

**Commonwealth of Pennsylvania  
Department of Health**



**BUREAU OF DRUG AND ALCOHOL PROGRAMS**

**DRUG AND ALCOHOL  
PROGRAM REPORTS**

**PART 1**

- **OVERVIEW**
- **ANNUAL REPORT FOR FISCAL YEAR 2008 - 2009**
- **PROGRESS REPORT FOR 2009 - 2010**
- **THE PENNSYLVANIA STATE PLAN FOR THE CONTROL, PREVENTION, INTERVENTION, TREATMENT, REHABILITATION, RESEARCH, EDUCATION AND TRAINING ASPECTS OF DRUG AND ALCOHOL ABUSE AND DEPENDENCE PROBLEMS FOR STATE FISCAL YEAR 2010 - 2011**
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- **PREVENTION / TREATMENT DATA AND FINANCIAL INFORMATION**

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# **PART 1**

## **CHAPTER ONE: OVERVIEW**

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## **CHAPTER THREE: WOMEN AND CHILDREN'S ANNUAL REPORT 2008-09**

# **CHAPTER ONE: OVERVIEW**

## **BUREAU OF DRUG AND ALCOHOL PROGRAMS DEPARTMENT OF HEALTH**

In 1972, the General Assembly established a health, education and rehabilitation program for the prevention and treatment of drug and alcohol abuse through the enactment of the Pennsylvania Drug and Alcohol Abuse Control Act, Act 1972-63, as amended, 71 P.S. §1690.101 et seq. This law established the Governor's Council on Drug and Alcohol Abuse, which was to be chaired by the Governor. The Council was subsequently reorganized through Reorganization Plan 1981-4, which transferred its responsibilities and its administrative authorities to the Department of Health (Department). The Council was designated as the advisory body to the Department on issues surrounding drug and alcohol programs. Act 1985-119 amended Act 1972-63, changing the name of the Council to the Pennsylvania Advisory Council on Drug and Alcohol Abuse and designating the Secretary of Health, or his designee, as the chairperson. Since the Council's inception, the provision of publicly funded drug and alcohol treatment and prevention services has had a strong community orientation through a system of Single County Authorities (SCAs).

The Pennsylvania Drug and Alcohol Abuse Control Act requires the Department to develop a State Plan for the control, prevention, intervention, treatment, rehabilitation, research, education and training aspects of drug and alcohol abuse and dependence problems. This plan shall include, but not be limited to, provisions for the:

- Coordination of the efforts of all State agencies in the control, prevention, intervention, treatment, rehabilitation, research, education and training aspects of drug and alcohol abuse and dependence problems so as to avoid duplications and inconsistencies in the efforts of the agencies;
- Coordination of all health and habilitation efforts to deal with the problem of substance abuse, including, but not limited to, those relating to vocational rehabilitation, manpower development and training, senior citizens, law enforcement assistance, parole and probation systems, jails and prisons, health research facilities, mental retardation facilities and community mental health centers, juvenile delinquency, health professions, educational assistance, hospital and medical facilities, social security, community health services, education professions development, higher education, commonwealth employees health benefits, economic opportunity, elementary and secondary education, highway safety and the civil service laws;
- Encouragement of the formation of local agencies (now called SCAs) and local coordinating councils, as well as promotion of cooperation and coordination among such groups, and the encouragement of communication of ideas and recommendations from such groups to the Department;

- Development of model drug and alcohol abuse and dependence control plans at the local level, utilizing the concepts incorporated in the State plan. The plans shall be reviewed on a periodic basis, but not less than once per year, and reviewed to keep them current;
- Assistance and consultation to local governments, public and private agencies, institutions, organizations and individuals with respect to the prevention and treatment of drug and alcohol abuse and dependence;
- Cooperation of organized medicine to disseminate medical guidelines for the use of drug and controlled substances in medical practice;
- Coordination of research, scientific investigations, experiments and studies relating to the cause, epidemiology, sociological aspects, toxicology, pharmacology, chemistry, effects on health, dangers to public health, prevention, diagnosis and treatment of drug and alcohol abuse and dependence;
- Investigation of methods for the more precise detection and determination of alcohol and controlled substances in urine and blood samples, and by other means, and publication on a current basis of uniform methodology for such detections;
- Establishment of training programs for professional and non-professional personnel with respect to drug and alcohol substance abuse and dependency;
- Development of a model curriculum, including the provision of relevant data and other information, for utilization by elementary and secondary schools for instructing children, parent-teacher associations, adult education centers and private citizen groups about drug and alcohol substance abuse and dependency;
- Preparation of a broad variety of educational, prevention and intervention material for use in all media, to reach all segments of the population, that can be utilized by public and private agencies, institutions and organizations in programs with respect to alcohol and drug abuse and dependence;
- Establishment of educational courses on the causes and effects of, and treatment of, drug and alcohol abuse and dependence for personnel who come into contact with drug and alcohol abuse and dependence problems;
- Recruitment, training, organization and employment of professional and other persons, including recovering drug and alcohol abusers and dependent persons, to organize and participate in programs of public education;
- Treatment and rehabilitation services for male and female juveniles and adults who are charged with, convicted of or serving a criminal sentence for any criminal offenses under the commonwealth. Provision of similar services shall be made for juveniles adjudged to be delinquent, dependent or neglected;

- Grants and contracts from the appropriate State department or agency for the prevention, intervention and treatment of drug and alcohol dependence. The grants and contracts may include assistance to local governments and public and private agencies, institutions and organizations for prevention, intervention, treatment, rehabilitation, research, education and training aspects of the drug and alcohol abuse and dependence problems within the commonwealth. Any grant made or contract entered into by a department or agency shall be pursuant to the functions allocated to that department or agency by the State Plan;
- Preparation of general regulations for, and operation of, programs supported with assistance under this Act;
- Establishment of priorities for deciding allocation of the funds under this Act;
- Review of the administration and operation of programs under this Act, including the effectiveness of such programs in meeting the purposes for which they are established and operated, and the preparation of annual reports of its finding;
- Evaluation of programs and projects carried out under this Act and dissemination of the results of such evaluations; and,
- Establishment of such advisory committees as the Department may deem necessary to assist the Department in fulfilling its responsibilities under this Act.

The following goals are necessary to fulfill the Department's mission in developing a State Plan for the control, prevention, intervention, treatment, rehabilitation, research, education and training aspects of drug and alcohol abuse and dependence problems:

- Facilitate the recovery of drug and alcohol dependent persons;
- Decrease the probability of drug and alcohol experimenters from becoming dependent;
- Assist this and future generations in avoiding drug and alcohol abuse or dependence;
- Assist society in becoming fully informed about drug and alcohol abuse and dependence; and,
- Develop open lines of communication between the Department, community agencies and its service providers.

The Department shall provide the following services:

- Be responsible for the efficient performance of duties and responsibilities as prescribed in Act 63 and the Reorganization Plan No. 4 of 1981;
- Function as the Single State Agency for the acquisition and disposition of federal and state drug and alcohol funds;

- Assure the development, coordination and adoption of a State Plan for the control, prevention, intervention, treatment, rehabilitation, research, education and training aspects of drug and alcohol abuse and dependence problems;
- Serve as the policy making body that directs operations pertaining to the implementation of the State Plan;
- Review and adopt regulations for the operation of community agencies and coordinating councils under Act 63 and the Reorganization Plan No. 4 of 1981;
- Encourage the formation of community agencies and coordinating councils in an effort to promote local cooperation and communication;
- Determine policy and coordinate and evaluate the efforts of community agencies in the commonwealth;
- Establish funding priorities for SCAs; and,
- Approve grants and contracts.

The Department is also responsible for the licensing of freestanding drug and alcohol abuse treatment facilities. These responsibilities are carried out under the power and duties contained in Articles IX and X of the Public Welfare Code (62 P.S. § 901-922, 1001-1059), as transferred to the Department by Reorganization Plans 1977-2 (71 P.S. § 751-25) and 1981-4 (71 P.S. § 751-31). Standards for licensing freestanding treatment facilities are provided in 28 Pa. Code Chapter 709.

Drug and alcohol abuse treatment activities that are a part of a health care facility are also subject to the licensure requirements for a health care facility under 28 Pa. Code Part IV. The health care facility receives a license under the Health Care Facility Act, 35 P.S. §448.101 *et seq.* and covers those drug and alcohol activities which are part of a health care facility. The Department also issues a certificate of compliance to the drug and alcohol abuse treatment component within the health care facility that certifies that program areas meet the minimum standards germane to drug and alcohol abuse treatment under the Pennsylvania Drug and Alcohol Abuse Control Act. (See 28 Pa. Code § 711.2(b)).

In addition to enabling legislation and operating regulations, a provision of the federal Public Health Service Act, 42 U.S.C. § 300x *et seq.*, places additional requirements on how drug treatment abuse and prevention funds are used. This statute authorizes use of the Substance Abuse Prevention and Treatment Block Grant. The Department is designated as the Single State Agency to plan and allocate the Block Grant in combination with the state appropriation to Single County Authorities' (SCAs) and other community-based programs, based upon population, competitive awards and other factors. SCAs serve as local administrative entities for a catchment area that includes one or more Counties. Currently, there are 49 SCAs serving the 67 counties in the commonwealth. It is the SCAs' responsibility to determine the needs of their catchment area and engage providers to deliver the appropriate services. In some cases, the Department may directly engage a provider for specific services or services with a statewide impact.

While the Department has regulatory responsibility through its licensure authority over both public and private drug and alcohol abuse treatment facilities, its primary purpose is to develop a drug and alcohol abuse treatment system that is responsive to the needs of public clients. The system that has been developed encompasses a continuum of services from primary prevention through treatment aftercare. The Department's Bureau of Drug and Alcohol Programs (BDAP) requires the SCAs to implement case management services to ensure proper placement within the continuum. BDAP is also moving the SCAs towards greater accountability by instituting outcome measures to ascertain the effectiveness of services.

BDAP allocates funds to the SCAs through two mechanisms, one of which involves funding based on county population data provided "across the board" to the SCAs. This method constitutes the majority of state and federal funds allotted to the counties. The second mechanism employs the request for applications (RFAs), whereby BDAP determines if critical populations (e.g., addicted women) or important services (e.g., case management) need statewide coverage, direction and program or policy determination. BDAP issues the request, which contains specific guidelines, and selects agencies that are best able to develop and implement the programs. These agencies then receive grants to provide these services. The funding provided by BDAP to support the system, both federal and state dollars, is considered to be funding of last resort.

#### Statement of Policy

Pursuant to Section 1690.104 (71 P.S. §§1690.101-1690.115) Departmental Powers and Responsibilities, the Department of Health (Department) is responsible for the development of a State Plan. Per §§1690.104(a)(3), (a)(5), (a)(15) and (a)(17), the Department reserves the right to coordinate the agencies or organizations for the planning and administration of community-based services. The Bureau of Drug and Alcohol Programs (BDAP) is the entity designated by the Department to fulfill these responsibilities and functions as the Single State Agency (SSA) for federal funds and planning.

It is BDAP's position that no central authority can determine precisely what services are necessary in each of the 67 counties of this commonwealth. Therefore, a statewide system of Single County Authorities (SCAs) has the responsibility of assisting BDAP in planning for community-based drug and alcohol services, to include: assessing needs; managing and allocating resources; and evaluating the effectiveness of prevention, intervention, treatment and case management services.

## **CHAPTER TWO**

**ANNUAL REPORT  
FOR THE PERIOD  
STATE FISCAL YEAR 2008/2009**

**PROGRESS REPORT  
STATE FISCAL YEAR 2009/2010**

**THE PENNSYLVANIA STATE PLAN  
FOR THE  
CONTROL, PREVENTION, INTERVENTION,  
TREATMENT, REHABILITATION, RESEARCH,  
EDUCATION AND TRAINING ASPECTS OF  
DRUG AND ALCOHOL ABUSE  
AND DEPENDENCE PROBLEMS  
(as required by Act 63 – 1972)**

**STATE FISCAL YEAR 2010/2011**

## **BUREAU OF DRUG AND ALCOHOL PROGRAMS**

### **BACKGROUND**

The Department of Health's (Department) Bureau of Drug and Alcohol Programs (BDAP) has the primary role of developing a plan for the provision of drug and alcohol services in the Commonwealth of Pennsylvania. As part of that role, BDAP has two primary responsibilities, one of which is to allocate federal and state funds to local communities to support substance abuse prevention, intervention, treatment and treatment-related programming. BDAP utilizes Single County Authorities (SCAs) to determine the needs of local catchment areas and to utilize allocated funds to contract with service providers for the delivery of services.

A second responsibility is to maintain oversight of its drug and alcohol system through the monitoring of SCAs and to develop new prevention, intervention and/or treatment programs or adapt existing ones to enhance the current service delivery system. This often requires sensitivity to the needs of a particular geographic region or particular subpopulations. This section describes BDAP's major goals and objectives, as a Bureau, and, more specifically, within each Division/Section within the Bureau. Each section describes the responsibilities of the Bureau/Division/Section and outlines the goals and objectives in a past, present and future format. The past is represented by the Annual Report for FY 2008-09; the present consists of the progress occurring for FY 2009-10 and the future is represented by the State Plan for FY 2010-11.

## PREVENTION

The Bureau of Drug and Alcohol Programs (BDAP), Division of Prevention (Division), has the primary responsibility to provide for the development, oversight and management of substance abuse prevention services throughout Pennsylvania. The Division of Prevention strives to increase the implementation of prevention programs, age-appropriate strategies, policies and practices that are outcome-based on research proving effectiveness and/or best practices within the substance abuse field. The system oversight, management of data and the evaluation of services is supported by the nationally recognized Performance-Based Prevention System (PBPS) software. The major focus is to reduce risk factors associated with substance use and promote the development of healthy lifestyles that positively impact individuals across their lifespan, communities, families and schools.

BDAP funds these efforts through grant agreements with Single County Authorities (SCAs) throughout the commonwealth. SCAs are required to utilize all six Federal Strategies and the Institute of Medicine (IOM) Prevention Classifications within the Strategic Prevention Framework model to ensure the delivery of single and recurring prevention services. All SCA funded prevention services must be outlined in the SCA's County Comprehensive Strategic Plan, including the funding sources used to support the program services. All SCA funded prevention services must be reported in PBPS regardless of the funding source. Those funding or delivering drug and alcohol prevention services shall work with their local SCA to assure that their prevention activities fit the local strategic plan. All data collected on these services will be reported to the local SCA and BDAP. The data reported must incorporate the data elements collected in the PBPS.

### SIX FEDERAL STRATEGIES

The six (6) Federal Strategies, comprised of the overall concept of services that prevent or reduce the use and abuse of alcohol, tobacco and other drugs, are defined as:

- Information Dissemination – provides awareness and knowledge on the nature and extent of alcohol, tobacco and drug use, abuse and addiction and the effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.
- Education – involves two-way communication, which is distinguished from the Information Dissemination category, by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this category are to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages) and systematic judgment abilities.
- Alternative Activities – operates under the premise that healthy activities will deter participants from the use of alcohol, tobacco and other drugs (ATOD). The premise is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by ATOD, and would, therefore, minimize or eliminate use of ATOD. These

activities must be directly linked to an educational or skill-building activity.

- Problem Identification and Referral – targets those persons who have experienced first use of illicit/age-inappropriate use of tobacco and those individuals who have indulged in the first use of illicit drugs and alcohol. This helps to assess if the behavior of such individuals can be reversed through education.
- Community-Based Process – aims directly at building community capacity to enhance the ability of communities to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities include organizing, planning, enhancing efficiency and effectiveness of services, inter-agency collaboration, coalition building and networking.
- Environmental – establishes or changes written and unwritten community standards, codes, ordinances and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the population. This category is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those that relate to action-oriented initiatives.

### **Institute of Medicine (IOM) Prevention Classifications**

Defined below are the three (3) IOM Prevention Classifications that can contain the six (6) major federal strategies. Included are examples of activities that comprise the overall concept of services that prevent or reduce the use and abuse of ATOD:

- Universal Preventive Interventions - activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
- Selective Preventive Interventions - activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated Preventive Interventions - activities targeted to individuals in high-risk environments identified as having minimal but detectable signs or symptoms foreshadowing a disorder or having biological markers indicating predisposition for a disorder, but not yet meeting diagnostic levels.

### **Strategic Prevention Framework Model**

SCAs and those funding or delivering drug and alcohol prevention services must ensure that all five steps of the Strategic Prevention Framework (SPF) are adhered to in the implementation of performance-based prevention: Needs Assessment, Capacity, Planning, Implementation and Evaluation. Cultural capacity and sustainability must also be considered throughout all five (5) steps of the SPF model.

- Needs Assessment - The needs assessment is designed to profile population needs, resources and readiness to address needs and gaps. The process involves the collection and analysis of data to define problems within a geographic area. Assessing resources includes

identifying service gaps, assessing cultural competence and identifying the existing prevention infrastructure in the county and/or community. It also involves assessing readiness and leadership to implement programs, strategies, policies and practices.

The SCAs, as well as those funding or delivering drug and alcohol prevention services, must use a data driven decision-making process to determine which risk and protective factors will be utilized to create a “Comprehensive Strategic Plan.” Structured and relevant programs, strategies, policies and practices are essential to successfully reduce risk and enhance protective factors in specific targeted populations and geographic areas. The Needs Assessment must be the process utilized to identify risk and protective factors.

- Capacity - The SCA and those funding or delivering drug and alcohol prevention services must increase efforts to mobilize and/or build capacity to address needs. Building capacity involves the mobilization of resources within a community. A key aspect of capacity building is convening key stakeholders, coalitions and service providers to plan and implement sustainable prevention efforts during the planning and implementation phase. The mobilization of resources includes financial and organizational resources, as well as the creation of partnerships. Readiness, cultural competence and leadership capacity are addressed and strengthened through education and systems thinking. Additionally, capacity building should include a focus on sustainability, as well as an evaluation of capacity.
- Planning - Planning involves the creation and development of a plan that includes implementing programs, strategies, policies and practices that create a logical, data-driven plan that reduces the risk factors and enhances the protective factors that contribute to substance abuse in a specific county/community. The planning process produces strategic county-wide and community targeted goals, as well as logic models and preliminary action plans. In addition, it also involves the identification and selection of evidence-based strategies that include changes in programs, strategies, policies, and practices that will reduce substance abuse. Even though one community may show similar alcohol-related issues, the underlying factors that contribute most to them will vary between communities. If the programs, strategies, policies and practices do not address the underlying risk and protective factors that contribute to the problem, then the intervention is unlikely to be effective in changing the substance abuse problem or behavior.
- Implementation – SCAs and those funding or delivering drug and alcohol prevention services are required to implement and provide ongoing monitoring of their Comprehensive Strategic Plan. This includes, but is not limited to, the collection of process measure data, performance targets and the fidelity of implementation. Any modifications and changes that are made to the original programs must be documented throughout the implementation of the program, utilizing the developer’s program fidelity/adaptation instrument and reported in the SCA’s Annual Outcome Evaluation Report. This is to understand whether or not expected outcomes have been attained as a result of adaptations made to programs.
- Evaluation – The SCAs must evaluate their Comprehensive Strategic Plan. The SCAs must measure the impact of the implemented programs, strategies, policies, practices and identify areas for improvement.

## Current Initiatives

- Strategic Prevention Framework State Incentive Grants (SPF-SIG)
  - Reducing alcohol use and related problems among persons 11 through 21 years of age
  - Seventeen grants awarded to Single County Authorities (SCAs)
- Performance-Based Prevention: Strategic Prevention Framework
  - Assessment
  - Capacity Assessment and Building
  - Planning
  - Implementation
  - Evaluation
- Student Assistance Programs
- Underage Drinking Projects
  - Town Hall Meetings
  - “Getting Back Alive” Tutorial Project
  - FullApologies.com Web initiative
  - Underage Drinking Forums
- Drinking and Driving
- Prescription Drugs and Deaths from Overdose
- Coordination with the Pennsylvania National Guard Counterdrug Program

## Programs and Strategies

BDAP encourages SCAs and prevention providers throughout the commonwealth to utilize Evidence-based and State Approved Effective Programs as a part of their comprehensive approach within their counties. Each SCA is required to deliver at least 25 percent of services through a combination of Evidence-based and State Approved Effective Programs.

Using a combination of Evidence-based and State Approved Effective Programs, along with the administering of State Approved Effective Strategies based on local community needs, has proven to be a highly successful and effective way of reducing risk factors associated with substance use/abuse. SCAs plan and deliver program services by considering and addressing underage drinking risk and protective factors, youth attitudes towards use, youth-perceived risk attitudes concerning consumption and by tracking social indicator data.

Evidence-based, State Approved Effective Programs, and State Approved Effective Strategies are defined as follows:

Evidence-based Programs include strategies, activities, approaches and programs which are:

- Shown through research and evaluation to be effective in the prevention and/or delay of substance use/abuse.
- Grounded in a clear theoretical foundation and have been carefully implemented.
- Reviewed by other researchers to ensure that proper evaluation findings exist.
- Replicated and produced desired results in a variety of settings.

State Approved Effective Programs meet the following criteria:

- Program/principle has been identified or recognized publicly, and has received awards, honors or mentions.
- Program/principle has appeared in a non-referenced professional publication or journal  
Note: It is important to distinguish between citations found in professional publications and those found in journals.
- BDAP will consider programs that were purchased from a developer to be Innovative Programs (e.g., Babes, Project Meds, Parent-to-Parent, etc.).

State Approved Effective Strategies are defined as programs which:

- Capture activities that are not otherwise specified as an evidence-based or innovative program.
- Provide basic ATOD awareness/education, as well as everyday alternative prevention activities.

Each of the three program categories listed above must be delivered through single services and/or recurring services types and be recorded as such in the data base. SCAs are required to provide 20 percent of services through recurring events. Single and Recurring Services are defined as follows:

- Single Service Type – Single prevention services are one-time activities intended to inform general and specific populations about substance use or abuse (examples: Health Fairs, Speaking Engagements).
- Recurring Service Type – Recurring prevention services are a pre-planned series of structured program lessons and/or activities. These types of services are intended to inform, educate, develop skills and identify/refer individuals who may be at risk for substance use or abuse. A recurring prevention activity needs to have an anticipated measurable outcome, to include, but not be limited to, Pre/Post Test (examples: Classroom Education, Peer Leadership Programs, Peer Mentoring, ATOD Free Activities Recurring).

There are approximately 41 evidence-based and 49 State Approved Effective Programs that are currently being delivered throughout the commonwealth that address drug use. Some of these programs include, but are not limited to:

- Project ALERT - a drug education program for middle-school students;
- Too Good For Drugs - a school-based prevention program designed to reduce the intention to use alcohol, tobacco and illegal drugs in middle and high school students;
- Students Against Destruction Decisions (SADD) – a student-run program for addressing substance abuse issue within local schools;
- The Reality Tour Program - a volunteer-based drug awareness program that is a dramatic, interactive walk in the life of a teen addicted to heroin;
- Families That Care - Guiding Good Choices - a program for parents;
- Communities Mobilizing for Change on Alcohol (CMCA) - a community-organizing program designed to reduce adolescent access to alcohol by changing community policies and practices; and,

- Student Assistance Program (SAP) – a mandatory intervention program provided within the school setting intended to identify and address problems negatively impacting student academic and social growth.

BDAP also collaborates with and supports several other state agencies and organization in their efforts to reduce substance use/abuse.

- PA DUI Association / Pennsylvanians Against Underage Drinking (PAUD)
- Pennsylvania Liquor Control Board (PLCB)
- Pennsylvania Commission on Crime and Delinquency (PCCD)
- Pennsylvania Department of Education
- Pennsylvania Department of Public Welfare
- Pennsylvania Department of Transportation
- Commonwealth Prevention Alliance (CPA)
- Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA)
- Pennsylvania Prevention Director’s Association (PPDA)
- Drug Free Pennsylvania
- Pennsylvania National Guard Counterdrug Program

## **ANNUAL REPORT FY 2008-09, PROGRESS REPORT FY 2009-10 AND STATE PLAN FY 2010-11**

**PRIORITY: To increase the statewide awareness and reduce the incidence of underage drinking, underage drinking and driving, and drinking and driving.**

### **ANNUAL REPORT FY 2008-09**

The Pennsylvania Interagency Coordinating Committee on the Prevention of Underage Drinking, led by the Deputy Secretary of Health for Health Promotion and Disease Prevention, discussed policies and program development across the commonwealth. This committee was to be responsible for the development of the STOP Act Annual Report which, to date, has not yet become a requirement from the U.S. Department of Health and Human Services.

BDAP continued to assist the Substance Abuse and Mental Health Services Administration (SAMHSA), in collaboration with the Federal Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), in supporting national initiatives on underage drinking. BDAP supported the Reach Out Now (RON) underage drinking prevention initiative in communities across the nation. The Center for Substance Abuse Prevention (CSAP) collaborated with Scholastic Inc. to develop and disseminate effective school-based underage alcohol use prevention materials to participating fifth- and sixth-grade classrooms across the nation in March. In addition, CSAP supported and encouraged community-based organizations to collaborate with schools in conducting Reach Out Now Teach-Ins. Each organization was responsible for inviting prominent community leaders, such as mayors and local celebrities, to deliver classroom presentations. They also conducted media outreach, thereby increasing community awareness of the underage drinking issue. Teach-In leaders used a specially designed lesson plan that was interactive and engaging.

BDAP encouraged all Single County Authorities and community-based organizations who conducted 2008 Town Hall Meetings to participate in SAMHSA's Reach Out Now Campaign in 2009, which many did. The tracking of those Teach-Ins were maintained in BDAP's online Performance-based Prevention System (PBPS).

BDAP partnered with other state agencies to address underage drinking related issues, including collaborating with the Pennsylvania Commission on Crime and Delinquency in order to incorporate new alcohol-related questions into the 2009 Pennsylvania Youth Survey.

BDAP partnered with the Pennsylvania Departments of Transportation, and Education, the Governor's Office, Drug Free Pennsylvania and the Pennsylvania Liquor Control Board in an effort to stop teens from drinking and driving and decrease the amount of fatalities/incidences amongst teens 14-17 years old. A campaign was implemented that included TV ads and a new Web site, [www.FullApologies.com](http://www.FullApologies.com). A secondary goal of this Web site was to educate teens about alternative plans of action after they have consumed alcohol -- contrary to them getting behind the wheel of a car.

Another project implemented by this collaborative effort was a school-based prevention initiative

entitled “Getting Back Alive.” The focus of this program is to educate teenagers on the dangerous consequences of drinking and driving or riding with someone that has been drinking. The three main goals of the program are to 1) inspire/motivate students to think about making a plan for not drinking and driving, 2) plan to call for a safe way home if they are out drinking and 3) to be less likely (following the program) to ride with someone who has been drinking. The program targets students in grades 9-11 and is presented in the form of open discussion, a DVD of drunk driving TV spots and personal testimonies of victims of drunk driving. Teachers, other school faculty and volunteers were trained to implement the program. The program is delivered through Health, Physical Education, English and Drivers Training classes. The program was piloted in 20 high schools across the commonwealth and delivered to 2,152 students in 2008.

The Strategic Prevention Framework State Incentive Grant (SPF SIG) is a five-year grant from the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Substance Abuse Prevention (CSAP). BDAP was awarded this \$10,465,000 grant in October 2006. The purpose of SPF SIG is to enable qualified applicants to design and implement accessible, efficient and integrated alcohol prevention services throughout the commonwealth. As required by SAMHSA/CSAP, the Pennsylvania State Epidemiological Outcomes Workgroup (SEOW) examined data on alcohol, tobacco and other illicit drug (ATOD) consumption and its consequences and compiled “The Pennsylvania State Epidemiological Profile.” The priorities chosen by the PA SEOW and the SPF SIG Advisory Council for the purposes of the SPF SIG grantees are:

**Focus:** Reducing alcohol use and related problems among persons 11 through 21 years of age:

- To prevent (reduce) the early initiation and regular use of alcohol in middle and high school
- To prevent (reduce) drinking and driving among persons ages 16 through 21
- To reduce the illegal use and misuse of alcohol among persons ages 18 through 21

Planning Grantees (high need and low capacity) began one year of planning in July 2008 and submitted their strategic plan in June 2009. Implementation Grantees (high need and high capacity) developed and submitted their strategic plan in December 2008 and began implementing programs. The seven Planning SCA Grantees are Crawford, Erie, Green, Huntingdon/Mifflin/Juniata, Lackawanna, Mercer and Schuylkill. The ten Implementation Grantees are Armstrong-Indiana, Bedford, Berks, Bucks, Chester, Delaware, Lancaster, Montgomery, Washington and Westmoreland. There are 13 SCAs addressing priority #1 - to prevent (reduce) the early initiation and regular use of alcohol in middle and high school; four SCAs addressing priority #2 - to prevent (reduce) drinking and driving among persons ages 16 through 21; and four SCAs addressing priority #3 - to reduce the illegal use and misuse of alcohol among persons ages 18 through 21. Several SCAs are addressing multiple priorities.

BDAP partners with the Multi Agency Safety Team (MAST) which is coordinated by the Pennsylvania Department of Transportation (Penn DOT). The MAST has developed “The Drive Safe PA Strategic Highway Safety Plan” (SHSP), which is currently in final review. The document includes the Executive Summary; Vision, Mission, and Goal; Vital Seven Safety Focus Areas; Additional Safety Focus Areas; Implementation Process; Glossary of Acronyms and Abbreviations; and Contact Information. In addition to the SHSP data, the MAST members analyze and review Fatality Trends and Current Year Projection and data reports from other

agencies such as, but not limited to, Penn DOT – Highway Safety and Safety Administration, the Pennsylvania State Police and the Department of Health.

## **PROGRESS REPORT FY 2009-10**

BDAP continues to partner with multiple agencies regarding the “Getting Back Alive” Program, which focuses on educating teenagers in grades 9-12 on the dangerous consequences of drinking and driving or riding with someone that has been drinking. The material was updated and the program is to be expanded to 270 schools throughout the commonwealth in the spring of 2010. Various agencies have been gathering data and the partner agencies have analyzed the data to determine which schools in the commonwealth have the highest need, as demonstrated by DUI underage drinking crash data. BDAP has been meeting with partner agencies to determine which school districts will receive the “Getting Back Alive” Program this school year. Approximately one-half of all high schools in the commonwealth will have received the “Getting Back Alive” program once it has been expanded to include the additional 270 schools.

In addition, the SPF SIG underage drinking priorities give the 17 grantees, the opportunity to address underage drinking through a variety of evidence-based programs and environmental programs and strategies. The grantees have developed community plans which outline:

- The data-driven processes from which priority risk factors for the chosen priority emerged;
- The activities involved in mobilizing and building the capacity of the grantee and the community;
- The planning process through which specific evidence-based intervention strategies were identified that the grantee will use to address priorities, including a logic model; and,
- A work plan for implementing selected strategies, including how the grantee will conduct SPF efforts in both a sustainable and culturally competent manner.

BDAP expects the Strategic Plan to provide the foundation for ongoing work that grantees will engage in over the next few years.

The SPF SIG Advisory Council and the State Epidemiological Outcomes Workgroup are scheduled to meet quarterly to guide the efforts of the SPF SIG. Through these efforts, the Advisory Council continues to be responsible for providing direct feedback to BDAP regarding the development of specific program deliverables/products from the perspective of state policy development, community/county interests, culture competency and individual/organizational experience and expertise.

BDAP continues to participate in the statewide Multi Agency Safety Team (MAST), which is tasked with the development and implementation of the Comprehensive Strategic Highway Safety Improvement Plan (CSHSIP). In addition to other highway safety issues, this group focuses on underage drinking and driving.

BDAP staff are members of the committee which plans the Annual Community Forum Against Underage Drinking, sponsored by the Center for Traffic Safety in York, PA. The annual event is a community-based program aimed at increasing student awareness to the risks and consequences of underage drinking and other destructive decisions. The forum aims to empower all participants in

the three counties served by the Lincoln Intermediate Unit #12 (York, Adams, Franklin) to take an active role in underage drinking education and prevention. Approximately 400 identified students will participate in the event in March 2010.

## **STATE PLAN FY 2010 -11**

The 17 SPF SIG grantees will continue implementing evidence-based programs and environmental programs and strategies which focus on reducing alcohol use and related problems among persons 11 through 21 years of age. Grantees are required to meet quarterly with their Community Level Planning Council to be inclusive of all key stakeholders in the targeted community. Each site will be responsible for collecting outcomes data to be entered into the Performance-Based Prevention System (PBPS) and the federal reporting system. Sites will also participate in local and statewide evaluation.

BDAP will continue to collaborate with the Northeast Center for the Application of Prevention Technologies for technical assistance to the SPF SIG project at the state level and to the grantees.

BDAP will continue to collaborate with various agencies and organizations to address underage drinking and underage drinking and driving related issues.

BDAP will continue to work in partnership with Drug Free Pennsylvania, the Department of Transportation and Education, the Governor's Office, the Pennsylvania Liquor Control Board and Battelle to expand the school-based prevention program, "Getting Back Alive," to students in grades 9-12 which focuses on educating teenagers on the dangerous consequences of drinking and driving or riding with someone that has been drinking.

BDAP will continue to participate in the statewide Multi Agency Safety Team (MAST) which is tasked with the development and implementation of the Comprehensive Strategic Highway Safety Improvement Plan (CSHSIP). In addition to other highway safety issues, this group focuses on underage drinking and driving.

BDAP staff plan to continue participating in the planning and implementation of the Annual Community Forum Against Underage Drinking sponsored by the Center for Traffic Safety in York and the Annual Impaired Driving Initiative Campaign. The annual event is a collaborative community-based program aimed at increasing the awareness of students to the risks and consequences of underage drinking and other destructive decisions.

National Guard services will continue to be provided statewide as a result of a Memorandum of Understanding between the Department of Health and the Pennsylvania National Guard Drug Demand Reduction Division. The National Guard will continue to provide services to BDAP, SCAs and the local community, as well as expand services to reach more communities in 2010.

BDAP intends to continue working with SAMHSA, in collaboration with the Federal Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), to support national initiatives on underage drinking. BDAP will encourage the reoccurrence of the Underage Drinking Town Hall Meetings and/or the Reach Out Now (RON) underage drinking prevention initiative if they become national initiatives in 2010. These meetings will continue to bring together public

officials, parents and youth, community leaders and organizations in health, education, law enforcement, highway safety and alcohol control in order to learn more about the science and consequences of underage drinking and to discuss how their community can best prevent underage alcohol use by reducing demand, availability and access. The tracking of any meetings held will continue to be maintained using BDAP's online Performance-based Prevention System (PBPS).

In addition, BDAP will continue to encourage SCAs and those funding or delivering drug and alcohol prevention services to focus on social norms campaigns, town hall meetings and designated driver programs.

**PRIORITY: Improve prevention outcomes through data-driven management.**

## **ANNUAL REPORT FY 08-09**

The Pennsylvania State Epidemiological Outcomes Workgroup (SEOW) continued to meet quarterly to discuss Pennsylvania data. This workgroup developed the "Pennsylvania State Epidemiology Profile on Substance Use and Consequences" in the Spring of 2007. The Workgroup continually reassessed the data sets, service gaps, use-consequence data of substance use and recommended policy or service delivery changes to modulate substance use consumption and consequence patterns within the commonwealth. The profile included consumption patterns and related problems in the state as well as the identification of potential geographic target areas and populations. The information contained in the profile was also used to determine the alignment of state and local resources. In addition, the document assisted local planners to determine the magnitude of the substance abuse problem, as well as assess local capacity and readiness to respond to findings. BDAP, the Pennsylvania Department of Health-Bureau of Statistics and Penn State University worked with the Administrative Office of Pennsylvania Courts to gather data from the court system. This data will be utilized in the updated State Epidemiological Profile and will be utilized by those funding or delivering drug and alcohol prevention services across the commonwealth.

Although SAMHSA/CSAP does not require States to collect the National Outcomes Measures (NOMs) survey as part of the Substance Abuse Prevention and Treatment (SAPT) Block Grant, BDAP felt it was important for those receiving services funded by the SAPT Block Grant to respond to the survey questions. BDAP required SCAs and prevention providers to administer the Adult and Youth (ages 12-18) NOMs once to all single services that count attendees and all recurring service participants from October 1 through November 30 of each year. The convenience survey was to be administered once per attendee/participant. After administering the NOMs, SCAs were required to record the survey results into PBPS by January 31, 2009. During SFY 08/09, 10,993 youth 12-18 years of age took the NOMs survey during their participation in BDAP-funded prevention services. During the same time period 3,558 adults 18 and older completed the NOMs survey while participating in BDAP-funded prevention services.

### **SFY 2008/2009 Youth NOMs Survey Findings**

- 83.93 percent of youth reported no alcohol use in the past 30 days, an increase of 1.41 percent compared to SFY 07/08.

- 65.84 percent of youth report they have never used alcohol, an increase of 1.50 percent compared to SFY 07/08.
- 95.02 percent of youth reported that during the past 12 months they have not driven a vehicle while under the influence, a decrease of .33 percent compared to SFY 07/08.
- 41.42 percent of youth reported they would be more likely to work for an employer who randomly drug and alcohol tests his employees, an increase of 1.10 percent compared to SFY 07/08.
- 84.55 percent of youth reported they have never used marijuana, an increase of 1.18 percent compared to SFY 07/08.
- 91.56 percent of youth reported they have never used other illegal drugs, an increase of .21 percent compared to SFY 07/08.
- 17.34 percent of youth reported they first used alcohol between the ages of 12-14, a decrease of .87 percent compared to SFY 07/08.
- 43.55 percent of youth reported that people are at great risk of harming themselves physically and in other ways when they have five or more alcoholic beverages once or twice a week, an increase of .21 percent compared to SFY 07/08.
- 62.39 percent of youth strongly disapprove of someone their age trying marijuana or hashish once or twice, an increase of 2.69 percent compared to SFY 07/08.

### **SFY 2008/2009 Adult NOMs Survey Findings**

- 32.44 percent of the adults reported they took their first drink between the ages 15 and 17, a decrease of .41 percent compared to SFY 07/08.
- 50.50 percent of the adults reported they have never used marijuana, an increase of 8.39 percent compared to SFY 07/08.
- 33.63 percent of adults reported they would be more likely to work for an employer who random drug and alcohol tests on their employees, a decrease of 1.49 percent compared to SFY 07/08.
- 80.69 percent of adults reported that, during the past 12 months, they have not driven a vehicle while under the influence, an increase of 2.23 percent compared to SFY 07/08.
- 23.12 percent of adults reported that, during the past 12 months, they have spoken to their children many times about the dangers or problems associated with the use of tobacco, alcohol or other drugs an increase of 1.62 percent compared to SFY 07/08.
- 53.17 percent of adults reported that people are at great risk of harming themselves physically and in other ways when they smoke marijuana once or twice a week, an increase of 4.58 percent compared to SFY 07/08.

### **Needs Assessment**

As a part of the data review process, BDAP considered the possibility of combining the Prevention and Treatment Needs Assessment Process, which will include an assessment across the lifespan.

BDAP and the Pennsylvania Department of Health, Bureau of Statistics, worked together to develop the “Key Representative Survey” to be utilized with the Division of Prevention’s Needs Assessment process. The goal of this survey was to get information from key representatives in a given community. For the purposes of this survey, a key representative is a professional or volunteer person who has special knowledge and experience in a particular role in the community

that is somehow affected by substance abuse.

While BDAP stressed the importance of the correct use of the “Key Representative Survey,” a survey was also developed to survey the general population as well. The “Convenience Survey” is additionally available for targeting people who are attending certain events or meetings and/or participating in existing groups, health fairs, various meetings, school events, etc.

Those funding or delivering drug and alcohol prevention services were required to have anticipated measurable outcomes when providing recurring prevention activities, which include, but are not limited to, Pre/Post Tests and/or surveys.

## **PROGRESS REPORT FY 2009-10**

The Pennsylvania State Epidemiological Outcomes Workgroup (SEOW) continues to meet to discuss Pennsylvania data. The Workgroup is identifying new data sets and analyzing most recent data sets as they continue to revise the “Pennsylvania State Epidemiology Profile On Substance Use and Consequences.” The workgroup continually reassesses the data sets; discusses service gaps and use-consequence data of substance use; and recommends policy or service delivery changes to modulate substance use consumption and consequence patterns within the commonwealth. The revised document assists local planners to determine the magnitude of the substance abuse problem and to assess local capacity and readiness to respond to findings.

BDAP requires SCAs and prevention providers to administer the Adult and Youth (ages 12-18) NOMs once to all single services that count attendees and recurring service participants from October 1 through November 30, 2009. BDAP continues to encourage SCAs to analyze the NOMs surveys and to administer and enter pre/post tests for evidence-based programs into PBPS. The results of this data will not be available until the fourth quarter of SFY 09/10.

BDAP continues to enhance the PBPS data system by developing additional reports within the system, incorporating a method for capturing cost bands (costs which reflect dollars spent on the actual delivery of service/individual), which is to become a requirement by SAMHSA/CSAP. BDAP will also add functions to the existing planning module.

BDAP continues to work with the established Prevention Workgroup and the PBPS Data Workgroup to build upon data-driven management principles.

## **STATE PLAN FY 2010 -11**

SPF-SIG will continue to require the use of NOMS and SCAs awarded SPF SIG funding will be expected to turn in all NOMs-related data, including pre/post tests and six-month follow-up. Data will continue to play an important role in the SPF process, especially as the Implementation Grantees end the first year of prevention programming. By reviewing data from various programs, SCAs will be able to review both the process and outcome measures in order to make appropriate revisions where needed.

BDAP will make final decisions regarding combining the Prevention and Treatment Needs Assessment Process with input from the SCAs and prevention providers attending the

Performance-Based Prevention System Planning Meetings or various other workgroup meetings. The Prevention Needs Assessment is conducted every two years to serve as a basis for Single County Authority prevention planning efforts.

BDAP intends to hold meetings and trainings for the SPF SIG evaluators so that the evaluation process will run smoothly and the required federal, state, and local data can be collected.

BDAP will continue to require SCAs and prevention providers to administer the Adult and Youth (ages 12-18) NOMs once to all single services that count attendees and all recurring service participants from October 1 through November 30 of each year.

BDAP will continue to require SCAs to enter prevention service data into PBPS within two weeks of service delivery and will encourage SCAs to analyze services delivered at the local level to ensure that:

- The six federal strategies are utilized
- Twenty-five percent of program services are delivered through a combination of evidence-based and innovative programs
- Twenty percent of services are provided through recurring events
- Adult and Youth Prevention NOMs are collected at single and recurring services
- Prevention service data is entered into the Performance Based-Prevention System

BDAP plans to move the Performance-Based Prevention System (PBPS) to KIT Solutions during this fiscal year. The KIT service model embraces the concept that software is not a commodity that is built, but a service that constantly evolves. A primary benefit of using KIT to host, maintain and support the PBPS is being a member of the Learning Community. The Learning Community is made up of states that are using a tailored version of PBPS. The Learning Community meets face-to-face once a year prior to the National Prevention Network (NPN) annual conference and a few times a year in a virtual online meeting. The intent of the Learning Community is to share ideas and ways of applying and using the PBPS and data. Any new functionality developed by one member of the Learning Community can be integrated into all others at no additional development charges. Some of the benefits that KIT offers:

- SCAs and providers would be able to utilize Geographic Information System/Mapping of data and services delivered.
- SCAs and providers would capitalize on new technical advances as KIT currently holds several Federal contracts with SAMHSA, CSAP, and the Office of National Drug Control Policy.
- BDAP, SCAs and Providers would need less staff time devoted to technical matters.
- SCAs and providers would benefit from reduced down-time associated with system outages.
- SCAs and providers would benefit from reduced travel costs regarding training.
- SCAs and providers would find their data to be more accessible.
- BDAP Prevention staff would have more time to focus on prevention programming related to duties and not to technical support and testing issues that are currently plaguing PBPS.

**PRIORITY: Enhance the Pennsylvania prevention system capacity.**

**ANNUAL REPORT FY 2008-09**

BDAP participated in the Service to Science (STS) national initiative supported by SAMHSA/CSAP to enhance the evaluation capacity of innovative programs and practices that address critical substance abuse prevention or mental health needs within the commonwealth. STS consists of a combination of training events and customized technical assistance aimed at providing participants with technical assistance that will help programs evaluate their efforts with increasing levels of methodological rigor. Those recommended by BDAP for participation in the Service to Science were Coalition Pathways, Inc., Lead and Seed Environmental Approach in Erie and New Options in Norristown, Pennsylvania.

In order to assure the effectiveness of SPF SIG state and local efforts, a comprehensive cross-agency prevention plan was developed. The Strategic Prevention Framework (SPF) is intended to be a living process, whereby the state and communities build on what is already working, develop capacity where none exists and apply what is learned. The SPF SIG state plan will serve as the guiding document for substance abuse prevention stakeholders who are engaged in SPF SIG-funded programs, policies and practices.

**PROGRESS REPORT FY 09-10**

The Division is participating in the 2009-2010 Service to Science (STS) national initiative supported and spearheaded by SAMHSA/CSAP. This year, three (3) Pennsylvania innovative programs were recommended to participate in STS initiatives: Media Straight Up, the Just One Campaign and Getting Back Alive.

BDAP continues to enhance cross-agency prevention efforts through the SPF SIG and the Pennsylvania Interagency Coordinating Committee on the Prevention of Underage Drinking. BDAP also maintains its support of current cross-agency efforts by continuing to attend committee meetings such as, but not limited to, the Commonwealth Student Assistance Programs Interagency Committee, Center for Safe Schools Conference Planning Committee, New Options Steering Committee, State Juvenile Firesetters Prevention and Intervention Advisory Group, Suicide Prevention Monitoring Committee, Disproportionate Minority Contact Committee, Statewide Positive Behavior Support State Leadership Team, PA State Fetal Alcohol Spectrum Disorder Task Force, the Commonwealth Prevention Alliance, Pennsylvania Prevention Providers Association and the Pennsylvania National Guard.

The Division of Prevention plans to partner with the training section at BDAP to implement a training workgroup to address future training needs for prevention.

The 17 SPF SIG grantees attended a two-day Grantee training and technical assistance meeting in order to increase the capacity. The following topics were addressed at the training: assessing the consequence and consumption patterns, assessing risk and protective factors, assessing resources and readiness, building and mobilizing capacity, developing a plan of action plus hands-on exercises.

BDAP is also enhancing capacity across the commonwealth by participating in the Pennsylvania State System of Higher Education (PASSHE) Alcohol Grant Consortium. The three goals for the grant are:

- Enhance the existing State System Special Projects Committee on Alcohol to become a system-wide coalition inclusive of representatives of all 14 State System institutions, key internal and agency constituents
- Implement identified evidence-based programs at the participating PASSHE universities for the purpose of reducing underage alcohol use and binge drinking among first year students residing in campus residence halls
  - Implementation of Brief Alcohol Screening and Intervention of College Students (BASICS) on all of the participating campuses
  - Implementation of a system-wide social norms marketing campaign that is linked to specific student learning outcomes
- Identify what the Coalition considers additional priorities and activities to be undertaken based on the outcomes of strategic planning process.

The Division participates in the PA Drug and Alcohol (D&A) Coalition, whose purpose is to identify and build a coordinated system of care in Pennsylvania capable of collaboratively offering quality healthcare that addresses the needs and priorities of Pennsylvanians regarding substance use and co-occurring prevention, intervention, treatment and recovery. All care designed shall be safe, effective, person-centered, timely, culturally competent, efficient and equitable. All subsequent system changes shall be guided and based on best science and practice guidelines, when available. All stakeholders shall be welcome to participate in this Coalition to ensure broad representation and achieve consensus related to all proposed changes. A recent addition to the D&A Coalition was the Prevention Sub-committee which met for the first time in December 2009.

## **STATE PLAN FY 2010-11**

BDAP will continue to partner with various other state, federal, and local agencies in all of its efforts to continue to build Prevention Capacity. As SPF SIG moves towards its third year, BDAP is prepared to offer its SPF SIG recipients technical assistance in the form of site visits, one-on-one discussions, trainings, meetings/conferences or other means required to better strengthen the SCA's capacity.

BDAP will also continue to hold SPF SIG Advisory Council meetings and also encourage new members to become involved, as new ideas and insights will be valuable as we move into the third year of the program.

BDAP plans to further build the capacity of the SCAs and prevention providers by working with the Northeast Center for Application of Prevention Technologies to offer online courses on various topics to specific Pennsylvania participants.

BDAP will continue to enhance cross-agency prevention efforts through SPF SIG, the Pennsylvania Interagency Coordinating Committee on the Prevention of Underage Drinking, and by continuing to attend committee meetings such as the Commonwealth Student Assistance Programs Interagency Committee, Pennsylvania State System of Higher Education (PASSHE)

Alcohol Grant Consortium, the Multi Agency Safety Team (MAST), which is coordinated by the Pennsylvania Department of Transportation (Penn DOT), Center for Safe Schools Conference Planning Committee, New Options Steering Committee, State Juvenile Firesetters Prevention and Intervention Advisory Group, Suicide Prevention Monitoring Committee, Disproportionate Minority Contact Committee, Statewide Positive Behavior Support State Leadership Team, PA-State Fetal Alcohol Spectrum Disorder Task Force, the Commonwealth Prevention Alliance, Pennsylvania Prevention Providers Association, Pennsylvania National Guard, among others.

**PRIORITY: Identify and implement realistic recommendations to positively impact on workforce issues within the commonwealth.**

Background: The subcommittees of the Pennsylvania Workforce Development Taskforce met in the Summer of 2005 and identified the following preliminary recommendations in preparation for BDAP's participation in the second three-state workforce summit that occurred October 19, 2005. The following preliminary recommendations were approved by the Deputy Secretary for Health Promotion and Disease Prevention for implementation on August 16, 2006:

- The Compensation Subcommittee recommended cost of living allocations for the field that are tied to the inflation index and plans to work with the Single County Authorities (SCAs) to help them design incentive packages for preferred providers as a way for providers to earn more based on standardized benchmarks. Additionally, Loan Forgiveness legislation will be supported for persons working in the drug and alcohol field;
- The Marketing Subcommittee is defining recruitment strategies for high schools and community colleges in addition to developing partnerships with recovery organizations in order to identify how to effectively engage volunteer and paid recovering community individuals into our field. All levels of recruitment efforts will require marketing materials for distribution;
- The Administrative Relief Subcommittee chose to look at ways to reduce the paperwork burden required through regulation and grant agreement requirements. This reduction in paperwork will allow more time to clinically treat addicts and make those that work in the field feel that they are having a positive impact, rather than just doing administrative paperwork; and,
- The Credentialing/Licensing Subcommittee decided to identify ways to expand opportunities to access our field for non-degreed and/or recovering individuals. Pennsylvania's certification process, as well as licensing/staffing regulations, must be reviewed to determine how best to proceed.

## **ANNUAL REPORT FY 2008-09**

The four subcommittees met as needed throughout the fiscal year and the following is a summary of what occurred during that time:

Compensation Subcommittee - BDAP submitted a Program Revision Request (PRR) for a Cost of Living Adjustment, but it was not accepted for further consideration by the Department. BDAP's fiscal and training sections considered implementing preferred provider training. This was implemented in the state of Delaware and the Armstrong/Indiana SCA. The training would not be mandatory, but could be a way for SCAs to provide additional funds to programs with a proven track record. The loan forgiveness legislation did not pass, and provider organizations were encouraged to support any future legislation on this subject.

Marketing Subcommittee - The Marketing subcommittee 1) discussed conducting a needs assessment of what community college and high school counselors are encountering related to the D&A field; 2) held meetings with community college and high school counselors to obtain their feedback; 3) recruited local counselors to the subcommittee; 4) discussed what information from the Pennsylvania Department of Health Public Health Information Clearinghouse could be used for marketing activities; 5) contacted the Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA) and the National Guard regarding recruitments for the subcommittee; 6) requested workforce development materials from Institute for Research, Education and Training in Addictions (IRETA); 7) attended health fairs and career days to recruit volunteers and develop materials for the Web site. The subcommittee also looked for members representing the individuals recovering from addiction, minorities and veterans.

Administrative Relief Subcommittee – The members realized issues related to this topic impact many areas of the substance abuse field, so the decision was made to break-out into two workgroups, as follows:

- Program Workgroup - One of the members of the workgroup developed a binder that contained utilization review and admissions forms required by SCAs that go beyond the forms required by the Departments of Health and Public Welfare. The information in the binders identified the administrative burden created for inpatient providers that have multiple SCA contracts. At the December meeting of the Program Workgroup, it was decided to make a presentation at PACDAA using the binder of forms. At the PACDAA meeting, the SCAs expressed that a bigger issue was the case management requirements driving most of this duplication. It was decided that most of these issues would be addressed in the rewrite of BDAP's Treatment Manual and that the sub-committee should put a hold on these discussions until the Treatment Manual update was completed.
- Administrative Workgroup - This workgroup decided to survey SCAs with multi-year contracts to determine if multi-year contracts were a viable approach in reducing administrative burden or if there were county mandates/needs that had to be addressed yearly. Fiscal staff has met with Department of Public Welfare staff concerning audits requirements and whether or not both departments could have the same requirements to eliminate the administrative burden and expense of programs needing multiple audits. There were also discussions with the Deputy Secretary of OMHSAS (Office of Mental

Health and Substance Abuse Services) concerning a memorandum of understanding that could address administrative duplication.

Credentialing/Licensing Subcommittee - The biggest difficulty encountered by this subcommittee was the lack of treatment provider participation. There were two Department of Health Licensing Alerts that came from discussions in the subcommittee. One Alert clarified the list of acceptable college degrees qualifying someone to be a Counselor (Licensing Alert 03-08). The other Alert relates to the time involved to directly supervise Counselor Assistants. If a person has a bachelor's degree, but one that is not acceptable to meet requirements for a Counselor, that person must be hired as a Counselor Assistant. As a Counselor Assistant, the program must provide an intensive level of supervision with direct supervisory oversight. The Alert allows the program to request an exception to provide intensive supervision. If approved, only direct supervision is necessary for a Counselor Assistant with a bachelor's degree (Licensing Alert 02-08). A PRR was submitted to request funds that could offset the costs associated with intensive supervision of the counselor assistants, but it was not accepted for further consideration by the Department.

Staff from BDAP, OMHSAS, within the Department of Public Welfare (DPW), and the Governor's Policy Office established the Pennsylvania D&A Coalition, consisting of state officials, provider associations, advocacy groups and treatment providers. The purpose of the Coalition was to work together to identify and resolve issues negatively impacting the substance abuse field. One of the sub-committees specifically focused on identifying and addressing workforce issues.

## **PROGRESS REPORT FY 2009-10**

Due to staff shortages, the fiscal situation caused by the budget impasse, and the lack of attendance by provider representatives, the subcommittees did not meet in 2009. BDAP staff continued to meet to discuss ongoing initiatives and workforce activities outside of the Taskforce and its subcommittees.

With the assistance of PACDAA, a survey was distributed to the field to ascertain the extent of the drug and alcohol workforce problem in Pennsylvania. BDAP received 102 responses by the May 1, 2009 deadline. The following information was gathered from the survey results: 1) When asked why a position was vacant for a period of time, 57 responses indicated that the salary was too low and 72 responses that the applicant degree did not meet licensing requirements. 2) The average tenure was 3.54 years. 3) Of the 195 counselors that voluntarily left during the past year, 47 left for better salary or benefits, and 31 left for promotion opportunity available elsewhere.

The Administrative Relief Subcommittee convened a one-day Focus Group to brainstorm on ways to reduce the administrative burden related to requirements and paperwork generated at the initial client contact. The meeting took place on June 25, 2009, with representatives from PACDAA (a state-wide inpatient services provider), IRETA and the Divisions of Treatment and Drug and Alcohol Program Licensure. The Focus Group made suggestions related to monitoring/licensing duplication, SCA forms, monitoring frequency and assessment requirements. While PACDAA and BDAP continue to work on Focus Group suggestions, the assessment requirements have been reduced in the updated Treatment Manual.

BDAP staff continued to participate in the Pennsylvania D&A Coalition. A report was completed in July 2009 regarding the efforts made by each sub-committee and can be found at [www.ireta.org/](http://www.ireta.org/).

## **STATE PLAN FY 2010-11**

BDAP will continue to work with the Division of Drug and Alcohol Program Licensure, the Office of Legal Counsel, the SCAs and the Pennsylvania Certification Board to address workforce issues. BDAP will continue to participate in the Pennsylvania D&A Coalition's Workforce Committee.

BDAP plans to reconvene the Workforce Development Taskforce annually, update members on all workforce activities implemented by the Department of Health and the D&A Coalition and solicit members' input on all workforce issues.

# TREATMENT

## BACKGROUND

The Bureau of Drug and Alcohol Programs (BDAP), Division of Treatment (Division), is responsible for program planning and development of standards, policies, guidelines, service descriptions and outcome data for the clinical functions of the substance abuse case management and treatment systems. In addition, the Division is responsible for the program planning, development, implementation and oversight of standards, policies, guidelines, service descriptions and outcome data for compulsive and problem gambling services.

The Division responds to the needs and demands of treatment professionals and publicly funded clients in Pennsylvania who are in need of substance abuse treatment services and/or compulsive and problem gambling services in a variety of ways:

- Facilitates program development, based on state and federal research data, which targets the need for programming and treatment placement tools that maximize the accessibility and effectiveness of treatment services;
- Evaluates data and research, via a comprehensive approach, as it relates to the development, promotion and implementation of treatment services;
- Assesses training needs within the counties and the state for treatment professionals and responds with targeted technical assistance and regional training initiatives to meet those needs; and,
- Collaborates with state agencies, such as the Governor's Policy Office, the Department of Public Welfare (DPW), Office of Mental Health and Substance Abuse Services (OMHSAS), the Office of Children, Youth and Families (OCYF), the Office of Medical Assistance (OMAP), the Department of Corrections (DOC), Pennsylvania Commission on Crime and Delinquency (PCCD), the Pennsylvania Board of Probation and Parole (PBPP), the Department of Education, the Department of Revenue and the Pennsylvania Gaming Control Board (PGCB), as well as local agencies, to develop programming and coordinate systems which serve the multiple needs of substance abusers and/or problem gamblers throughout the Commonwealth of Pennsylvania.

Historically, drug and alcohol treatment has been delivered in an acute care model, rather than a chronic care approach that addresses a person's needs across the lifespan of recovery. Recovery from alcohol and other drug dependency is a highly individualized journey that includes the pursuit of spiritual, emotional, mental and physical well-being. The recovery process may be supported through the use of medication that is appropriately prescribed and taken.

There is a movement in the drug and alcohol field from an acute care model of treatment to a recovery management model, also known as a chronic care approach to recovery. The recovery management model is based on the philosophy of a Recovery-Oriented System of Care (ROSC). The foundation of this approach includes: accessible services; a continuum of care that involves

pre-treatment, treatment, continuing care and recovery support services rather than crisis-oriented care; a strength-based and person-centered planning process; acknowledgement of the important role that families and other allies can play in supporting a person's recovery process; and culturally competent care that is age and gender appropriate. Where possible, all of these should be embedded in the person's community and home using natural supports. This approach also includes using the experiences of recovering individuals and their families in the design and implementation of ROSC through their representation on advisory councils, boards, task forces and committees at the federal, state and local levels. BDAP has begun to identify ways to incorporate the elements of a ROSC as the Bureau moves toward the implementation of a recovery management model.

BDAP also remains committed to ensuring that individuals receive timely assessments to determine their treatment and non-treatment needs, as well as access to the most appropriate levels of care, if treatment is warranted. BDAP has established Single County Authority (SCA) benchmark performance requirements related to timely access to assessment and admission to treatment, as follows:

- Fiscal Year 2010-2011: 9 percent or less wait longer than 7 days for assessment;
  - Fiscal Year 2011-2012: 8 percent or less wait longer than 7 days for assessment;
  - Fiscal Year 2012-2013: 7 percent or less wait longer than 7 days for assessment;
  - Fiscal Year 2013-2014: 6 percent or less wait longer than 7 days for assessment; and,
  - Fiscal Year 2014-2015: 5 percent or less wait longer than 7 days for assessment.
- 
- Fiscal Year 2010-2011: 10 percent or less wait longer than 14 days for admission to treatment\*;
  - Fiscal Year 2011-2012: 9 percent or less wait longer than 14 days for admission to treatment\*;
  - Fiscal Year 2012-2013: 8 percent or less wait longer than 14 days for admission to treatment\*;
  - Fiscal Year 2013-2014: 7 percent or less wait longer than 14 days for admission to treatment\*; and,
  - Fiscal Year 2014-2015: 7 percent or less wait longer than 14 days for admission to treatment\*.

(\*Individuals requiring detox must be admitted within 24 hours of identifying the need for this level of care.)

Once the need for treatment is identified, SCAs are required to make placement decisions using the most current version of standardized criteria. For adults, the Pennsylvania Client Placement Criteria (PCPC) must be used; for adolescents, the SCAs must use criteria from the American Society of Addiction Medicine (ASAM).

## **ANNUAL REPORT FY 2008-09, PROGRESS REPORT FY 2009-10 AND STATE PLAN FY 2010-11**

**GOAL: Develop program guidelines for public education, awareness and training regarding the prevention and treatment of compulsive and problem gambling.**

### **ANNUAL REPORT FY 2008-09**

#### **Problem Gambling Information Distribution**

BDAP continued to distribute an assortment of problem gambling-related pamphlets through the Pennsylvania Department of Health Public Health Information Clearinghouse (PADOHPHIC), including brochures developed specifically for Pennsylvania. Bensinger DuPont, Inc. the contracted provider of Hotline services for BDAP, also distributed pamphlets, as appropriate, to callers who requested information.

#### **Training and Certification**

BDAP continued to provide problem gambling training through the Mini-regional training events, as well as through BDAP's specialized training initiative. These trainings were offered free of charge and were approved for Pennsylvania Certification Board (PCB) and National Council on Problem Gambling (NCPG) certification. During the Fiscal Year 2008-2009, 18 Problem Gambling trainings were held and 201 persons were trained. The goal was to provide clinical staff with Level I (Beginners) and Level II (Advanced) training that would lead to certification in Problem Gambling.

#### **Hotline**

BDAP contracted with Bensinger DuPont, Inc. to provide toll-free Hotline services for Problem Gamblers in Pennsylvania. The toll-free number is published on the BDAP Web page, on all print materials available through PADOHPHIC; it is also available on casino signage required by the Pennsylvania Gaming Control Board. During Fiscal Year 2008-2009, 408 persons called the Hotline, with 111 of these calls being problem gambling specific. These individuals were referred to either treatment programs, mailed information about problem gambling, given information about Gamblers Anonymous (GA) or referred to other treatment. The total number of persons calling the Hotline included persons looking for information about lottery numbers, directions to gambling venues and other non-problem gambling topics.

#### **Prevalence Study**

The Behavioral Risk Factor Surveillance System (BRFSS) is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. The survey is conducted by the Centers for Disease Control and Prevention. Of all Pennsylvania adults aged 18 and older (surveyed from January 1, 2008 through December 31, 2008), a total of 46.2 percent (95 percent Confidence Interval: 44.2-48.2 percent) have gambled in the past 12 months. This is not a significant change in those that have gambled, compared to the

2007 Behavioral Risk Factor Surveillance System (BRFSS) survey. In 2008, males gambled at a significantly higher rate than females (52.6 percent and 40.4 percent respectively), and 47.8 percent (CI: 45.6-49.9 percent) of white, non-Hispanics gambled, which is significantly higher than the 31.5 percent (CI: 24.0-38.9 percent) of black non-Hispanics who gambled. Among those whose annual household income was \$35,000 or more, 50.6 percent gambled. That is significantly higher than those whose annual household income was less than \$35,000, where 42.6 percent gambled. Among current smokers, 51.7 percent gambled. This is significantly higher than non-smokers, where 44.6 percent gambled. Also, 56.4 percent of those who drank alcohol in the past 30 days gambled, which is significantly higher than the 33.6 percent of those who did not drink alcohol in the past 30 days and gambled. There were no significant differences reported on gambling in the past 12 months based on age, education level or marital status among all Pennsylvanians.

The Pennsylvania Youth Survey (PAYS) is sponsored and conducted by the PA Commission on Crime and Delinquency every two years. This survey of school students in sixth, eighth, tenth and twelfth grades gathers information relative to their behavior, attitude and knowledge concerning alcohol tobacco, drugs, violence and gambling. In 2007, eighth, tenth and twelfth graders all gambled at similar rates (31.0 percent, 32.0 percent, and 32.8 percent respectively), and those grades were all significantly higher than sixth graders (19.3 percent). In 2007, eighth, tenth and twelfth graders spent more than they intended on gambling at a significantly higher rate (5.5 percent, 6.4 percent, and 7.5 percent respectively) than sixth graders (3.3 percent). Playing bingo for prizes or money was the most popular type of gambling for grades 6 (54.4 percent) and 8 (49.0 percent). This type of gambling decreased for grades 10 (35.4 percent) and 12 (27.1 percent). Twelfth graders (28.5 percent) bought lottery tickets at a higher rate than tenth graders (19.0 percent) while 22.2 percent of sixth graders and 22.8 percent of eighth graders have bought lottery tickets. There was a significant increase in betting on sporting events between grades 6 (24.5 percent) and 8 (31.9 percent). Grades 8, 10 (30.7 percent), and 12 (26.7 percent) were similar for this behavior. Similarly, there was a significant increase in betting on table games between grades 6 (22.3 percent) and 8 (29.0 percent). Grades 8, 10 (27.0 percent), and 12 (25.3 percent) were similar for this behavior as well.

### **Problem Gambling Consortium**

BDAP continued to meet with representatives from the Pennsylvania Gaming Control Board (PGCB), the Pennsylvania Lottery Commission, the Pennsylvania Harness Racing Commission, and the Pennsylvania Horse Racing Commission to discuss gambling related issues. The purpose of this group was to share information about their respective organizations as gambling developed across the commonwealth, to learn from each other about the problems the gaming public may face and to provide resources to each other. Issues addressed were the numbers of persons admitted to the PGCB Self Exclusion program, the number of providers, training events, the number of clients admitted to treatment and the providing of information to the general public. Additionally, another group of these representatives met throughout the year to plan for National Problem Gambling Awareness Week (NPGAW).

## **Problem Gambling Web Page**

The Problem Gambling Web page contained information about problem gambling resources and provided links to other Web sites for additional information, training and certification information, the South Oaks Gambling Screen (SOGS), etc. The Web site also contained the Problem Gambling Treatment Manual, all of the necessary forms to become a provider, forms for billing and statistical purposes and a list of providers across the commonwealth. As Problem Gambling Treatment Providers were approved, they were added to the Web site. The number of hits/visits to the problem gambling page averaged 1,467 per month.

## **Treatment System**

Outpatient problem gambling counseling services have been made available within the commonwealth since September 2008. Providers, who have been approved under the Department's Participating Provider Agreements (PPAs), have been receiving reimbursement for these services since that date. As of June 2009, the Department had PPAs with 41 providers. As of that same date, 50 problem gambling clients had been admitted to services. Thirty-seven of these individuals were male and 13 were female, 43 were white with 7 being African American. The average age of those seeking treatment was 19. The majority of providers were in the Western Pennsylvania area, including Allegheny, Westmoreland and Washington Counties. The next largest concentration of providers was in the Southeastern Pennsylvania area, including Philadelphia and Montgomery Counties. BDAP staff also participated in conference calls with the Association of Problem Gambling Service Administrators, Inc. (APGSA), a national organization committed to supporting the development of state of the art publicly-funded problem gambling services.

## **Mini-Grant Program**

BDAP developed and implemented a mini-grant program in March 2009 that enabled community organizations, local government and other interested agencies to apply for funds, up to \$5,000 per state fiscal year, for public education and outreach. These events, held in local venues, facilitate the increase of knowledge regarding problem gambling and the resources available to assist those in need. By the end of Fiscal Year 2008-2009, two events were held with an attendance reported to be 133 for both events. One grant was used to provide problem gambling information to clergy, and the other was to provide intervention information for employees of community outreach centers.

## **Pilot Prevention Project**

BDAP began discussions with the Council on Compulsive Gambling of Pennsylvania (CCGP) on piloting a problem gambling prevention project in three school districts, as well as a university in the state. CCGP will develop an evidence-based prevention curriculum for use in these school systems.

## **PROGRESS REPORT FY 2009-10**

### **Problem Gambling Information Distribution**

BDAP continues to distribute an assortment of problem gambling-related pamphlets through the Pennsylvania Department of Health Public Health Information Clearinghouse (PADOHPHIC), including brochures developed specifically for Pennsylvania. Bensinger DuPont, Inc., the contracted provider of Hotline services for BDAP through December 31, 2009, and the Council on Compulsive Gambling of PA, the new contractor for Hotline services, also distributes pamphlets, as appropriate, to callers who request information.

### **Training and Certification**

BDAP continues to provide problem gambling training through Mini-regional training events, as well as through BDAP's specialized training initiative. In October 2009, BDAP conducted three four-day Level I (Beginners) and Level II (Advanced) Problem Gambling trainings, which meet the requirements established by the NCPG and the PCB to become certified as a problem gambling counselor. BDAP continues to provide trainings, free of charge, in order to increase the number of problem gambling treatment providers throughout the state. As of December 31, 2009, a total of 297 persons have attended problem gambling trainings. BDAP will repeat the four-day trainings in April 2010.

### **Hotline**

BDAP held a contract with Bensinger DuPont to provide toll free hotline services for problem gamblers in Pennsylvania through December 31, 2009. The toll free number is published on the BDAP Web page, on all print materials available through PADOHPHIC and on casino signage required by the Pennsylvania Gaming Control Board. During the first half of FY 2009-2010, 350 persons called the Hotline, with 91 persons calling about problem gambling issues. Those individuals were referred to treatment programs, mailed information about problem gambling, given information about Gamblers Anonymous (GA) or referred to other types of treatment. The total number of persons calling the Hotline includes persons looking for information about lottery numbers, directions to gambling venues and other information. Effective January 1, 2010, the Department contracts with the CCGP for the provision of Problem Gambling Hotline services. Data collection continues as it had with the previous vendor.

### **Prevalence Study**

The Behavioral Risk Factor Surveillance System (BRFSS) is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. The survey is conducted by the Centers for Disease Control and Prevention. The Pennsylvania Youth Survey (PAYS) is sponsored and conducted by the PA Commission on Crime and Delinquency every two years. This survey of school students in sixth, eighth, tenth and twelfth grades gathers information relative to their behavior, attitude and knowledge concerning alcohol tobacco, drugs, violence and gambling. When it becomes available, BDAP will review the data received from the 2009 BRFSS and the 2009 PAYS.

## **Problem Gambling Consortium**

BDAP continued to meet with representatives from the Pennsylvania Gaming Control Board (PGCB), the Pennsylvania Lottery Commission, the Pennsylvania Harness Racing Commission and the Pennsylvania Horse Racing Commission to discuss gambling related issues. The group has extended invitations to include the Pennsylvania Department of Aging, the Pennsylvania Department of Education, Pennsylvania Commission on Crime and Delinquency, Governor's Advisory Commission on African American Affairs, Governor's Advisory Commission on Asian American Affairs, Governor's Advisory Commission on Latino Affairs, Pennsylvania Commission for Women, Governor's Advisory Council on Rural Affairs and the CCGP. The purpose of this group is to share information about their respective organizations as gambling developed across the commonwealth, to learn from each other about the problems the gaming public may face, and to provide resources to each other. Issues being addressed are the numbers of persons admitted to the PGCB Self Exclusion program, the number of providers, training events, the number of clients admitted to treatment, and the providing of information to the general public. This consortium will now add NPGAW activities as one of its primary objectives. Agenda items during this FY include discussion of methods to reach minority populations, and how to deal effectively with youth gambling. With the passing of Act 1 of 2010, the group will be involved with providing feedback and consultation related to the changes and adjustments the Act requires. This group will continue a discussion about inserting problem gambling issues into National Recovery Month events in September 2010.

## **Problem Gambling Web Page**

The Problem Gambling Web page contains a variety of resources about problem gambling prevention, treatment and training/certification opportunities. The Web page also contains links for additional information, including problem gambling research studies, self-help groups, gambling addiction publications, problem gambling prevention grant opportunities and the SOGS, just to name a few. Moreover, the Web site includes the Problem Gambling Treatment Manual, all of the necessary forms to become a problem gambling treatment provider, forms for billing and statistical purposes, and a list of providers across the commonwealth. In December 2009, the DOH Web site was completely updated including the problem gambling page. The Web site is regularly updated as new information, Policy Bulletins and new problem gambling treatment providers are added. From June 2009 to December 2009, the Web site averaged 1710 hits/visits per month.

## **Treatment System**

Outpatient problem gambling counseling services continue to be provided, and BDAP has expanded the provider network to meet additional demands for service. BDAP continues to accept new applications from appropriate agencies and individuals who wish to become certified. From July 2009 through December 2009, 44 clients have been admitted to problem gambling treatment services. Forty individuals were white, 3 were African American and 1 was Asian. The average age is 22. There are a total 54 treatment providers in the state. The largest number of providers is in the Western Pennsylvania area with a concentration in Allegheny County, and the next largest number of providers is in the Philadelphia and Montgomery County areas.

## **Mini-Grant Program**

BDAP continues to provide mini-grants to community organizations, local government and other agencies for the purpose of public education and outreach. BDAP continues to promote the mini-grant program through the Web site, Listserv and at various community and stakeholder functions. From July 2009 through December 2009 six Mini-Grants have been approved and four events have taken place. Over 160 persons attended these events, and target audiences included staff from nursing and retirement facilities, attorneys, judges, probation officers and other persons involved in the court system, as well as the Hispanic community surrounding one of the casinos.

## **Pilot Prevention Project**

BDAP has contracted with the CCGP to implement a pilot problem gambling prevention program called “Smart Choices.” This program is to be utilized in school districts, as well as a university setting, as yet to be identified. This prevention program addresses the potential for problem gambling in citizens of the Commonwealth of Pennsylvania, including school-age children and college students. The program is starting with the fifth and tenth grades in the Philadelphia School District, and meetings are planned to continue setting up this program in the Allegheny County area for the next school year.

## **STATE PLAN FY 2010-11**

In January 2010, the General Assembly passed new legislation addressing the addition of table games in Pennsylvania casinos. This legislation, Act 1 of 2010, also modified the Department’s responsibilities as it relates to the compulsive and problem gambling program. Act 1 also requires the Department to develop and implement a strategic plan which delineates all of the required components for Pennsylvania’s compulsive and problem gambling program. In addition, the Department of Health, in consultation with the Pennsylvania Gaming Board, must prepare and submit an annual report on the impact of the programs funded by the compulsive and problem gambling treatment fund to the Governor and to the members of the General Assembly. The report shall include aggregate demographic-specific data, including race, gender, geography and income of those individuals treated. Given the requirement of a compulsive and problem gambling program specific plan and annual report, all future gambling information will be contained in those documents. Consequently, this goal will no longer be a part of this document.

**GOAL: Create and implement an “All Hazards Plan” that encompasses natural and man-made emergencies or disaster efforts, as it pertains to the substance abuse system.**

## **ANNUAL REPORT FY 2008-09**

A final “All Hazards Plan” was completed. In June 2009, SCAs were sent an Emergency Preparedness Survey developed by Gaudenzia ACCESS, the subcontractor for the All Hazards Plan and emergency preparedness, to determine their level of preparedness for a variety of disaster scenarios. The Division and subcontractor began to tabulate and analyze the results of the surveys in order to develop emergency preparedness training tailored to the identified needs of the SCAs, as well as a template for SCAs to utilize in developing or updating their emergency preparedness

plans. However, due to a limited response, it was decided that the survey would be resent to those SCAs who did not respond initially. BDAP continued to be involved in several committees/consortiums on emergency preparedness issues.

## **PROGRESS REPORT FY 2009-10**

Due to a limited SCA response to the Emergency Preparedness Survey that the subcontractor developed, the survey was resent. With these additional responses, the overall results are being tabulated and analyzed with the intent of developing emergency preparedness training tailored to the needs of the SCAs. In conjunction with the Treatment Division and the Training Section, the subcontractor will begin developing emergency preparedness training for the SCAs. BDAP continues to be involved in several committees/consortiums on disaster preparedness issues.

## **STATE PLAN FY 2010-11**

The Division will continue to work with the subcontractor and the Training Section to develop trainings for the SCAs, as well as an SCA template. BDAP will also continue working with preparedness groups including Department of Public Welfare and OMHSAS to be able to provide information to SCAs and providers about preparedness and disaster related issues.

**GOAL: Develop and implement a statewide plan to increase awareness regarding Fetal Alcohol Spectrum Disorder (FASD).**

## **ANNUAL REPORT FY 2008-09**

The 2008 statewide FASD Action Plan was reformatted, approved and officially unveiled on September 8, 2008. BDAP reconvened the FASD Task Force to assist with the execution of the plan. An Executive Committee of the Task Force, comprised of individuals from various state and community agencies, was created to provide additional leadership and oversight to the Task Force and for mobilization of the Action Plan. Periodic meetings of both the Executive Committee and the Task Force were scheduled.

As is consistent with the Action Plan and BDAP's commitment to increasing public knowledge regarding FASD, awareness activities were conducted during the week of September 8-14, 2008, at locations throughout the commonwealth. An Awareness Week Subcommittee comprised of Task Force members was created to assist in the formation and implementation of these activities. Awareness Week was initiated with an informational Expo/Press Conference at the State Capitol on September 8, 2008, during which the Action Plan was unveiled. The baby bottle distribution project was conducted for the second consecutive year and was expanded to include additional Women's Health Care Facilities with outreach to additional recipients. Also, a targeted awareness campaign was conducted on the campus of Bloomsburg University in cooperation with the Drug, Alcohol and Wellness Network and three student groups, including two Greek organizations. Awareness information was distributed to students, as were prevention message t-shirts. In the evening, a national expert gave an FASD presentation for which participants received academic credit for attending. Community tavern and restaurant partners within the town of Bloomsburg

supported the message of “no alcohol use during pregnancy” by having their servers wear the prevention message t-shirt throughout Awareness Week. An FASD Education Resource Guide was created and distributed to Women’s and Women with Children Treatment Providers across the state for use during Awareness Week and throughout the year. Twenty-three thousand awareness ribbons were distributed across the state by 22 SCA offices and various other community partners. Activities were held in over 30 counties, representing all six health districts, with an estimated 30,000 individuals in the commonwealth being impacted during the week.

In addition to the above-noted activities, BDAP made a concerted effort to increase FASD training. During Awareness Week, two trainings were conducted, one on each side of the state, with a total of 155 individuals in attendance. A Training of Trainers was conducted in October 2008 in cooperation with the Substance Abuse and Mental Health Services Administration’s (SAMHSA) FASD Center for Excellence, during which seven individuals were instructed in presenting FASD trainings. Bureau staff made several FASD presentations to various organizations as well.

## **PROGRESS REPORT FY 2009-10**

Bureau staff conducted various initiatives across the commonwealth in observance of FASD Awareness Week, September 8-14, 2009, beginning with a Kickoff Event on Tuesday, September 8, at Gaudenzia’s Vantage House for Women, Lancaster, PA. The Kickoff was attended by approximately 100 individuals from various organizations and the general public. Presentations were given by Mr. Steven Seitchik (BDAP), Ms. Janice Kopelman (Deputy Secretary of Health Promotion and Disease Prevention), Senator Lloyd Smucker, Dr. Daniel Weber (Lancaster General Hospital), Dr. Jeffrey Martin (Lancaster General Hospital), Mr. Michael Harle (Gaudenzia, Inc.) and a Gaudenzia consumer. Thirteen community service organizations provided display tables at the event. The news media, specifically Fox 43 and Blue Ridge Cable, were on hand for coverage of this event.

Other initiatives included activities on two state university campuses: the Indiana University of Pennsylvania (IUP) and Bloomsburg University. An all-day BDAP sponsored training for the general public, students and faculty was held at IUP. In addition, an evening seminar presentation was held specifically for students and faculty. Students received academic credit for attending. At Bloomsburg University, Bureau staff did three classroom presentations for students and faculty. The Bureau also sponsored a second FASD training held at Eagleville Hospital in Norristown, PA.

Other activities conducted during Awareness Week included: the baby bottle distribution campaign, in which 3,000+ baby bottles containing an FASD informational flyer were given out by 31 obstetric/gynecologist offices or crisis pregnancy centers within 26 counties of the state; an FASD Awareness Ribbon Campaign, in which 22,000 ribbons were distributed by 36 SCAs and over 68 Community Partners during organized FASD Awareness activities; and the provision of over 50 “Drinking and Reproductive Health: A Fetal Alcohol Spectrum Disorders Prevention Tool Kit,” offering continuing medical education credits to women’s healthcare providers for learning how to identify women at risk of drinking during pregnancy. Approximately 100 Public Service Announcements explaining the dangers of drinking alcohol during pregnancy were also distributed and played on local cable channels, as well as in doctor’s offices throughout the week. In total, 47,000 pieces of educational/informational materials were distributed across the state during FASD Awareness Week, with activities occurring in every county of the commonwealth.

## **STATE PLAN FY 2010-11**

BDAP will continue to move forward with the implementation of the FASD State Plan, which will be put into action over a five-year period, with reviews occurring every two years. The Executive Committee is expected to play an integral part in the implementation of the plan, as will the Task Force. Members have agreed to actively participate in workgroups, which will be essential to assure adequate manpower and expertise for the plan's success. Periodic meetings will be scheduled with the overall Task Force to update its members regarding the status of the plan.

FASD Awareness Day activities will continue to be expanded and will run the week of September 6-10, 2010, at locations throughout the commonwealth. The Awareness Week subcommittee will continue to assist in the formation and implementation of activities and will make widespread involvement across the commonwealth possible. It is expected that the baby bottle distribution project will be expanded and that awareness campaigns will continue to be targeted to communities that have colleges and universities. It is also anticipated that cooperative efforts will resume between BDAP and the Pennsylvania State Liquor Control Board. Finally, efforts will continue to increase FASD training through the BDAP training system.

**GOAL: Establish a panel of parents to meet three times a year to study family and community access to alcohol and drug abuse information, intervention and treatment services, and make recommendations to the Health and Human Services Committee and to BDAP.**

## **ANNUAL REPORT FY 2008-09**

In its 2006 session, the General Assembly of Pennsylvania passed House Resolution 585, directing the Department of Health to establish a parent panel to study and address family and community access to alcohol and drug abuse information, intervention and treatment services. The Parent Panel Advisory Council (PPAC) met on September 26 and December 5, 2008 and on March 20 and May 18, 2009, with support and technical assistance provided by BDAP. Between scheduled meetings, PPAC members conducted interviews with SCA staff to determine systemic challenges being experienced across the Commonwealth.

## **PROGRESS REPORT FY 2009-10**

PPAC has continued to meet throughout state fiscal year 2009-2010 with meetings held on September 18th and October 9th, with the culminating efforts of PPAC occurring on November 16, 2009, when they presented their recommendations to the Health and Human Services Committee.

PPAC authored a 71 page report, "From Pain to Passion: How Improving Public Policy Can Save Our Kids!," which included their recommendations, as well as their personal stories. The content of the November 16 testimony included highlights from the report, as well as a slideshow presentation featuring their own children, who were impacted by the disease of addiction. The focal points of the recommendations were summarized under the following headings: Leadership and Structure, Resources, Measurement and Accountability, Legislation and Sustaining State

Focus and Attention. The testimony was well-received by the legislators of the committee and the report was also sent to all members of the General Assembly. An electronic copy of the PPAC document is located on the BDAPs Web site:

<http://www.portal.state.pa.us/portal/server.pt/community/drugalcohol/14221>.

Additional presentations were made by the PPAC to the Drug and Alcohol Advisory Council, and individual members made presentations to their local communities.

## **STATE PLAN FY 2010-11**

Although PPAC has finalized and presented its recommendations to the Health and Human Services Committee as outlined in House Resolution 585, it is the intent of the BDAP to provide ongoing support for its continuation in order to assist with the implementation and monitoring of the recommendations. It is also anticipated that members of this committee will be able to make valuable contributions to other work being done on substance abuse prevention and treatment within the commonwealth.

**GOAL: Increase the availability of Buprenorphine within the substance abuse treatment system.**

## **ANNUAL REPORT FY 2008-09**

The Buprenorphine Access Workgroup recommendations to overcome barriers to Buprenorphine treatment access were forwarded to the Secretary of Health for his review and approval. They were subsequently approved for implementation. These recommendations fell into three categories: education, regulation and reimbursement.

The education-related recommendations included: promoting the use of standardized language and terminology regarding medication-assisted treatment; amending current training curriculum to include appropriate information and courses; reviewing SCA policies which limit the utilization of Buprenorphine; and working with the Pennsylvania Medical Society, the Hospital and Healthsystem Association of Pennsylvania and the Pennsylvania Psychiatric Society (Addiction Subcommittee) to develop and promote continuing education opportunities for physicians regarding medication-assisted treatment.

The regulation recommendation included: a waiver, by exception, for non-residential facilities to the requirement in 28 Pa. Code Chapter 715 § 715.1 General Provisions, stating that “an entity within this Commonwealth which uses agents for maintenance detoxification of persons shall obtain approval of the Department to operate a narcotic treatment program” for programs that utilize a Schedule III opioid medication to do so. A Licensing Alert announcing the exception process for non-residential facilities was issued on February 1, 2008.

Under reimbursement, a recommendation was approved by the workgroup that the Secretary of Health send a letter to the Secretary of the Department of Public Welfare (DPW), requesting that DPW proactively review all HealthChoices Managed Care Organization policies governing the authorization and payment of Buprenorphine services. Specifically, the workgroup was concerned

these policies require a patient to “fail first” in another treatment modality prior to authorizing the use of Buprenorphine, and restrict the amount of time a patient can be prescribed Buprenorphine. In addition, the letter to the DPW Secretary contained a recommendation requesting that DPW examine ways, such as exceptions, to classify physicians who are certified to prescribe Buprenorphine as “specialists.”

This classification will allow patients to maintain their primary care provider while receiving Buprenorphine services.

## **PROGRESS REPORT FY 2009-10**

The Workgroup continues to meet during this FY to further discuss and review progress on implementing the recommendations that were previously approved by the Secretary of Health in FY 08/09. Items discussed included Education, Regulatory Requirements related to 28 Pa. Code Chapter 715 § 715.1, Reimbursement, Prescription Monitoring as it relates to Diversion and Expansion of Access to Treatment Services. The Workgroup will continue to meet for further discussion of these topics, and three specific workgroups will be established to develop: 1) recommendations on reimbursement; 2) Chapter 715 regulations applicable for residential levels of care; and 3) education and training for physicians prescribing Buprenorphine.

## **STATE PLAN FY 2010-11**

The Division plans to continue holding meetings of the Buprenorphine Access Workgroup which will collaborate with the Department’s Division of Drug and Alcohol Program Licensure to: 1) further explore the feasibility of expanding the scope of the exception to 28 Pa. Code Chapter 715 §715.1 for residential levels of care; and 2) monitor progress on recommendations made regarding prescription monitoring as it relates to diversion. The Workgroup shall also review any recommendations made by the specific workgroups in regards to education, reimbursement and expansion of access to treatment services.

**GOAL: Provide screening, testing, referral and case management services for individuals at risk for Hepatitis C.**

## **ANNUAL REPORT FY 2008-09**

For FY 2008/2009, State funds were allocated to continue the Philadelphia, Allegheny, Northampton and Clearfield/Jefferson Hepatitis C Projects. State funding for program improvements and/or development was utilized by:

- Allegheny’s Hepatitis C Project, which was coordinated through Mercy Behavioral Health and includes eleven sites, four of which are methadone clinics.
- Clearfield/Jefferson’s Hepatitis C Project, which involves seven locations, including one methadone site.

- Northampton's Hepatitis C Project, which is operated through New Directions Treatment Services, a methadone provider who utilizes five of its sites for services.
- Philadelphia's Hepatitis C Project, which is integrated into the Early Intervention Service for HIV Disease at a total of 56 sites.

For the State Fiscal Year 2008-2009, one county (Blair) made a decision to discontinue the project due to funding concerns.

Through annual meetings with all the Hepatitis C Project sites, the Bureau of Communicable Diseases, the Bureau of Epidemiology, Roche Pharmaceuticals and the Philadelphia Department of Public Health, the Department continued to ensure that the sites adhered to established protocols in providing Hepatitis C services in the Commonwealth of Pennsylvania. Allegheny, Clearfield, Jefferson, Northampton and Philadelphia counties continue screening, testing, counseling and case management services for clients at risk for Hepatitis C. All sites are fully operational and compliant with all reporting requirements.

For FY 2008/2009, the number of participants in Hepatitis C pre-test counseling and testing was 585 in Allegheny, 110 in Clearfield/Jefferson, 287 in Northampton, and 5,187 in Philadelphia. Of those tested, 131 in Allegheny, 27 in Clearfield/Jefferson, 98 in Northampton, and 2,383 in Philadelphia tested positive. Post-test counseling was provided to 425 participants in Allegheny, 98 in Clearfield/Jefferson, 129 in Northampton, and 4,411 in Philadelphia.

## **PROGRESS REPORT FY 2009-10**

BDAP continued funding to Allegheny, Clearfield/Jefferson, Northampton and Philadelphia counties to increase screening, testing, counseling and case management services for clients at risk for Hepatitis C. All sites are fully operational and compliant with all reporting requirements. Through annual meetings with all the Hepatitis C Project sites, the Bureau of Communicable Diseases, the Bureau of Epidemiology, Roche Pharmaceuticals and the Philadelphia Department of Public Health the Department continued to ensure that the sites adhered to established protocols in providing Hepatitis C services in the Commonwealth of Pennsylvania.

## **STATE PLAN FY 2010-11**

BDAP will continue to collaborate with the Bureaus of Epidemiology and Communicable Diseases, as well as Roche Pharmaceuticals, through annual meetings. These will include all Hepatitis C Project sites in order to ensure the ongoing success of the Hepatitis C programs funded through this initiative. BDAP will continue to review and analyze outcome data from the projects participating in the program, which are provided via quarterly reports.

**GOAL: Reconvene the Clinical Standards Committee (CSC) to make recommendations to BDAP regarding best practices and the identification, assessment, placement and treatment of alcohol and other drug problems for citizens of Pennsylvania.**

## **ANNUAL REPORT FY 2008-09**

The CSC was reconvened in February 2009 and consists of representatives from providers, SCAs, Managed Care Organizations, physicians, recovery advocacy organizations, educational institutions and state agencies. The immediate goal of the CSC was to review the Pennsylvania Client Placement Criteria (PCPC) regarding implementation, utilization, content and structure for relevance and merit. Eight subcommittees were formed to assist in the review of the PCPC: the American Society of Addiction Medicine (ASAM)-PCPC Crosswalk; Co-occurring Disorders, Criminal Justice; Cultural Competency and Sexual Orientation; Screening Brief Intervention and Referral to Treatment; Pharmacotherapy; Women/Women with Children; and PCPC Utilization. Each subcommittee has a corresponding work statement and timeline for task completion.

## **PROGRESS REPORT FY 2009-10**

The CSC and subcommittees continue to meet on a regular basis. The CSC continues its work in reviewing the PCPC regarding implementation, utilization, content and structure for relevance and merit.

The Co-Occurring Disorders subcommittee is drafting revisions to the Co-Occurring Disorders special needs and considerations paper that is part of the current PCPC. The revisions will specifically address: 1) ensuring that persons with co-occurring disorders gain access to appropriate and quality treatment specific to the individual's needs; 2) current evidence-based practices which can be applied to addictions treatment to ensure that adults who have co-occurring disorders receive optimal care; 3) barriers (i.e., policy, financial, etc.) to the application of recommended evidence-based practices; and 4) training considerations that may be needed to effectively implement the recommended evidence-based practices.

The Criminal Justice subcommittee is drafting revisions to the "*Research to Practice Brief: Understanding, Assessing, and Treating Substance Use Disorders Among the Criminal Justice Population*" for inclusion in the Special Needs and Considerations section of the revised PCPC. These revisions will specifically address: 1) the most current evidence-based practices that can be applied to addictions treatment to ensure that adults who are part of the criminal justice system receive optimal care; 2) barriers (i.e., policy, financial, etc.) to the application of recommended evidence-based practices; and 3) training considerations that may be needed to effectively implement the recommended evidence-based practices.

The Cultural Competence and Sexual Orientation subcommittee is drafting revisions to the cultural competency and sexual orientation special needs and considerations papers that are part of the current PCPC. These revisions will specifically address: 1) the most current evidence-based practices that can be applied to addictions treatment to ensure that adults receive the most culturally competent care; 2) the most current evidence-based practices that can be applied to addictions treatment to ensure that adults receive treatment that is sensitive to their sexual

orientation; 3) barriers (i.e., policy, financial, etc.) to the application of recommended evidence-based practices; and 4) training considerations that may be needed to effectively implement these recommended evidence-based practices.

The charge of the PCPC-ASAM Crosswalk subcommittee is evaluating a crosswalk of the PCPC and the ASAM that was developed by BDAP several years ago. This subcommittee is also drafting a written document that addresses: 1) how the two criteria systems compare with respect to the number and types of levels of care; 2) the process for assessing patient need for treatment and level of care placement; 3) application of initial assessment results to determine what level of care the patient should receive; 4) the process for determining the length of treatment the patient should receive within a given treatment level; 5) the process for determining when a patient should be discharged from a specific level of care; 6) approaching addiction as a chronic illness requiring a coordinated continuum of care with supportive services; 7) special patient populations; and 8) how the above components would be practically and effectively applied within the existing Pennsylvania addiction treatment system.

The Pharmacotherapy subcommittee is drafting revisions to the Pharmacotherapy special needs and considerations paper that is part of the current PCPC. These revisions will specifically address: 1) pharmacotherapy that can be used with addiction treatment processes to determine if a patient is appropriate for this form of treatment; 2) suggested ways these interventions can be applied effectively across any level of care represented within the PCPC; 3) barriers (i.e., policy, financial, etc.) to the application of this evidence-based practice; and, 4) training considerations that may be needed to effectively implement this evidence-based practice.

The Screening Brief Intervention and Referral to Treatment subcommittee is developing a special considerations paper and criteria for a new level of care pertaining to intervention-related activities for inclusion in the PCPC. In considering this new level of care, the subcommittee will include: 1) the definition and application of intervention services within Pennsylvania; 2) how placement for intervention services can be incorporated into the PCPC; 3) the most current evidence-based practices for applying intervention activities; barriers (i.e., policy, financial, etc.) to the application of recommended evidence-based practices; and 4) training considerations that may be needed to effectively implement these recommended evidence-based practices.

The PCPC utilization subcommittee is working to determine the major problem areas of the PCPC. In order to address this charge, the committee is developing an instrument/survey which will identify the strengths and weaknesses of the PCPC. The subcommittee will administer this tool with PCPC users, analyze the data collected from the administration of this tool and provide a written summary of the identified strengths and weaknesses.

The Women and Women with Children subcommittee is drafting revisions to the Women's Issues and Women with Children special needs and considerations papers that are part of the current PCPC. These revisions will specifically address: 1) the most current evidence-based practices that can be applied to addictions treatment to ensure that adult women and women with children receive optimal care; 2) barriers (i.e., policy, financial, etc.) to the application of recommended evidence-based practices; and 3) training considerations that may be needed to effectively implement these recommended evidence-based practices.

## **STATE PLAN FY 2010-11**

The CSC and the subcommittees will meet throughout the fiscal year to continue their efforts related to the review and revision of the PCPC. It is the intent of the CSC to finish all PCPC revisions by March 2011.

## PROGRAM MONITORING

### BACKGROUND

The Bureau of Drug and Alcohol Programs (BDAP), Division of Program Monitoring (Division), has the primary responsibility to oversee the Single County Authorities (SCAs) adherence to grant agreement requirements and that the SCAs carry out their administrative functions effectively to assure the timely access to, and the provision of, a quality service delivery system, while efficiently managing all available resources at the local level. The Division conducts annual Quality Assurance Assessments (QAAs) of the SCAs. The QAA process is designed to assess the SCAs administratively, fiscally and programmatically.

Administratively, the review consists of the following major elements: service coordination contracts with funded organizations, continuum of care verification, community representation on the local advisory council, personnel structure of the SCA, insurance coverage and fiscal structure, timeliness of required reports, subcontractor work statements and the performance monitoring of the providers of service. Internal fiscal reviews by BDAP's Fiscal Section occur throughout the fiscal year and provide a close inspection of fiscal reports and budget information associated with Department dollars.

Programmatically, the QAA process: 1) ensures that the local drug and alcohol service delivery system is a quality system, with particular emphasis on client confidentiality; 2) addresses emergent care needs; 3) ensures timely access to assessment and treatment services; appropriately utilizes the Pennsylvania Client Placement Criteria (PCPC) for level of care determinations, continuing stay reviews and discharge planning; 4) verifies availability of case management services; 5) provides a quality review of performance-based prevention activities; and 6) implements Federal Block Grant requirements. The Federal Block Grant requirements include, but are not limited to, provisions for interim and ancillary services, capacity management and outreach efforts, all of which are designed to increase services to the identified priority populations of pregnant women and injection drug users.

The Department of Health (DOH) was given the responsibility through Act 71 of 2004, "The Pennsylvania Race Horse Development and Gaming Act," to develop programs related to providing services to the citizens of Pennsylvania who are experiencing problems with compulsive gambling. Those programs approved by the Department through Participating Provider Agreements (PPAs) will be monitored by the Division for adherence to PPA requirements.

In January 2010, the General Assembly passed new legislation addressing the addition of table games in Pennsylvania casinos. This legislation, Act 1 of 2010, also modified the Department's responsibilities as it relates to the compulsive and problem gambling program. The Division will continue monitoring PPA's as planned. However, the Division will need to work with Bureau staff to determine what responsibilities the Division will take on as Act 1 is fully implemented.

## **ANNUAL REPORT FY 2008-09, PROGRESS REPORT FY 2009-10 AND STATE PLAN FY 2010-11**

**GOAL: On-site Quality Assurance Assessment (QAA) Review Monitoring of Single County Authorities (SCAs) and Gambling Provider Reviews.**

### **ANNUAL REPORT FY 2008-09**

Annual monitoring was on schedule until mid-year. The Division had three D&A Program Representative vacancies and, given budget concerns, was unable to fill the positions amid a hiring freeze during the fall of 2008. The decision was made to take the remaining SCAs scheduled between January and June of 2009 and space these QAA visits throughout the remaining 2009 calendar year. In addition to QAA monitoring challenges created by Division vacancies, the Bureau still intended for the Division to monitor approved gambling providers for adherence to their PPA. A gambling tool was developed, and spacing out the QAA visits as described was thought to allow time for the Division to begin monitoring approved providers of gambling services during the fiscal year. However, this monitoring did not occur as planned. Bureau priorities changed and the Division's time was needed in reviewing the proposed five-year Grant Agreement beginning July 1, 2010.

### **PROGRESS REPORT FY 2009-10**

The Division began the fiscal year with the intention to provide on-site QAAs to the remaining SCAs that were not able to be monitored during FY 2008-09. With the budget impasse lasting several months, SCAs were looking to County government or other entities for loans to cover staff salaries, where possible. Consequently, very few prevention, intervention, treatment or treatment-related services were provided during this difficult fiscal time. The decision was made to monitor only federal block grant requirements, which could be completed without on-site visits to the SCAs.

Although no gambling treatment providers have been monitored midway through the fiscal year, the Division intends to begin monitoring providers during the last quarter of this fiscal year. The number of providers to be monitored and the amount of time needed on-site remains somewhat unknown. However, once the process begins, Division management staff will be better able to establish specific protocols related to monitoring approved gambling providers. The feedback obtained during this initial monitoring period will be discussed with the Division of Treatment so decisions can be made about making needed policy changes in the Gambling Services Manual.

While the Division routinely provides technical assistance (TA) as part of the QAA process, Division staff began providing TA visits outside of the QAA process as a way to assist SCAs in the enhancing management of their service delivery system. Bureau staff continues to refine their review of fiscal, program, data and personnel information, as well as how these component areas interrelate. As a result, the review process has raised questions or required clarification about the information provided by the SCAs. This internal review and discussion with all Divisions and sections attempts to focus on fiscal and administrative efficiencies so as to include the quality of

service delivery beyond the scope of specific requirements identified in the Grant Agreement. It seemed appropriate to identify a way to work with the SCAs, not only to address questions generated by this internal review, but to help them to evaluate how their own fiscal, program, data and personnel information interrelate at the local level. SCA Administrators would be able to apply this type of review for evaluation and oversight of its management and service delivery operations. The Division scheduled one TA visit during January 2010, and it anticipates providing at least one more during FY 2009-10.

## **STATE PLAN FY 2010-11**

The Division will continue monitoring SCAs and approved gambling providers. Additional monitoring responsibilities may be added as a result of Act 1. Given the addition of gambling provider monitoring and as-needed TA visits, not all SCAs may be able to be monitored on an annual basis. Rather, it is anticipated that SCAs will be monitored on an 18-month basis for FY 2009-10 and throughout the upcoming Grant Agreement (July 2010-June 2015). A new requirement of the five-year Grant Agreement with the SCAs beginning July 1, 2010, is that the SCAs providing licensed drug and alcohol treatment services--referred to as functional SCA treatment units--will receive an on-site monitoring visit regarding requirements specific to providing functional treatment services. This on-site review will be part of an approval process to determine if the SCA is permitted to retain its functional treatment unit as part of the SCA. This monitoring visit will be completed by Division staff, but may also include other Bureau staff, as needed.

# TRAINING

## BACKGROUND

The Bureau of Drug and Alcohol Programs' (BDAP) training system provides continuing education and skill-building courses to meet the needs of the substance abuse and problem gambling fields. These courses focus on state-of-the-art concepts presented by experts and practitioners in the substance abuse and problem gambling treatment and prevention fields and other ancillary fields. BDAP has an extensive list of skilled trainers able to conduct trainings throughout the commonwealth. The major components of the training system are:

### Mini-Regional Trainings

The Mini-Regional Trainings (MRTs) are one-day events containing up to four core or basic courses. The MRTs are offered every other month in each of the six health districts. The courses are rotated through each of the health districts providing each district with up to 24 courses per year. There is no charge for participation in the MRTs.

### On-Site Trainings

The on-site trainings allow service providers and Single County Authorities (SCAs) the opportunity to request trainings specific to their needs at little or no cost to the requestor. All requests for on-site training must be coordinated through the respective SCA to ensure maximum use of the training site and trainer.

### Specialized Trainings

These trainings usually address new initiatives or changes in policies or practices. These trainings are often initiated by BDAP and are usually mandatory. They may also include courses that do not have sufficient attendees in any one specific area of the commonwealth. These courses will be centralized and presented as a specialized training.

### PA Case Management Network (PACNET)

PACNET holds their annual conference in October and usually requests the Bureau to sponsor several trainings during the conference. In 2009, PACET requested a total of 15 for the three-day conference.

### Public Health Information Clearinghouse

The Information Clearinghouse provides, upon request, information on a wide variety of public health issues. Materials are provided and shipped free of charge. The clearinghouse catalog is available online at [www.health.state.pa.us/padohric/](http://www.health.state.pa.us/padohric/).

**ANNUAL REPORT FY 2008-09, PROGRESS REPORT FY 2009-10  
AND STATE PLAN FY 2010-11**

**GOAL: Better Utilization of Training Resources.**

**ANNUAL REPORT FY 2008-09**

Through restructuring of the training system, BDAP was able to increase attendance and reduce the no-show rate at Mini-Regional Trainings and on-site trainings. Regional Training Institutes have not been presented during this reporting period, due to issues of contracting for sites. The following table lists the course types and attendance for the past two fiscal years:

Course Type	Number of Courses		Participants	
	07-08	08-09	07-08	08-09
On-site	277	267	4610	5,845
Mini-Regional Trainings	125	132	2134	2,568
Specialized	39	39	1333	1,197
PACNET	14	15	186	186
Training of Trainers	2	3	16	34
Regional Training Institute	35	0	234	0
<b>Total</b>	<b>492</b>	<b>456</b>	<b>8389</b>	<b>9,830</b>

**PROGRESS REPORT FY 2009-10**

The Training Advisory Workgroup has met several times and has identified some problem areas and made recommendations to address them. One major recommendation was to implement online training. The Bureau is currently working to contract for an online training package that will be used to present some of the didactic courses. It is anticipated that the system will be available by July 2010.

BDAP is in a constant process of reviewing training needs and determining the need for scheduling various Trainings of Trainers (TOT) to expand the trainer base. A TOT is scheduled for February 2010 for Clinical Supervision trainers.

**STATE PLAN FY 2010-11**

BDAP is continually exploring a variety of ideas to improve utilization of training resources.

## BACKGROUND

The ultimate goal of the public health **performance management process\*** is to use quantifiable data to strengthen the quality of the public health system, thereby improving health outcomes for the public. This process guides decision makers to identify and track health-related benchmarks, as well as indicators of the quality of care and appropriate health outcome indicators. When well-supported and appropriately implemented, a performance management process can improve the quality of the health care system over what might be attained by traditional management methods. Our data systems should be used to identify areas of exemplary performance, which can lead to sharing information about effective practices. Public accountability is enhanced by ongoing efforts to monitor data to improve services.

As the single state agency for drug and alcohol funds in Pennsylvania, the Bureau is uniquely positioned to infuse performance management throughout the system to improve the quality of services, client satisfaction and outcomes. Current state data systems provide a foundation on which to build a performance management approach to improving treatment and prevention results towards addiction. Integrating substance abuse treatment and prevention data with other state agency data sets allows us to answer an even broader range of key questions from our management, staff, service providers, legislators, service recipients and public constituents. For example, by eventually integrating non-client identifying Alcohol and Other Drugs (AOD), Medicaid and other data, we can:

- **Identify** a sub-group of AOD clients with high utilization of physical health care services;
- **Estimate** medical care-related cost savings that might result from increasing AOD services to this target group;
- **Decide** to expand treatment capacity and utilization of treatment services among this target group;
- **Evaluate** the impact of that programmatic decision on physical health care utilization and other client outcomes; and
- **Share** results with stakeholders.

State agencies collect a variety of information on individuals they serve or encounter. The BDAP maintains drug and alcohol data as a routine part of operations. Treatment data is collected through the Client Information System (CIS), and prevention data is collected through the Performance-Based Prevention System (PBPS). Along with our federal agency, the Substance Abuse Mental Health Services Administration (SAMHSA), we continue to define outcome measures for prevention and treatment related to substance abuse disorders. National Outcome Measures (NOMs) include abstinence from drug and alcohol use, increased school attendance/employment and cost effectiveness. Much of the data currently collected has provided agencies with basic information on the number of services, number of people served and the types of services.

BDAP's Data Section has been actively involved in shaping the NOMs discussion, as well as looking to develop additional measures that the state will use to measure the effectiveness of its evolving statewide treatment and prevention systems. BDAP, in conjunction with the Institute of

Research, Education and Training in Addictions (IRETA), has defined state performance-based measures. The Data Section's responsibilities also include collecting and maintaining data supporting Pennsylvania's Federal Block Grant reporting, Drug and Alcohol Services Information System (DASIS) Treatment Episode Data Set reporting, Pennsylvania Gambling Addiction reporting, Single County Authority reporting and the BDAP Training Management System (BTMS). The Data Section also manages statewide communications to the substance abuse and gambling addiction fields through the Communicator, Portal, Listserve and other information systems.

\*As used in this document, performance management refers to the process of using performance measures and other data to improve the efficiency and effectiveness of organizations (Landrum & Baker, 2004). Performance measures are quantitative indicators that have been identified by program administrators as valid and reliable measures of program success or program difficulties.

## **ANNUAL REPORT FY 2008-09, PROGRESS REPORT FY 2009-10 AND STATE PLAN FY 2010-11**

**GOAL: To improve communication with the substance abuse and gambling fields and the general public.**

### **ANNUAL REPORT FY 2008-09**

For FY 2008/09, BDAP's Listserve reached 2,081 registered opt-in members. These members received 116,608 e-mails, of which 98 percent were delivered successfully. Members opened emails 31 percent of the time and read those same emails 25 percent of the time.

During 2008, the BDAP Communicator, BDAP's standard method of informing SCAs of important information from the bureau, posted and sent 96 targeted messages. BDAP also expanded the use of the Communicator for members of the Treatment Data System Committee and the Division of Program Monitoring. The Division of Treatment continues to use the BDAP Communicator as a tool for the SCAs to post their Needs Assessments and Treatment Plans. The Treatment Division then posts the approvals to the BDAP Communicator.

### **PROGRESS REPORT FY 2009-10**

In January 2010, as part of the Bureau's ongoing effort to increase BDAP Listserve membership by 5 percent each year, there were 2,508 registered e-mail addresses showing over a 20 percent increase from last year. The Bureau sent 63,531 emails with a 98 percent delivery rate. Of that number, 27 percent were opened and 22 percent of those e-mails were read.

BDAP continues to use the BDAP Communicator as its main targeted communication with SCAs. Our targeted communications to the SCAs from the Communicator are receiving over 40 percent open and read rates. Through 2009, the BDAP Communicator introduced 114 posts and sent approximately the same number of communications to SCA Administrators.

### **STATE PLAN FY 2010-11**

BDAP will continue to use the Listserve to provide information to the field and the community. In 2009-2010, the Bureau will be working to increase our outreach in subscriptions by 5 percent each year. We will look to increase open and read rates throughout the year by 3 percent each.

BDAP looks to maintain and integrate the BDAP Communicator into the new Treatment Data System through Really Simple Syndication (RSS) feeds. This would produce a beneficial result to the SCAs of having more of a one-stop shop.

**GOAL: To maintain a national leadership role with drug and alcohol prevention data collection.**

## **ANNUAL REPORT FY 2008-09**

BDAP worked to identify technical issues that resulted from major changes in capturing participant-level data entry in the PBPS application. The Division of Prevention and the Data Section with Bureau of Information Technology isolated these issues.

Through a continued initiative, BDAP worked collaboratively with the Bureau of Health Statistics to analyze and make all data findings more precise and consistent within Prevention and all BDAP areas. This was successfully accomplished with the expansion of the data section in the 08/09 State Plan, as well as the addition of a narrative component to the data presented.

## **PROGRESS REPORT FY 2009-10**

BDAP has been working to move the PBPS reporting system back to KIT Solutions. KIT originally created the PA PBPS, and the system has since been enhanced and improved. The Division of Prevention and the Data Section works with BIT to ensure data integrity and quality are maintained through this process. More effective reports to assess outcomes are a major goal for BDAP in 2009/2010. The overall goal is to successfully enhance PBPS towards implementation of our public health **performance management process**. BDAP believes this move will benefit the field in the long term, while showing the accountability by providing the “right data” in reporting in the short term.

## **STATE PLAN FY 2010-11**

BDAP will continue to advance PBPS. This will be accomplished through both the successful move to KIT Solutions and, most importantly, the PBPS users group.

The PBPS users group will continue to work on identifying other areas of improvement. In addition, the users group will continue to assist BDAP with evaluating and revising Prevention Outcome Measures.

Benefits to SCAs and providers from a successful move to KIT will include:

- New technical advances. KIT currently holds several Federal contracts with SAMHSA, Center for Substance Abuse Prevention (CSAP), and Office of National Drug Control Policy (ONDCP). This allows the 17 states that they also contract with “to have an edge up” on NOMS and other reporting requirements.
- Less staff time devoted to technical matters. Since KIT manages data base system contracts with the Federal Government and multiple states, they can offer Pennsylvania the latest cutting edge prevention system, up-to-date technology, user friendly navigation and a system with minimum to no downtime. System updates do not require Information Technology personnel.
- Reduced down-time associated with system outages. KIT has over 70 Information Technology support staff, who work in specialized areas of the system. Therefore, issues

that arise in the database system are fixed at time of discovery. KIT offers technical assistance for troubleshooting and provides solutions until 8 P.M. during the work week.

- Reduced travel costs when it comes to training. KIT provides PBPS, prevention 101 and MDS training online. This could mean a huge savings in travel costs, as well as staff time, for both the SCAs and prevention providers.
- Data will be more accessible. KIT offers a number of standard reports and the ability to create unique reports specific to the Bureau's needs. Additionally, GPS mapping services are also available.

**GOAL: To advance the deployment of the new treatment data collection system and become a national leader in drug and alcohol treatment outcomes.**

## **ANNUAL REPORT FY 2008-09**

BDAP participated in a collaborative multi-agency effort to bring the new treatment system Request for Proposal (RFP) to fruition. The partners involved included the Governor's Office, the Office of Administration, the Department of Public Welfare's Office of Mental Health and Substance Abuse Services, the Department of General Services (DGS) and the Department of Health to combine business requirements for a DGS-issued RFP. In late October 2008, an RFP was issued for the replacement of the Client Information System and Behavioral Health System. After an extensive evaluation process, a vendor was selected by multi-agency effort to support the substance abuse services field statewide.

## **PROGRESS REPORT FY 2009-10**

In October 2009, DGS awarded Core Solutions the contract to begin construction of a new statewide Treatment Data System. BDAP is working with all its interagency partners and stakeholders involved in the creation of a new data system. A Treatment Data System Committee was formed to address the development of the new Treatment Data System. Members include SCAs, providers and related associations. All were in attendance for the November 2009 project kick-off meeting to launch development of the system. Currently, the Treatment Data System Committee is completing a discovery process and gap analysis on the system components and data elements in relation to our current business processes.

## **STATE PLAN FY 2010-11**

BDAP will continue to work with the SCAs, providers, related associations and internal commonwealth stakeholders regarding the discovery, development and testing phases of the new system. In Spring 2012, BDAP anticipates offering a statewide full service Treatment Data System to the SCA and provider community.

**GOAL: To develop and maintain the Bureau of Drug and Alcohol Programs Web site.**

### **ANNUAL REPORT FY 2008-09**

In 2009, the BDAP Data Section planned a new Bureau Web site. Along with the Department's Web site, BDAP's Web site was converted to WebCentric, the Commonwealth Content Management System (CMS).

During FY 2008/09, BDAP's home page averaged 5,322 views. The Web views to the Gambling Page averaged 1,394; the Training Page averaged 1,724; and the Data Page averaged 575 views. After the popularity of the BDAP Home Page, these three pages also hold valuable resource information.

### **PROGRESS REPORT FY 2009-10**

The new BDAP and Gambling Web site was launched in December 2009, one month ahead of schedule. The new Web site was redesigned within the new state portal and was constructed using WebCentric. The Web site has a new look and feel, while organizing information better for its various audiences and stakeholders. Web site traffic has increased to an average of 4,433 views on the BDAP home page per month.

### **STATE PLAN FY 2010-11**

Web site maintenance and updates for the new Web site will be performed by appropriate BDAP staff. Staff will be trained and assigned according to content familiarity.

The Pennsylvania Department of Health Public Health Information Clearinghouse (PADOHPHIC) operates as the information clearinghouse for the Pennsylvania Department of Health. In a statewide effort to promote healthy lifestyles for all Pennsylvanians, PADOHPHIC's mission is to serve as a resource center and provide a wide range of health-related information. The Web application that currently runs the Public Health Clearinghouse is being revamped to contain new features, such as: online shopping cart ordering; a better search engine; and an easier to use interface. BDAP looks to complete this project with BIT by July 2010.

**GOAL: Utilize technology to improve operations.**

### **ANNUAL REPORT FY 2008-09**

All BDAP applications were stabilized through fiscal year 08-09. The BDAP Communicator continued to be utilized by the Bureau to communicate to the SCAs. The BDAP Training Management System (BTMS) usability was enhanced from its current state with several reports added. Furthermore, the Web site was upgraded to the new Webcentric technology. BDAP's Data Section will begin a discovery, evaluation and benefits process to all applications. The resulting

assessment of better streamlining operations and surveying stakeholders on a needs basis will continue to be centralized and simplified.

## **PROGRESS REPORT FY 2009-10**

A discovery process has been initiated to evaluate all BDAP technology currently in use and to assess whether separate applications can be integrated, including the SCA Data System (SDS) and the BDAP Communicator. This integration is in relation to provider monitoring reports. SCA discussions about the integration and incorporation of contract and contact information from the SDS to the new Treatment Data System have taken place and will continue. No final decisions have been made about the resulting integration to date, although they are under consideration.

## **STATE PLAN FY 2010-11**

SDS will be streamlined and integrated into the new Treatment Data System to enhance and assist operations and keep “consistency and ease of use” in mind for SCAs and BDAP staff. The key is to provide fewer logins to remember and less data entry, combined with more potential for empowering the SCAs and provider community with more resources at their fingertips.

## **CHAPTER THREE**

### **WOMEN AND CHILDREN'S ANNUAL REPORT (as required by Act 65 of 1993)**

**STATE FISCAL YEAR 2008/2009**

## WOMEN AND CHILDREN'S REPORT

Act 65 of 1993 authorizes the Department of Health (DOH) to establish and fund residential drug and alcohol treatment programs for pregnant women and women with dependent children. The DOH contract with Single County Authorities (SCAs) authorizes expenditure of the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant allocations for Women with Children and Pregnant Women to include all levels of care that offering specific services to this population. Such services are SAPT Block Grant requirements.

Consistent with that mandate, DOH has developed programs designed for women accompanied by their children. In addition to therapies dealing with substance use disorders, the women and children programs offer training in parenting, social and life skills development, family therapy/family reunification and other activities related to their rehabilitation. Children are given age appropriate education regarding substance abuse, and, if school age, they are enrolled in a nearby school. Women and children programs across the commonwealth have worked diligently to establish a positive working relationship with staff from the local school districts so that the children are served in the best possible way. Additionally, programs across the continuum of care have been developed within individual SCAs by willing providers that offer similar services at a level of intensity appropriate to individual types of service.

During the course of FY 2008-2009, service capacity for women/women with children was as follows:

- Programs providing residential treatment services exclusively for pregnant women and/or women with dependent children = 15
  - Total Capacity for Women = 271
  - Total Capacity for Children = 300+
- Short Term Residential Programs for women = 8
  - Total Capacity = 177
- Halfway House Programs = 13 (two of which also house children)
  - Total Capacity for Women = 269
  - Total Capacity for Children (at 2 facilities) = 51

SCAs are contractually required to provide access to a full continuum of care and provide preferential services for this population. As a result, a number of treatment providers have developed gender-specific components to existing programs that serve the needs of this population, either on-site or by referral to appropriate agencies. Age-appropriate prevention programs for the children of women in treatment are provided as well, through agreements with prevention providers or specially trained child development staff.

Expected outcomes for the women-centered and need-specific programming for women and children include:

- Development of knowledge and skills to maintain a self-directed recovery and abstinence from alcohol and other drugs;

- Education and life skills to become productive members of society;
- Prevention/education for accompanying children;
- Reduction in perinatal addictive disorders;
- Reduction in acute health care costs;
- Reduction in legal system involvement and criminal behavior;
- Reduction in unemployment;
- Reduction in homelessness;
- Development of parenting skills for mothers; and
- Improved communication skills for mothers and children.

During FY 2008-2009, the following residential women with children programs were in operation:

- Family Links (Allegheny)
- Family Links (Lehigh)
- Family House (Montgomery)
- Family House New Options for Women (NOW) (Philadelphia)
- Gaudenzia - Fountain Springs (Schuylkill)
- Gaudenzia - Kindred House (Chester)
- Gaudenzia - New Image (Philadelphia)
- Gaudenzia - Vantage (Lancaster)
- Gaudenzia – Winner (Philadelphia)
- Genesis II - Caton Village (Philadelphia)
- Interim House - West (Philadelphia)
- Libertae Family House (Bucks)
- My Sister's Place (Philadelphia)
- Samara House (Chester)
- Sojourner House Inc. (Allegheny)

In addition, there were 13 halfway house programs that specifically provided services to women. Some of these facilities can accommodate pregnant women, and some are able to accommodate children:

- Abstinent Living at the Turning Point (Washington)
- Another Way (Fayette)
- Clem-Mar House, Inc. (Luzerne/Wyoming)
- Catholic Charities Diocese of Harrisburg (Dauphin)
- Community House, Inc. (Erie)
- Cove Forge Renewal Center (Cambria)
- Gatehouse for Women (Lancaster)
- Gaudenzia-New Destiny (Schuylkill)
- Highland House (Lawrence)
- Lighthouse for Women (Washington)
- Liberate (Bucks)
- PA Organization for Women in Early Recovery (Allegheny)
- Pine Ridge Manor (Centre)

There were eight facilities across the commonwealth that provided short-term residential treatment programs exclusively for women:

- Diagnostic and Rehabilitation Center (Philadelphia)
- Eagleville Hospital (Montgomery)
- Interim House (Philadelphia)
- Lighthouse for Women (Washington)
- Pyramid Health Care - Gratitude House (Blair)
- Second Beginning - Genesis II (Philadelphia)
- Womanspace (Montgomery)
- Womanspace (Philadelphia)

BDAP provides technical support and assistance to Women and Their Children Heal (WATCH). WATCH is a coalition of women and women with children providers whose mission is the enhancement of gender-specific drug and alcohol programs and the protection of mandated services for women, pregnant and parenting women and their children. WATCH is in the process of finalizing a “White Paper,” focusing on gender-responsive treatment for women with substance use disorders. All recommendations will be forwarded to BDAP. In cooperation with BDAP’s Treatment Division and Training Section, WATCH is developing a training curriculum that will encompass best practices in providing treatment services to women. BDAP will continue to provide technical assistance to WATCH in the development of the “White Paper.”

# PART 2

PREVENTION / TREATMENT DATA

AND

FINANCIAL INFORMATION

## **Data Analysis Compiled from the Performance Based Prevention System (PBPS) State Fiscal Year 2008-2009**

The Division of Prevention strives to increase the implementation of substance abuse prevention policies and practices that are based on the latest research within the substance abuse field. Overall, it can be demonstrated that policy change has led to more recurring and evidence-based/innovative programs (more intense and research-based services) overall. The following tables and graphs are an analysis of that information.

### **Prevention Services in Pennsylvania**

In Figure 1, Total Prevention Services are shown for all BDAP-funded services reported through the Performance-Based Prevention System (PBPS). From State Fiscal Year 2004-2005 through 2007-2008, there was an incremental decrease in total services, as SCAs and their contracted providers increased recurring services. For State Fiscal Year 2008-2009, an increase of over seven thousand indicates an overall stabilization of services. BDAP anticipates that this decrease in total services will stabilize, as providers become more efficient with delivery of these more effective recurring services.

### **Prevention Services by Single and Recurring Type**

Figure 2 details the move towards a more balanced approach to service delivery. Upon BDAP's State Fiscal Year 2004-2005 data review, it was realized that the SCA comprehensive plans that were being delivered should include a more balanced approach between single and recurring services. Thus, in State Fiscal Year 2005-2006, BDAP implemented a more defined policy stating 20 percent of all services must be done in a recurring fashion. BDAP, SCAs and their contracted prevention providers are now accountable for providing recurring services. Research shows that over time, recurring services will have a greater impact on Pennsylvanians. Figure 2 shows that single services have stabilized, and recurring services have been increasing steadily over the last four State Fiscal Years. Figure 3 further illustrates this change in policy by showing the number of people served in single services (attendees) and recurring services (participants). In the State Fiscal Years following the new policy, total attendees have been on the decline, and total participants have been increasing.

The following defines single and recurring services:

**Single Service Type** – Single prevention services are one-time activities intended to inform or educate general and specific populations about substance use or abuse (examples: Health Fairs, Speaking Engagements).

**Recurring Service Type** – Recurring prevention services are a pre-planned series of structured program lessons and/or activities. These types of services are intended to inform, educate, develop skills and identify/refer individuals who may be at risk for substance use or abuse. A recurring prevention activity needs to have an anticipated measurable outcome, which may include pre- and post-testing (examples: Classroom Education, Peer Leadership Programs, Peer Mentoring, Alcohol, Tobacco and Other Drug (ATOD) Free Activities Recurring).

Figure 1

# Total Prevention Services as Reported to PBPS State Fiscal Years 2004-2005 through 2008-2009

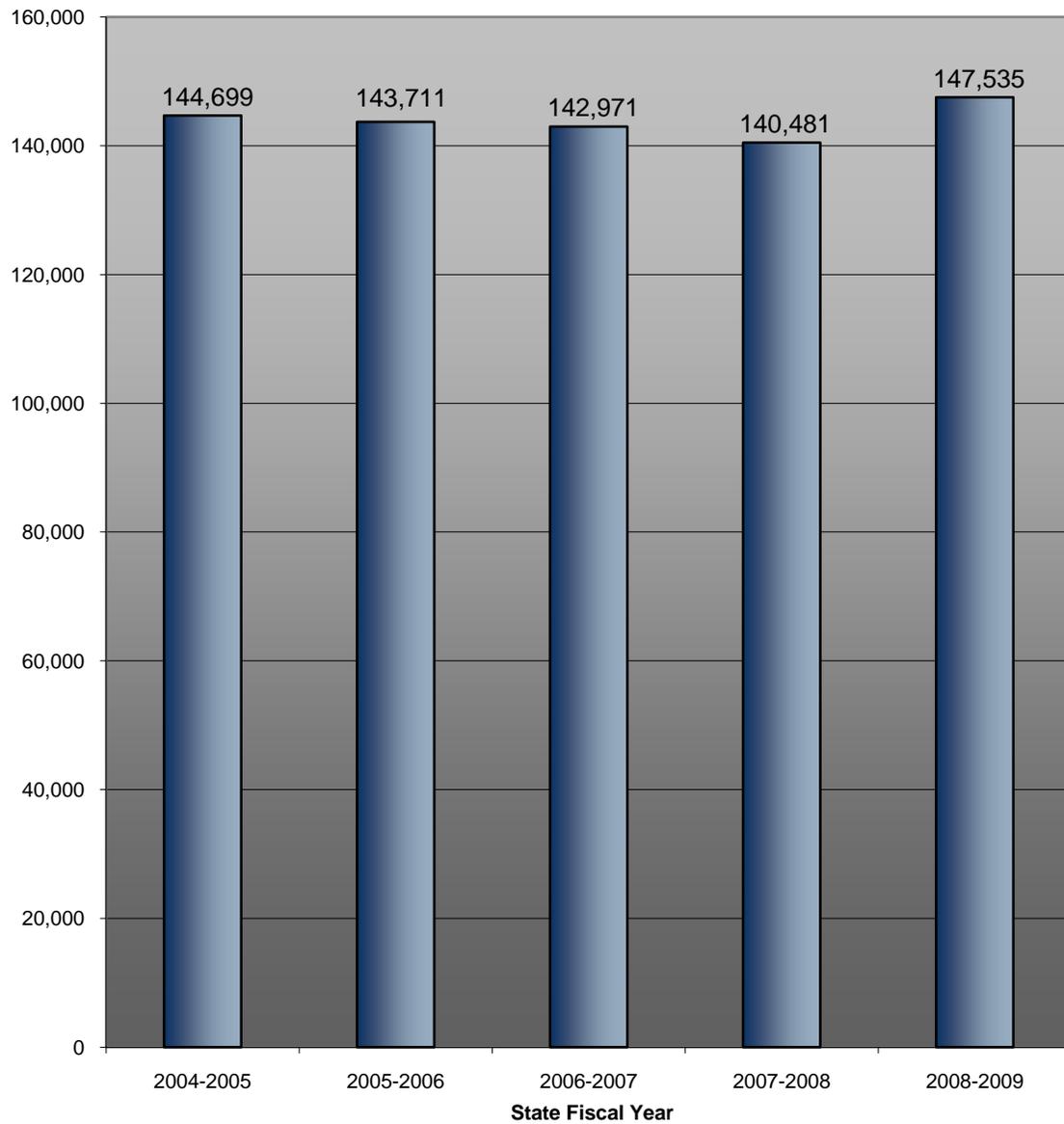


Figure 2

# Single and Recurring Prevention Services as Reported to PBPS State Fiscal Years 2004-2005 through 2008-2009

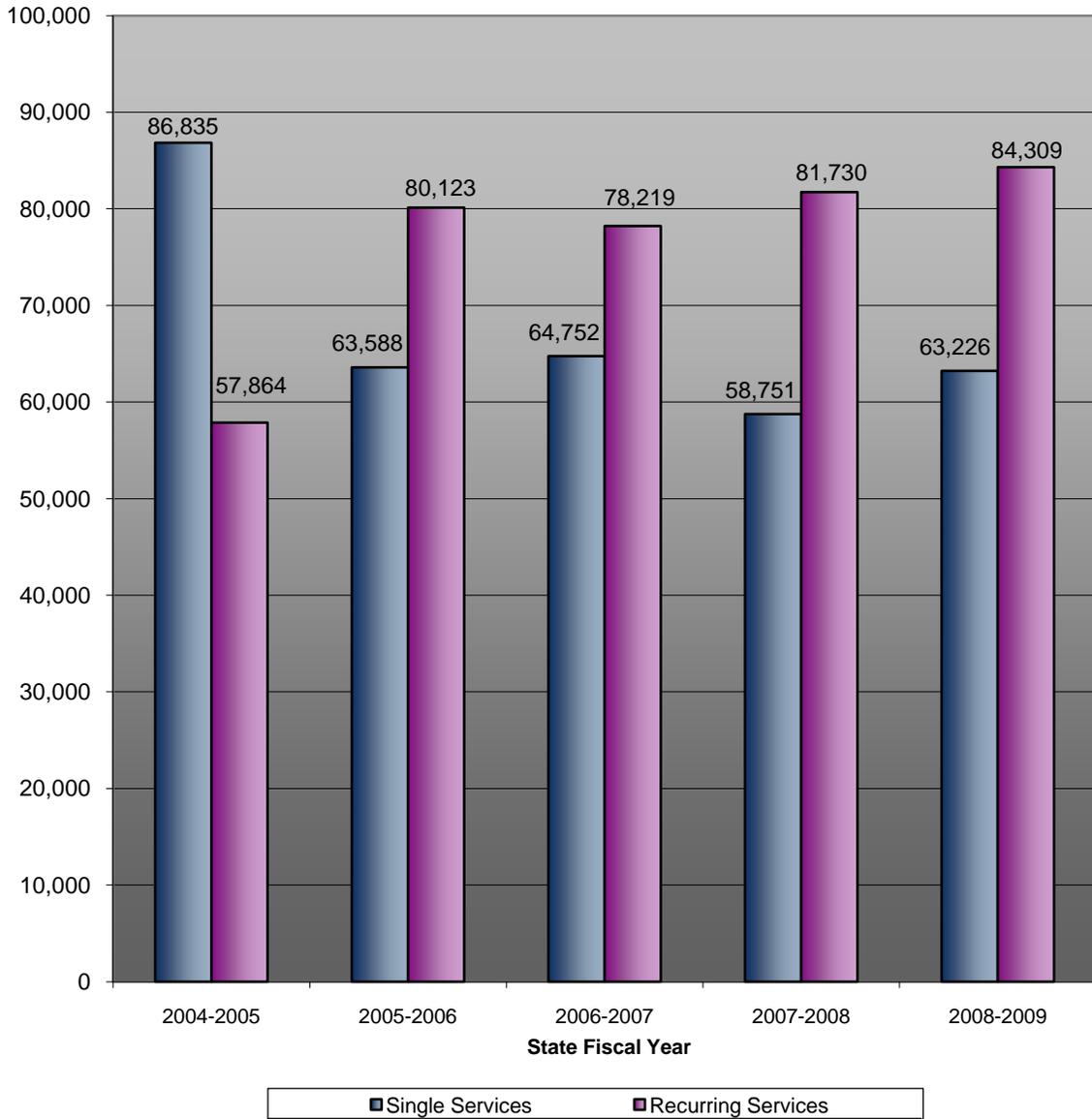
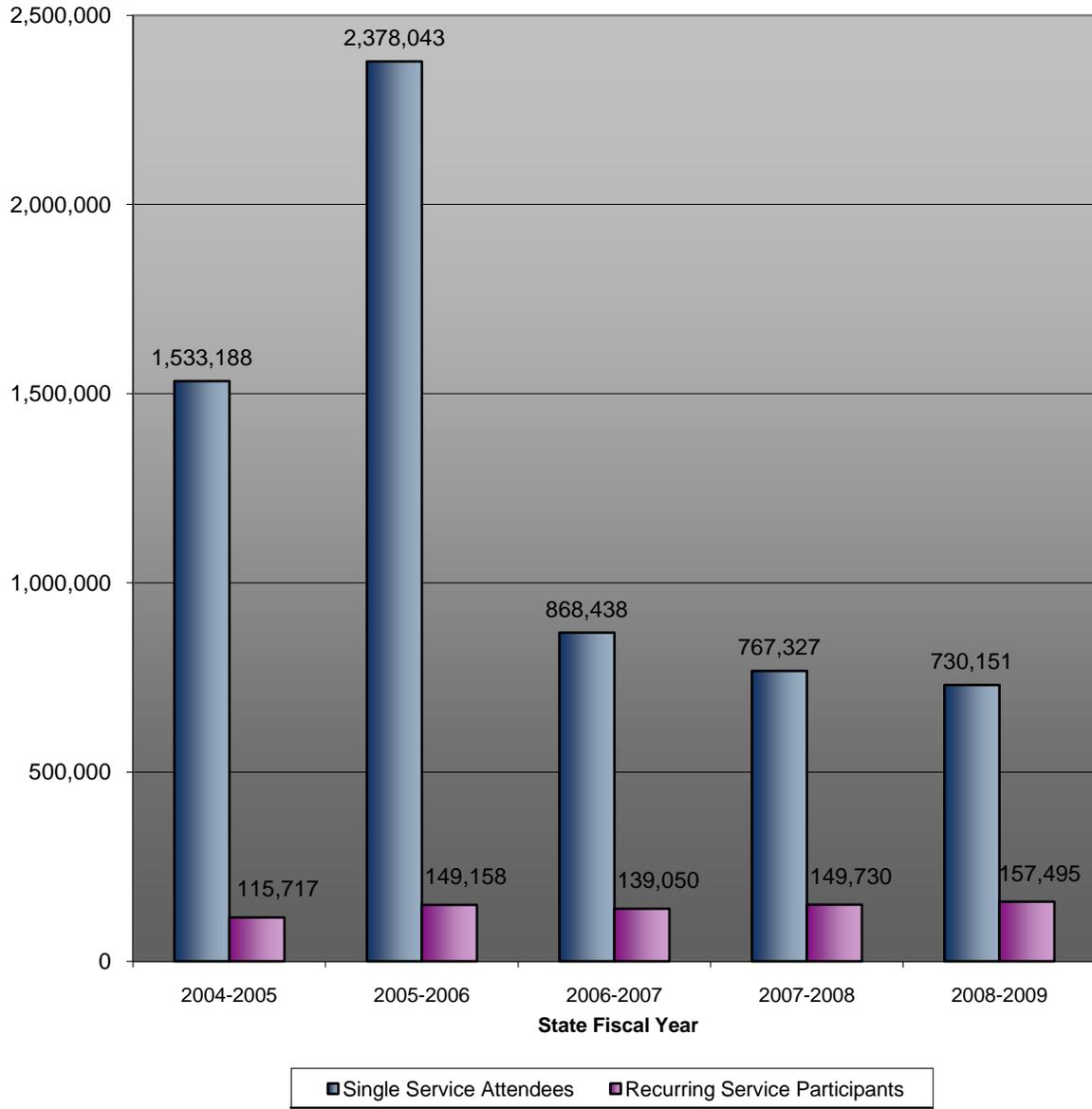


Figure 3

# Prevention Service Attendees and Participants State Fiscal Years 2004-2005 through 2008-2009



## **Evidence-based, Innovative, and Generic Programs**

The graph in Figure 4 demonstrates a four-year trend of the three prevention service categories: Evidence-Based, Innovative, and Generic. In a move towards a more accountable approach, BDAP required a minimum of 25 percent innovative and evidence-based services. This policy started in State Fiscal Year 2005-2006. The graph shows the policy is working as intended. There has been an increase in evidence-based and innovative services and a decrease in generic services. Evidence-based and innovative programs provide more rigor and effectiveness than generic programs.

The programs are defined as follows:

**Evidence-based Programs** include strategies, activities, approaches and programs which are:

- Shown through research and evaluation to be effective in the prevention and/or delay of substance use/abuse
- Grounded in a clear theoretical foundation and carefully implemented
- Reviewed by other researchers to ensure that proper evaluation findings exist
- Replicated and produced desired results in a variety of settings

**Innovative Programs** meet the following criteria:

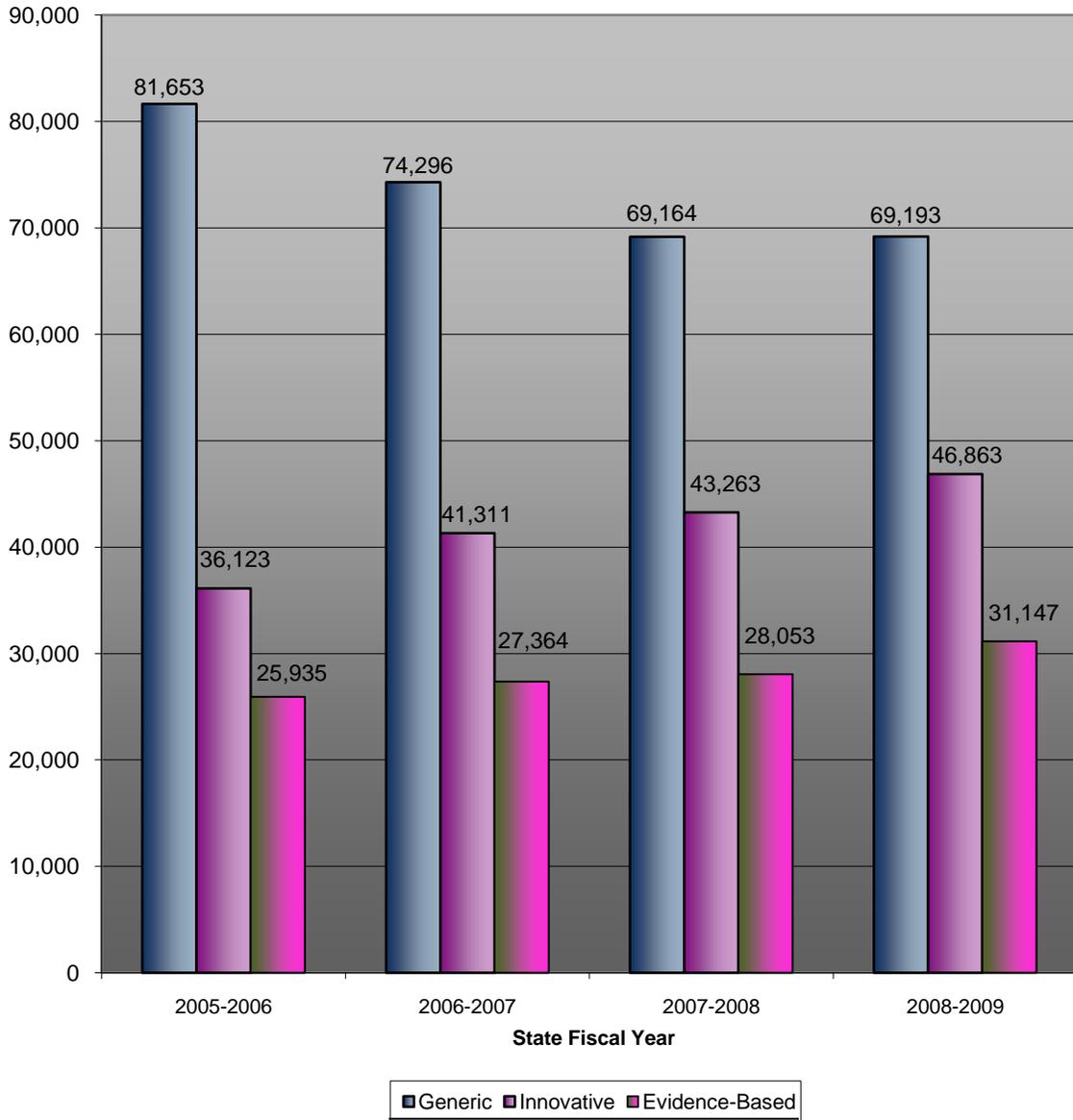
- Program/principle has been identified or recognized publicly and has received awards, honors or mentions
- Program/principle has appeared in a non-referred professional publication or journal
- Programs that were purchased from a developer to be Innovative Programs may be considered by BDAP. Examples of these types of programs include: Beginning Alcohol and Addiction Basic Education Studies, Project Meds, Parent-to-Parent, etc.

**Generic Programs** are defined as programs which:

- Capture activities that are not otherwise specified as evidence-based or innovative programs
- Provide basic alcohol, tobacco and other drug awareness/education, as well as everyday alternative prevention activities.

Figure 4

## Prevention Services by Program Category as Reported to PBPS State Fiscal Years 2005-2006 through 2008-2009



## **Institute of Medicine (IOM) and Prevention**

In 1994, the Institute of Medicine (IOM) developed a model to show the effectiveness of a continuum of care. The IOM model includes three prevention classifications based on the degree of risk factors in the target population: universal, selective and indicated. They are defined as follows:

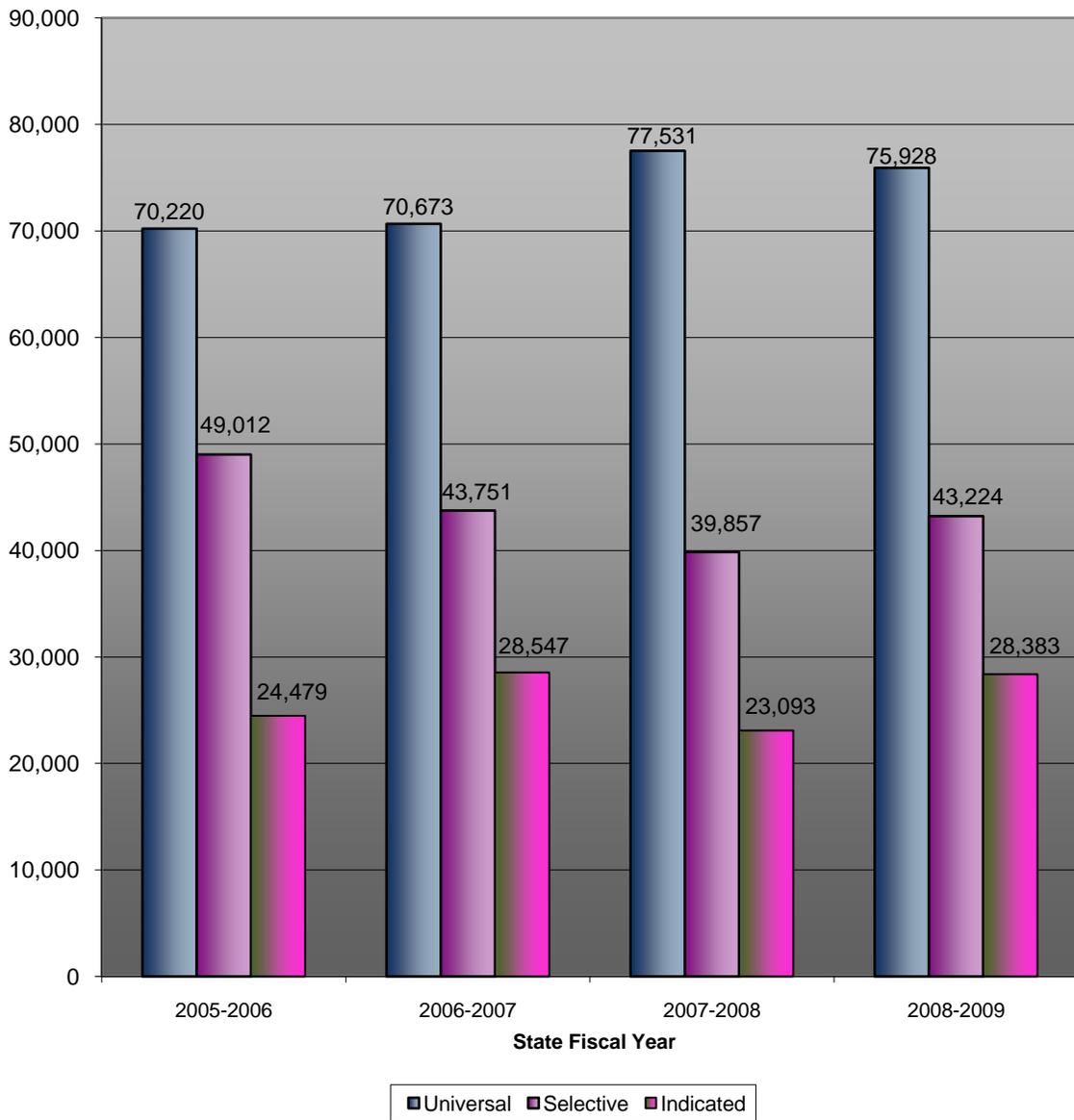
- Universal strategies address the entire population;
- Selective strategies focus on subsets or subgroups of the population exposed to greater levels of risk; and
- Indicated strategies are designed to prevent the onset of substance abuse in individuals who have initiated the use of alcohol or other drugs.

These classifications were adopted by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Center for Substance Abuse Prevention (CSAP) and the Centers for the Application of Prevention Technologies (CAPTS).

Figure 5 shows a four year trend of reporting data under the IOM requirements. These results are due to the CSAP strategic prevention framework that encouraged targeting specific populations and communities. The trend data shows all population category counts stabilizing, while providing those individuals at greater risk with more effective services.

Figure 5

# Prevention Services by Institute of Medicine Population Categories as Reported to PBPS State Fiscal Years 2005-2006 through 2008-2009



## Federal Strategies in Prevention

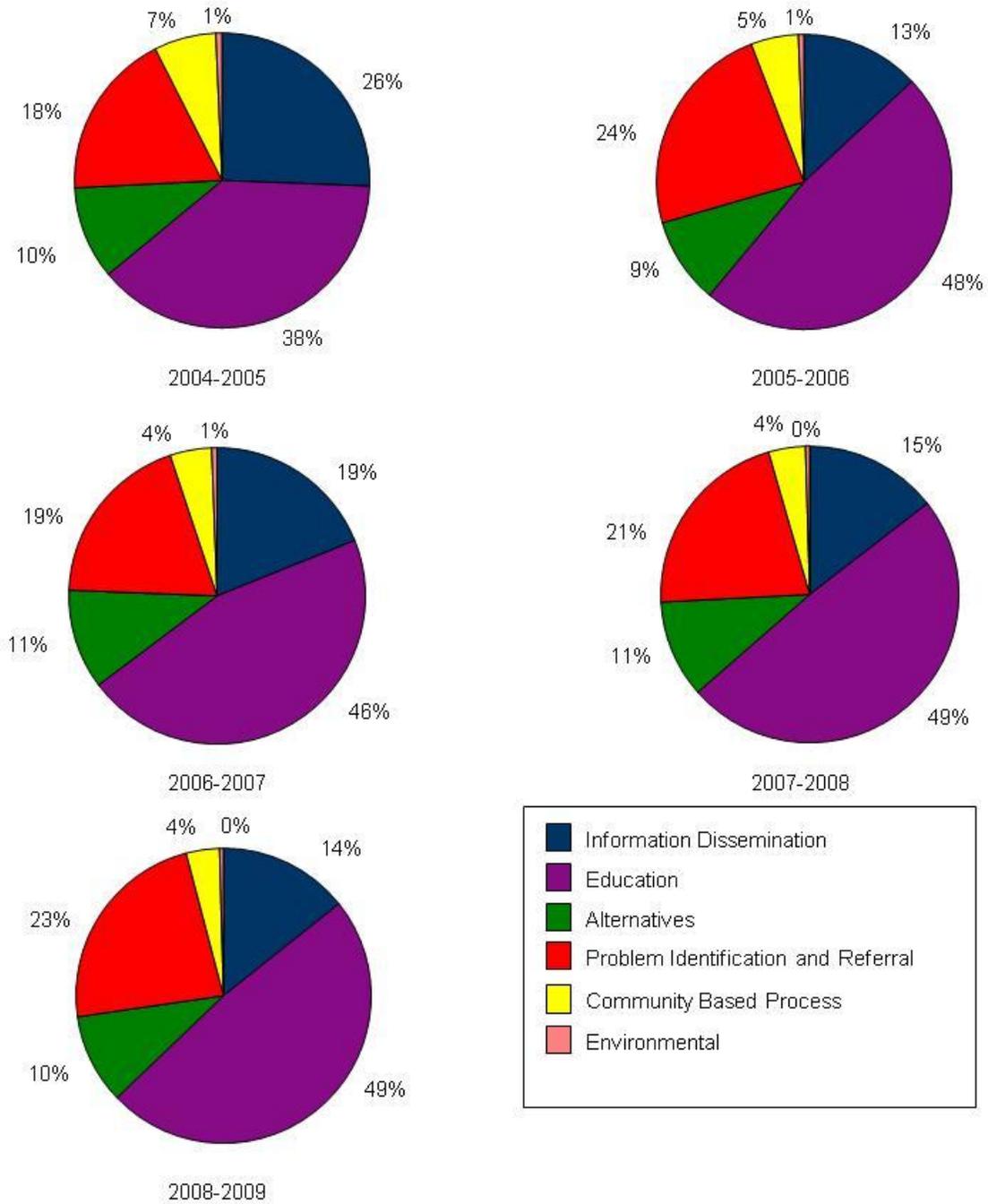
Figure 6 demonstrates a five-year trend of the six Federal Strategies. They are comprised of the overall concept of services that prevent or reduce the use and abuse of alcohol, tobacco and other drugs. There has been a slight decrease in the Information Dissemination strategy, due to it naturally falling into the single service model. Approximately 50 percent of all strategies are education oriented, and the remaining 50 percent are in support of the education strategies. Overall, this trend data shows a balanced approach to prevention services.

The six Federal Strategies are defined as:

- **Information Dissemination** – provides awareness and knowledge on the nature and extent of alcohol, tobacco and drug use, abuse and addiction and the effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.
- **Education** – involves two-way communication, which is distinguished from the Information Dissemination category by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this category are to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages) and systematic judgment abilities.
- **Alternative Activities** – operates under the premise that healthy activities will deter participants from the use of alcohol, tobacco and other drugs. The premise is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by, alcohol, tobacco and other drugs (ATOD) and therefore minimize or eliminate use of ATOD. These activities must be directly linked to an educational or skill-building activity.
- **Problem Identification and Referral** – targets those persons who have experienced illicit/age-inappropriate use of alcohol, tobacco or other drugs in order to assess if their behavior can be reversed through education.
- **Community-Based Process** – aims directly at building community capacity to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities include organizing, planning, enhancing efficiency and effectiveness of services, inter-agency collaboration, coalition building and networking.
- **Environmental** – establishes or changes written and unwritten community standards, codes, ordinances and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the population. This category is divided into two subcategories: activities which center on legal or regulatory initiatives and those that relate to action-oriented initiatives.

Figure 6

# Prevention Services by Federal Strategy as Reported to PBPS State Fiscal Years 2004-2005 through 2008-2009



Defined below are the three IOM Population Categories. The six Federal Strategies can be done in each population category. Figure 7 shows these population categories broken out by Federal Strategy for state fiscal year 2008-2009. Included in the definitions are examples of activities that comprise the overall concept of services that prevent or reduce the use and abuse of alcohol, tobacco and other drugs.

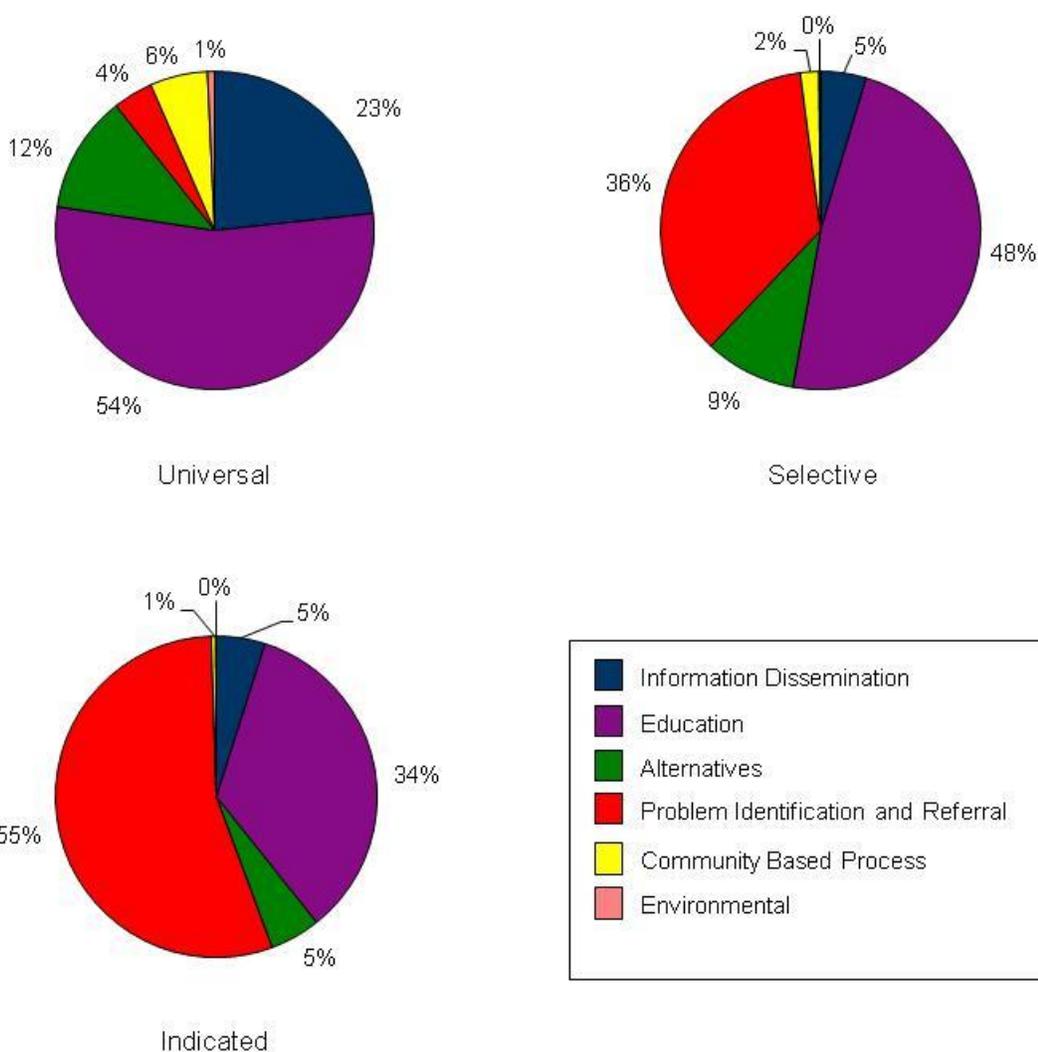
**Universal Preventive Interventions** are activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk. Information Dissemination is a large part of informing large general audiences successfully. Education to the universal population is also an important aspect of prevention programming. The Division of Prevention has the goal of increasing Community-Based Processes in the future.

**Selective Prevention Interventions** are activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than the universal population. Education and Problem Identification/Referral are a large part of successfully providing service to this audience at this stage. Problem Identification/Referral is used with this higher risk population to get them into more intense prevention services. Continuing to provide this balance of services to this population is our goal.

**Indicated Preventive Interventions** are activities targeted to individuals in high-risk environments identified as having minimal but detectable signs or symptoms foreshadowing a disorder or having biological markers indicating predisposition for a disorder, not yet meeting diagnostic levels. Again, Education and Problem Identification/Referral are a large part of providing service to this audience successfully.

Figure 7

# Institute of Medicine Population Categories by Federal Strategy Prevention Services as Reported to PBPS in 2008-2009



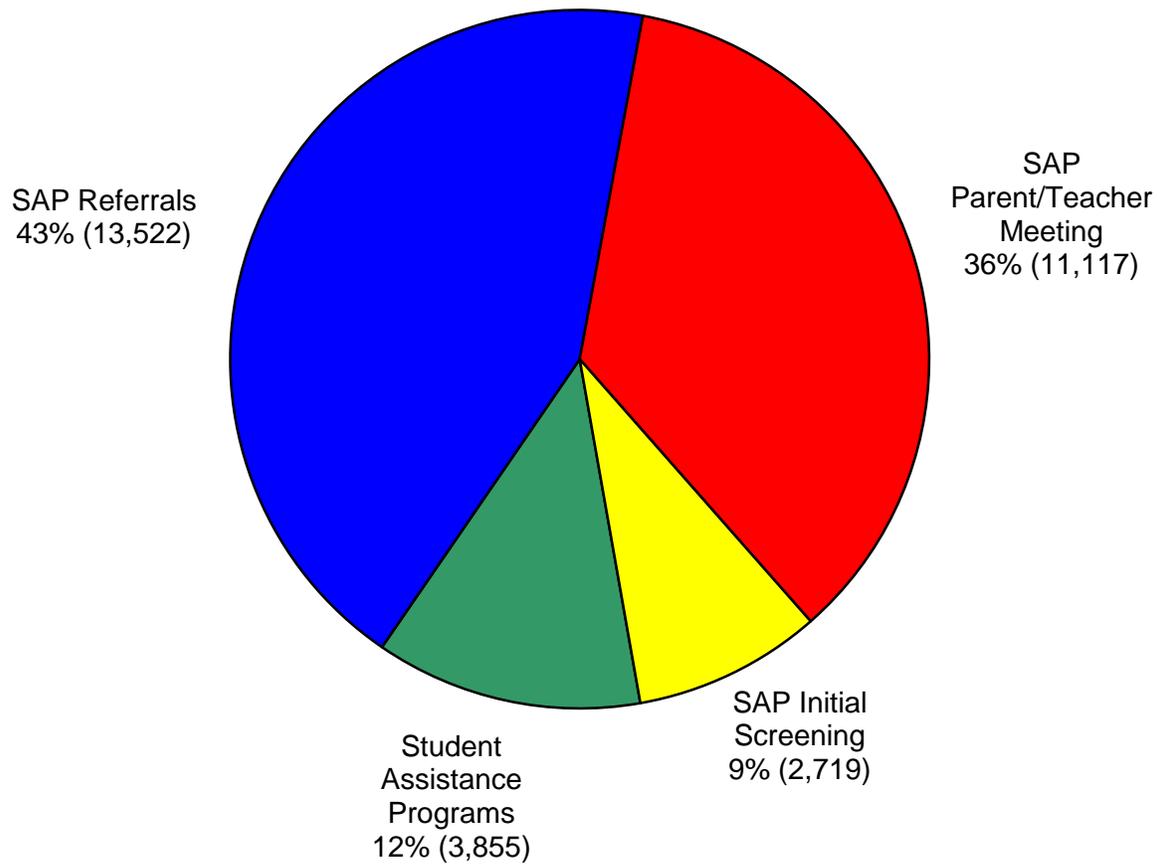
## **Student Assistance Data**

The Student Assistance Program (SAP) is an important intervention for the youth in Pennsylvania. Figure 8 shows all SAP services broken down into their specific approach (service code). These referrals were initiated by teachers, parents or counselors. These are recurring educational services that are provided to SAP-identified students only. SAP assists school personnel in identifying issues like alcohol, tobacco and other drugs, as well as mental health issues which can impede students' success. Services include assessment, consultation, referral and/or small group education for SAP-identified youth. SAP is mandated to all 48 SCAs to complement their prevention initiatives.

Figure 8

# Student Assistance Programs (SAP) as Reported to PBPS SFY 2008-2009

## Service Codes



Total SAP Services: 31,213

**Youth National Outcome Measures (NOMs) Survey Results as Reported to the Performance Based Prevention System (PBPS)  
October 1, 2008 to November 30, 2008**

The following survey results were gathered from Pennsylvania youth within the age groups 6-11, 12-14, 15-17, and 18 and older who received recurring prevention services from October 1-November 30, 2008. The October to November timeframe helps provide some consistency to these survey results from year to year. These results were voluntarily submitted by prevention providers across the state. Therefore, please consider these results to be a survey of convenience.

The results are presented categorically by Institute of Medicine (IOM) population groups (see definitions earlier). For questions pertaining to actual substance use (30 day or lifetime), please note the Selective and Indicated populations generally exhibit higher rates. This helps to show that the Selective and Indicated populations are being targeted appropriately. These data also illustrate the well-known fact that substance use increases with age.

\*\* Statistics are not displayed or calculated for low survey counts. This is due to the unreliability of statistics based on small numbers of events.

How old were you the first time you  
had a drink of an alcoholic beverage?

IOM Group	Age Group	Used in Lifetime	Total Respondents	Percentage Used in Lifetime
Universal	6-11	72	690	10.4 percent
Selective	6-11	13	107	12.1 percent
Indicated	6-11	**	**	** percent
Universal	12-14	547	2901	18.9 percent
Selective	12-14	211	662	31.9 percent
Indicated	12-14	37	84	44.0 percent
Universal	15-17	288	571	50.4 percent
Selective	15-17	331	477	69.4 percent
Indicated	15-17	157	202	77.7 percent
Universal	18 and Older	27	44	61.4 percent
Selective	18 and Older	69	77	89.6 percent
Indicated	18 and Older	44	46	95.7 percent

**Youth National Outcome Measures (NOMs) Survey Results as Reported to the Performance Based Prevention System (PBPS)  
October 1, 2008 to November 30, 2008 (continued)**

During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?

IOM Group	Age Group	Used in Past 30 Days	Total Respondents	Percentage Used in Past 30 Days
Universal	6-11	30	690	4.3 percent
Selective	6-11	6	107	5.6 percent
Indicated	6-11	**	**	** percent
Universal	12-14	227	2901	7.8 percent
Selective	12-14	98	662	14.8 percent
Indicated	12-14	12	84	14.3 percent
Universal	15-17	164	571	28.7 percent
Selective	15-17	170	477	35.6 percent
Indicated	15-17	90	202	44.6 percent
Universal	18 and Older	13	44	29.5 percent
Selective	18 and Older	39	77	50.6 percent
Indicated	18 and Older	39	46	84.8 percent

During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use?

IOM Group	Age Group	No	Total Respondents	Percentage No
Universal	6-11	289	690	41.9 percent
Selective	6-11	50	107	46.7 percent
Indicated	6-11	**	**	** percent
Universal	12-14	1342	2901	46.3 percent
Selective	12-14	337	662	50.9 percent
Indicated	12-14	43	84	51.2 percent
Universal	15-17	323	571	56.6 percent
Selective	15-17	242	477	50.7 percent
Indicated	15-17	89	202	44.1 percent
Universal	18 and Older	23	44	52.3 percent
Selective	18 and Older	41	77	53.2 percent
Indicated	18 and Older	17	46	37.0 percent

**Youth National Outcome Measures (NOMs) Survey Results as Reported to the Performance Based Prevention System (PBPS)  
October 1, 2008 to November 30, 2008 (continued)**

During the past 12 months, have you driven a vehicle while you were under the influence of alcohol only?

IOM Group	Age Group	Yes	Total Respondents	Percentage Yes
Universal	6-11	12	690	1.7 percent
Selective	6-11	1	107	0.9 percent
Indicated	6-11	**	**	** percent
Universal	12-14	53	2901	1.8 percent
Selective	12-14	34	662	5.1 percent
Indicated	12-14	7	84	8.3 percent
Universal	15-17	31	571	5.4 percent
Selective	15-17	41	477	8.6 percent
Indicated	15-17	18	202	8.9 percent
Universal	18 and Older	4	44	9.1 percent
Selective	18 and Older	16	77	20.8 percent
Indicated	18 and Older	12	46	26.1 percent

How old were you the first time you used any other illegal drug?

IOM Group	Age Group	Used in Lifetime	Total Respondents	Percentage Used in Lifetime
Universal	6-11	9	690	1.3 percent
Selective	6-11	2	107	1.9 percent
Indicated	6-11	**	**	** percent
Universal	12-14	73	2901	2.5 percent
Selective	12-14	43	662	6.5 percent
Indicated	12-14	12	84	14.3 percent
Universal	15-17	88	571	15.4 percent
Selective	15-17	142	477	29.8 percent
Indicated	15-17	54	202	26.7 percent
Universal	18 and Older	10	44	22.7 percent
Selective	18 and Older	26	77	33.8 percent
Indicated	18 and Older	16	46	34.8 percent

**Youth National Outcome Measures (NOMs) Survey Results as Reported to the Performance Based Prevention System (PBPS)  
October 1, 2008 to November 30, 2008 (continued)**

How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?

IOM Group	Age Group	Replied No Risk or Slight Risk	Total Respondents	Percentage Replied No Risk or Slight Risk
Universal	6-11	137	690	19.9 percent
Selective	6-11	29	107	27.1 percent
Indicated	6-11	**	**	** percent
Universal	12-14	466	2901	16.1 percent
Selective	12-14	194	662	29.3 percent
Indicated	12-14	30	84	35.7 percent
Universal	15-17	149	571	26.1 percent
Selective	15-17	202	477	42.3 percent
Indicated	15-17	90	202	44.6 percent
Universal	18 and Older	16	44	36.4 percent
Selective	18 and Older	32	77	41.6 percent
Indicated	18 and Older	20	46	43.5 percent

How old were you the first time you used marijuana or hashish?

IOM Group	Age Group	Used in Lifetime	Total Respondents	Percentage Used in Lifetime
Universal	6-11	13	690	1.9 percent
Selective	6-11	2	107	1.9 percent
Indicated	6-11	**	**	** percent
Universal	12-14	94	2901	3.2 percent
Selective	12-14	85	662	12.8 percent
Indicated	12-14	17	84	20.2 percent
Universal	15-17	171	571	29.9 percent
Selective	15-17	239	477	50.1 percent
Indicated	15-17	116	202	57.4 percent
Universal	18 and Older	16	44	36.4 percent
Selective	18 and Older	55	77	71.4 percent
Indicated	18 and Older	29	46	63.0 percent

**Youth National Outcome Measures (NOMs) Survey Results as Reported to the Performance  
Based Prevention System (PBPS)  
October 1, 2008 to November 30, 2008 (continued)**

During the past 30 days, on how many days did you  
use marijuana or hashish?

IOM Group	Age Group	Used in Past 30 Days	Total Respondents	Percentage Used in Past 30 Days
Universal	6-11	7	690	1.0 percent
Selective	6-11	2	107	1.9 percent
Indicated	6-11	**	**	** percent
Universal	12-14	45	2901	1.6 percent
Selective	12-14	50	662	7.6 percent
Indicated	12-14	9	84	10.7 percent
Universal	15-17	72	571	12.6 percent
Selective	15-17	131	477	27.5 percent
Indicated	15-17	63	202	31.2 percent
Universal	18 and Older	6	44	13.6 percent
Selective	18 and Older	29	77	37.7 percent
Indicated	18 and Older	16	46	34.8 percent

**Data Analysis Compiled from the Client Information System (CIS)**  
**State Fiscal Year 2008-2009**

Licensed drug and alcohol treatment providers in Pennsylvania that receive federal, state or local funds from the Department of Health (DOH) are required to report the treatment services they provide to the Bureau of Drug and Alcohol Program's (BDAP's) Client Information System (CIS). Providers not receiving federal, state or local funds from the DOH are not required to report to the CIS, although some do so voluntarily. Therefore, the statistics generated from CIS should not be interpreted as a complete representation of all drug and alcohol treatment services in Pennsylvania.

## **Admissions and Unique Clients**

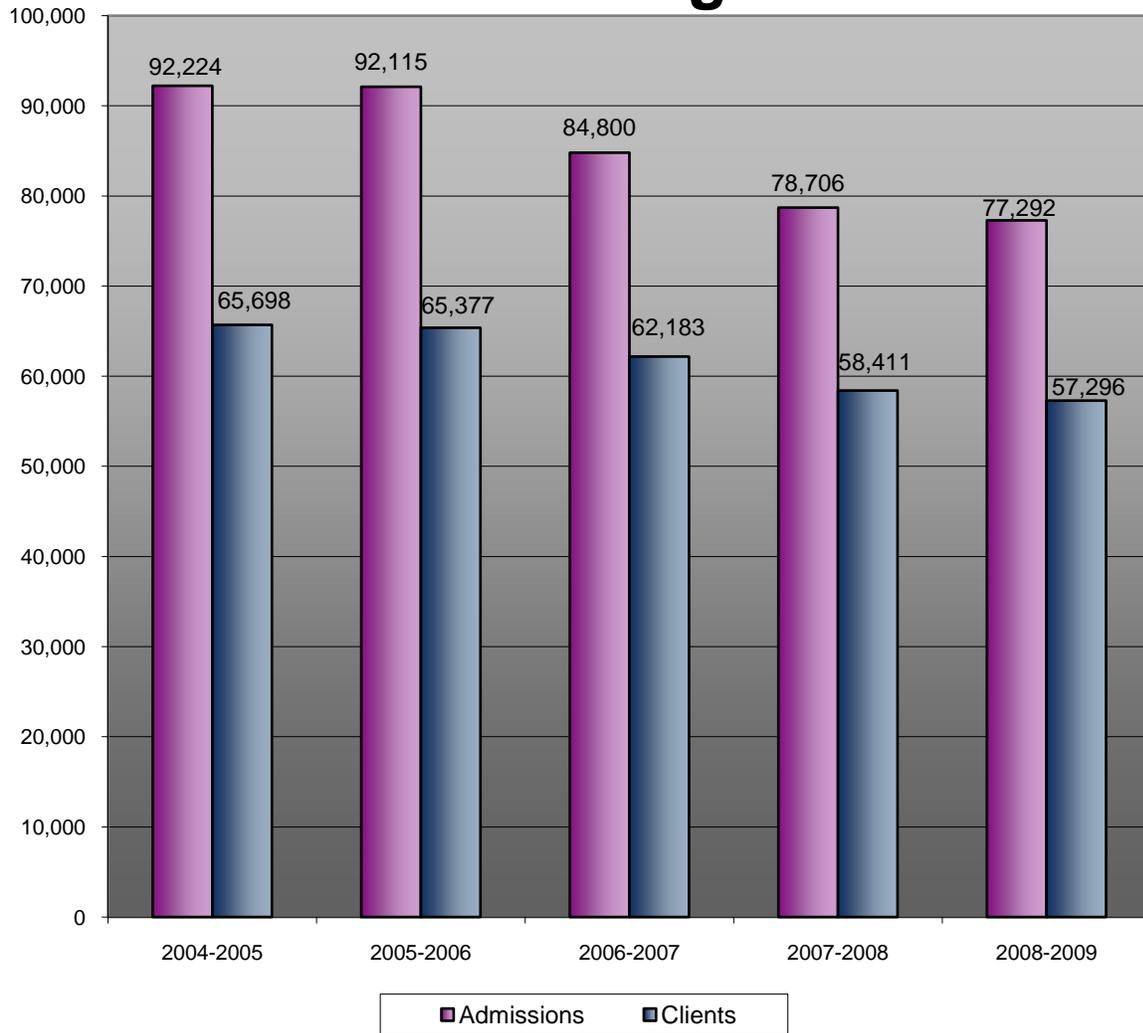
Figure 1 shows total admissions and total unique clients served for the past five state fiscal years. A unique client is a single person who has been admitted and has received any substance abuse treatment at a licensed provider during the given state fiscal year. An admission occurs when a client is admitted to receive substance abuse treatment at a licensed provider. Each time a client receives a new type of service or goes to a new provider, he is discharged and a new admission occurs. Consequently, each unique client can have multiple admissions.

The graph shows that admission totals and unique client totals are closely related. Both totals change in a similar pattern. In the past four state fiscal years (2005-2006 through 2008-2009), reported admissions and clients have been on the decline.

This is not necessarily a direct reflection of a decrease in need for treatment or a decrease in the amount of services provided. The SCAs and providers have reported treating fewer clients as a direct result of less funding to provide services. Also, the CIS is an old system and has become difficult to operate smoothly in the past few years. Many providers are using new operating systems that are causing compatibility problems. Therefore, this decline may be more of a reflection of data transfer issues and under or non-reporting from some providers. The Bureau of Drug and Alcohol Programs is in the process of remedying these issues.

Figure 1

# CIS Admissions and Unique Clients for State Fiscal Years 2004-2005 through 2008-2009



Clients are unique admissions counted once in the time period.

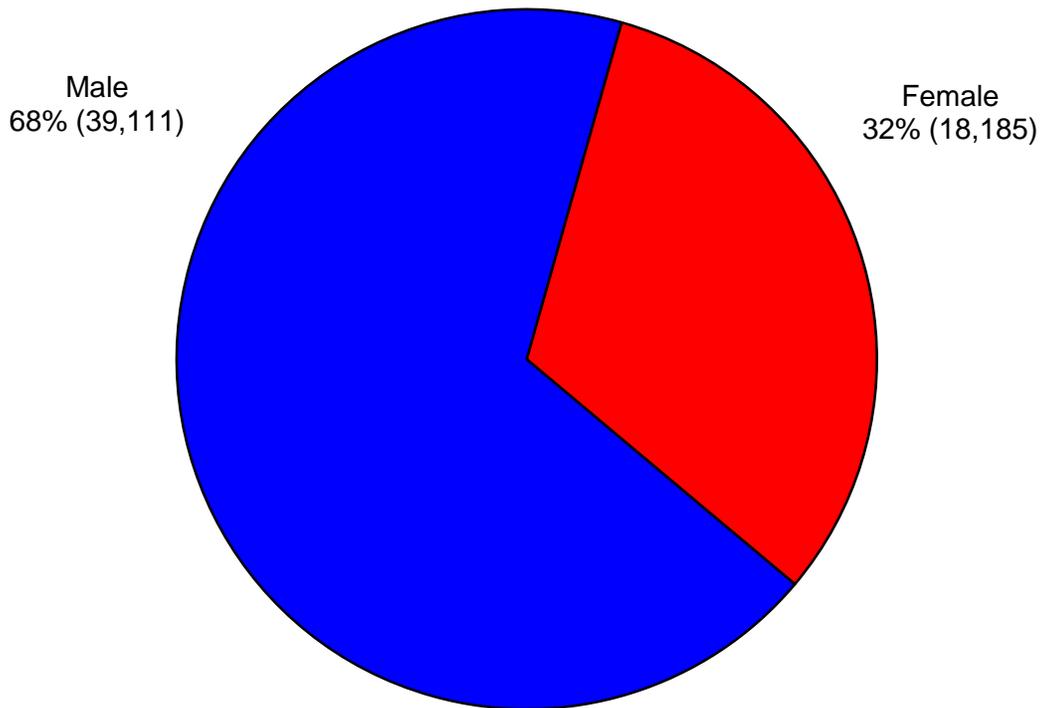
## **Client Demographics**

Clients that are treated by programs funded by the DOH are quite different from the general population in many ways. The following charts and narrative describe these differences. The majority (68 percent) of clients is male (Figure 2), while the general population is 49 percent male. Over half (59 percent) are in the 15-34 year old age group (Figure 3). There is a much higher percentage of African American clients in treatment compared to the total Pennsylvania population of African Americans (16 percent and 11 percent, respectively). There is a much lower percentage of Asian/Pacific Islander clients in treatment compared to the total Pennsylvania population (0.2 percent and 2.3 percent, respectively) [Figure 4]. There is a higher percentage of Hispanics in treatment compared to the general population (6 percent and 4.5 percent respectively) [Figure 5]. Nearly one in five (18 percent) clients in treatment is of unknown ethnicity [Figure 5], so the percentage of Hispanic clients in treatment may actually be even higher. All Pennsylvania population percentages are from the 2007 Pennsylvania State Data Center Estimates. There have been no significant changes concerning state client demographics over the last three fiscal years.

Figure 2

# CIS Unique Client Admissions SFY 2008-2009

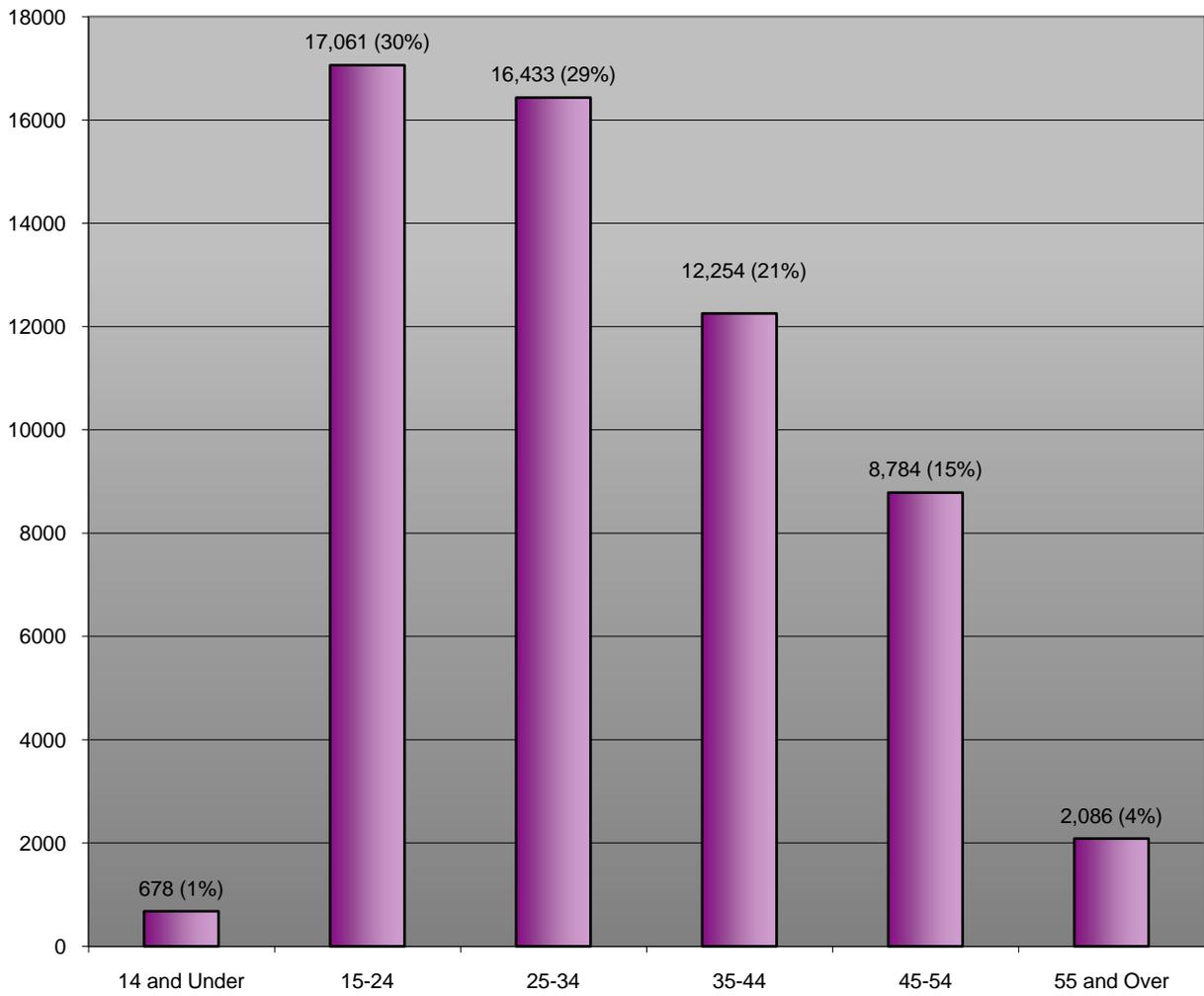
## Gender



Clients are unique admissions counted once in the time period.  
Total Clients=57,296

Figure 3  
**CIS Unique Client Admissions  
SFY 2008-2009**

**Age Groups**

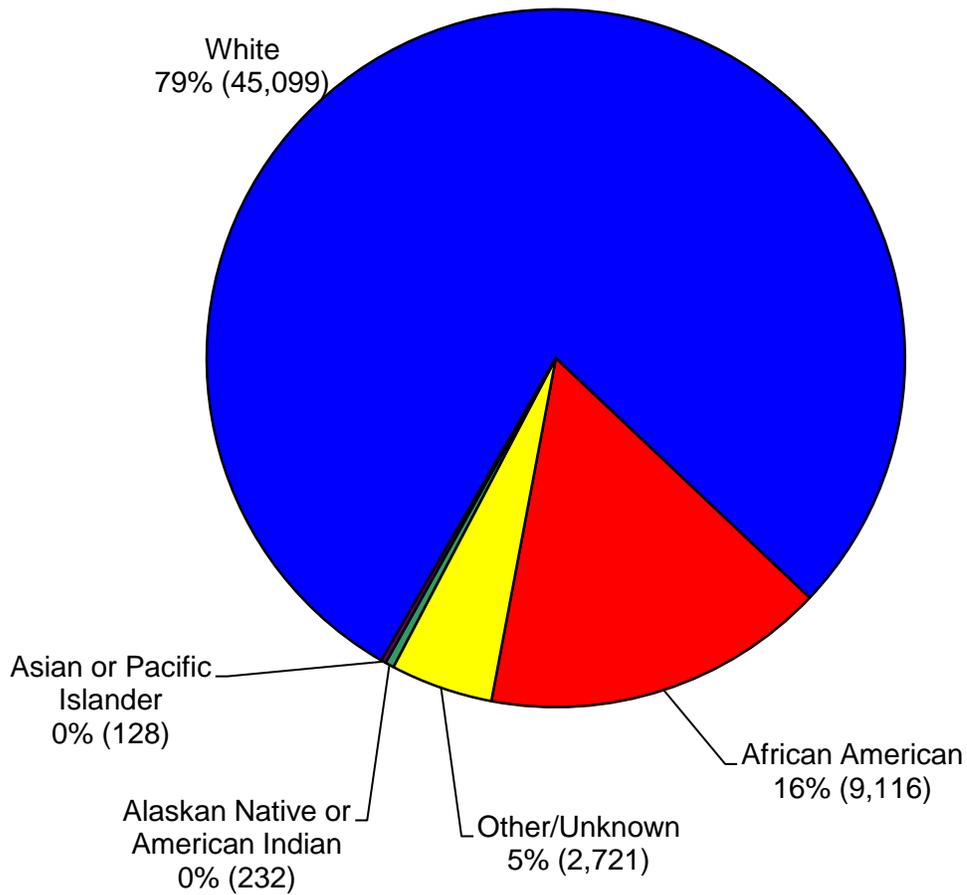


Clients are unique admissions counted once in the time period.  
Total Clients=57,296

Figure 4

# CIS Unique Client Admissions SFY 2008-2009

## Race

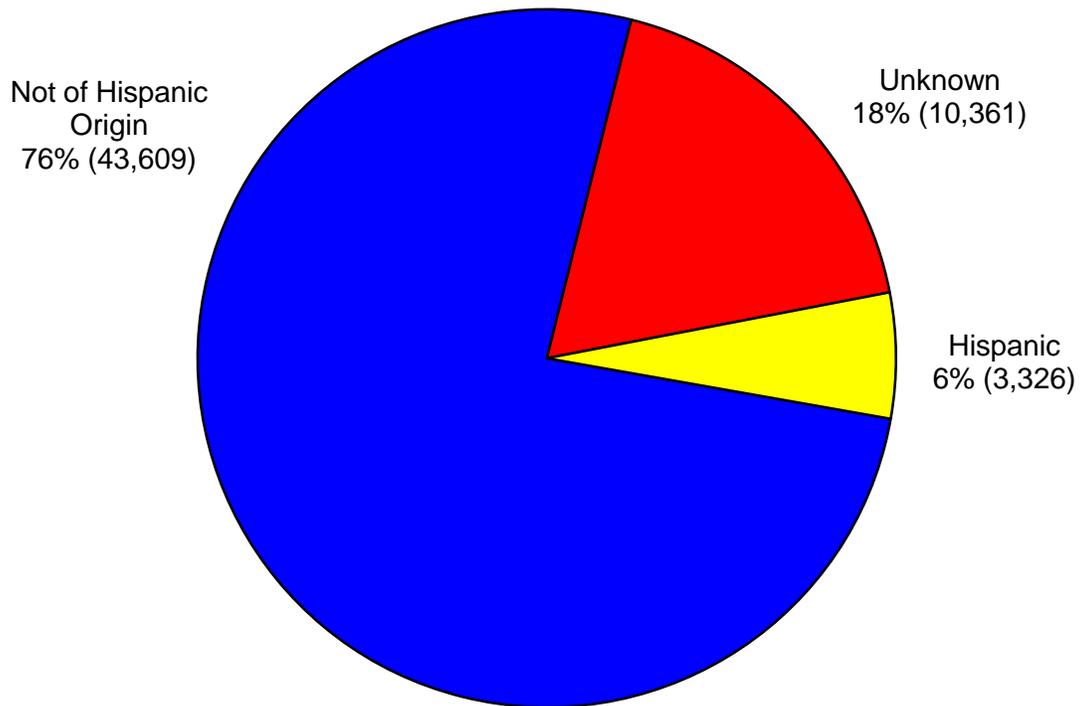


Clients are unique admissions counted once in the time period.  
Total Clients=57,296

Figure 5

# CIS Unique Client Admissions SFY 2008-2009

## Ethnicity



Clients are unique admissions counted once in the time period.  
Total Clients=57,296

## **Admissions Characteristics**

The Department of Health is a payer of last resort and many clients are unable to pay for the substance abuse treatment services they require. Therefore, many of these clients are at other disadvantages in addition to their substance abuse issues. The following charts and narratives describe some of these other disadvantages reported by clients during admission to substance abuse treatment.

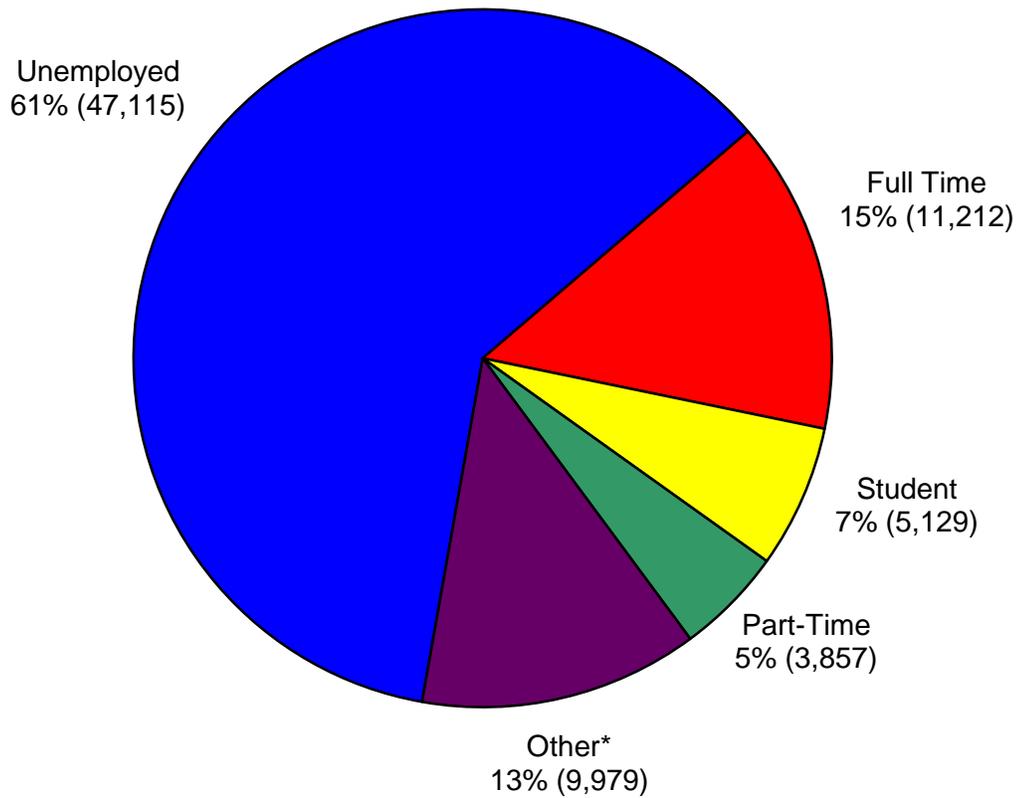
The majority (61 percent) of clients reported being unemployed. In addition, only 20 percent reported being employed on a full-time (15 percent) or part-time (5 percent) basis. The remaining admissions were of other employment statuses (Figure 6). Nearly three-fourths (73 percent) have never been married. Only 9 percent of clients were married when they were admitted. The remaining clients reported their status as divorced (11 percent), separated (5 percent) or widowed (1 percent) [Figure 7]. Nearly one third (31 percent) of clients were admitted under non-voluntary circumstances (Figure 8). This means they were involved in the criminal justice system, and substance abuse treatment was mandated. Trending this data over the last three fiscal years, there have been no significant changes concerning state client admission characteristics.

All of these characteristics show that BDAP clients face considerable obstacles beyond substance abuse. The lack of employment, family support and the high rate of involvement in the criminal justice system all present additional difficulties that many of BDAP's clients face.

Figure 6

# CIS Admissions SFY 2008-2009

## Employment Status



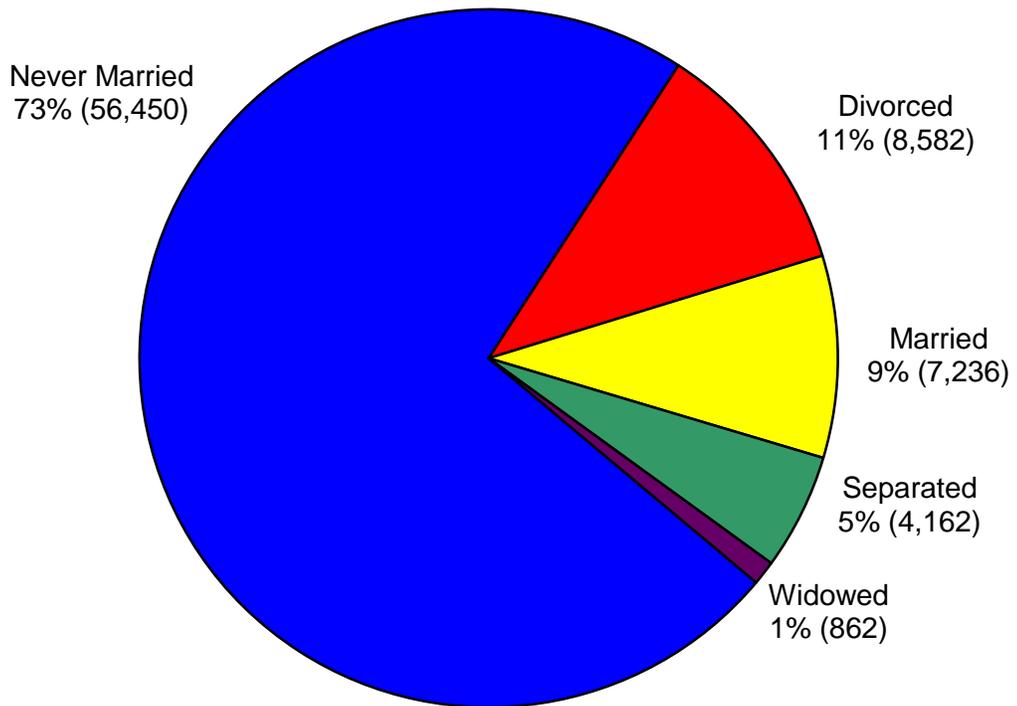
\*Other includes: Disabled, Leave of Absence, Retired, Homemaker, Armed Forces, Unknown, and Other Employment Status.

Total Admissions=77,292

Figure 7

# CIS Admissions SFY 2008-2009

## Marital Status

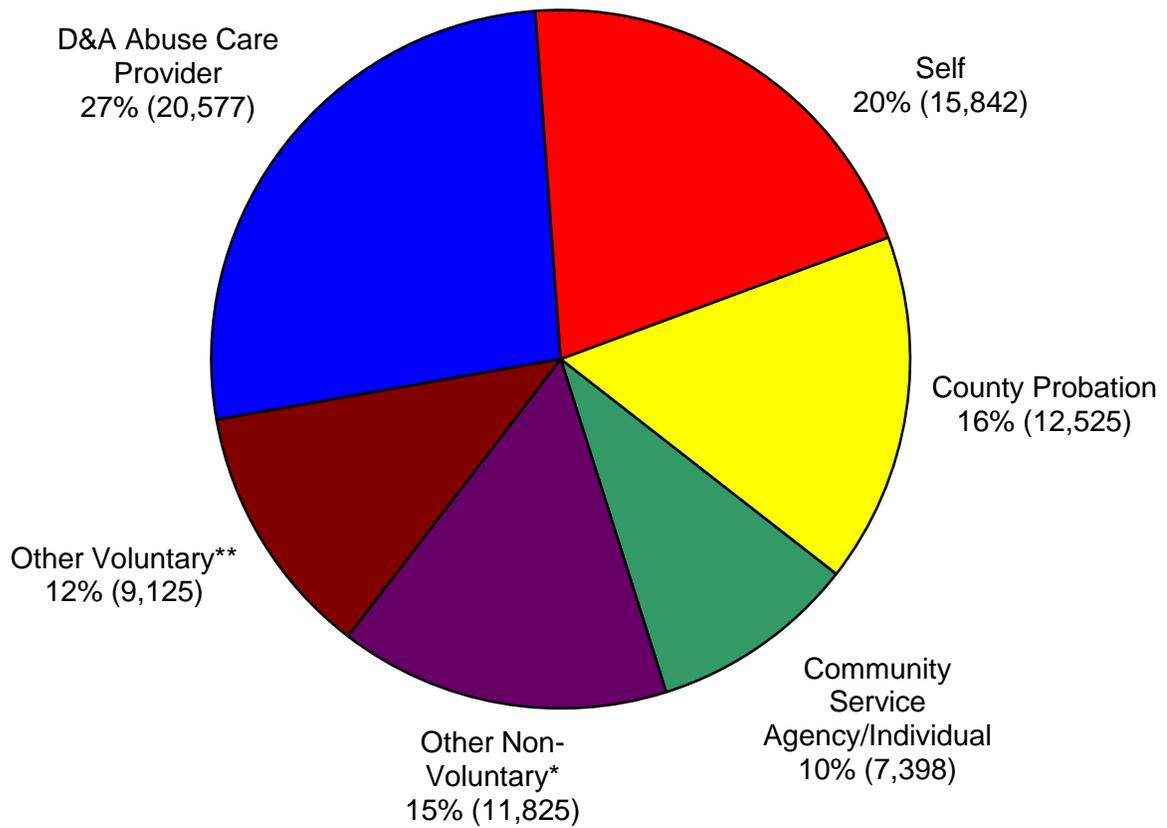


Total Admissions=77,292

Figure 8

# CIS Admissions SFY 2008-2009

## Referral Sources



\*Other Non-Voluntary includes: Court (Judge), Federal Parole, State Parole, County Parole, Federal Probation, State Probation, and Other Non-Voluntary.

\*\*Other Voluntary includes: Hospital/Physician, Family/Friend, School, Diversion Programs, Employer/EAP, Clergy/Religious, and Other Voluntary.

Total Admissions=77,292

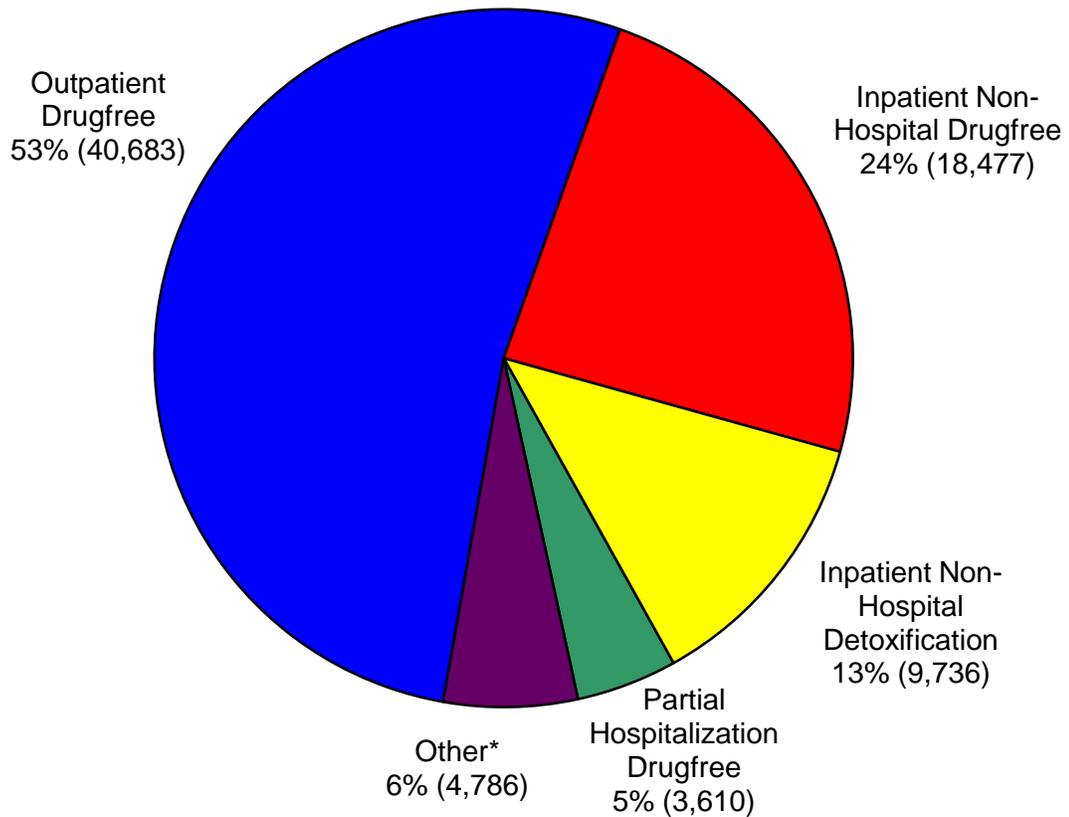
## **Types of Treatment**

There are several different types of treatment available to clients in Pennsylvania. Treatment modality usage varies widely by SCA, so these statewide figures might not give an accurate representation of local area modality utilization. The most prevalent type of treatment received is of the Outpatient Drug-free type, with 53 percent of clients receiving this modality (Figure 9). This is also the least intensive, most inexpensive modality. Nearly a quarter (24 percent) of admissions was of the Inpatient, Non-Hospital Drug-free type. Such treatment is more intensive, with the client living and receiving treatment services at the facility. There have been no significant changes concerning treatment modalities trend data over the last three fiscal years.

Figure 9

# CIS Admissions SFY 2008-2009

## Treatment Modalities



\*Other includes: Correctional Institution: Detox, Drug Free, Experimental. Inpatient Hospital: Detox, Drug Free, Experimental, Other Chemotherapy. Inpatient Non-Hospital: Experimental, Other Chemotherapy. Outpatient: Detox, Experimental, Maintenance, Other Chemotherapy. Partial Hospital: Detox, Experimental, Other Chemotherapy. Shelter: Drug Free, Experimental.  
Total Admissions=77,292

## Patterns of Drug Use

Clients are admitted to treatment for a wide range of primary substances of abuse. Different groups of clients also use very different types of substances. The following charts and narrative illustrate this. The most common primary substance of abuse is alcohol (35 percent). Marijuana/hashish (20 percent), cocaine/crack (15 percent) and heroin (14 percent) account for another 49 percent of admissions. The remaining 16 percent is composed of other opiates/synthetics (9 percent) and other drugs (7 percent) [Figure 10].

There has been little overall change in the primary drugs reported over the past five State Fiscal Years (Figure 11). However, marijuana/hashish has shown a slight spike this year. It will not be known if this is a trend or an anomaly until more years of data are available. The Bureau will continue to monitor and investigate. The only drug that has shown substantial and consistent growth in the past five years is the other opiates/synthetics category (Figure 12). In State Fiscal Year 2004-2005, this category accounted for 5.2 percent of admissions. In State Fiscal Year 2008-2009, it accounted for 8.9 percent of admissions. This is an increase of 71 percent over the past five years.

Admissions for particular primary drugs of abuse vary by gender, race, ethnicity and age group. Males are admitted for alcohol use more frequently (36 percent) than females (31 percent), as well as more frequently for marijuana/hashish (22 percent and 16 percent, respectively). Females are admitted for cocaine/crack use more frequently (18 percent) than males (14 percent) [Figure 13].

Whites were admitted for alcohol use more frequently than African Americans (35 percent and 30 percent), more than twice as frequently for heroin (16 percent and 6 percent), and nearly four times more frequently for other opiates/synthetics (10.3 percent and 2.6 percent). African Americans were admitted about twice as often for cocaine/crack than whites (27 percent and 13 percent) and more frequently for marijuana/hashish (29 percent and 18 percent) [Figure 14].

Non-Hispanics were admitted for alcohol more frequently than Hispanics (36 percent and 31 percent) and three times as frequently for other opiates/synthetics (9 percent and 3 percent). Hispanics were admitted more frequently for heroin than Non-Hispanics (19 percent and 12 percent) and more often for crack/cocaine (20 percent and 15 percent) [Figure 15].

Primary drugs of choice also vary quite significantly among age groups (Figure 16). Use of alcohol increases with age: the older the client is at admission, the higher the percentage of individuals who reported alcohol as their primary drug of choice. Marijuana/hashish is similar but the relationship is negative--the older the client is at admission, the lower the percentage who reported marijuana/hashish as their primary drug of choice. The percentage using the remainder of the drug categories peaks at an age group near the middle of the age distribution. Heroin begins this pattern earlier than crack/cocaine.

The age group 14 and under is admitted for marijuana/hashish use most frequently (41 percent), although this age group accounts for only 1 percent of admissions. Many in this age category receive services through programs not reported in the CIS. Clients in this age group are of particular interest, because they require more specialized services than their older counterparts. The age group 15-24 is also of particular interest, due to the transitional nature of this age category

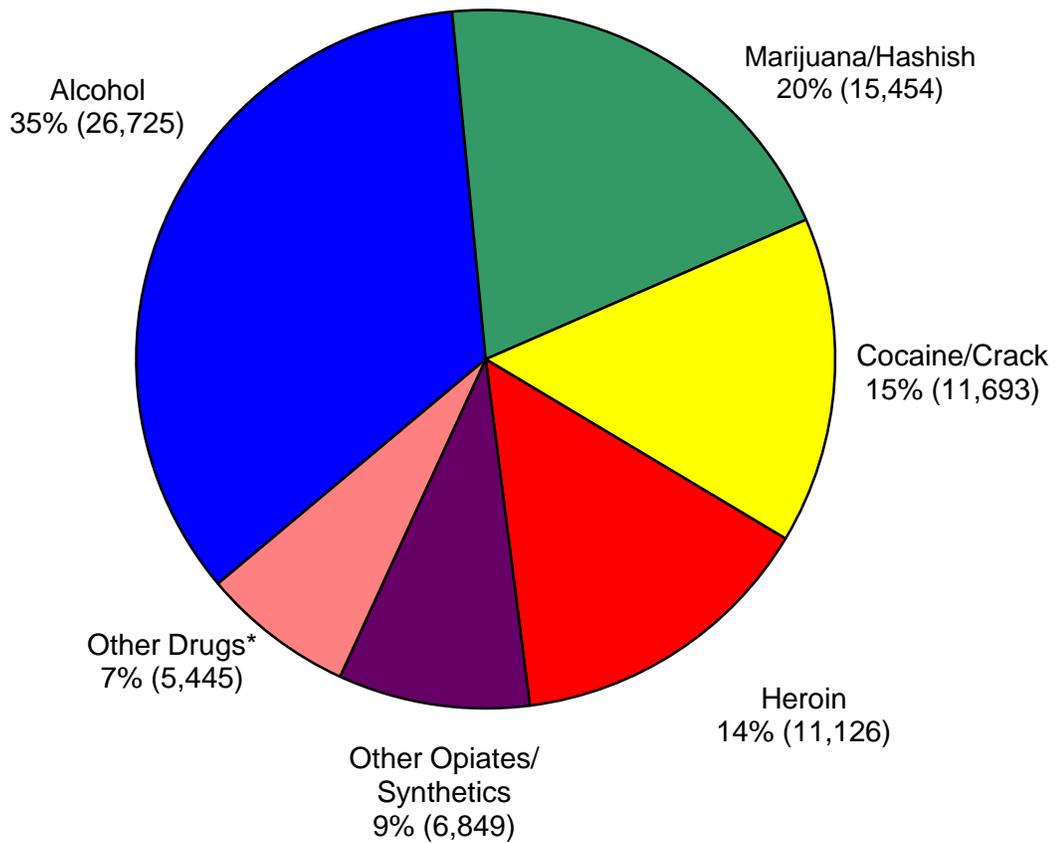
(Figure 17). This age group has been further broken down into ages 15-17 (4,141 admissions), 18-20 (6,207 admissions), and 21-24 (12,539 admissions).

Marijuana/hashish is the most prevalent drug of choice for the groups 15-17 and 18-20 (44 percent and 33 percent, respectively), but usage decreases by 25 percent between these two age groups as a person becomes progressively older. It decreases further to 24 percent of all admissions in the 21-24 age group. Heroin begins to be seen much more in the 18-20 age group (15 percent), and for age group 21-24, heroin makes up an even higher percentage (21 percent) of admissions. This is an increase of 40 percent in heroin use from 18-20 to 21-24.

Figure 10

# CIS Admissions SFY 2008-2009

## Primary Drug of Choice

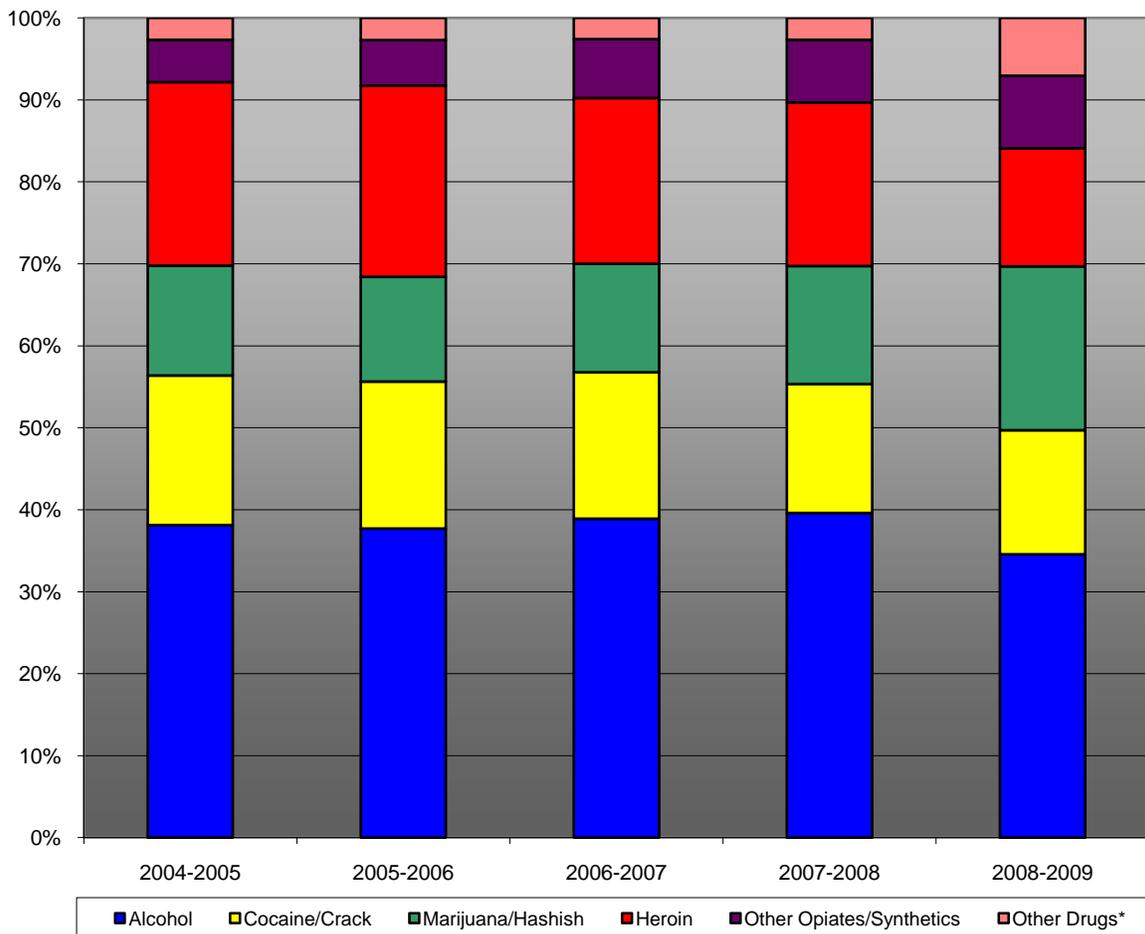


\*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.  
Total Admissions=77,292

Figure 11

# CIS Admissions for State Fiscal Years 2004-2005 through 2008-2009

## Primary Drug of Choice



\*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.

Figure 12

# CIS Admissions for Other Opiates/Synthetics State Fiscal Years 2004-2005 through 2008-2009

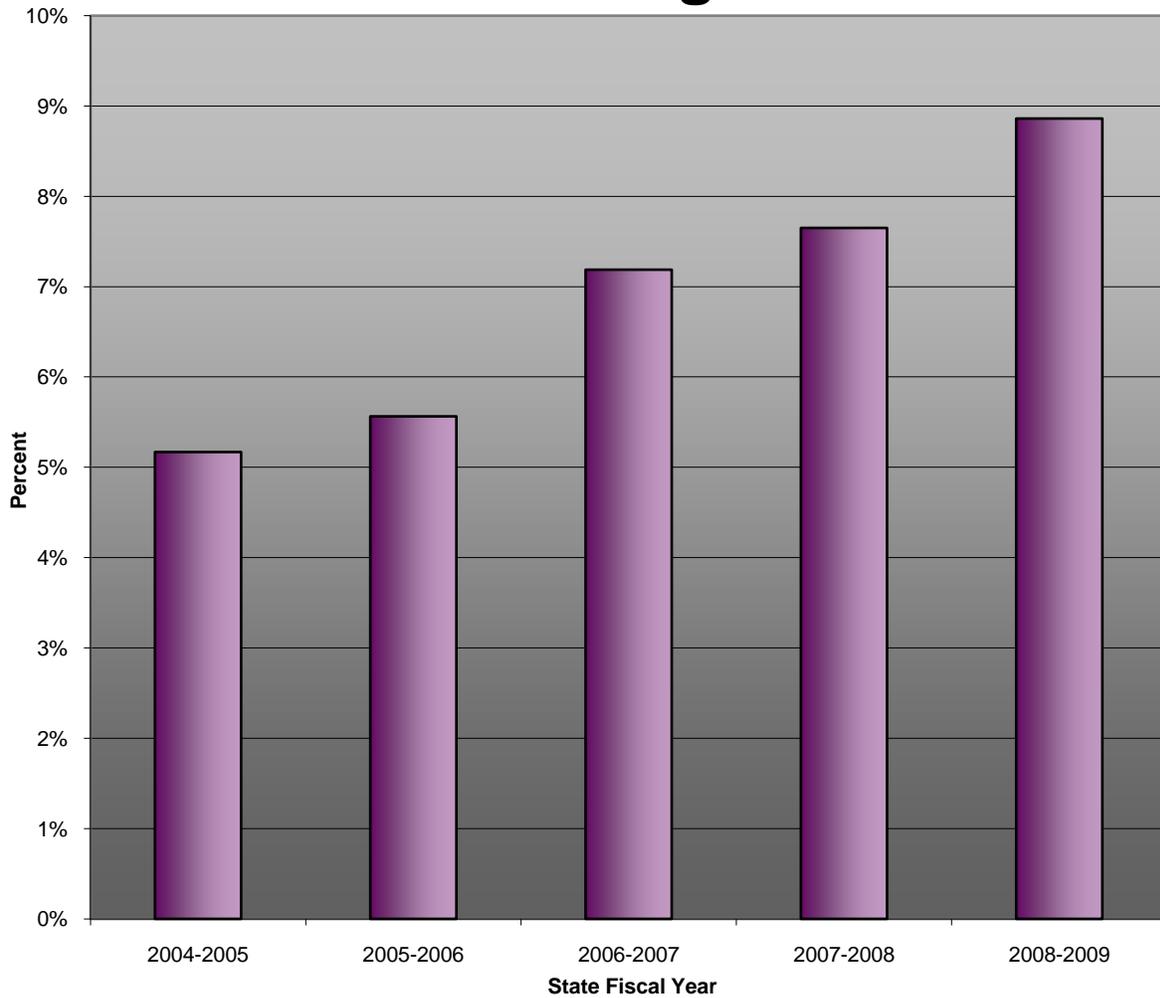
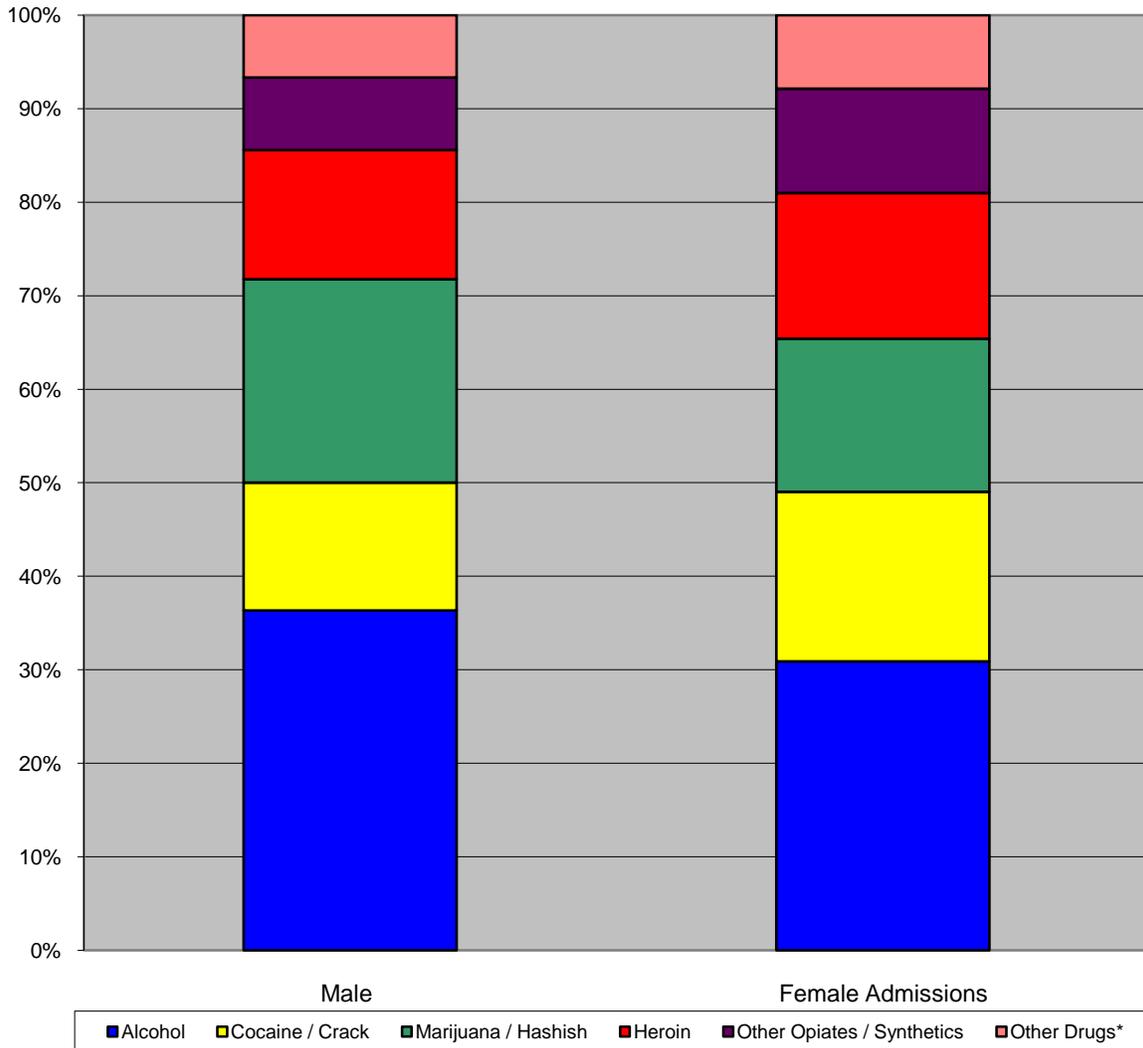


Figure 13

# CIS Admissions SFY 2008-2009

## Primary Drug of Choice by Gender

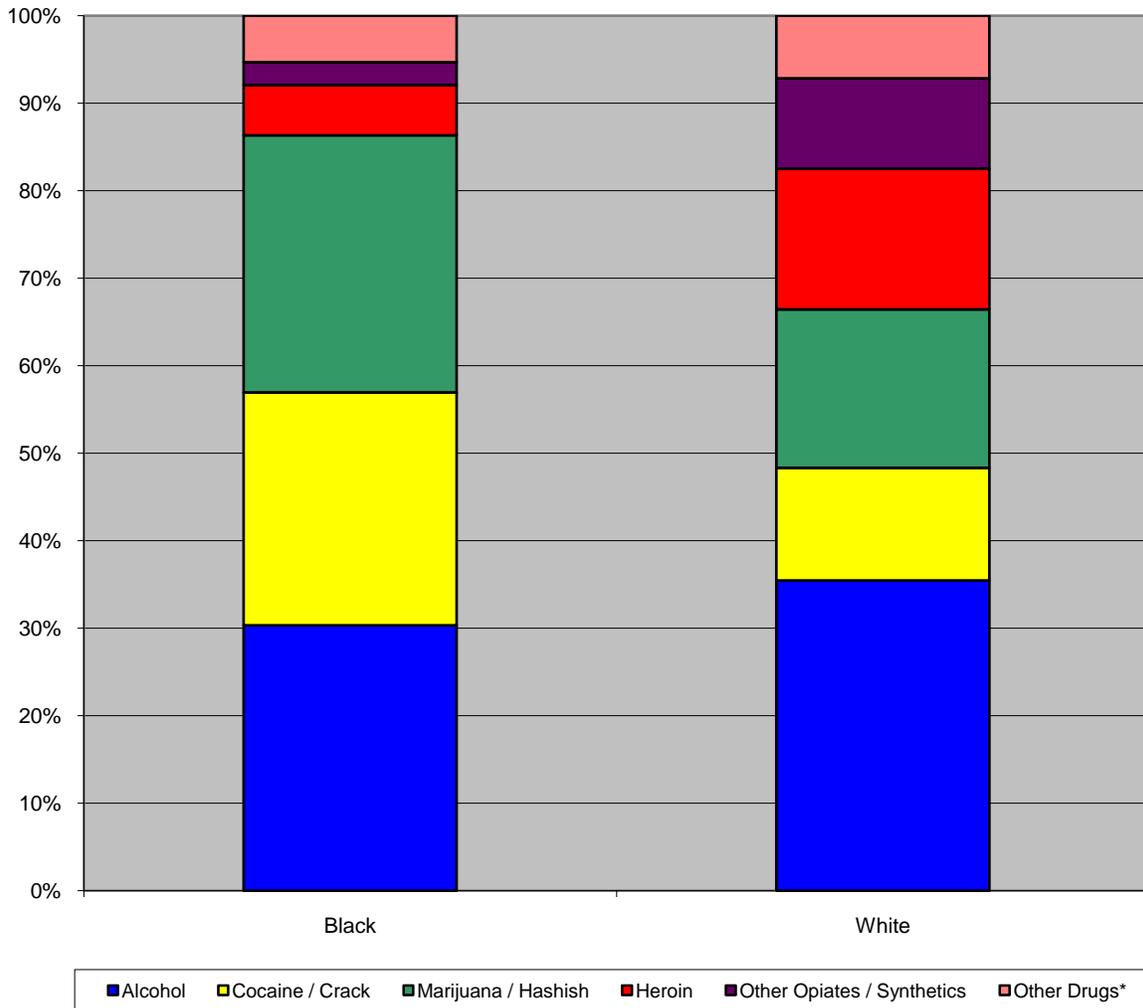


\*Other Drugs includes: Other Opiates/Synthetics, Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.  
Total Admissions=77,292

Figure 14

# CIS Admissions SFY 2008-2009

## Primary Drug of Choice by Race



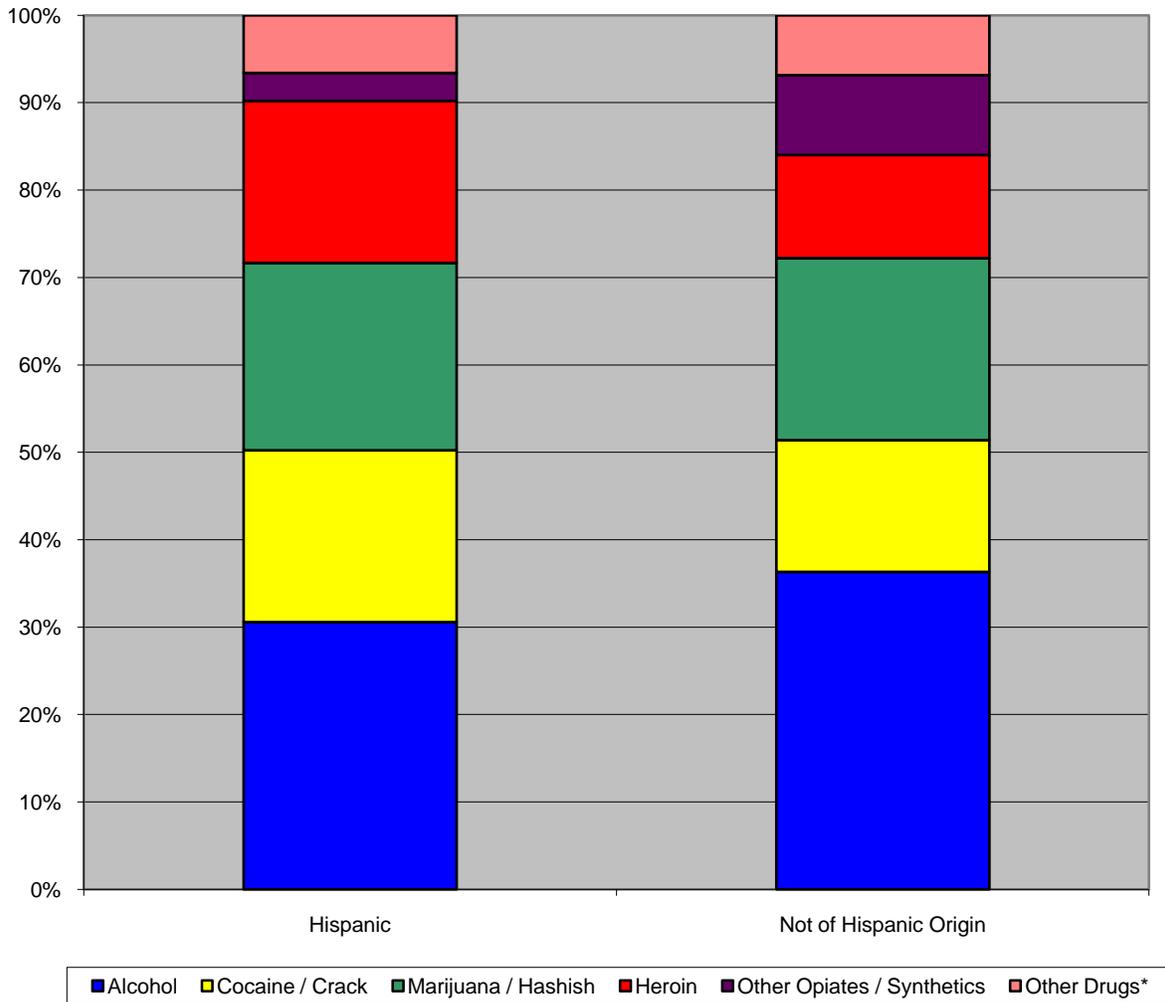
\*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.

Total Admissions for Black and White=73,525 (95% of Total Admissions)

Figure 15

# CIS Admissions SFY 2008-2009

## Primary Drug of Choice by Ethnicity



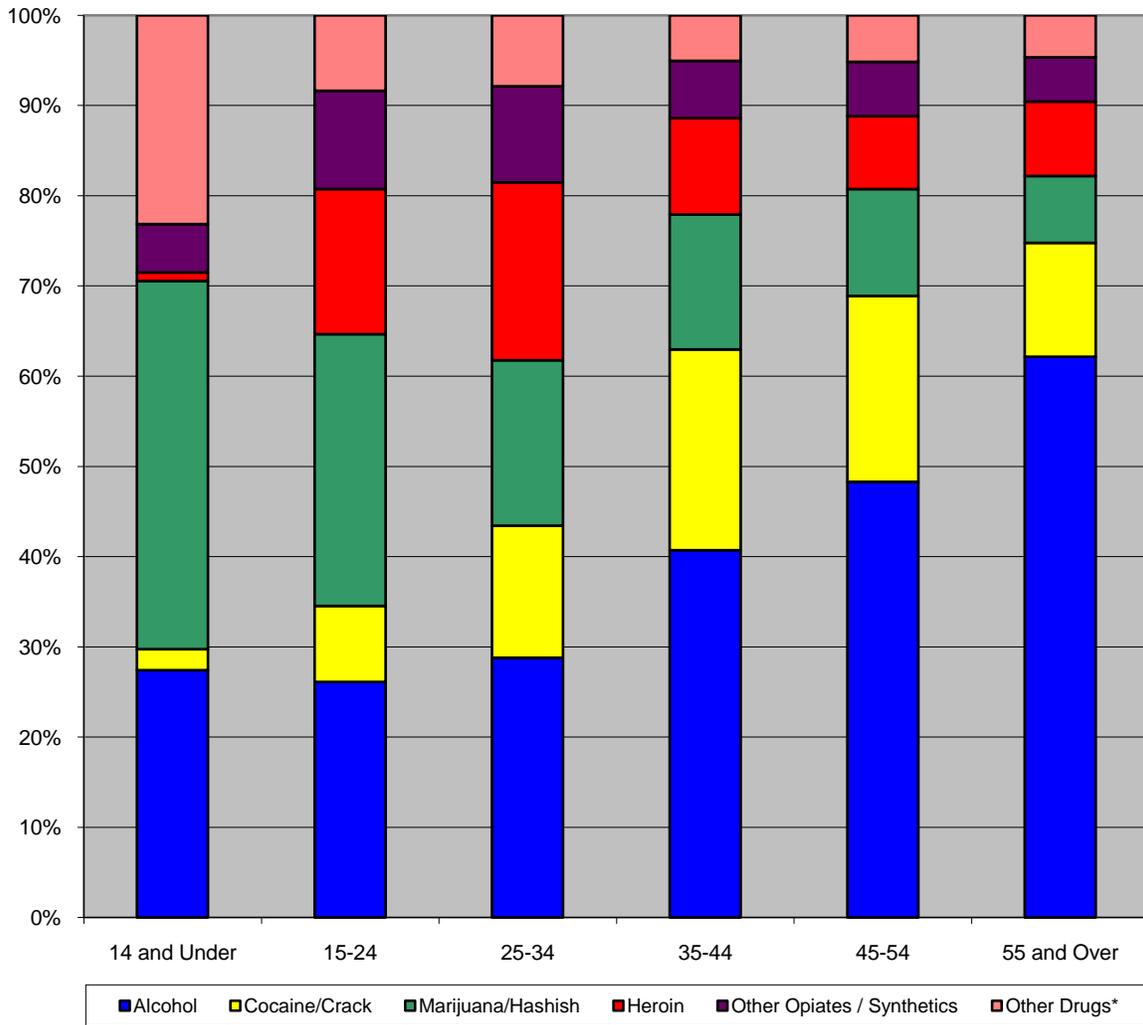
\*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.

Total Admissions for Hispanic and Not of Hispanic Origin=61,920 (80% of Total Admissions)

Figure 16

# CIS Admissions SFY 2008-2009

## Primary Drug of Choice by Age Group



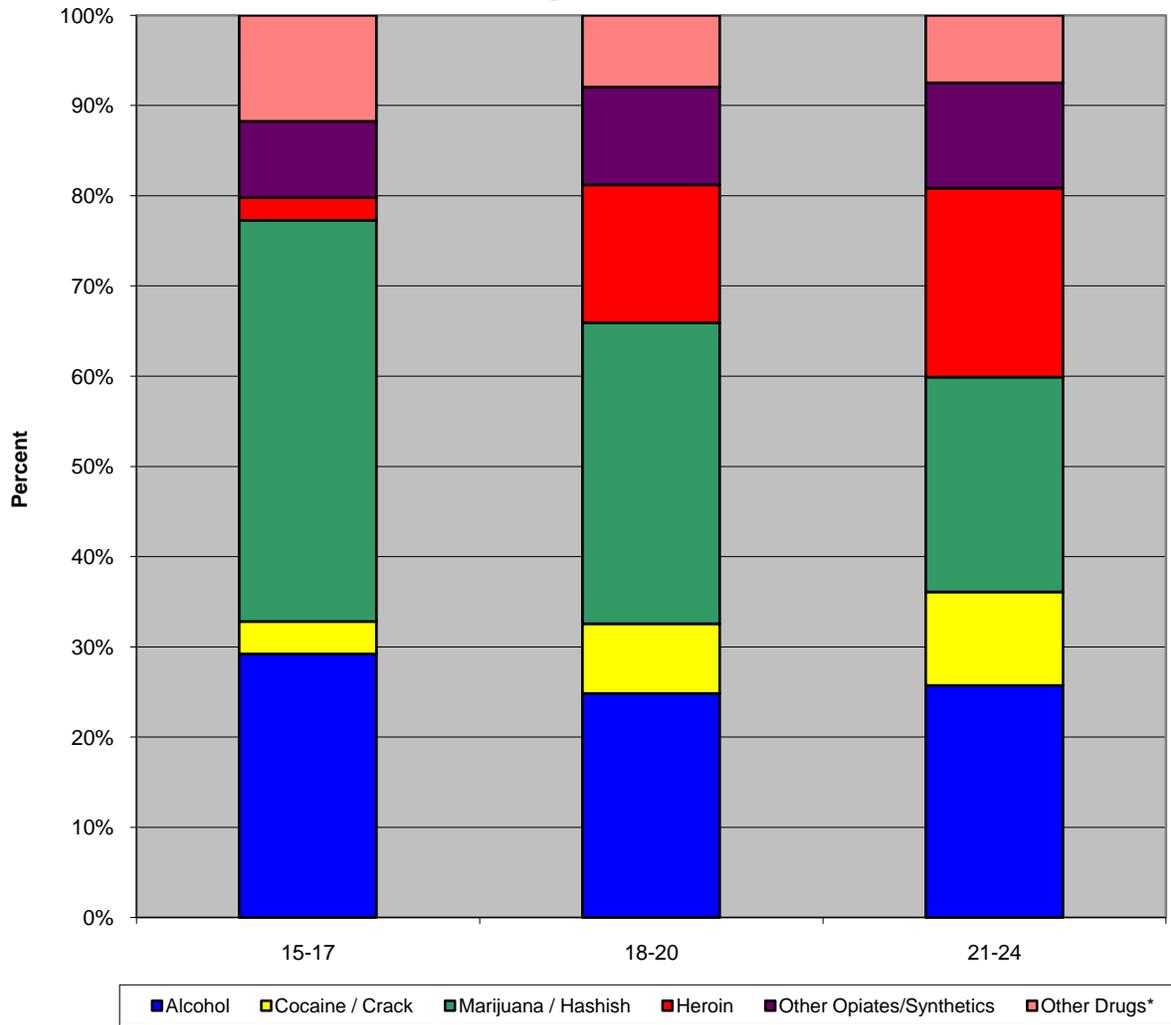
\*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.

Total Admissions=77,292

Figure 17

# CIS Admissions SFY 2008-2009

## Primary Drug of Choice by Age Group Ages 15-24



\*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.

Total Admissions=22,887

## **Discharges**

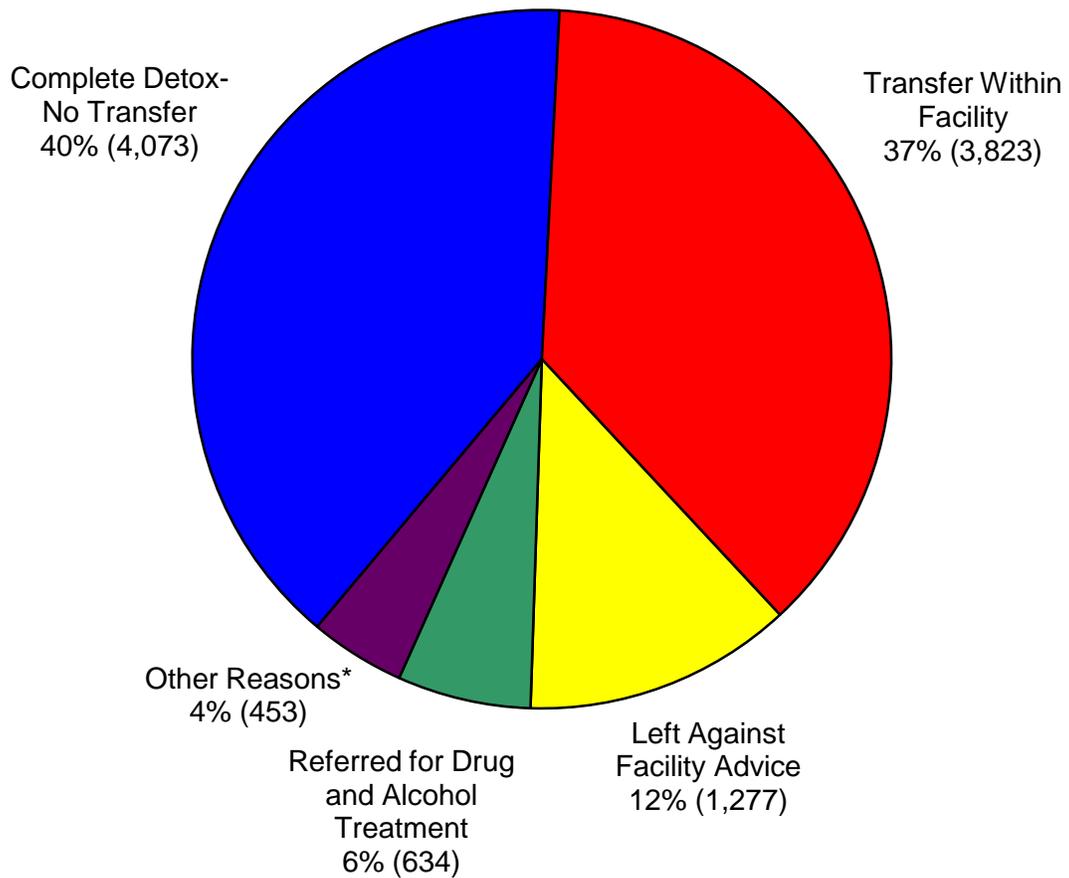
When a client has completed a particular type of treatment or changes treatment providers, a discharge record is submitted to the CIS with an associated reason for discharge. There are two main types of discharges: detoxification and non-detoxification. The kind of service rendered in detox and non-detox treatments is very different, so there are different reasons for being discharged from the two categories. The following discharge data is associated with admissions that occurred in state fiscal year 2008-2009. No significant changes occurred from previous years. Therefore, no trend data has been presented.

After detox treatment was completed, 43 percent of patients were either transferred within the facility or were referred to another facility for drug and alcohol treatment. However, 40 percent completed their detox and were not transferred (Figure 18). Nearly half (49 percent) of those discharged from non-detox treatment completed their treatment and had not used substances (Figure 19).

Figure 18

# CIS Discharges SFY 2008-2009

## Detox Reasons for Discharge

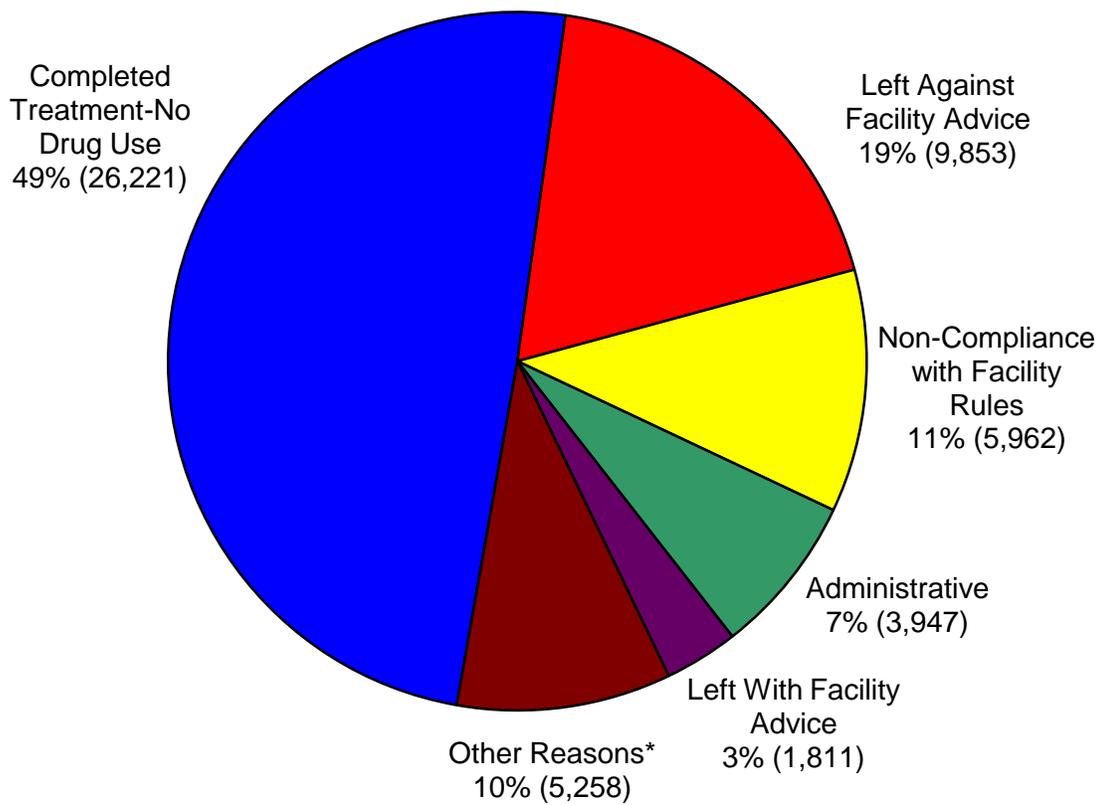


\*Other Reasons includes: Left with Facility Advice, Non-Compliance with Facility Rules, and Jailed.  
Total Discharges=10,260

Figure 19

# CIS Discharges SFY 2008-2009

## Non Detox Reasons for Discharge

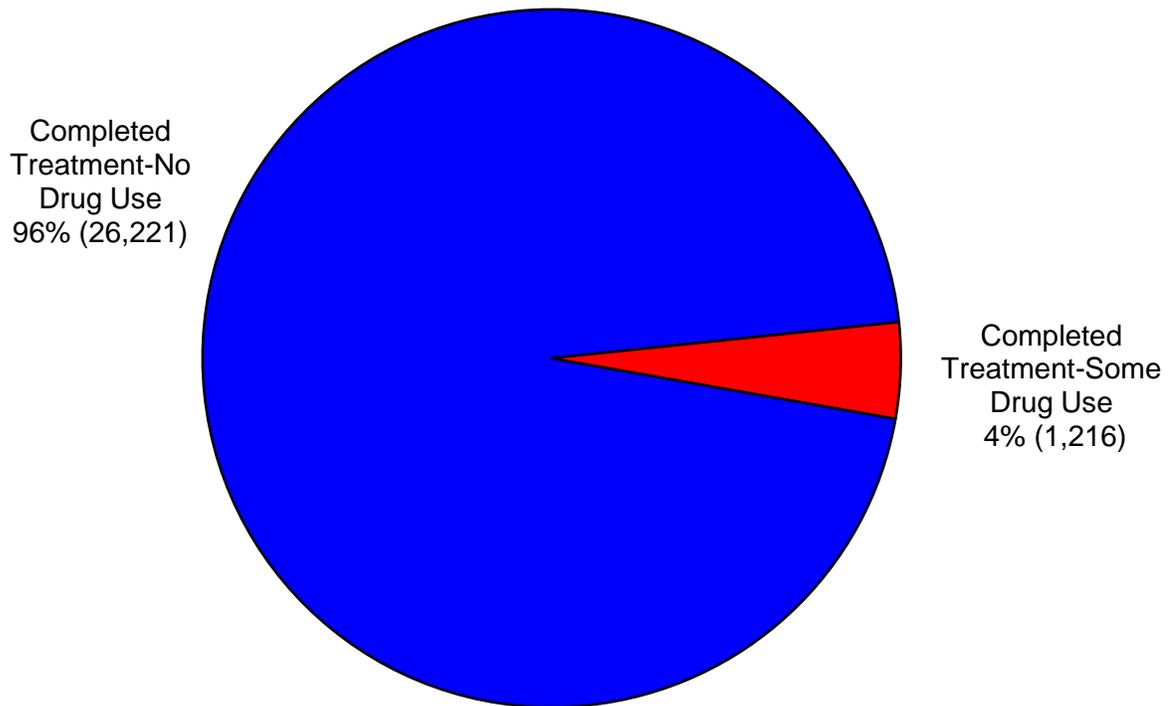


\*Other Reasons includes: Referred to Another Drug and Alcohol Facility, Jailed, Completed Treatment-Some Drug Use, Relocation, Medical, Referred to a Non-Drug and Alcohol Facility, and Death.  
Total Discharges=53,052

Figure 20

# CIS Discharges SFY 2008-2009

## Non Detox Reasons for Discharge for those who completed treatment



Total Discharges Completing Treatment=27,437

## Outcome Measures

Outcome measures show how much clients have changed during their time in substance abuse treatment. A certain characteristic of a client is recorded when he is admitted to treatment and when he is discharged from treatment. The amount of change in these characteristics between admission and discharge is then recorded as an outcome measure.

Upon entering treatment, each client and the provider work together to come up with a personalized treatment plan. This plan details the goals the client and provider agree upon, as well as how they plan to accomplish them. Pennsylvania does not consider total abstinence to be the only goal of treatment. A client can make significant progress at a specific level of care, even though there is still some substance use. Completing the goals of the treatment plan is the main aim of the substance abuse treatment providers.

Over half (51 percent) of those discharged completed their treatment goals (Figure 19). The vast majority (96 percent) of those completing their goals did not use substances, while 4 percent completed their treatment goals but still had some substance use (Figure 20). No significant changes occurred from previous years.

The following outcomes are collected for all clients for the federally required National Outcome Measures (NOMs). The results will be presented, even though these specific metrics may not always be part of each individual client's treatment goals.

### Employment

The employment outcome measure records if the client is employed (full-time, part-time or student) at admission and discharge. Overall, clients improved from 32 percent employed at admission to 36 percent employed at discharge (Figure 21). No significant changes occurred from previous years.

### Arrests

The arrests outcome measure records the client's arrest status. At admission, the client is asked if he has been arrested in the **two years previous to admission**. At discharge, the client is asked if he has been arrested **since entering treatment**.

Because of the big difference in period of time in which arrests could have occurred at admission versus discharge, the admission numbers are most likely artificially higher than the discharge numbers. This makes the admission numbers more of a classification status (involvement with criminal justice) than a baseline measurement to show change. However, only 3 percent of clients were arrested in the time they were engaged in treatment programs (Figure 22). No significant changes occurred from previous years.

### Alcohol Abstinence

The alcohol abstinence outcome measure records whether the client is abstinent from alcohol in the 30 days prior to admission and discharge. Only those clients listing alcohol as a drug of choice

(primary, secondary or tertiary) are considered for the calculation. Overall, clients improved from 32 percent abstinent at admission to 70 percent abstinent at discharge (Figure 23). No significant changes occurred from previous years.

### Other Drug Abstinence

The other drug abstinence outcome measure records whether the client is abstinent from other drugs in the 30 days prior to admission and discharge. Only those clients listing non-alcohol substances as a drug of choice (primary, secondary or tertiary) are considered for the calculation. Overall, clients improved from 25 percent abstinent at admission to 63 percent abstinent at discharge (Figure 24).

The somewhat high percentage of those already abstinent from alcohol and other drugs (32 percent and 25 percent, respectively) at admission occurs in part because the CIS requires a new admission each time a client changes type of service or provider. Many admissions (27 percent) were referred from a drug and alcohol service provider. Therefore, these clients have already been in drug and alcohol service and may have already begun abstaining from substances. No significant changes occurred from previous years.

Figure 21

# Outcome Measure Employment Status State Fiscal Year 2008-2009

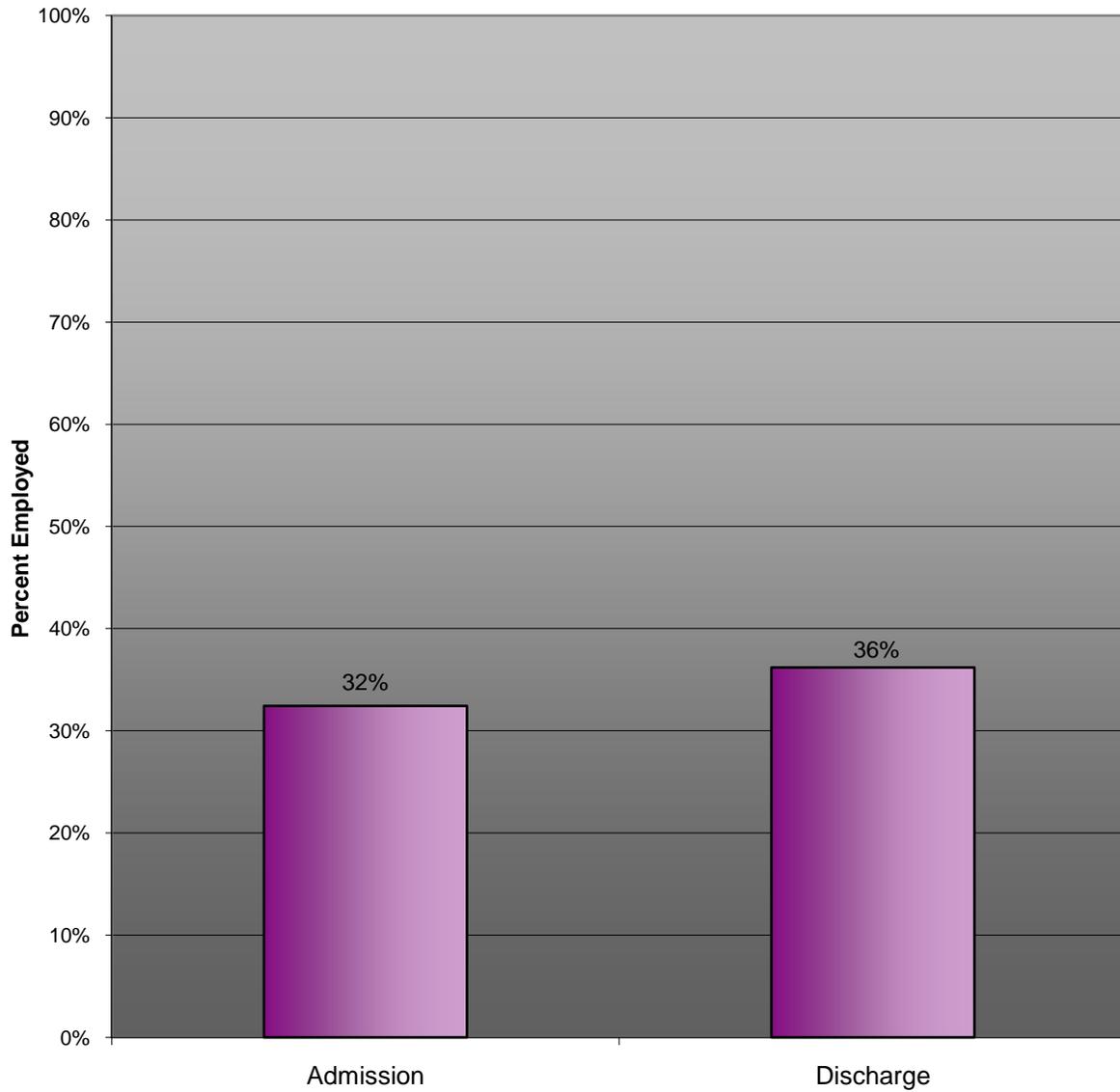


Figure 22

# Outcome Measure Arrests State Fiscal Year 2008-2009

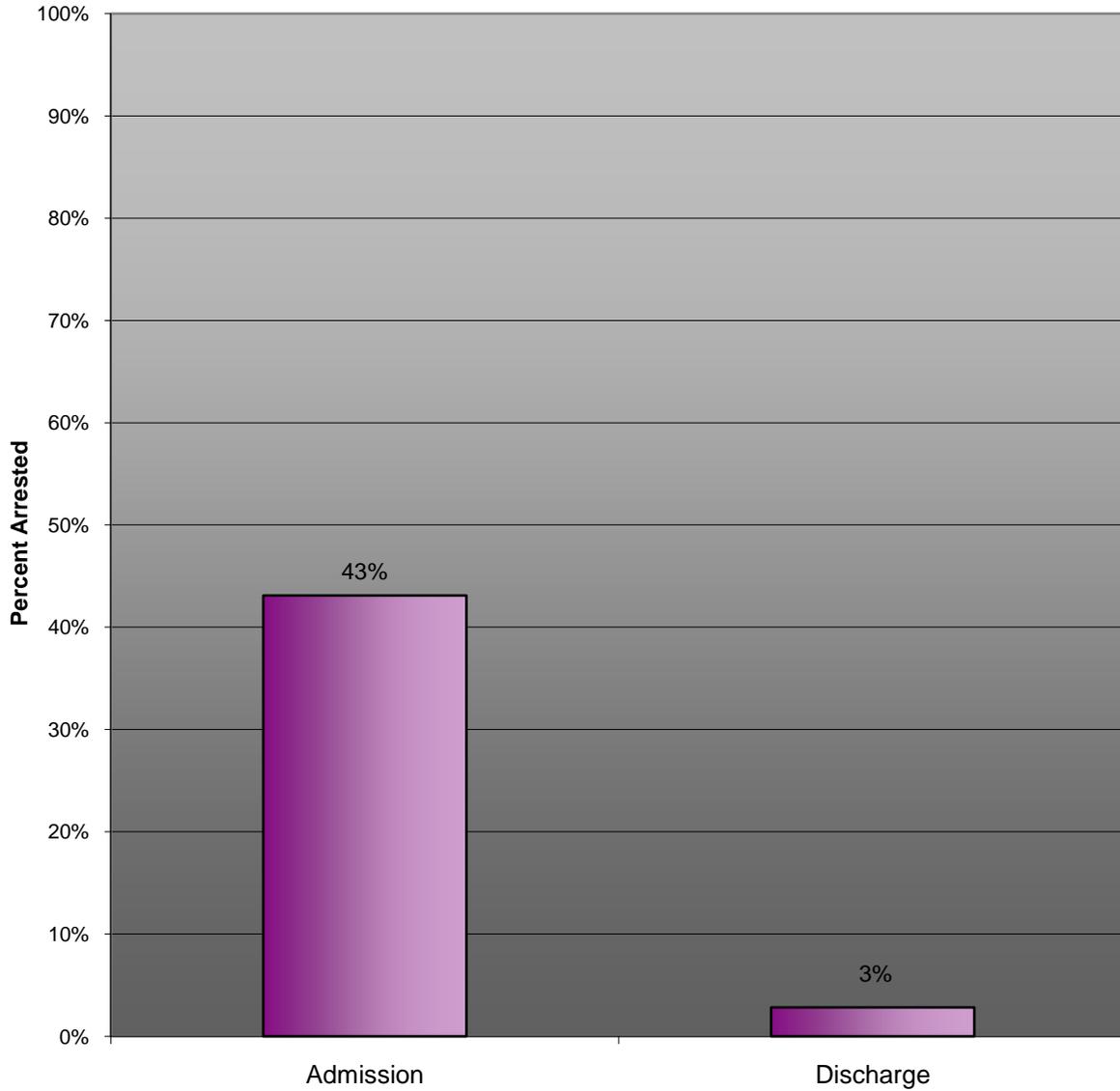


Figure 23

# Outcome Measure Alcohol Abstinence State Fiscal Year 2008-2009

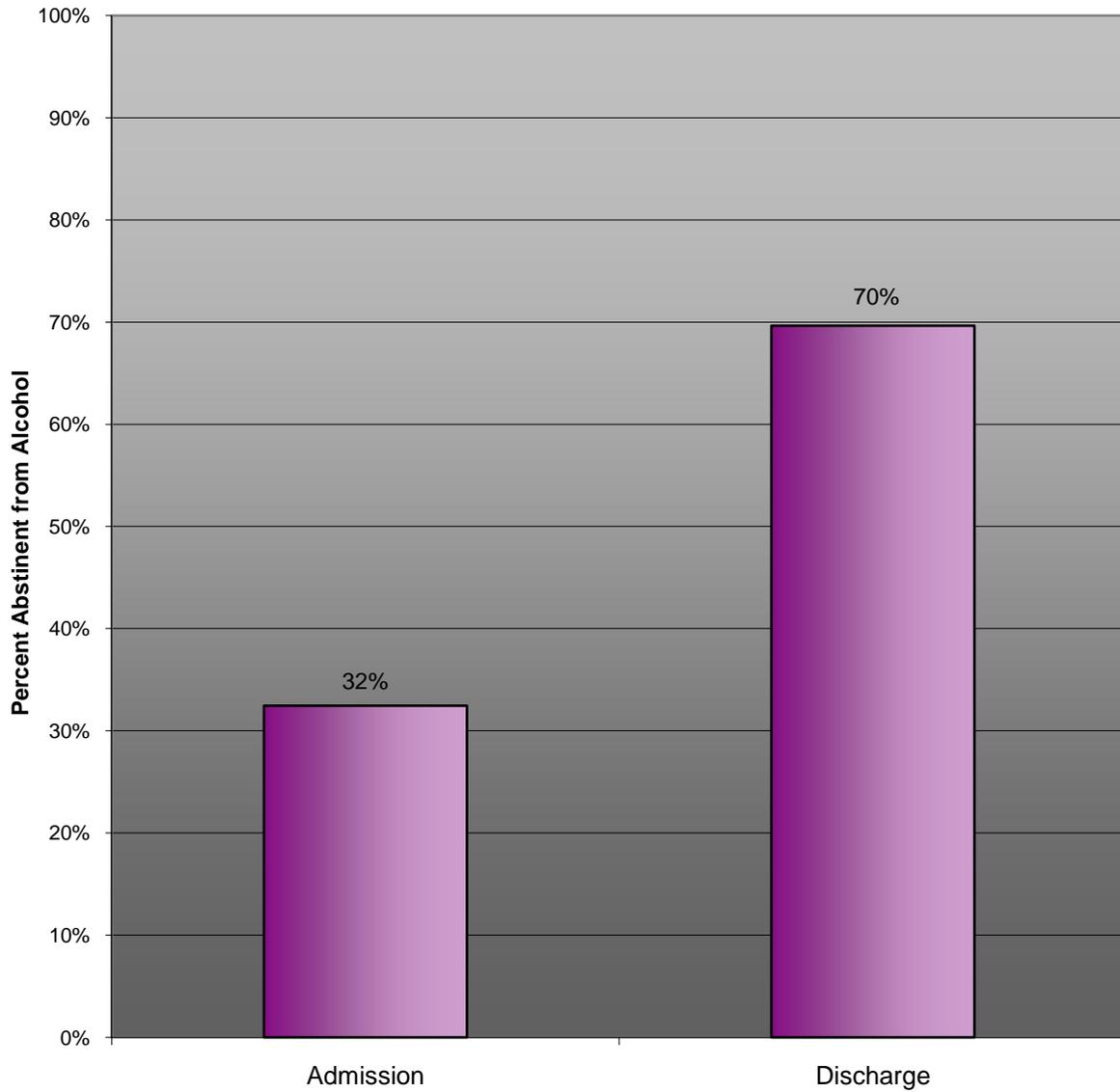
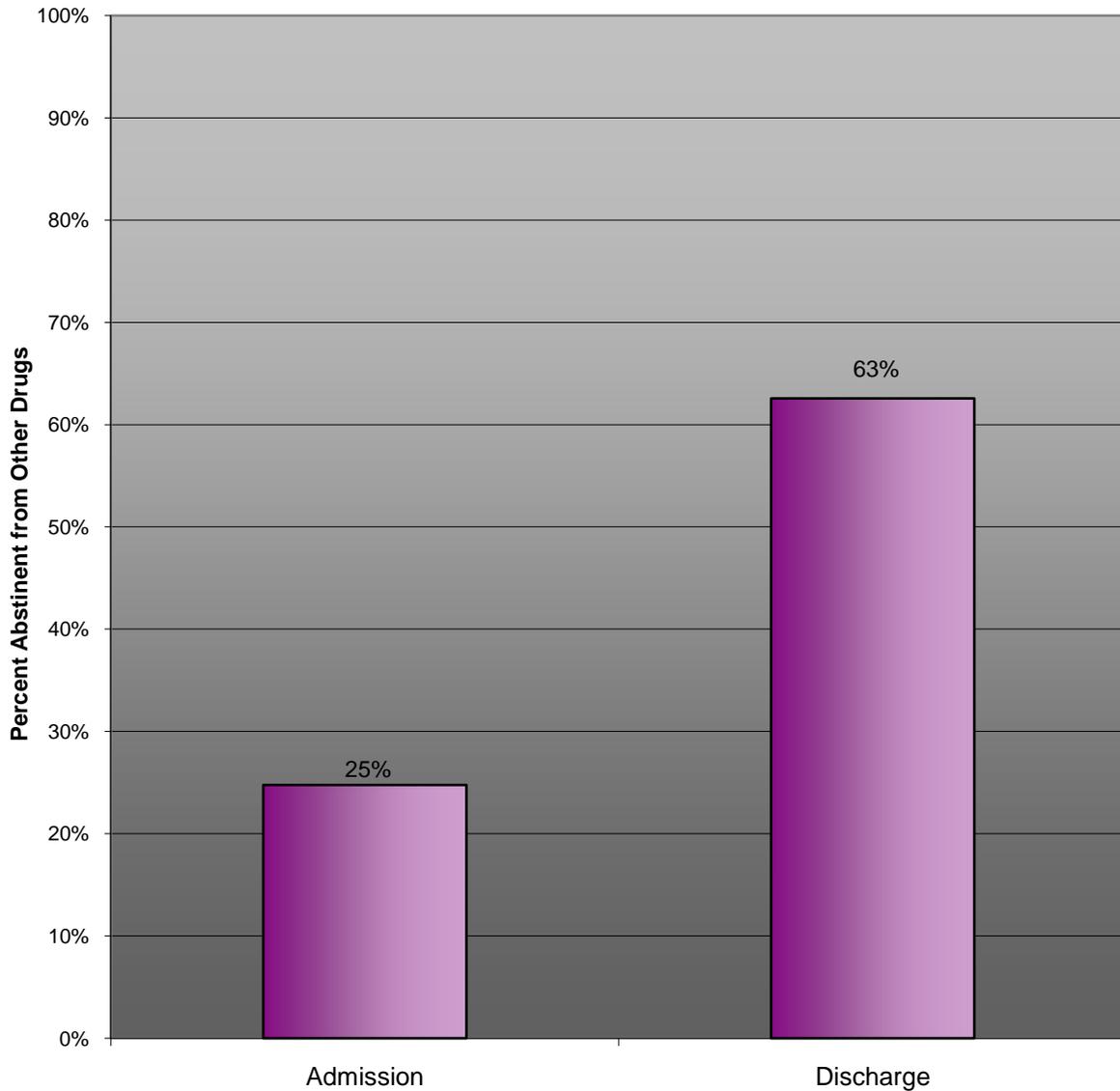


Figure 24

# Outcome Measure Other Drug\* Abstinence State Fiscal Year 2008-2009



\*Other Drugs includes: Cocaine/Crack, Marijuana/Hashish, Heroin, Other Opiates/Synthetics, Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.

## Single County Authority Expenditures for Fiscal Year 2008-09 (All Sources)

SINGLE COUNTY AUTHORITY	TOTAL BDAP FUNDS	TOTAL COUNTY FUNDS	TOTAL OTHER FUNDS	TOTAL FUNDS
Allegheny	\$12,418,080	\$322,146	\$6,701,263	\$19,441,489
Armstrong/Indiana	\$1,064,184	\$0	\$1,519,215	\$2,583,399
Beaver	\$1,186,924	\$55,000	\$785,089	\$2,027,013
Bedford	\$436,071	\$0	\$200,979	\$637,050
Berks	\$3,359,923	\$1,724,352	\$3,223,381	\$8,307,656
Blair	\$1,034,499	\$36,702	\$729,535	\$1,800,736
Bradford/Sullivan	\$538,638	\$26,138	\$385,062	\$949,838
Bucks	\$3,486,167	\$344,162	\$2,541,117	\$6,371,446
Butler	\$964,120	\$20,244	\$1,068,370	\$2,052,734
Cambria	\$958,597	\$40,640	\$641,579	\$1,640,816
Cameron/Elk/McKean	\$827,610	\$66,568	\$751,521	\$1,645,699
Carbon/Monroe/Pike	\$1,020,139	\$63,284	\$1,513,457	\$2,596,880
Centre	\$783,891	\$42,693	\$575,776	\$1,402,360
Chester	\$2,398,393	\$529,935	\$3,754,946	\$6,683,274
Clarion	\$380,243	\$14,358	\$180,525	\$575,126
Clearfield/Jefferson	\$948,021	\$0	\$1,048,573	\$1,996,594
Col/Montour/Snyder/Union	\$820,026	\$17,013	\$536,103	\$1,373,142
Crawford	\$688,013	\$28,082	\$1,102,601	\$1,818,696
Cumberland/Perry	\$1,601,983	\$204,713	\$1,188,533	\$2,995,229
Dauphin	\$2,501,457	\$480,379	\$992,341	\$3,974,177
Delaware	\$3,706,882	\$120,865	\$1,821,914	\$5,649,661
Erie	\$3,402,893	\$241,920	\$2,393,205	\$6,038,018
Fayette	\$1,009,941	\$0	\$1,686,298	\$2,696,239
Forest/Warren	\$351,810	\$12,663	\$217,593	\$582,066
Franklin/Fulton	\$608,376	\$124,949	\$344,364	\$1,077,689
Greene	\$348,282	\$9,568	\$241,830	\$599,680
Huntingdon/Mifflin/Juniata	\$698,046	\$0	\$353,008	\$1,051,054
Lackawanna	\$1,413,851	\$69,630	\$960,840	\$2,444,321
Lancaster	\$2,338,792	\$97,893	\$1,769,037	\$4,205,722
Lawrence	\$721,784	\$0	\$1,122,455	\$1,844,239
Lebanon	\$729,492	\$36,618	\$602,462	\$1,368,572
Lehigh	\$2,310,083	\$123,168	\$2,256,462	\$4,689,713
Luzerne/Wyoming	\$1,962,632	\$211,165	\$2,089,800	\$4,263,597
Lycoming/Clinton	\$927,719	\$51,741	\$1,495,237	\$2,474,697
Mercer	\$1,019,274	\$63,750	\$694,844	\$1,777,868
Montgomery	\$4,036,477	\$174,682	\$2,037,405	\$6,248,564
Northampton	\$1,699,902	\$224,085	\$1,426,015	\$3,350,002
Northumberland	\$563,891	\$30,427	\$378,945	\$973,263
Philadelphia	\$22,339,887	\$1,262,413	\$19,593,117	\$43,195,417
Potter	\$169,083	\$12,554	\$99,197	\$280,834
Schuylkill	\$1,227,931	\$29,472	\$1,067,845	\$2,325,248
Somerset	\$545,404	\$20,203	\$126,678	\$692,285
Susquehanna	\$294,730	\$18,387	\$162,424	\$475,541
Wayne	\$293,971	\$99,800	\$193,430	\$587,201
Tioga	\$309,993	\$10,712	\$116,683	\$437,388
Venango	\$416,832	\$14,513	\$455,045	\$886,390
Washington	\$1,403,545	\$0	\$971,114	\$2,374,659
Westmoreland	\$2,478,335	\$38,386	\$1,732,214	\$4,248,935
York/Adams	\$1,954,874	\$0	\$1,264,036	\$3,218,910
TOTAL	\$ 96,701,691	\$ 7,115,973	\$ 77,113,464	\$ 180,931,127

## Single County Authority Expenditures by Funding Level for Fiscal Year 2008-09 (All Sources)

SINGLE COUNTY AUTHORITY	TOTAL ADMINISTRATION	TOTAL PREVENTION	TOTAL INTERVENTION	TOTAL TREATMENT	TOTAL AMOUNT
Allegheny	\$1,955,946	\$2,389,228	\$3,908,570	\$11,187,745	\$19,441,489
Armstrong/Indiana	\$414,728	\$541,618	\$132,331	\$1,494,722	\$2,583,399
Beaver	\$356,785	\$186,172	\$134,650	\$1,349,406	\$2,027,013
Bedford	\$105,169	\$263,751	\$1,060	\$267,070	\$637,050
Berks	\$674,768	\$1,670,768	\$818,087	\$5,144,033	\$8,307,656
Blair	\$197,124	\$286,439	\$91,443	\$1,225,730	\$1,800,736
Bradford/Sullivan	\$105,235	\$159,639	\$101,599	\$583,365	\$949,838
Bucks	\$897,958	\$1,014,963	\$821,875	\$3,636,650	\$6,371,446
Butler	\$247,669	\$200,399	\$236,735	\$1,367,931	\$2,052,734
Cambria	\$184,099	\$217,358	\$98,935	\$1,140,424	\$1,640,816
Cameron/Elk/McKean	\$225,419	\$219,521	\$3,800	\$1,196,959	\$1,645,699
Carbon/Monroe/Pike	\$213,550	\$413,604	\$167,155	\$1,802,571	\$2,596,880
Centre	\$193,657	\$273,388	\$22,420	\$912,895	\$1,402,360
Chester	\$959,784	\$513,613	\$87,010	\$5,122,867	\$6,683,274
Clarion	\$91,815	\$76,832	\$46,878	\$359,601	\$575,126
Clearfield/Jefferson	\$108,595	\$842,917	\$114,919	\$930,163	\$1,996,594
Col/Montour/Snyder/Union	\$197,847	\$267,308	\$116,182	\$791,805	\$1,373,142
Crawford	\$126,286	\$287,903	\$27,562	\$1,376,945	\$1,818,696
Cumberland/Perry	\$240,333	\$697,042	\$292,844	\$1,765,010	\$2,995,229
Dauphin	\$423,346	\$800,788	\$127,007	\$2,623,036	\$3,974,177
Delaware	\$629,696	\$618,572	\$475,113	\$3,926,280	\$5,649,661
Erie	\$337,919	\$1,024,728	\$830,159	\$3,845,212	\$6,038,018
Fayette	\$257,429	\$631,798	\$216,995	\$1,590,017	\$2,696,239
Forest/Warren	\$109,807	\$50,747	\$36,642	\$384,870	\$582,066
Franklin/Fulton	\$251,548	\$118,103	\$47,450	\$660,588	\$1,077,689
Greene	\$92,638	\$184,931	\$72,063	\$250,048	\$599,680
Huntingdon/Mifflin/Juniata	\$255,202	\$168,066	\$24,668	\$603,118	\$1,051,054
Lackawanna	\$203,304	\$426,239	\$188,364	\$1,626,414	\$2,444,321
Lancaster	\$517,025	\$1,220,594	\$136,400	\$2,331,703	\$4,205,722
Lawrence	\$141,566	\$384,335	\$265,719	\$1,052,619	\$1,844,239
Lebanon	\$243,886	\$153,130	\$90,145	\$881,411	\$1,368,572
Lehigh	\$426,101	\$768,838	\$557,675	\$2,937,099	\$4,689,713
Luzerne/Wyoming	\$327,236	\$718,011	\$113,620	\$3,104,730	\$4,263,597
Lycoming/Clinton	\$289,064	\$420,934	\$28,748	\$1,735,951	\$2,474,697
Mercer	\$229,012	\$509,829	\$47,375	\$991,652	\$1,777,868
Montgomery	\$757,147	\$891,330	\$467,754	\$4,132,333	\$6,248,564
Northampton	\$321,902	\$358,291	\$415,583	\$2,254,226	\$3,350,002
Northumberland	\$181,265	\$82,943	\$143,033	\$566,022	\$973,263
Philadelphia	\$8,545,087	\$3,965,461	\$3,143,394	\$27,541,475	\$43,195,417
Potter	\$82,708	\$37,200	\$450	\$160,476	\$280,834
Schuylkill	\$294,076	\$524,130	\$91,788	\$1,415,254	\$2,325,248
Somerset	\$90,643	\$101,767	\$40,011	\$459,864	\$692,285
Susquehanna	\$35,543	\$80,600	\$16,500	\$342,898	\$475,541
Wayne	\$140,259	\$98,884	\$50,303	\$297,755	\$587,201
Tioga	\$73,198	\$60,603	\$0	\$303,587	\$437,388
Venango	\$127,217	\$113,114	\$18,994	\$627,065	\$886,390
Washington	\$344,861	\$458,431	\$11,970	\$1,559,397	\$2,374,659
Westmoreland	\$950,994	\$1,383,544	\$91,588	\$1,822,809	\$4,248,935
York/Adams	\$416,250	\$315,099	\$258,917	\$2,228,644	\$3,218,910
<b>TOTAL</b>	<b>\$24,592,696</b>	<b>\$27,193,504</b>	<b>\$15,232,482</b>	<b>\$113,912,445</b>	<b>\$180,931,127</b>

For further information contact:

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Bureau of Drug and Alcohol Programs  
02 Kline Plaza  
Harrisburg, PA 17104**

**Phone: 717-783-8200**

**Fax: 717-787-6285**

**Web site: <http://www.health.state.pa.us/bdap>**

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**Edward G. Rendell  
Governor  
Commonwealth of Pennsylvania**

*Everette James, Secretary of Health  
Pennsylvania Department of Health*

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