PA DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS 2019 PEER REVIEW Cumulative Summary

Residential Treatment Providers of Co-Occurring Disorders

pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

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 2019. This process, which is a requirement mandated by the federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG), 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 2018 through winter of 2019, with the actual review process taking place in April and May of 2019.

For the 2018-2019 fiscal year, DDAP chose to review Residential Treatment Providers of Co-Occurring Disorders. DDAP representatives secured participating sites, then 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 to minimize travel requirements. A total of five programs agreed to participate in this year's process. The following table shows the sites reviewed with the corresponding reviewers and date of visit.

Site	Reviewers	Date of Review
Gaudenzia Common Ground (Harrisburg)	Sarah Hawkins and Maria Lacey (New Perspectives at White Deer Run)	May 9
New Perspectives at White Deer Run (Lebanon)	Jon Gamble and Anthony Shelly (Gaudenzia Common Ground)	May 7
Gage House (Erie)	Holly Martin and Kandi Madoskey (Greenbriar Treatment Center)	May 7
Greenbriar Treatment Center (Washington)	David Brooks and Jodie Klus (Gaudenzia Crossroads)	May 2
Gaudenzia Crossroads (Erie)	Erin Mrenak and Mary Viglione (Gage House)	May 1

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, housing, 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 compliance, statistics and demographic data.

The peer review process utilized three specific data collection tools. The first two were distributed prior to site visits and centered on gathering preliminary information. The first tool used was a pre-survey, designed to gather input from all staff at each program. The pre-survey consisted of 30 statements about various program traits, on which respondents noted their level of agreement using a Likert Scale. Additionally, the pre-survey consisted of 16 topics on which the respondents rated their agency's performance using a Likert Scale. To maintain anonymity, the surveys were analyzed across all site reviews, as opposed to being site-specific. A site contact survey coincided with the distribution of the pre-survey. The site contact survey was used to gather statistical information about the program's performance from one key contact through a once-only request for information that might be unknown to the interviewees. Copies of these tools can be found in the Appendix.

The third tool was used for gathering information during the site visits as part of the Peer Site Review process. MCI staff designed a tool to guide the reviewers as they interviewed agency staff. The survey was broken down into six sections and 28 total questions grouped by: Screening/Intake, Assessment/Treatment Planning, Treatment, Aftercare, Staffing and Administration, and other Miscellaneous topics such as staff morale and training. Program specific guidelines were used to construct survey questions that focused on the chosen type of programming. 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 the materials needed to conduct the review, pertinent contact information, reimbursement forms, a check list, and a copy of the site visit survey tool. Reviewers were asked to participate in one of two conference calls (March 19th and March 20th) 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 participants.

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. It was requested that each site have six staff available (if possible) for interviews on the day of the site review. Once the reviews were completed, reviewers were asked to report back to MCI with review findings by May 24th. MCI staff then compiled final results for each individual site and also completed an overall analysis. A final report was compiled and delivered to DDAP officials in June 2019.

Pre-Survey Results

The first portion of the site review process was the administration of a pre-survey. All staff members associated with the Residential Treatment Providers of Co-Occurring Disorder programs that were reviewed were asked to participate. The pre-survey focused on organizational and operational behaviors within each facility. In addition, the survey asked respondents to rate areas of operations that are pertinent to organizational functions. The survey allowed a greater number of staff members to have input in the review process and supplemented the data collected from the interviews conducted during the site review. The results that follow are cumulative for all participating sites, due to the small number of returns from some of the programs. Analyzing individual site returns would not be feasible and may, in fact, allow for breach of anonymity with responses. A total of 79 surveys were returned.

Part One

Part one of the pre-survey consisted of a list of 30 statements to which survey participants were asked to rate their level of agreement using a 5-point Likert scale (1 = Strongly Disagree, 5 = Strongly Agree) for each item. In addition, a column of Not Sure/Not Applicable was provided. Analysis of results consisted of ranking each statement by highest level of agreement to lowest level of agreement. High agreement statements (more than 75% of respondents either strongly agreed or agreed) are those that were generally supported by the respondents and are identified in **green text**. Low agreement statements (50% or more respondents were either neutral/unsure, disagreed or strongly disagreed) are identified with **red text**. These percentages were chosen only for sampling purposes. The complete table of statements has been re-ranked in order of highest agreement to lowest agreement for this report.

N = 79	SA & A	N	SD & D
Clients are made well aware of the program expectations when they are admitted.	90%	8%	2%
Our staff members do a thorough job of assessing clients' problems and needs.	86%	10%	4%
Clients are connected with aftercare services.	85%	12%	3%
Staff members are able to build rapport with clients in a reasonable amount of time.	83%	9%	8%
Staff members have knowledge of the challenges faced by our clients.	81%	15%	4%
The interventions utilized are useful in meeting clients' needs.	80%	15%	5%
Staff members are willing to try new things to improve treatment.	80%	18%	2%
Our program staff collaborate well with key agencies in our community.	77%	20%	3%
Treatment goals are appropriately matched to each stage of a client's recovery.	77%	15%	8%

N = 79	SA & A	N	SD & D
Staff members maintain appropriate professional boundaries with clients.	**77%**	**17%**	**6%**
Client's treatment is adjusted based on their changing needs.	**77%**	**17%**	**6%**
My personal workspace is conducive to completing my job responsibilities.	73%	18%	9%
I trust the professional judgment of my coworkers.	73%	19%	8%
Clients view this program as beneficial to their treatment.	71%	20%	9%
Staff begin coordinating aftercare services for clients well prior to discharge.	71%	19%	10%
Clients have significant input into the development of their treatment plans.	68%	27%	5%
Our agency creates an environment in which professional growth is encouraged.	68%	18%	14%
Client's social supports are effectively engaged while the client is receiving treatment.	65%	30%	5%
I am satisfied with the training available to staff.	64%	17%	19%
Mental Health issues are addressed at the same level as drug and alcohol issues.	63%	18%	19%
Our program has a clear definition of success.	62%	30%	8%
Our physical building is conducive to meeting our clients' needs.	57%	25%	18%
Staff members feel they are supported by management.	56%	19%	25%
Staff members communicate well with one another.	55%	24%	21%
Our program staff have access to technology as needed.	54%	33%	13%
Staff members cooperate with one another in a way that supports the program.	53%	35%	12%
Staff members report a sense of high morale.	**44%**	**29%**	**27%**
Clients have access to occupational and vocational counseling.	**38%**	**40%**	**22%**
We have adequate staff in place to meet our clients' needs.	**37%**	**25%**	**38%**
Employee wages and benefits are appropriate and comparable with those at similar agencies.	**35%**	**32%**	**33%**

Summary

Overall, 11 of the 30 statements were met with high levels of agreement. The statement with the highest level of agreement was "Clients are made well aware of the program expectations when they are admitted," with 90% of respondents either indicating Strongly Agreed or Agreed. Four statements were met with greater than 80% high level of agreement: "Our staff members do a thorough job of assessing clients' problems and needs" (86%); "Clients are connected with aftercare services" (85%); "Staff members are able to build rapport with clients in a reasonable amount of time" (83%); and "Staff members have knowledge of the challenges faced by our clients" (81%). Four of the statements were identified as being low agreement: "Employee wages and benefits are appropriate and comparable with those at similar agencies" (35%); "We have adequate staff in place to meet our clients' needs" (37%); "Clients have access to

occupational and vocational counseling" (38%); and "Staff members report a sense of high morale" (44%).

Another way to look at the results of this section of the pre-survey is to rank them by mean score. The following tables illustrate the results in this fashion.

N = 79	Mean
Clients are made well aware of the program expectations when they are admitted.	4.41
Clients are connected with aftercare services.	4.34
Staff members have knowledge of the challenges faced by our clients.	4.21
The interventions utilized are useful in meeting clients' needs.	4.20
Staff members are willing to try new things to improve treatment.	4.20
Our program staff collaborate well with key agencies in our community.	4.16
Our staff members do a thorough job of assessing clients' problems and needs.	4.11
Staff members are able to build rapport with clients in a reasonable amount of time.	4.09
Staff members maintain appropriate professional boundaries with clients.	4.06
Client's treatment is adjusted based on their changing needs.	4.03
Treatment goals are appropriately matched to each stage of a client's recovery.	3.97
I trust the professional judgment of my coworkers.	3.96
My personal workspace is conducive to completing my job responsibilities.	3.94
Clients view this program as beneficial to their treatment.	3.91
Staff begin coordinating aftercare services for clients well prior to discharge.	3.87
Clients have significant input into the development of their treatment plans.	3.85
Our program has a clear definition of success.	3.82
Client's social supports are effectively engaged while the client is receiving treatment.	3.81
Mental health issues are addressed at the same level as drug and alcohol issues.	3.76
Our agency creates an environment in which professional growth is encouraged.	3.75
Our program staff have access to technology as needed.	3.67
I am satisfied with the training available to staff.	3.66
Staff members cooperate with one another in a way that supports the program.	3.65
Our physical building is conducive to meeting our clients' needs.	3.48
Staff members communicate well with one another.	3.44
Staff members feel they are supported by management.	3.38

N = 79	Mean
Staff members report a sense of high morale.	3.25
Clients have access to occupational and vocational counseling.	3.22
Employee wages and benefits are appropriate and comparable with those at similar agencies.	2.97
We have adequate staff in place to meet our clients' needs.	2.90

Part Two

Part two of the pre-survey consisted of a list of 16 general themes related to organizational activities and traits. Survey participants were asked to rate their view of their program's overall performance on a 5-point Likert scale varying from 5 = Very Strong to 1 = Weak. High strength statements (75% or more of respondents answered Very Strong or Strong) are those that were generally supported by the respondents and are identified in **green text**, and low strength statements (less than 50% of respondents responded very strong or strong) are identified with **red text**. These percentages were chosen only for sampling purposes. The analysis below consists of ranking each statement from greatest identified strength to lowest identified strength.

N = 79	VS & S	N	VW & W
Treatment Components/ Programming	**78%**	**16%**	**7%**
Staff- Client Relationships	**75%**	**20%**	**5%**
Aftercare Planning	71%	20%	9%
Intake process	71%	17%	12%
Treatment Planning	70%	23%	7%
Relationships with Outside Agencies	70%	26%	4%
Staff Professionalism	65%	25%	10%
Perception within Treatment Community	63%	27%	10%
Management Performance	62%	25%	13%
Co-worker Relationships	62%	30%	8%
Staff- Management Relationships	59%	30%	11%
Professional Development	58%	27%	15%
Working Conditions	57%	29%	14%
Communication	51%	30%	19%
Technology Access	**48%**	**33%**	**19%**
Staff Morale	**46%**	**25%**	**29%**

Summary

Two of the topic areas were met with high levels of strength: Treatment Components/ Programming (78%) and Staff-Client Relationships (75%). Two areas showed low levels of strength: Staff Morale (46%) and Technology Access (48%).

As illustrated with part one, another way to look at the results of the pre-surveys is to rank them by mean score. The following tables illustrate the results of this section in this fashion.

N = 79	Mean
Treatment Components/ Programming	4.10
Relationships with Outside Agencies	4.03
Staff- Client Relationships	4.03
Intake Process	3.99
Aftercare Planning	3.97
Treatment Planning	3.94
Perception within Treatment Community	3.89
Co-worker Relationships	3.76
Staff Professionalism	3.75
Management Performance	3.71
Staff- Management Relationships	3.61
Professional Development	3.59
Working Conditions	3.57
Technology Access	3.45
Communication	3.44
Staff Morale	3.23

NOTE: The reader should understand that the data from the pre-surveys may or may not reflect the overall feeling of all staff working within the programs or agencies. The reader should recognize that other issues may weigh in on the performance of the organizations beyond those noted in the summarized findings of the pre-survey.

Cumulative Site Review Summary

The peer site reviews of Residential Treatment Providers of Co-Occurring Disorders, which were the culmination of the entire Peer Review process that took place from December 2018 through June 2019, were completed during May of 2019. Specifics regarding dates of reviews and reviewer-site pairings can be found in the project methodology section of this report. This report is a generalized summary of system-wide findings from the reviews. Individual site-specific reports were created for each program that participated in the process.

Note: it is important to point out that the contents of this report are based solely off of the responses given by interviewees during the site visit. The Mercyhurst Civic Institute uses only the responses that are recorded by interviewers and returned to our office to formulate the summary of results. It should also be noted that interviewees at each site responded to the best of their knowledge to questions. Some responses may not give a complete representation of functional aspects of a program.

Topic 1: Screening/Intake

Sites that participated in the 2019 Peer Review process have both similarities and differences in how they screen potential clients during the intake process. The most notable similarity is that the initial screening is primarily done over the phone. In some cases it may be conducted face-to-face, but this is the exception. The programs typically rely on an intake coordinator-type position to do the screening; however, some sites reported that other positions are engaged in screening. One program noted that is primarily handled by nursing/medical staff. Another site referred to a "sales force" that is used to generate referrals to the program, though it was not mentioned whether or not they actually conduct screenings. As part of the screening process, all of the programs collect demographic information, as well as medical history, current and past usage, mental health issues, etc. What differs between sites is the level of information gathered for "secondary" categories, such as family supports, suicide, employment, and educational background. It should be noted, however, that even though a site may not have reported as collecting this information, it may be that the interviewees during the process just did not mention these categories.

DDAP encourages their sites to adhere to the 'No Wrong Door' policy, which ensures a person needing treatment will be identified, assessed and receive treatment regardless of where they enter the realm of services. All programs reported following this philosophy, some more stringently than others. Interviewees at all sites noted that if a client is not a good "fit" for the program, staff will work to find proper treatment for them. A couple of the programs are

within agencies that have multiple service offerings, and finding appropriate levels of care is reportedly not difficult.

Programs often use the input of a client's family and friends, who may provide information as part of the assessment process. Family may participate in family counseling or issues may be addressed as part of the treatment plan. It should be noted that any input must be agreed upon by the client, and a consent signed to release information. One of the participating programs uses a family questionnaire upon intake, and incorporates this information into the treatment planning process. All of the programs incorporate some level of family involvement into their offerings.

Clients with suicidal or self-harm tendencies may also enter the programs. Across the sites, staff are trained to look for signs of suicidal ideation, self-harm, or self-injurious behavior (such as fresh wounds, scars, etc.) during intake, and to make provisions to ensure the client's safety. All sites also report using the Clinical Institute Withdrawal Assessment (CIWA) and Clinical Opiate Withdrawal Scale (COWS) instruments to identify symptoms of withdrawal; these tools were said to be very effective. Individual who enter the program while visibly impaired/under the influence are placed into withdrawal management for further assessment and treatment.

Topic 2: Assessment /Treatment Planning

Various methods are used to assess and evaluate the client's treatment and service needs and subsequently develop treatment goals and objectives. The following are commonly used and have been identified in the Treatment Improvement Protocol 42 developed by SAMHSA as integral to the assessment process:

- *Substance Abuse Evaluation:* information is primarily gathered by clinical and medical staff; most notable tools used are biopsychosocial, nursing assessment, and drug and alcohol assessment tools.
- *Mental Health Evaluation:* medical, clinical and psychiatric staff are responsible for this evaluation; psychiatric and psychological evaluations, biopsychosocial, Life Events Checklist-5, PCL-5 for Post-Traumatic Stress Disorder, and reports from previous providers are primarily used.
- *Physical Health/Medical Evaluation:* medical staff conduct these evaluations; nursing assessments are most notably used.
- *Entitlements (SSI, Medicaid, etc):* sites reported multiple staff gather this information; clients typically come to staff with needs, as opposed to staff spending significant time identifying needs during the assessment process; often information is found through the utilization review process.

- *Client Status (strengths, goals, family support, readiness, etc):* clinical team primarily gathers information, with some input from medical staff; tools used include ASAM and biopsychosocial evaluation.

During the assessment process, therapists attempt to determine how a client's mental health impacts their substance abuse. Overall, sites gather this information from clients and synthesize it into a treatment plan. Clinical staff apply the information from the initial screening and further assess to identify problematic areas that need to be addressed while the client is in treatment. Information is also typically shared among staff at team meetings, which provides the opportunity for input from various clinical perspectives and helps to ensure that the client's needs are being addressed in an integrated manner.

There were no universal, formal time frames in which clients are reevaluated. Most of the site interviewees noted it happens quite often on an informal basis. It could be in a group session, or it could take place whenever the nurse checks on them; most often, treatment plan progress is assessed by the primary clinician/clinical team and discussed with the client during individual sessions. Regarding intervention strategies at each stage of change, most responses referred to clients being "met where they are at," and that counselors will adjust treatment plans based on their assessment of what the client needs.

Interviewees were asked what works with their assessment/treatment planning process. Overall, sites reported the processes are individualized, use detailed assessment data, use client input, and include clients' history.

Topic 3: Treatment

As clients have various needs for treatment, it is imperative that programs address specific needs and considerations. Examples are language barriers, physical limitations, or cultural differences. All of the participating programs take these into consideration, one way or another. Most commonly, programs offer specialized groups. Many staff reported being trained to be aware of cultural differences and how not recognizing them can impact treatment with a client. While programs will incorporate needs and considerations, they are also careful as to maintain fidelity to program services and treatment.

The most commonly used treatment modes/techniques cited by interviewees were Cognitive Behavioral Therapy, Motivational Interviewing, and incorporating the 12-step model into programming. Sites also typically embrace the Therapeutic Community model and structure for their program. Clients are often engaged in individual and group settings. All programs offer a

wide variety of group topics for their clients. While mental health and drug and alcohol recovery groups are staples in all programs, some site offerings include groups focused on yoga, art therapy, music, or gender identity, among others. Family and friends can be engaged in a client's treatment process as well. A couple of programs were noted for having a formalized engagement process for those family supports.

Topic 4: Aftercare

Continuing care is addressed in many methods across sites. The following are common aftercare services, and generalities of how the sites incorporate them:

- *Life Skills Education:* clients typically referred to local OVR and education centers; money management groups may be offered within programs as well.
- *Relapse Prevention:* all programs offer some sort of support, typically in groups; clients may be referred to halfway houses; relapse prevention plans are typically drawn up for clients, with follow-up appointments scheduled.
- *12-Step/Double Trouble:* all programs supply clients with meeting locations in their area.
- *Case Management:* some programs offer in-house, while others refer to another agency; case managers typically work with clients for housing needs, insurance, employment, clothing, etc.
- *Vocational Training/Education/Employment:* most use OVR and GED services.

Most respondents define a successful discharge as one where a client meets their goals and has an aftercare plan set up. The client will also show signs of progressing, be compliant with medications, and maintain supports. Interviewees felt that their discharge process and aftercare planning could be improved if they have more follow-ups with the client or a dedicated staff member to coordinate aftercare services. In some instances, there is a lack of continuing treatment programs within a geographic area to which the client might be referred.

Topic 5: Staffing and Administration

Staff were asked to comment on their current workload. Responses varied, as some said it was manageable while others stated that they are overworked. Most respondents believe that their program is under-staffed, which impacts the duties that have to be carried out each day. There are certain boundary issues that cause issues within programs, as well. Most notable are boundary issues between techs and clients, leading to improper relationships. In some programs, management shows favoritism towards certain employees. Morale varies not only among sites, but also with the respondents within each program. Overall it is "O.K.", and tends

to be improving. The most widely suggested way to improve staff morale is to do better at recognizing staff for their efforts. Pay raises, staff bonding events, and decreasing workloads were also cited, as was improving communication.

Staff are afforded multiple training opportunities. Some of the most useful are cultural diversity, sexual identity, ASAM, and Cognitive Behavioral Therapy. Interviewees said they could benefit from more/better trainings in de-escalation, relapse prevention, current drug trends, and becoming a Certified Recovery Specialist.

Topic 6: Miscellaneous Assessment Issues

Interviewees were asked to note what makes their program effective. Common responses included paying close attention to clients, adopting the Therapeutic Community model, offering individualized treatment, and "meeting clients where they are at." Most felt their program is welcoming and embracing of all, and having staff in recovery allow clients to relate. When asked what can be improved upon, responders stated that facilities seem to be outdated and in some cases "run-down" with not enough space for all services needed. Some cited the need for more resources and opportunities for clients to develop life skills.

There is a belief that the programs are seen positively in the community, though it did seem that some interviewees did not know how to answer this question. Some interviewees noted that if the person is seen poorly in the community, it could be attributable to clients not succeeding or putting much into their recovery, and the program is deemed at fault.