



***PA DEPARTMENT OF DRUG  
AND ALCOHOL PROGRAMS  
2017 PEER REVIEW  
Cumulative Results***

Single County Authority Assessment Process



Prepared by the Mercyhurst University Civic Institute

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## Project Methodology

The annual Pennsylvania Department of Drug and Alcohol Programs (DDAP) Peer Site Review initiative was conducted during the spring of 2017. This process, which is a requirement mandated by the federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funding stream, focuses on a different program type each year. During the process, a minimum of 5% of sites offering the selected programmatic service must be reviewed by peers from like agencies. Planning for the annual initiative took place in the fall of 2016 through winter of 2017, with the actual review process taking place in April and May of 2017.

For the 2016-2017 fiscal year, DDAP chose to review Single County Authority (SCA) Assessment processes. Traditionally, provider programs have been chosen for review. The inclusion of the funding sources this year provided the opportunity to gather input into the methods through which clients are offered treatment services within their community. A total of six SCAs had agreed to participate in this year's process.

Once DDAP representatives secured participating sites, reviewers were recruited to conduct the site visits. One of the most interesting and unique aspects of this initiative is that representatives from other agencies visit and conduct interviews with their peers, affording them the opportunity to learn best practices in a hands-on discussion-oriented environment. Participants also develop network resources that can be used in their professional careers. Reviewers were matched to sites by geographical proximity in an effort to keep the reviewers within a reasonable drive to the facility that they review. The following table shows the sites reviewed with the corresponding reviewers assigned to each site, and date of visit.

Site	Reviewers	Date of Review
Bedford County/Personal Solutions	Peter Czeck (Juniata Co. Drug and Alcohol)	May 8, 2017
	Billie Kile (York Adam Drug and Alcohol Commission)	
Centre County	Jamie Johnson (Chester Co Department of Drug and Alcohol Services)	May 5, 2017
	Audrey Gladfelter (York Adams Drug and Alcohol Commission)	
Lawrence County Drug and Alcohol Commission	Jennifer Weigle (Somerset Co. Drug and Alcohol Commission)	May 4, 2017
Tioga County Department of Human Services	Jennifer Dormer (Columbia Montour Snyder Union Drug and Alcohol Services)	May 5, 2017
	Jennifer Reeder (Lycoming Clinton West Branch Drug and Alcohol Abuse Commission)	

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Venango County Substance Abuse Program	Anita Robinson (Crawford County Drug and Alcohol Executive Commission, Inc.)	May 1, 2017
	Nicole Salvo (Armstrong/Indiana/Clarion Drug and Alcohol Commission)	
Wayne County Drug and Alcohol Commission	Margie Rivera (Bucks County Drug and Alcohol Commission)	May 3, 2015
	Ana Rosado (Bucks County Drug and Alcohol Commission)	

The Mercyhurst University Civic Institute (MCI) has been assisting DDAP with the coordination and analysis of the peer review process since the 2006-2007 fiscal year. The MCI, based in Erie, PA, has a history of conducting program evaluations for state and local juvenile, family, criminal justice, and drug and alcohol programs. DDAP representatives and MCI staff structured the review process in a manner that focused on qualitative information such as strengths/weaknesses, work processes, and organizational behavior, while placing less emphasis on statistics and demographic data. Historically, there had been a separate pre-survey distributed prior to the site visits that would gather input and allow for maximum staff input into the process. As SCAs were reviewed this year, it was determined after talking to site contact staff that there actually were not enough staff to warrant including this step. Therefore, only a site-visit tool would be used during the 2016/2017 process.

The site visits were used for gathering information for the Peer Site Review process. MCI staff designed a tool that would guide the reviewers in their interviews with agency staff. The survey was broken down into five sections and 43 total questions based on: assessment process and components, Levels of Care, priority populations, trainings, program strengths and weaknesses, and other miscellaneous topics. The complete site visit survey tool can be found in the Reviewer Guide located in the Appendix of the Cumulative Site Report accompanying this document. Interviewee responses can be found in each site's individual report.

In order to prepare the reviewers for the site visits, an in-depth reviewer's guide was developed and sent to participating reviewers. This guide included all materials needed to conduct the review, pertinent contact information, reimbursement forms, interviewing tips, and a description for each question on the site visit survey tool. Reviewers were asked to participate in one of two conference calls (April 3 and April 6) led by MCI staff. The conference calls were set up to review the training manual, questions on the site visit survey tool, and responsibilities of the site reviewers.

Immediately after the conference calls took place, site contacts were informed that a reviewer would be in touch within the next two weeks to set up a date for the visit. In addition, it was

requested that each site have six staff available for interviews on the day of the site review. Unfortunately, due to the limited number of assessment staff at some of the sites, not all facilities were able to accommodate this number of staff to be interviewed. Once the reviews were completed, reviewers were asked to report back to MCI with review findings by May 26<sup>th</sup>. MCI staff then compiled final results for each individual site as well as an overall analysis. A final report was compiled and delivered to DDAP officials in June 2017.

## Site Review Summary

The site reviews for this year's initiative all took place during the first two weeks of May 2017. Individualized site reports were compiled based on findings from each of the site-specific interviews conducted. This cumulative report, however, contains general findings of all the sites. While some responses were very similar from one site to another, there were significant differences with other sites. The following report is a summary of the cumulative findings from all six site visits.

### ***Topic 1: Assessment Structure and Process***

#### Assessment Components

When asked about the tools that are used during the process, interviewees noted that they used a tool that incorporates DDAP assessment requirements, which has become standard at five of the six participating sites. The standardized DDAP tool as the primary piece for making their recommendations. There were a mix of responses on whether it is conducted electronically or by using the paper format. Some sites have not altered the assessment tool, while others have made amendments to it to better suit their needs and make the process more efficient. Examples of what has been added are sections to allow for clinical impressions and comparisons to PCPC data. A couple of the responding sites also incorporate Michigan Alcohol Screening Test and Drug and Alcohol Screening Test information into the process. One site uses its own tool that it took great lengths to develop; while it does contain much of the same information as forms used at other sites, it differs in many aspects. This unique tool contains sections to focus on non-treatment needs of clients and incorporates DSM questions as well.

There are generally not any issues that prevent the workers from completing an assessment within seven days of first contact with the individual at any of the programs reviewed. Across sites, it was said that if on the rare occasion it does happen, it is due to 'client choice'; typically the client no-shows, has to work, or may ask to be rescheduled due to another personal reason. One program noted that they block off time for 'walk-ins', and if they become backlogged with assessments they can use this time to make sure all individuals are seen in a timely manner.

Sites reported that they have very low non-placement rates for those referred into service. While exact figures were difficult to obtain, common estimates were 5% or less of clients do not enter treatment once they have been approved. Again, this comes down to client choice,

including lack of full disclosure of their drug use, certain court cases that prohibit their involvement, and a lack of bed availability in which the client chooses not to wait. One of the programs incorporates an intervention group that assists in motivating clients into treatment.

When asked how long it takes to complete an assessment, the range of answers was anywhere from 1 to 3 hours. The most common timeframe cited, however, was about 1.5 hours. Often staff feel overwhelmed and rushed to get through it in a timely manner. The length and amount of paperwork were described as burdensome. There was not a common change that was suggested to make it better, other than to shorten it. However, some interviewees noted that there is redundancy from one section to another, and that there were some sections that were irrelevant in making proper Level of Care recommendations.

Interviewees were asked about which components of the assessment process are given the most weight for making Level of Care decisions. The most commonly identified components included the following: drug use history, current use including the amount and the last usage, past treatment history, family drug use history, and mental health. In addition to the assessment, staff also use information from other assessments (i.e. MAST, PCPC, and biopsychosocial) as well as information from outside agencies. Sites reported having strong contacts with outside agencies such as Children and Youth Services and probation departments.

### Mandatory Assessment Components

DDAP requires certain components be included in the assessment. All are mandatory, though some are considered more useful than others. The following are themes that were common in most responses.

- *Demographics*: Most sites reported that basic information on the individual is collected, but at times can be used for other purposes, such as determining benefit eligibility.
- *Education*: There were mixed feelings on the usefulness of this section. Some sites recognized that it ties into literacy and comprehension issues the client may face; others stated that it does not tie in to primary treatment needs.
- *Employment*: The majority of sites feel that this section does not lend itself to primary treatment needs. However, there is some usefulness as it sheds light on motivation, and whether or not the client has private insurance.
- *Military*: All interviewees found this component useful, especially in terms of determining PTSD in clients. Sites can also refer client to services specifically for veterans.

- *Physical Health*: There were concerns regarding some clients not being able to receive services due to physical disabilities. Assessors also find that a client's physical pain may have led to their drug addiction.
- *Drug and Alcohol*: All interviewees found this component useful, typically the most helpful section in determining Level of Care recommendations.
- *Abstinence and Recovery Periods*: Understanding what was helpful in past periods of sobriety provides the assessor useful information on what type of treatment may be most beneficial. Being able to understand past use and treatment history allows assessor to understand what may and may not work in terms of treatment.
- *Behavioral and Emotional Health*: Some clients face dual diagnosis issues. If they need mental health services, it can be determined within this section.
- *Family/Social/Sexual*: The most common use of this section is determining whether or not there is a family history of drug and alcohol abuse. Many respondents felt that the questions regarding sexual activity made clients uncomfortable.
- *Spiritual*: There were mixed responses regarding this section, as some saw little or no relevance in it. Others see this as a potential source of support for a client.
- *Living Arrangements*: Respondents overwhelmingly use this section to determine what type of living arrangements and home support the client will have.
- *Abuse History*: This was often said to be important in determining the impact of past trauma, particularly for women, and whether trauma helped cause the initial abuse of substances.
- *Legal Issues History*: This is primarily used to determine what degree of legal issues were caused by substance use.
- *Gambling*: Not seen as being very relevant to the assessment process.
- *Potential Barriers to Treatment*: Sites will typically try to identify any barriers prior to making recommendation to alleviate any issues that may arise later.

### Special Considerations

Interviewees were asked about the special considerations given prior to placement in order to determine and maximize retention in a particular type of service. The following are common themes that arose during the reviews of the six sites.

- *Co-Occurring Disorders*: Overwhelmingly sites use this section to determine the severity of dual-diagnosis symptoms in clients. Findings also help to determine what type of facility the client will be referred to.

- *Cultural/Ethnic/Language Considerations:* The sites reviewed do not find this to be an issue with the clients that they serve; many of the sites are in rural, less diverse areas. Respondents do feel that they are equipped to deal with these needs, however, if or as needs arise.
- *Sexual Orientation and Gender Identity:* Staff are aware of the issues that this population may face and will work with them to find a provider that may have special programming to fit their needs. Some treatment providers are more accepting and understanding of the issues.
- *Medication-Assisted Treatment:* All of the reviewed sites work with MAT providers in the counties (some counties are more advanced in their offerings). Suboxone and Vivitrol are the most widely-used treatment options.
- *Women with Dependent Children:* Sites had wide variance in how they work with this population. Some counties have providers that are adept at offering treatment to those in this situation; others lack services to mothers with children.
- *Women's Issues:* Responses were very similar to those about serving women with dependent children.
- *Criminal Justice Involvement:* Staff interviewed feel that their sites work well with criminal justice agencies and court systems in an effort to get needed treatment to the clients. Unfortunately, depending on the offenses committed by the client, some providers may not be able to accept them, delaying treatment.
- *Impairment (i.e. hearing, learning):* Not a pressing need for these sites; however, respondents do feel that they are equipped to deal with these needs if or as needs arise.

## **Topic 2: Levels of Care**

Across the sites reviewed, there was much commonality in what assessors see as lacking in their communities. There is a lack of (or no) partial hospitalization, halfway houses, and inpatient programs. Some of the counties also struggle with adolescent offerings. It was also noted that there is a need for weekend and evening services for clients. The programs that are available for clients are often at capacity, causing wait times to be too long. Typically the sites have developed good, working relationships with local providers. This allows them to 'work around' space shortage issues, often by enrolling the client in lower-level services until spaces open up.

The interviewees reported that there are times when they will refer a client to services at a Level of Care other than the one that is recommended. Usually this is due to the client choosing not to enter a certain type of treatment program. Reasons for this varied, and include fear of job loss, housing/transportation, child care issues, or mandates placed upon them by the criminal justice system.

In addition to the appropriate Level of Care, interviewees reported that they also refer clients to a variety of other services. Education and employment assistance are high on the list of priorities, as are social services (i.e. food stamps, medical assistance) and safe, affordable housing.

### ***Topic 3: Priority Populations***

DDAP has set forth five populations for whom providing services must be a priority. Difficulties and experiences working with each vary from site to site. The following issues were commonly identified by the interviewed staff during the process.

- *Pregnant injection users and pregnant substance users:* There are no issues with assessing this population. The difficulty is finding treatment providers who are willing to take them, as some can't or won't for various reasons. Some counties see lack of bed space. Other providers will not take them past a certain time in their pregnancy. Often the women will be referred to a hospital for immediate help if treatment is not secured.
- *Injection drug users:* Many of these individuals need immediate attention, which is not always available. Often they come in with withdrawal symptoms present. Some counties see high 'walk-in' rates in this population.
- *Overdose survivors:* It was reported that clients in this population were often not completely honest in reporting a history of overdoses or the extent of their drug use.
- *Veterans:* Most interviewees stated there were no problems, but it was noted that getting them benefits through the VA can be complicated.

In order for the priority populations to be seen quickly, staff prioritize the assessments for these clients. Sites typically work with providers to align services quickly, but often face difficulty in finding bed availability. Some sites also 'flag' these individuals so when an opening comes up, they are first to have access to the spot.

Interviewees report that the assessments of non-priority individuals are typically not affected by the need to assess priority populations; however, it is possible that treatment for non-priority individuals could be pushed back. Staff said that this issue rarely occurs, and typically the sites will find time to get the assessments completed. It was said that there will always be equal services provided.

#### ***Topic 4: Miscellaneous Assessment Issues***

##### *Treatment Principles and Benchmarks*

Overall, the staff of sites visited feel that they have the ability to make the proper Level of Care recommendations for clients who are assessed. The assessment tools are thorough enough to allow them to do so; however, many respondents believe that prior experience and knowledge gained on-the-job are also key. A suggestion was given that it would be helpful if the assessor could schedule an outpatient appointment immediately, rather than having to wait for a provider to call back.

When asked about integrating the treatment principles of Recovery Oriented Systems of Care, Trauma-Informed Care, and Evidence-Based Practice into the assessment process, the interviewees at the sites had various responses.

- *Recovery Oriented Systems of Care*: Most sites will monitor each level on their own, but there are those SCAs that employ recovery specialists to do this in-depth.
- *Trauma Informed Care*: Most sites said that they are familiar with this in one manner or another. However, some are not as well versed on this topic and continue to learn about the impact trauma has on clients.
- *Evidence Based Practices*: Most sites said that they are familiar with this in one manner or another. However, some sites are starting to understand these types of programs better. Some providers are not well versed in them, as well.

In regards to meeting the identified benchmarks, respondents across the sites noted that availability of bed space (especially in Detox) and client choice are what prohibits them from reaching standards required by DDAP. Often times, some of the insurers view treatment timeframes differently, which causes issues.

##### *Trainings*

The interviewees had differing opinions on the DDAP-required trainings on assessments. Some of the respondents said that they were fine and conveyed information that should be required. Other interviewees commented on them being 'dry' and lacking 'practical use'. The majority of interviewees believe that they learn more through on-the-job experience than they do through the trainings. Staff had also commented on the lack of ongoing training opportunities offered to them, and respondents suggested they could benefit from learning about cultural

competency, drug trends, and mental health. One suggestion was to have practical application and assessment practice during trainings.

### Miscellaneous

Other than treatment, the most pressing needs of the individuals served include stable and affordable housing, transportation, employment/education, and child care. Interviewees felt that the assessment process properly identified the recommended Level of Care and all other needs of clients. The SCAs reportedly work very well with local case management programs; in fact, several of them also house the county-level case management services.

### ***Topic 5: Strengths/Weaknesses***

At the conclusion of each interview, staff were asked to identify the strong points of their programs and assessment process. Many commented on the solid relationships that they have with outside agencies. The SCAs tend to have caring, knowledgeable staff in place that are trained to meet the needs of each client.

There were identified areas of weakness, as well. The primary issue that was discussed was the lengthiness of the assessment process. The primary, standardized assessment tool was said to be very redundant, and in need of tweaking to make for a 'smoother' evaluation. Several sites also commented on being short staffed.