded in the seventh and first quarter immediately preceding GDPP. In the quarter immediately following the clients' entry into GDPP, the arrest rate was 10% which was

[27] Convictions could not be examined reliably to reflect criminal activity after entry into GDPP because there is usually a lag of about six months or longer after an arrest before a case is adjudicated in the courts. Also, court data on convictions is usually not recorded for several months in the database on criminal recidivism used in this report. Therefore, post-GDPP entry data on convictions is considered incomplete.
[28] Of the 124 clients who were admitted between July 1 and October 31, 2002, 54 were admitted in October.

within the range of the prior eight quarters. The arrest rate in the post-GDPP period could reflect fluctuation that was already apparent in the prior eight quarters.

The number of felony arrests in any quarter ranged from two (rate = 2%) to seven (rate = 6%) over the eight pre-quarters and one post. Given the small number of felonies from one quarter to the next, no conclusion can be drawn about the potential impact that participation in GDPP might have on felony arrests. A longer follow-up period would be needed to assess the impact.

8 Lessons Learned

The project directors in each of the seven GDPP sites were asked to describe the lessons they had learned from this project and to offer recommendations about how to meet the needs of gravely disabled clients in the future. (See Appendices E and F for county descriptions of barriers, problems, solutions, and lessons learned.)

Their comments and recommendations fall into four general categories:

- Complex needs of the gravely disabled client
- Success of individualized case management
- Importance of cross-system collaboration
- Future programs for treating the gravely disabled client

Complex Needs of the Gravely Disabled Client

The Gravely Disabled clients entered the pilot program facing unusually complex challenges because of the intensity of their addictions; their distinct co-occurring mental and substance abuse problems; and their complex health, housing and economic needs. They were addicted to various substances, principally alcohol, methamphetamines or other stimulants, crack/cocaine, and heroin. Many were out of touch or legally restricted from family contact. Some had lost their driver's licenses and were legally prohibited from driving. A number were homeless, and many were unemployed and relied on public assistance.

In the words of the program administrators, GDPP clients had a historic pattern in which they would "struggle with sobriety and exhaust all their allotted funding hours in the process." They tended to "wander away from help initially, often undermining early service engagement." A number of the gravely disabled clients had left prior residential or outpatient chemical dependency programs without completion, and some had experienced repeated detoxifications.

Several of the GDPP program administrators indicated that therapy and case management had to be immediately responsive to the intensity of clients' specific addiction, co-occurring health and mental health disorders and related life problems. For example, in one program, clients in early treatment for methamphetamine addiction met in groups up to four times a week for two hours a session, had individual and conjoint sessions, and were required to participate in community-based self-help groups. The program administrators maintained that therapy worked best when it was flexible enough to retain clients who were struggling to remain abstinent.

Other administrators mentioned the importance of addressing the economic, medical, and housing needs. One mentioned that, "We found that almost every client who entered into

this program [in our county] was physically unhealthy." GDPP case managers helped the clients apply for medical and economic assistance and, whenever possible, tried to arrange suitable housing.

Organic brain damage was mentioned by one administrator as evident from the difficulty clients exhibited in their thought processes and control of impulse behavior. The underlying problems for a number of clients appeared to be related to early traumatic events in their lives. These traumatic events, whether experienced in the past or in more current situations in their lives, tended to interfere in their current functioning and posed unique challenges to the staff for this program.

One GDPP administrator commented: "Most traditional chemical dependency programs presume, by design, that consumers who enter treatment are "ready" for treatment. This population seems to respond extremely well to a welcoming attitude and interventions that clinically match the consumer's stage of change/readiness.… Patience is prerequisite to success with this population. People who are gravely disabled require more time to work through the various stages of change. They require more time to grasp and process those matters that need good cognition, and they need extra time spent in practicing new skills. They need intensive case management that involves more than brokering services from behind a desk or over the phone. They need help advocating for themselves. They need to be allowed to make mistakes and they need to be treated as something more than just their diagnosis."

Success of Individualized Case Management

GDPP administrators stressed that the challenge for CD professionals was to "think outside traditional boxes" in order to engage clients, work with them to define effective treatment, and support success in multiple areas. It was important to quickly "build rapport and gather as much information as soon as possible" when clients presented themselves. Case managers had to demonstrate to clients that they could "assist and support client's motivation, goal setting and navigation through the process of accessing community resources." Case managers and GDPP administrators stressed that this required persistence, uncommon time commitment and was "exhausting."

At all points, from referral to stabilization, case managers used what one respondent termed "assertive advocacy" for "increased access to…community resources." At the point of project entry, case managers helped clients secure the medical treatment, mental health treatment, transitional housing, or transportation that would be absolutely necessary for chemical dependency treatment to proceed successfully. The caseworkers' assistance to clients applying for services such as publicly funded housing often meant the difference between whether or not clients received the service.

Clients required stabilization help with "a full array of services," often including chronic health problems, re-establishing family relationships, establishing employability and vocational rehabilitation, education, housing, financial eligibility, credit assistance, legal assistance, transportation, food, clothing, and utilities.

An important lesson from the GDPP was how challenging it was to obtain trained and experienced staff for this population of high-risk, difficult clients who require exceptionally broad areas of support. GDPP administrators reported a diverse set of skills necessary for intensive case management of the gravely disabled clients. As one explained, "Clinical training should include broader case management training beyond the cursory training now provided that barely exceeds clinical file documentation."

One of the most salient features of the GDPP program was a willingness to continue to work with clients who had occasional relapses. In more traditional treatment programs, participation can be terminated if a client relapses in their use drugs or alcohol. In the GDPP, however, clients were allowed to remain in the program even after a relapse. In the words of one client, the strength of the program can be summed up as follows: "You guys seemed to see something in me that I couldn't see anymore. You didn't give up on me even when I got drunk again." The client, a 50 year old homeless man with countless prior attempts at treatment, had been abstinent for six months, had contacted previously estranged family members and had assumed responsibility for his past behavior, and was enrolled in classes to prepare for possible future employment. This man, who said, "society gave up on me years ago," is now looking to the future with new hope and commitment.

Importance of Cross-System Collaboration

An important success of the GDPP was the effective collaboration among providers and between provider teams and community actors in order to assure that clients received appropriate and adequate resources at each stage of their recovery. Therapy providers devised new ways to collaborate especially to bridge different mental health and chemical dependency approaches. One project reported the first close collaboration within its network of mental health and chemical dependency professionals who were working together in "all aspects of the treatment process." Another local network reported first working on integrating mental health assessment and treatment with a chemical dependency treatment protocol.

Collaborating across disciplines and between providers, however, was not without its problems. One county reported regularly facing dilemmas over which provider "owned the client" for liability purposes.

The GDPP program administrators also identified the importance of building strong relationships with a number of community players besides substance abuse and mental health treatment experts. These included local law enforcement personnel, medical staff at hospital emergency departments, community services office staff, and public housing managers.

Future Programs for Treating the Gravely Disabled Client

Future efforts to serve gravely disabled clients will face challenges in maintaining the necessary level of coordination between agencies with different core activities, such as medical, legal, and mental health. Future chemical dependency providers should

consider serving these clients as "cross system service broker[s] to link potential clients with appropriate services, including stable housing, financial eligibility, educational assistance and other community resources."

Providers in the GDPP found pulling funding together for clients to be challenging and, in some cases, inadequate (as reported in one county project whose clients had difficulty obtaining needed dental services and psychotropic medications). Some county GDPP programs sought alternate sources of public funding from ADATSA, title XIX and SSI disability programs.

The length of time used to treat gravely disabled clients was questioned by at least one program administrator, who wrote: "A 90 day (3 months) stabilization and initial treatment program is not an optimum time. This program should be designed around a stay of 120 days (4 months) to stabilize, find and develop meaningful relationships, and thus positive support, in the community."

Future efforts to provide more comprehensive treatment alternatives to clients with severe and chronic disabilities associated with substance abuse will need to determine what funding arrangements are suitable for establishing effective treatment programs for gravely disabled clients' extremely broad range of needs. More effort would be needed to obtain the resources to help gravely disabled clients end their dependence on alcohol and other drugs and achieve greater stability in their lives.

Appendix A: Client Selection Criteria

How did you select clients for this project? For example, what characteristics or common problems did clients have that made them eligible?

Clallam

In collaboration with staff from local chemical dependency treatment agencies, local mental health centers, the homeless shelter, Lower Elwha Klallam Tribe and Clallam County Health and Human Services, the target population was defined as high utilizers of services with special emphasis on persons with co-occurring disorders, persons addicted to methamphetamine, those who have been incarcerated and those involved with Child Protective Services.

Clark

All clients meet the RCW definition of gravely disabled.

Clients have been referred from Crisis Services, CADC Detox Unit, Corrections, Southwest Washington Hospital (emergency department), other clients, self, family members, Center for Dual Diagnosis Recovery, and housing programs.

Columbia

In this project, we focused in on the chronic inebriates, as defined by individuals who are high utilizers of emergency rooms, interactions with law enforcement, detox centers, as well as prior failed attempts at treatment. Other descriptive features and common problems of all the clients in this program were homelessness and unemployment.

Snohomish

A minimum of at least two of the following eligibility criteria must be met for patient's to be served in the methamphetamine (meth) pilot.

1. Previous unsuccessful treatment attempt(s)
2. Homeless and/or lack of sober support system
3. Multiple drug related arrests
4. DCFS involvement (attempt to regain custody of children, will be given priority.)
5. Untreated medical and/or mental health issues.

Evergreen Manor Inc. (EGM)

Each client assessed in the agency was screened for inclusion in the project by completion of a 'group placement recommendation' form. The form outlined the criteria for inclusion in the project. We worked primarily from the county-designated criteria, along with the county-designated priority lists. To some extent, clients self-sorted out of the group due to the time that the group was offered.

Our clients were primarily methamphetamine addicted and often used other substances as well. All were eligible for publicly funded treatment. In the subset of other criterion, our clients appear to have a high level of DCFS involvement, homelessness and lack of support systems, and untreated medical/mental health issues. Because of this, although they were eligible for services under the Gravely Disabled Project, they often needed ancillary medical or financial support. This meant that although they required we utilize Title XIX, ADATSA, or other funding tracks that offered the support services they needed, rather than simply utilizing the treatment available under the Gravely Disabled Project.

Northwest Alternatives (NWA)

Clients were selected if they met the following criteria: Methamphetamine late stage with criteria regarding legal, treatment and situational issues.

Spokane County

Clients were selected based on the eligibility criteria set forth in the Statement of Work (SOW) by the County Coordinator for Chemical Dependency and the Regional Support Network for Spokane County. Criteria included:

- Must be 18 years of age or older,
- Have an existing mental disorder, substance use disorder, or a co-occurring mental health/substance use disorder,
- Gravely disabled as a result of alcohol or other psychoactive chemical use
- Gravely disabled as a result of danger or serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety
- Gravely disabled as a result of manifesting severe deterioration in routine functioning evidenced by repeated and escalating loss of cognition or volitional control over his or her actions and is not receiving care as essential for his or her safety
- Are not currently be receiving services from a mental health or chemical dependency provider (detox/sobering/interim services excluded)
- At imminent risk for psychiatric hospitalization
- Abstinence is not a requirement

Stevens County

Clients were carefully screened according to ASAM PPC 2-R to meet at least level II.I. Additional criteria were the client has at least one failed treatment experience with demonstrated chronic relapses, and the client has used drugs or alcohol within the last 30 days (exception: if client has been in a controlled setting i.e. in-pt, jail). The client needed to be willing to engage in treatment and work towards total abstinence. 37 clients were referred to this program with five that failed to engage in the program, and one that aborted treatment after 15 weeks. Four clients were in need of a higher level of care and were referred for Intensive Inpatient Treatment.

Thurston County

Inclusion Criteria

- Male or Female
- All races
- 18 years or older

Chemically dependent individuals in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or manifest severe deterioration in routine functioning evidenced by repeated and escalating loss of cognition or volitional control over his or her actions and is not receiving care as essential for his or her health or safety; or is a high utilizer of treatment services and other resources, including the chronic public inebriate.

Common Characteristics among project participants

1. Homeless
2. Unemployed
3. No health care insurance
4. High utilizers of community resources (hospital ED, detox, jail)
5. Many of our clients had previously been unsuccessful in going through the ADATSA application process.
6. Not maintaining compliance with drug treatment aftercare plans.
7. The participants also had historical backgrounds that prevented them from accessing housing resources.

Appendix B: Types of Treatment or Services

Clallam

The project was designed to provide intensive services to clients with co-occurring disorders. This was accomplished clinically by a chemical dependency and a mental health professional working together with a case manager.

Clients used the Matrix Model (a best practice, structured chemical dependency treatment program for methamphetamine addiction) one day a week and learned Dialectical Behavioral Therapy (a structured, cognitive/behavioral skills approach) during a second treatment group. A third group session involved a meeting with the clinical team, the clients and a support person of their choice. Family dynamics and other recovery-related topics were discussed every other week and there were bi-monthly "feedback" groups in which client progress was acknowledged similar to Drug Court. Clients in this pilot program also learned about mental health issues (such as medication compliance) and had access to psychiatric evaluations with follow-up care as needed. One-on-one counseling was with either the Mental Health or the Chemical Dependency counselor or both. In addition, short-term (4 - 8 sessions) educational groups (on parenting, life skills, and sexuality) were offered as an adjunct to the regularly scheduled group sessions.

A case manager was an integral part of the team. She addressed such client issues as housing, transportation, schooling and employment. She also compiled statistics on a regular basis providing ongoing measures of program progress.

Clark

Assessment, mental health evaluation, medical consultation, medication management if appropriate, group psychotherapy, motivational enhancement therapy, brief individual therapy, alcohol and other drug education, mental illness vs. mental wellness concepts, adult daily living skills, intensive case management, recreational activity, occupational therapy activities, and community support self-help group involvement. All assessment, treatment planning and case management is strength based.

Columbia

Inland Counseling Network was the lead treatment agency in this project. For the individuals in this program, they were provided Intensive Outpatient Treatment, Relapse Prevention, 24-hour case management, recreation activities, living skills classes, daily attendance at 12-Step meetings, as well as almost every weekend involvement in campouts and roundups sponsored by Alcoholics Anonymous and Narcotics Anonymous.

Snohomish

Evergreen Manor Inc. (EGM)

Clients participated in a stimulant-drug specific treatment track, following the Matrix model as closely as possible. A specific counselor was designated to work with this client group. Clients are seen in a two-hour group format, meeting two to four times per week. One of the weekly groups is designed for family participation. Clients are also seen in individual counseling sessions, and in conjoint sessions. Clients were offered intensive case management services in addition to treatment groups. They were required to participate in self-help groups in the community. These clients enjoyed a high level of accessibility to their counselor and were active participants in the process of determining how they moved through the levels of participation. In the initial engagement process, the clients were often seen in group four times per week, and individually on a different day.

Clients had the opportunity to participate with the same cohort through the duration of their care. In other words, as the client demonstrated ability to maintain abstinence and build support outside of the treatment program, they reduced the frequency of contact in the treatment program, attending the same group, but less frequently. This afforded clients in ongoing support of a counselor and group members that are familiar with the client's issues, and offered a 'model' for new clients to see success demonstrated.

Northwest Alternatives (NWA)

Case management when needed, Intensive Outpatient (IOP) MATRIX model of treatment, individual sessions, living stipend when appropriate, random UA's, family sessions, inpatient referrals when appropriate.

Spokane

All clients received short-term (up to four months) intensive outreach case management services. The principles, strategies, and techniques of Motivational Enhancement Therapy (MET) and Harm Reduction provided the foundation for all services rendered, with the primary goal being engagement and a therapeutic alliance that ultimately resulted in the client moving forward in the change process and engagement with treatment resources. In order to provide effective support and crisis stabilization for clients, discretionary funds were utilized to purchase goods and services as needed (e.g., psychotropic medications, transportation, utilities assistance, food vouchers, etc.). As client's crises stabilized and their ambivalence toward treatment resolved, case managers linked them to an appropriate treatment provider and continued to monitor their progress to assure successful transitions occurred.

Stevens

Stevens County's Bridge Builders treatment program was based on the Matrix program. This program is an evidence-based approach in cognitive behavioral treatment. The client

attended three group sessions and one Individual session every week. They were also required to submit to random UA's upon request. Additional case management services were offered such as transportation, and the client was given aid in accessing limited community resources.

Thurston

1. Individual case management
2. Inpatient detoxification (acute and stabilization)
3. Treatment assessment and plan
4. Continued follow up and re-engagement
5. Drug treatment referral and placement
6. Residential and out-patient drug treatment
7. Treatment retention, care coordination and aftercare

The project has two full time case managers. They use Strength Based Case Management and Motivational Interviewing techniques. The case managers utilized individual case management and counseling to assist and support client's motivation, goal setting and navigation through the process of accessing community resources and publicly funded drug detoxification and drug treatment services. The inpatient drug detoxification includes two components: phase one includes intensive, medically managed detoxification (24-72hrs) and phase two is stabilization or sobering beds (less intensive).

The project did not purchase residential or out-patient drug treatment. The project rather expedited individuals into existing publicly funded drug treatment services. These include ADATSA, involuntary commitment drug treatment at Pioneer Center North and out-patient drug treatment services.

Appendix C: County Goals and Outcomes

Clallam

Treatment completion rate - above 30 % statewide average for outpatient: As of this date the treatment completion rate is 71% (15 of 21 clients).

Progress toward recovery - as measured by change in the Addiction Severity Index: Ten clients who enrolled in the Program soon after it commenced were administered the ASI last fall and in January, 2003. There was a overall percentage increase of 1.78 points on a five-point scale. Areas showing the greatest positive change included, "Substance Use" at 3.30 points and "Arrests and Legal Issues" at 2.50 points. Overall there were no areas that reflected negative change. The remainder of the clients will be reassessed near the end of June.

Decrease of mental health symptoms - as measured by change in the Treatment Outcome Package (TOP): Eight clients were assessed using the TOP upon Program entry last fall and repeated it in January. Scores were compared in terms of positive change with an over-all shift in a positive direction of 6.89% on this six-point scale. Areas reflecting the greatest improvement included "Feelings" (17.50 %), "Other--Cognitive and Control issues" (12.63%) and "Stressful Events." (11.75 %). Again, overall there were no negative shifts and the response to the question, "What percent of your life would you rate as good?" averaged a positive shift of 10.38 %. The remainder of the clients will be reassessed near the end of June.

Decrease in the use of the emergency room: The statistics from the local Emergency Room indicate that eleven clients, (52%), have decreased or not accessed ER services; two clients (9%) have utilized medical services at the same level; and eight clients (38%) have actually increased ER usage since being in treatment. At least three of the eight clients, however, were out of the area in the previous year and so their increased use is not an accurate measure . It is of interest to note that at least six clients who accessed the ER did so for pain associated with dental problems.

Decrease in contact with law enforcement: As indicated in the client demographic discussion, nine of twenty-one clients (45%) had some kind of legal involvement during the year prior to beginning the Program. Comparison statistics are quite positive as 20 clients (95%) have either decreased or had no legal encounters at all since entering treatment.

Decrease in homelessness: Six clients were homeless upon entry into the Program,three are in Sober Houses, two are in the Homeless Shelter (a clean and sober facility) working on permanent housing, and the remaining client was helped to obtain their own apartment.

Increase of co-occurring treatment capacity in the region: The most obvious example of increased co-occurring treatment capacity is the Program's clinical team, which includes both a Chemical Dependency and a Mental Health professional. This is the first time two such professionals in Clallam County have been involved in all aspects of the treatment process, from assessment to groups to charting. Another related "first" is the assessment and treatment of mental health needs, including medication, which is integrated into the treatment protocols. Aside from the Program, an increase in co-occurring treatment capacity in the region can be observed in two Chemical Dependency Treatment Agencies who have hired Mental Health professionals to work with CD clients on a regular basis. It is also notable that one of the Community Mental Health Centers has plans to offer DBT groups to CD clients within the next year.

Increase in appropriate use of service utilization: An accurate evaluation of this outcome is difficult in the short time the Program has been operational. Client testimony indicates that Program clients are not being shifted from Mental Health treatment to CD treatment and back again, which, they indicate, has been a recurring situation in the past. Also, during the monthly inter-agency staffings, other professionals working with Program clients have indicated that their services are being utilized more appropriately by the clients. They attribute this to the recovery support inherent in the treatment

Clark

30 clients will be engaged in the project:

From September 2002 (start-up) through April 2003 thirty-eight (38) clients have been admitted to the program. Another three were referred but placed in another level of treatment.

30 clients will receive case management:

From September 2002 (start-up) through April 2003 thirty-eight (38) clients have received case management.

30 clients will receive treatment services:

From September 2002 (start-up) through April 2003 thirty-eight (38) clients have been admitted to the New Hope program

50% of the clients completing engagement will accept a referral and enter treatment:

Base outcome number to date: 19 clients
To date, eleven (11) clients have engaged in a lesser level of care phase of outpatient treatment.

Two (2) persons have been discharged to a greater level of care (inpatient program). Additionally, three (3) clients have stabilized and are in the work force.

80% will show a reduction in repeat admissions to detox, emergency rooms, and jail:

To date, only 1 client has been readmitted to detox two times. The reduction rate in detox admits is 94.7%

To date, only two clients have been incarcerated for violating terms of their probation.

The rate of reduction in incarcerations is 94.7%.

Emergency room presentations have dropped significantly. At the end of February nine (9) clients who had 306 ER services over the past year had dropped to 7 over a two to four month time span.

Testing and Evaluation:

- The *University of Rhode Island Change Assessment (URICA)* scale is used to measure the client's readiness for referral to other treatment options.
- The *Cognistat* (Neurobehavioral Cognitive Status Examination) is a short measurement tool used to rapidly assess intellectual functioning in five areas. Outcome results of the *Cognistat* indicate need for further testing or not.
- The *Woodcock-Johnson lll* is a comprehensive instrument used to measure cognitive function and achievement and as follow-up to the *Cognistat* as needs indicate.
- The *MMPl-2* is the most widely used and researched objective personality inventory and is used to provide an objective means of assessing abnormal behavior. A specialized setting-specific interpretation of scale scores to use with targeted support for alcohol and other drug treatment is included
- A coping inventory scale *Coping Response Inventory (CRI)* is used to identify the cognitive and behavioral responses used to cope with problems of stressful situations.
- The *Brown Attention Deficit Disorder Scales* is used to screen for ADD that examines a wide variety of factors believed to be associated with ADD. The *Brown ADD Scales* are effective tools for monitoring treatment responses

Columbia

Our objective through this program was to improve the participants quality of life, as measured by reduction in law enforcement and court contact, a reduction of need for accessing emergent medical care, increased employment, and motivation for working a long term recovery program. In general, we do believe that for the most part, many of our graduates achieved these objectives.

Snohomish

Evergreen Manor Inc. (EGM):

A primary goal of this project was to place methamphetamine addicts into a modality of treatment specifically geared to meet the needs of this population, thereby reducing impact on other systems/services. Long term results will be coming as these clients are tracked.

Counselors received training around working with methamphetamine addicts. Response to this was very positive, and some counselors adapted materials for use within the standard treatment modalities.

Retention and attendance in this group was improved over experience with the same subset of clients being treated in more standardized group. I believe part of the retention success is the method for dealing with relapse. Clients became less fearful of reporting struggles with abstinence and actual relapse as they saw the counselor work with clients who relapsed, as opposed to 'kicking out' the clients who struggle. Nonetheless, inpatient referrals were made for those clients who could not/would not stay clean.

Access to medical assistance was more difficult. Many of the clients had significant dental/medical needs, and although some systems were set up to provide access, many of the clients could obtain funding and medical coupons through more traditional funding, such as ADATSA. Accessing mental health, especially anti-depressant medications proved a challenge.

Northwest Alternatives (NWA)

We were able to see more people completing treatment and actually connecting with the MATRIX model of treatment that they received. Helping people who have been unsuccessful in the past help themselves. For the most part, as with any program there are people who struggle but this program has allowed us to dedicate more hours to people that are late stage chemically dependent who struggle with sobriety and exhaust all of their allotted funding hours in the process

Spokane

The primary objectives for the Project were as follows:

1. Identify and engage 100 clients within the target population using Harm Reduction and MET. The project served 127 clients through April 30, 2003. Harm reduction strategies and motivational enhancement principles were utilized with all consumers.
2. Avoid and reduce psychiatric or medical hospitalization, incarceration, and ER visits. Eleven of the 127 consumers (less than 9%) were hospitalized psychiatrically after being referred to the Project. Approximately 75% were at

imminent risk for hospitalization and the remaining 25% had a history of decompensation that has been used in the past as a predictor for future hospitalization. Fifty-five percent (55%) of consumers who have been discharged from the Project to date have been linked with appropriate stabilization resources and/or treatment providers.

3. Increase treatment retention and/or completion of those individuals referred to the Project. Twenty-six percent (26%) of Project clients were linked to outpatient or inpatient chemical dependency treatment services. Of those clients referred, 85% successfully completed inpatient chemical dependency treatment.

   Twenty percent (20%) of the clients served were linked to outpatient mental health treatment. Of those referred, 94% have continued in outpatient mental health services.

4. Serve as a cross-system services broker to link potential clients with appropriate services, including stable housing, financial eligibility determination assistance and other community resources. The following is a list of the types of resources secured by staff for clients:

   - Housing assistance,
   - Financial eligibility assistance,
   - Credit assistance,
   - Legal assistance,
   - Medical assistance,
   - Transportation assistance,
   - Food,
   - Clothing,
   - Vocation rehabilitation services,
   - Utilities assistance,
   - Chemical dependency and mental health treatment (public and private providers), and
   - Social and recreational access.

5. Provide transitional short-term crisis management stabilization services to enhance successful service referral linkages. The SOW allowed staff to assist with transitional services for clients who were referred to chemical dependency treatment until it was determined by staff and the chemical dependency provider that the consumer was successfully linked to treatment and no longer in need of support from Project staff. Once successful transition and stabilization occurred, clients were discharged from Project services.

6. Establish and maintain linkages with primary referral sources as well as treatment and support service referral sources. On-going contact was maintained with referral sources and treatment/resource providers for purposes of gathering further information and providing disposition information. An advisory committee was established to provide systematic community input and to help problem solve.

7. Link with the planned Spokane County Crisis Triage Center when established as the single hub for community crisis services including the grave disability outreach case management program. The Crisis Triage Center opening has been delayed to 2004 – this outcome is pending sufficient resources to resurrect this service at a later date.

Stevens County

The Gravely Disabled Project was implemented in Stevens County to promote Chemical Dependency treatment in a rural area with little or no public access to services. The Project was intended to provide an assessment of individual needs for placement at the appropriate level of care. The funding allowed Stevens County to retain a full time Chemical Dependency Professional and a Program Aide. The actual material for the program was the Matrix Model along with Harm Reduction.

The Bridge Builders Treatment Program was very successful in providing services to individuals in grave need of social services. Examples of related services and outcomes follow in response below:

The clients were aided in seeking social services to improve the quality of their lives. By improving the quality of their lives, the long-term prognosis for staying in recovery increases exponentially. Providing transportation to treatment and social services was invaluable in this rural area with no public transportation. Some of the clients live as far as 40 miles away and do not have a license or automobile available for their use. The program assisted clients in finding the appropriate services, and aided them with the paperwork to avoid frustration. This presented the clients with methods of problem solving skills expanding the boundaries of what they could accomplish if they were properly motivated to make changes and take chances on themselves.

Housing: 7 clients obtained or improved their housing arrangements with 3 being placed in a transitional apartment secured through Mental Health funding (Client were Co-occurring).

Employment: 6 clients became full time employed, and 1 completed a Pre-Vocational training period through the agency.

SSDI: 1 client was aided in processing her application for SSI, which she is now receiving.

Driver's License: 6 clients were able to apply and receive their licenses back with an additional 1 arranging finances to pay for insurance and licensing fees.

Mental Health: 6 clients are currently receiving Mental Health services. One is no longer in need of those services, and 2 that were referred for mental health treatment were found to not be in need of those services.

Education: 2 clients are taking college classes with another 3 working on getting their GED certificates. Two have completed the course work for Nursing Assistants.

Medical: All active clients are encouraged to seek medical attention with 5 actively taking care of medical services. One client died due to medical complications not related to Chemical Dependency

Child Protective Services: 3 clients have received their children back into the home with 1 additional client's CPS case has been closed.

Thurston County

- The project has placed many of the community 'high utilizers' in long-term drug treatment, thereby decreasing repeated detox stays.
- Cost savings through less emergency room visits of our clients, greater access to community resources.
- The number of clients served will be approximately 100 by years end.
- The project has received much community attention and praise. The project has been discussed and applauded at many community meetings for the great work it has accomplished. At the monthly county drug treatment provider meeting, we have received positive feedback from many community members and providers about our ability to reach out to clients that have been unsuccessful in the past.

Appendix D: Diagnoses in Chronic Illness Categories

Specific Diagnoses Contained In Chronic Disease Categories With Prevalence > 5%

Number of Clients	Diagnosis
	Psychiatric, Rank 3
49	Depressive Disorder Not Elsewhere Classified
17	Major Depressive Affective Disorder Recurrent Episode Severe Degree Without Psychotic Behavior
5	Unspecified Psychosis
11	Major Depressive Affective Disorder Recurrent Episode Unspecified Degree
9	Major Depressive Affective Disorder Single Episode Unspecified Degree
8	Unspecified Affective Psychosis
7	Major Depressive Affective Disorder Recurrent Episode Moderate Degree
6	Manic-Depressive Psychosis Unspecified
6	Other Manic-Depressive Psychosis
5	Major Depressive Affective Disorder Recurrent Episode Severe Degree Specified As With Psychotic Behavior
5	Major Depressive Affective Disorder Single Episode Severe Degree Without Psychotic Behavior
5	Neurotic Depression
5	Panic Disorder
5	Prolonged Posttraumatic Stress Disorder
4	Major Depressive Affective Disorder Single Episode Moderate Degree
3	Attention Deficit Disorder Of Childhood Without Hyperactivity
3	Hallucinations
3	Major Depressive Affective Disorder Recurrent Episode In Partial Or Unspecified Remission
3	Major Depressive Affective Disorder Single Episode Severe Degree Specified As With Psychotic Behavior
2	Adjustment Reaction With Prolonged Depressive Reaction
2	Other Specified Affective Psychoses
1	Acute Delirium
1	Acute Paranoid Reaction
1	Adjustment Reaction With Mixed Emotional Features
1	Agoraphobia With Panic Attacks
1	Attention Deficit Disorder Of Childhood With Hyperactivity
1	Major Depressive Affective Disorder Recurrent Episode Mild Degree
1	Major Depressive Affective Disorder Single Episode In Partial Or Unspecified Remission
1	Major Depressive Affective Disorder Single Episode Mild Degree
1	Manic Affective Disorder Single Episode Unspecified Degree
1	Obsessive-Compulsive Disorders
1	Other Specified Paranoid States
1	Unspecified Paranoid State

Substance Abuse, Rank 3

5	Unspecified Drug Dependence Unspecified Use
13	Drug Withdrawal Syndrome
5	Nondependent Amphetamine Or Related Acting Sympathomimetic Abuse Unspecified Use
4	Nondependent Cocaine Abuse Unspecified Use
4	Nondependent Opioid Abuse Unspecified Use
3	Drug-Induced Organic Affective Syndrome
2	Amphetamine And Other Psychostimulant Dependence Unspecified Use
2	Unspecified Drug-Induced Mental Disorder
1	Amphetamine And Other Psychostimulant Dependence Continuous Use
1	Cocaine Dependence Unspecified Use
1	Nondependent Opioid Abuse Continuous Use
1	Opioid Type Dependence Unspecified Use
1	Pathological Drug Intoxication

Pulmonary, Rank 3

5	Pneumonia Organism Unspecified
13	Asthma Unspecified Type Without Status Asthmaticus Or Acute Exacerbation Or Unspecified
5	Chronic Airway Obstruction Not Elsewhere Classified
7	Pulmonary Collapse
5	Extrinsic Asthma Without Status Asthmaticus Or Acute Exacerbation Or Unspecified
5	Other Emphysema
5	Unspecified Asthma With Acute Exacerbation
4	Obstructive Chronic Bronchitis With Acute Exacerbation
3	Hemoptysis
3	Pulmonary Eosinophilia
2	Chronic Laryngitis
2	Unspecified Pleural Effusion
1	Apnea
1	Bacterial Pneumonia Unspecified
1	Emphysematous Bleb
1	Intrinsic Asthma Without Status Asthmaticus Or Acute Exacerbation Or Unspecified
1	Obstructive Chronic Bronchitis Without Acute Exacerbation
1	Other Diseases Of Trachea And Bronchus Not Elsewhere Classified
1	Other Specified Forms Of Pleural Effusion Except Tuberculous
1	Pleurisy Without Effusion Or Current Tuberculosis
1	Pneumococcal Pneumonia [Streptococcus Pneumoniae Pneumonia]
1	Simple Chronic Bronchitis
1	Unspecified Chronic Bronchitis

Central Nervous System, Rank 3

5	Other Convulsions
7	Migraine Unspecified Without Intractable Migraine
6	Abnormal Involuntary Movements
2	Abnormality Of Gait
2	Common Migraine Without Intractable Migraine
2	Generalized Nonconvulsive Epilepsy Without Intractable Epilepsy
2	Hypersomnia With Sleep Apnea
2	Other Speech Disturbance

Central Nervous System, Rank 3 (Continued)

1 Alzheimer's Disease
1 Aphasia
1 Classical Migraine With Intractable Migraine So Stated
1 Classical Migraine Without Intractable Migraine
1 Congenital Reduction Deformities Of Brain
1 Epilepsy Unspecified Without Intractable Epilepsy
1 Insomnia With Sleep Apnea
1 Lack Of Coordination
1 Meningitis Due To Gram-Negative Bacteria Not Elsewhere Classified
1 Neurological Neglect Syndrome
1 Obstructive Hydrocephalus
1 Other Forms Of Epilepsy Without Intractable Epilepsy
1 Other Specified Neurosyphilis
1 Other Voice Disturbance
1 Polyneuropathy In Diabetes
1 Transient Paralysis Of Limb
1 Unspecified Delay In Development
1 Unspecified Extrapyramidal Disease And Abnormal Movement Disorder
1 Unspecified Site Of Spinal Cord Injury Without Spinal Bone Injury
1 Variants Of Migraine Without Intractable Migraine

Substance Abuse, Rank 4

17 Nondependent Alcohol Abuse Unspecified Drinking Behavior
16 Alcohol Withdrawal
7 Other And Unspecified Alcohol Dependence Unspecified Drinking Behavior
2 Other And Unspecified Alcohol Dependence Continuous Drinking Behavior
1 Acute Alcoholic Intoxication In Alcoholism Continuous Drinking Behavior
1 Acute Alcoholic Intoxication In Alcoholism Unspecified Drinking Behavior
1 Alcohol Amnestic Syndrome
1 Alcohol Withdrawal Delirium
1 Nondependent Alcohol Abuse Continuous Drinking Behavior

Skin, Rank 4

9 Cellulitis And Abscess Of Unspecified Sites
9 Cellulitis And Abscess Of Upper Arm And Forearm
7 Cellulitis And Abscess Of Foot Except Toes
6 Cellulitis And Abscess Of Leg Except Foot
5 Cellulitis And Abscess Of Hand Except Fingers And Thumb
4 Unspecified Local Infection Of Skin And Subcutaneous Tissue
3 Cellulitis And Abscess Of Face
3 Cellulitis And Abscess Of Trunk
3 Unspecified Cellulitis And Abscess Of Finger
Blisters With Epidermal Loss Due To Burn (Second Degree) Of Single Digit (Finger (Nail))
2 Other Than Thumb
2 Blisters With Epidermal Loss Due To Burn (Second Degree) Of Unspecified Site Of Upper Limb
2 Cellulitis And Abscess Of Buttock
2 Onychia And Paronychia Of Toe
1 Blisters With Epidermal Loss Due To Burn (Second Degree) Of Lip(S)
1 Blisters With Epidermal Loss Due To Burn (Second Degree) Of Palm Of Hand
1 Blisters With Epidermal Loss Due To Burn (Second Degree) Of Unspecified Site Of Hand

Skin, Rank 4 (Continued)

1 Burn Of Unspecified Degree Of Lip(S)
1 Burn Of Unspecified Degree Of Unspecified Site Of Hand
1 Cellulitis And Abscess Of Neck
1 Erythema Due To Burn (First Degree) Of Forearm
1 Erythema Due To Burn (First Degree) Of Single Digit (Finger (Nail)) Other Than Thumb
1 Onychia And Paronychia Of Finger
1 Other Specified Local Infections Of Skin And Subcutaneous Tissue
1 Unspecified Cellulitis And Abscess Of Toe

Gastro-Intestinal, Rank 3

14 Esophageal Reflux
6 Hepatitis Unspecified
5 Blood In Stool
5 Reflux Esophagitis
4 Hemorrhage Of Gastrointestinal Tract Unspecified
3 Acute Pancreatitis
2 Acute Duodenal Ulcer With Hemorrhage Without Obstruction
2 Diaphragmatic Hernia Without Obstruction Or Gangrene
2 Duodenal Ulcer Unspecified As Acute Or Chronic Without Hemorrhage Or Perforation Without Obstruction
2 Hematemesis
2 Intestinal Infection Due To Other Organism Not Elsewhere Classified
2 Unilateral Or Unspecified Inguinal Hernia Without Obstruction Or Gangrene
1 Acute Gastric Ulcer With Hemorrhage Without Obstruction
1 Bilateral Inguinal Hernia Without Obstruction Or Gangrene
1 Chronic Or Unspecified Duodenal Ulcer With Hemorrhage Without Obstruction
1 Dyskinesia Of Esophagus
1 Esophageal Hemorrhage
1 Foreign Body In Intestine And Colon
1 Hepatitis In Other Infectious Diseases Classified Elsewhere
1 Hernia Of Other Specified Sites Without Obstruction Or Gangrene
1 Other Specified Diseases Of Pancreas
1 Recurrent Unilateral Or Unspecified Inguinal Hernia Without Obstruction Or Gangrene
1 Ulcer Of Esophagus
1 Umbilical Hernia Without Obstruction Or Gangrene

Psychiatric, Rank 2

16 Bipolar Affective Disorder Unspecified
8 Bipolar Affective Disorder Depressed Unspecified Degree
4 Bipolar Affective Disorder Depressed Severe Degree Without Psychotic Behavior
4 Bipolar Affective Disorder Manic Unspecified Degree
3 Bipolar Affective Disorder Mixed Unspecified Degree
2 Bipolar Affective Disorder Depressed Moderate Degree
2 Bipolar Affective Disorder Manic Severe Degree Specified As With Psychotic Behavior
1 Bipolar Affective Disorder Depressed Severe Degree Specified As With Psychotic Behavior
1 Bipolar Affective Disorder Manic Severe Degree Without Psychotic Behavior
1 Bipolar Affective Disorder Mixed Moderate Degree
1 Bipolar Affective Disorder Mixed Severe Degree Specified As With Psychotic Behavior
1 Bipolar Affective Disorder Mixed Severe Degree Without Psychotic Behavior

Cardiovascular, Rank 5

14	Unspecified Essential Hypertension
7	Benign Essential Hypertension
3	Malignant Essential Hypertension

Skeletal, Rank 4

2	Chondromalacia Of Patella
2	Inflammatory Conditions Of Jaw
2	Nonunion Of Fracture
2	Tietze's Disease
2	Unspecified Disease Of The Jaws
2	Unspecified Internal Derangement Of Knee
1	Derangement Of Posterior Horn Of Medial Meniscus
1	Disorder Of Bone And Cartilage Unspecified
1	Disuse Osteoporosis
1	Malunion Of Fracture
1	Other Joint Derangement Not Elsewhere Classified Involving Lower Leg
1	Other Osteoporosis
1	Pathological Fracture Of Vertebrae
1	Recurrent Dislocation Of Joint Of Shoulder Region
1	Scoliosis (And Kyphoscoliosis) Idiopathic
1	Swan-Neck Deformity

Skeletal, Rank 5

5	Degeneration Of Lumbar Or Lumbosacral Intervertebral Disc
4	Displacement Of Lumbar Intervertebral Disc Without Myelopathy
2	Cervical Spondylosis Without Myelopathy
2	Closed Fracture Of Dorsal (Thoracic) Vertebra Without Spinal Cord Injury
2	Lumbosacral Spondylosis Without Myelopathy
2	Osteoarthrosis Localized Primary Involving Lower Leg
2	Osteoarthrosis Unspecified Whether Generalized Or Localized Involving Unspecified Site
2	Other Hammer Toe (Acquired)
1	Closed Fracture Of Lumbar Vertebra Without Spinal Cord Injury
1	Closed Fracture Of Nasal Bones
1	Closed Fracture Of Orbital Floor (Blow-Out)
1	Closed Fracture Of Other And Unspecified Part Of Body Of Mandible
1	Closed Fracture Of Other Facial Bones
1	Closed Fracture Of Sacrum And Coccyx Without Spinal Cord Injury
1	Closed Fracture Of Unspecified Site Of Mandible
1	Open Fracture Of Angle Of Jaw
1	Osteoarthrosis Localized Not Specified Whether Primary Or Secondary Involving Ankle And Foot
1	Osteoarthrosis Localized Not Specified Whether Primary Or Secondary Involving Pelvic Region And Thigh
1	Osteoarthrosis Localized Primary Involving Unspecified Site
1	Osteoarthrosis Unspecified Whether Generalized Or Localized Involving Ankle And Foot
1	Osteoarthrosis Unspecified Whether Generalized Or Localized Involving Lower Leg
1	Other Allied Disorders Of Spine
1	Other And Unspecified Disc Disorder Of Lumbar Region
1	Other And Unspecified Disc Disorder Of Unspecified Region

Skeletal, Rank 5 (Continued)

1 Sacroiliitis Not Elsewhere Classified
1 Spondylosis Of Unspecified Site Without Myelopathy

Psychiatric, Rank 1

5 Paranoid Type Schizophrenia Unspecified State
4 Schizo-Affective Type Schizophrenia Unspecified State
3 Paranoid Type Schizophrenia Chronic State
3 Unspecified Type Schizophrenia Unspecified State
2 Paranoid Type Schizophrenia Chronic State With Acute Exacerbation
1 Acute Schizophrenic Episode Unspecified State
1 Disorganized Type Schizophrenia Unspecified State
1 Residual Schizophrenia Unspecified State
1 Schizo-Affective Type Schizophrenia Chronic State With Acute Exacerbation
1 Simple Type Schizophrenia Unspecified State
1 Unspecified Type Schizophrenia Chronic State
1 Unspecified Type Schizophrenia Chronic State With Acute Exacerbation

Cardiovascular, Rank 3

3 Coronary Atherosclerosis Of Unspecified Type Of Vessel Native Or Graft
3 Other And Unspecified Angina Pectoris
2 Cardiac Dysrhythmia Unspecified
2 Coronary Atherosclerosis Of Native Coronary Artery
2 Other Specified Cardiac Dysrhythmias
2 Phlebitis And Thrombophlebitis Of Femoral Vein (Deep) (Superficial)
2 Sinoatrial Node Dysfunction
1 Abdominal Aneurysm Without Rupture
1 Acute Myocardial Infarction Of Anterolateral Wall Initial Episode Of Care
1 Cardiomegaly
1 Chronic Ischemic Heart Disease Unspecified
1 Embolism And Thrombosis Of Other Specified Veins
1 Paroxysmal Tachycardia Unspecified
1 Phlebitis And Thrombophlebitis Of Other
1 Premature Beats Unspecified

Genital, Rank 5

4 Other And Unspecified Ovarian Cyst
4 Unspecified Inflammatory Disease Of Female Pelvic Organs And Tissues
2 Acute Parametritis And Pelvic Cellulitis
2 Chronic Or Unspecified Parametritis And Pelvic Cellulitis
2 Unspecified Inflammatory Disease Of Uterus
1 Corpus Luteum Cyst Or Hematoma
1 Endometriosis Of Pelvic Peritoneum
1 Hypertrophy (Benign) Of Prostate
1 Other Specified Disorders Of Uterus Not Elsewhere Classified
1 Pelvic Peritoneal Adhesions Female (Postoperative) (Postinfection)

Diabetes, Type 2, Rank 3

10	Diabetes Mellitus Without Complication Type Ii Or Unspecified Type Not Stated As Uncontrolled
3	Diabetes Mellitus Without Complication Type Ii Or Unspecified Type Uncontrolled
2	Diabetes Mellitus With Other Specified Manifestations Type I Not Stated As Uncontrolled
2	Diabetes Mellitus With Other Specified Manifestations Type Ii Or Unspecified Type Not Stated As Uncontrolled
2	Diabetes Mellitus With Unspecified Complication Type I Not Stated As Uncontrolled
1	Diabetes Mellitus With Unspecified Complication Type I Uncontrolled
1	Diabetes Mellitus With Unspecified Complication Type Ii Or Unspecified Type Uncontrolled

Gastro-Intestinal, Rank 2

3	Alcoholic Cirrhosis Of Liver
3	Cirrhosis Of Liver Without Alcohol
2	Alcoholic Fatty Liver
2	Ascites
2	Chronic Hepatitis Unspecified
2	Chronic Pancreatitis
2	Other Chronic Hepatitis
1	Acute Alcoholic Hepatitis
1	Alcoholic Gastritis With Hemorrhage
1	Alcoholic Liver Damage Unspecified
1	Other Sequelae Of Chronic Liver Disease

Metabolic Disorders, Rank 4

3	Gouty Arthropathy
2	Gout Unspecified
1	Hypopotassemia

Renal, Rank 3

3	Calculus Of Ureter
2	Calculus Of Kidney
2	Urinary Calculus Unspecified
1	Congenital Atresia And Stenosis Of Urethra And Bladder Neck
1	Hematuria
1	Hydronephrosis
1	Pyelonephritis Unspecified
1	Renal Colic
1	Stricture Or Kinking Of Ureter
1	Urethral Stricture Unspecified
1	Urinary Obstruction Unspecified

Skeletal, Rank 3

2	Rheumatoid Arthritis
2	Traumatic Amputation Of Other Finger(S) (Complete) (Partial) Without Complication
1	Acute Osteomyelitis Involving Hand
1	Periostitis Without Osteomyelitis Involving Hand
1	Postlaminectomy Syndrome Of Lumbar Region
1	Systemic Lupus Erythematosus

Skeletal, Rank 3 (Continued)

1 Traumatic Amputation Of Leg(S) (Complete) (Partial) Unilateral Below Knee Complicated
1 Unspecified Osteomyelitis Involving Ankle And Foot
1 Unspecified Osteomyelitis Involving Hand
1 Unspecified Osteomyelitis Site Unspecified

Appendix E: Barriers/Problems/Solutions

Clallam

The first challenge occurred when the Chemical Dependency and the Mental Health professional began to work together as primary clinicians. The basic "helping" approaches were clear—support vs confront the client, protect the client vs allowing the client to experience natural consequences, not self-disclosing vs self as a role model, etc. As each became familiar with the other's approach, they began to work together more comfortably and to develop respect for their diverse attributes.

A final barrier, again unexpected, was the establishment of procedures and protocols for several different systems to interface. An outpatient CD facility provided the setting for most of the clinical work while an inpatient facility provided the Case Manager space and the use of their family room for larger groups. The program is administered through the county Department of Health & Human Services. Occasionally problems arose around these interfaces such as, "Who owns the client?" for liability purposes. Generally these were resolved by informal discussion in the Grant Partnership meetings (involving agency supervisors and program staff) which occurred on a quarterly basis.

Clark

Careful attention to understanding our treatment philosophy, therapeutic alliance and engagement, and the possible profiles of the targeted population helped minimize many problems. We were quick to adapt; so, achieving positive outcomes has not been especially difficult— we work with "difficult" clients on a continual basis.

We have discovered that, for the most part, a 90 (3 months) day stabilization and initial treatment program is not an optimum time. The program should be designed around a stay of up to 120 days (4 months) to stabilize, find and develop meaningful relationships, and thus
positive support, in the community

The Case Manager's role in the stabilization process is to assist clients in applying for funding (GAU, ADATSA, SSI), arrange housing, provide access to food banks and clothing banks, provide transportation to and from treatment and necessary appointments until the client is able to access public transportation and/or bus passes have been authorized, schedule clients for mental health/medical consultations and with prescriber.

After these immediate case management needs (the basics Maslow's hierarchy of needs) the Case Manager assists clients identify the case management goals they hope to achieve, helps them identify steps they need to take to achieve their goals with strong emphasis on taking small steps, one at a time, and documenting each successful step taken. Clients are also asked to identify the things they like about themselves early in the

goal planning process and encouraged to view their successes in terms of their innate personal strengths.

Columbia

One of the most difficult problems that we faced was having a coed living situation for our clients to reside in. Our Safe and Sober House was a six-bed facility, with separate sleeping rooms for the males and females. We had to set some very firm boundaries and rules, and increase our on-site case management. Our treatment team also learned that we had to have case management staff that also followed these same firm boundaries.

Snohomish

Evergreen Manor Inc. (EGM)

One of the problems in achieving successful outcomes was working with the many different systems in a client-oriented way. CD treatment professionals were, for the most part, comfortable working with this model of treatment. The staff assigned to provide direct services in this Project were selected for their enthusiasm for working both with this client group and this specific treatment modality. CD treatment professionals also have little stereotypes of certain drug addicts as "bad people". Professionals in other systems, such as law enforcement, DCFS, Healthcare and others have not always had exposure to working with addicts in recovery and sometimes hold stereotypes. Overcoming this misinformation can create barriers for CD clients who must deal with multiple systems when establishing their recovery and dealing with the consequences of their use. This project enabled the beginning of broad-based discussion and education that is valuable and should continue. Case Managers and Counselors provided education when able, and taught clients to advocate for themselves as well.

Northwest Alternatives (NWA)

Work with the patients who have trust issues on individual basis, explain safety rules and then accept them as who and where they are.

Spokane

The primary barriers to achieving positive outcomes tended to be primarily systems issues related to funding eligibility, capacity constraints, eligibility criteria for on-going services, and the precept that before a mental health disorder can be addressed, the chemical dependency issue needs to be addressed, or vice-versa. While many providers may indeed see the individual with co-occurring disorders as needing primary treatment for both disorders, funding streams often dictate who is eligible for what services and at what point in time.

Project staff sought to overcome these challenges though assertive advocacy on behalf of the consumer. An Advisory Team was established and met regularly to staff difficult

cases and help facilitate cross-systems brokerage of services and explore easier access pathways. Finally, Project staff quickly learned to navigate the county's various social service systems/agencies and forged effective working relationships with key representatives of the various agencies to expedite eligibility and access to services.

Stevens

There were no real barriers that made it difficult of achieve positive outcomes with the full support of Stevens County Counseling Services. If barriers were present in the early stages of the project they were overcome working together with Mental Health. The Agency places a high priority on clients' needs. If there were any barriers it would be the way the Gravely Disabled Grant funding could be used. In the original application for the Grant, Stevens County listed housing as a service we wished to provide. However, the Gravely Disabled funding could not be used for ADATSA clients with the exception of case management. Some limited housing was made available for those clients involved in both Mental Health and Chemical Dependency treatment. The Bridge Builders Program did place 3 co-occurring clients in Mental Health Transitional Housing.

Thurston

The original design of the project was to reach methamphetamine drug users that met the "gravely disabled" criteria. This initially proved to limit the project's ability to serve the appropriate number of individuals. As a result of this, the project case managers began to enroll more severe alcohol and heroin using individuals. This broadened the number of participants. As the project began to be recognized by the community and drug users, it started serving more and more methamphetamine gravely disabled individuals.

Appendix F: Lessons Learned

Clallam

The intensity of service and the severity of addiction and mental illness of the group required immense dedication to the purpose of the project. Having all the project participants in one group was exhausting to the staff over time but developed a cohesiveness between the participants that would not have occurred otherwise. Outside clinical consultation was helpful to the staff as well as the quarterly systems meetings.

Training, understanding and flexibility is critical for the chemical dependency and the mental health staff since they have differing orientations and approaches to care. Case management is a vital part of the program for assisting in the life domains outside of group.

Clark

That the most prominent substances used in this population were methamphetamines, heroin, and alcohol.

That most individuals in the program also exhibit signs suggesting organic damage interfering with thought process and control of impulse behavior. This may have occurred early in life, been related to past traumatic experiences, or may be directly related to PAS use. Onset is not the issue; dealing with it now is the issue.

A history of traumatic experiences either prior to or after the development of a PAS use disorder was noted with all of the clients. In some individuals the degree of current and/or past trauma seems to be interfering significantly with their current functioning.

Most of the individuals in this population also exhibit Axis ll traits (personality disorder criteria). What seemed to differentiate this population is that the particular traits or groups of traits seemed markedly resistant to change as well as more difficult to treat by staff. Staff working with this population need to have extensive training in mental health as well as PAS use treatment. Traits across all clusters (A, B, and C) of personality disorder diagnoses are represented.

The tendency of these clients to present quite well initially and at other times occasionally. However, the detrimental effect of "presenting quite well" at times is that others' expectations for their behavior may be based on these transient and temporary periods of higher functioning. Another complicating factor is the presence of criminal thinking in some of the clients. Although manipulating others may have a beneficial effect for some, it can also diminish empathy/help from others, as well as complicating the treatment and assessment process for the mental health professional/CDPs.

The presence of an Axis l disorder (i.e., depression, anxiety, bipolar, schizophrenia, etc.) results in a false positive diagnosis for a personality disorder.

Individuals with PAS use diagnoses have not developed the coping skills many of us take for granted. Developing these skills later in life (out of synch with age peers) is markedly more difficult.

Co-occurring disorders can be complicated to treat with the seriously and persistently mentally ill. One reason is the presence of a PAS use disorder complicates the treatment process when individuals begin to do the difficult work involved in lasting change, they become overwhelmed, tend to disengage from treatment, and return to the limited coping mechanisms— mainly the substance of choice. Another reason is that treating the psychiatric or psychological (mental health) disorder complicates the treatment of PAS use because symptomology can fluctuate so widely when PAS are on-board and interfering with prescribed medications.

One in ten individuals in the general population meet the criteria for a personality disorder.

Fifty percent (50%) of the general population exhibits at least one personality disorder trait (criteria) that interferes significantly in their lives.

Columbia

We learned a lot of lessons, which we will be applying if this program continues. For example, we will require that each case manager complete an ethics course, and if they are in recovery, that they be at least two years clean and sober. We also learned that the program we implemented for rule violations was essential, and our zero tolerance for rule violations kept the other clients accountable for their behaviors. We did have a case manager that did let some negative behaviors slide, and the other clients quickly picked up on this and used this to their advantage.

Other unique challenges were the health care needs of our clients. We found that almost every client who entered into this program was physically unhealthy. The costs for meeting these health care needs were at times quite high. We found that it was essential to apply for Basic Health immediately upon a clients admission into our program.

Snohomish

Evergreen Manor Inc. (EGM)

We found that these clients need a full array of services, not just chemical dependency treatment. They come to treatment needing basic support services, including medical care and economic assistance. The shortcoming of the Project turned out to be that as we became more familiar with this sub-population, we realized that it would require more than a change in treatment modality to accomplish positive outcomes. To the extent we

were able, we gave some of these clients housing in our new clean and sober house, where they received more intensive case management than is typically available through counseling alone. Many have attention deficits and physical debilitation and needed close support to simply make it through the day. Complex tasks were eased by the provision of case managers to help them follow through with eligibility instructions, making and meeting appointments with doctors, housing people, and others.

As counseling clients, they were extremely needy and took many more hours of the counselor's time than typical chemical dependency clients do. They become frantic in crises and need calming, and they have frequent crises. All of these crises represent opportunities for relapse that the counselor needed to address.

On the other hand, applying strategies from the Matrix model proved useful with this clientele. Shortening IOP groups from 3 to 2 hours was not only effective but seemed to increase motivation of the clients. They had less difficulty paying attention and felt more successful in treatment. Using many props and overheads helped them to focus when most counseling is highly verbal. Clients expressed so much satisfaction with this group that some of our other groups were adjusted to include some of the features of Matrix group.

This group was so successful that even with the loss of Gravely Disabled funding, we will continue this group for methamphetamine addicts. It meets the need of a population we serve in this county as well as improves outcomes with hard-to-treat clients. We consider this Project a resounding success and are grateful for the opportunity to have been a part of this pilot.

Northwest Alternatives (NWA)

Although these folks often times have mental health and/or severe issues in their lives they need to be treated with respect. Regardless of the problems that they are facing, they still are people that are struggling with chemical dependency issues and deserve patience and respect. As an agency we learned that the MATRIX model of treatment provided more opportunities for continued patient participation and is effective for other populations of late stage chemically dependent people and not isolated to those recovering from methamphetamine dependence.

Spokane

Finding dual-qualified and experienced staff to work with this high-risk and difficult population is extremely challenging.

Working with this population requires professionals to be creative and to think outside of the traditional boxes as to how to intervene and treat individuals. For many of these consumers, abstinence may not be an immediate goal. Consideration of Harm Reduction strategies should be explored for evidence based service delivery models for possible incorporation into chemical dependency and mental health systems.

Most traditional Chemical Dependency programs presume, by design, that consumers who enter treatment are "ready" for treatment. This population seems to respond extremely well to a welcoming attitude and interventions that clinically match the consumer's stage of change/readiness. While data may support the notion that "coerced" treatment is just as effective as non-coerced treatment, it stands to reason that a welcoming, inviting, non-judgmental and humane approach to treatment would be more beneficial. The end result – sobriety – may be the same, but the consumer's attitude about the experience will certainly vary according to their perception as to *how* they were treated.

Finally, patience is prerequisite to success with this population. People who are gravely disabled require more time to work through the various stages of change. They require more time to grasp and process those matters that need good cognition, and they need extra time spent in practicing new skills. They need intensive case management that involves more than brokering services from behind a desk or over the phone. They need help advocating for themselves. They need to be allowed to make mistakes and they need to be treated as something more than just their diagnosis.

Clinical preparation should include broader case management training beyond the cursory training now provided that barely exceeds clinical file documentation.

As noted at the beginning of this report, Project outcomes are still being evaluated. In addition, when DASA releases post-services outcome data, we will have a better understanding of this Project's effectiveness. We believe the core components of Harm Reduction and Motivation Enhancement should be given strong consideration into systems change as related to treatment retention and completion improvement.

Stevens

The Clients selected to participate in the Gravely Disabled Project at Stevens County Counseling Services did present some unique challenges. It made the Agency address Co-occurring Treatment in a new light. The No Wrong Door policy enable support of the Bridge Builders Program to reach, engage, and support individuals that would have otherwise continued to live a life style that was dangerous to themselves and the community. Providing services despite funding or organizational ideology is stressful, but well worth the effort. The Gravely Disabled Grant has made a big impact on the lives of the participants, and was well worth the effort.

Thurston

It's extremely important to build relationships with the community (eg: law enforcement, hospital ED, local jail staff). It has proven successful to be visible as a community resource. This has increased access to other community resources for these clients. Many opportunities became available when clients presented themselves with a case manager. For example, when a participant would apply for a publicly funded housing

project with a project case manager, it was more likely that the individual would gain access to that service.

We also learned that it is important to build a rapport and gather as much information as soon as possible about the project participants. This population tends to wander away from help initially. This is why individualized case management is so crucial for this population.

Anecdotally, the county has learned from many CD providers and others that having these services available has been extremely beneficial to clients, CD providers and first responders.

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