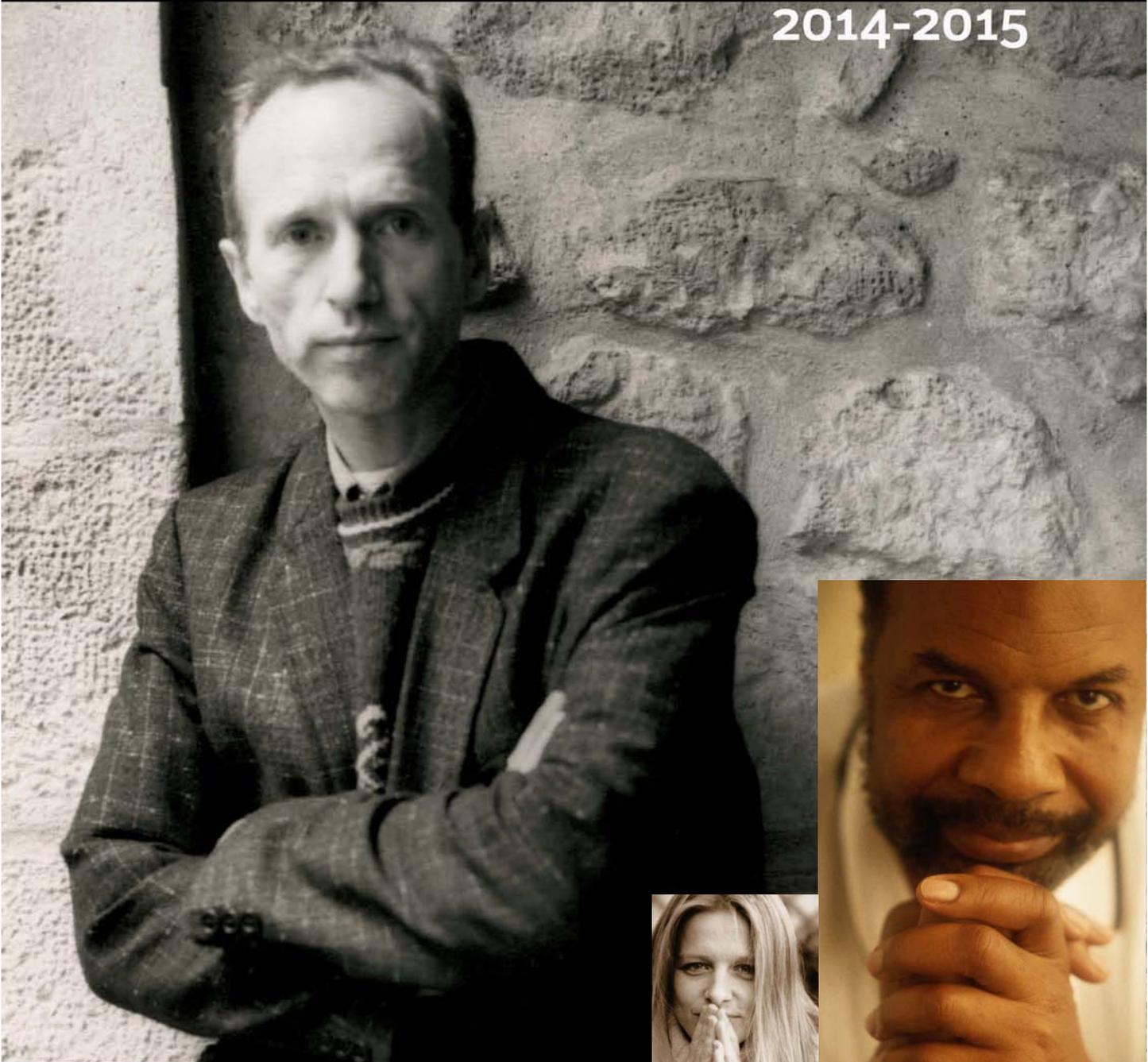


PENNSYLVANIA DRUG AND ALCOHOL ANNUAL PLAN AND REPORT

DRUG AND ALCOHOL ABUSE PREVENTION AND TREATMENT

2014-2015



pennsylvania
DEPARTMENT OF DRUG AND
ALCOHOL PROGRAMS

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PART 1: STATE PLAN AND PROGRAM REPORTS



CHAPTER 1

Overview and State Plan

THIS CHAPTER STATES THE MISSION, VISION AND VALUES ESTABLISHED BY THE DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS. THE CHAPTER INCLUDES A LETTER FROM THE SECRETARY, OUR GOALS AND STATE PLAN FOR FY 2014-2015.

ACKNOWLEDGEMENTS

The establishment of the Department of Drug and Alcohol Programs (DDAP or the Department) on July 1, 2012 secures Pennsylvania's place as a true leader in the country in addressing the wide ranging devastation caused by drug and alcohol abuse across the state. Our programs, over time, will have a dramatic positive impact on Pennsylvania's criminal justice system, child welfare, health care costs, the workplace, and highway safety, leading to benefits for all Pennsylvanians.

We gratefully acknowledge the General Assembly and Governor Tom Corbett for establishing this Department. The Department also thanks the Pennsylvania Association of County Drug and Alcohol Administrators, the Drug and Alcohol Service Providers Organization of Pennsylvania, the Rehabilitation and Community Providers Association, Pennsylvania Association for Treatment of Opioid Dependence, Commonwealth Prevention Alliance, Pennsylvania Prevention Directors Association, and the Pennsylvania Recovery Organizations Alliance for their support throughout the formation of the Department. Your ideas, advice, and recommendations have time and time again proved invaluable to the Department.

Without the support from the leadership and staff of numerous state agencies, the development of the Department would have been much more difficult. The expertise and enthusiastic support we have received is impressive, and has been helpful in this transition.

In particular, the administration and staff at the Department thanks the Department of Health (DOH), the Department of Human Services (DHS), the Pennsylvania Commission on Crime and Delinquency (PCCD), and the Office of Administration (OA) for the generosity they have displayed in providing support services, particularly in supporting the work of establishing the Department. The many hours of hard work and the resources these agencies have dedicated to the Department is admirable; without these services the daily operations of the Department could not have moved forward.

The Department thanks the dedicated Substance Abuse and Mental Health Services Administration staff for their help and direction during the period of transition from a Bureau to a Department. Your contributions have helped shape the Department in immeasurable ways.

Finally, we thank the Department staff for their daily efforts to make our accomplishments and our far-reaching goals a reality.

Fellow Citizens of Pennsylvania,

As a career prosecutor and as the Legislative Liaison for the Pennsylvania District Attorneys Association from 1986 to 2006, I have spent virtually my entire professional life looking for how to make Pennsylvania's homes and streets safer from crime. I found the answer in my work as Executive Director of the President's Commission on Model State Drug Laws in 1993, where I learned that three out of four criminal offenders suffer from untreated drug and alcohol addiction. I learned the remarkable fact that if we provide these offenders drug and alcohol treatment that is individually matched to each one's level of addiction, we will reduce recidivism by about 70%. Pennsylvania, with its County Restrictive Intermediate Punishment Treatment Program has had even greater success; 86% completing treatment go on to live crime-free lives. Returning to Pennsylvania, I spent my final years advocating on behalf of Pennsylvania prosecutors for more treatment.



I have also come to learn in the ensuing years that drug and alcohol addiction, although the major cause of crime in our nation, is much bigger than the crime issue most individuals with an addiction are still in the workplace. In fact, one out of four families suffers from drug and alcohol abuse, often in secret, and often with devastating results not just to the one with the disease but to the children or other family members. I've come to understand how it is a huge cost driver, not only in criminal justice, but also to human services, education, and healthcare. Although Pennsylvania does better than most states, most of those in need of drug and alcohol addiction treatment go without. We all pay dearly, both financially and in human suffering, for this failure to treat the disease.

While I am pleased with how far we have grown the Department in the past two years, there is more work to be done. It seems like we started only yesterday, yet we have hired new key staff from around the country, developed plans for the Department mission and goals which reach across a wide range of priorities, and established strong relationships and collaborations with other key Departments. In this short time, we have worked closely with our stakeholder groups to implement policy changes to improve the quality of care, implement new cross-departmental initiatives, and secured additional federal funding through grants and streamlined practices. And all of these changes also save taxpayer dollars.

Even with all this growth, I realize there is so much to do and our work has just begun. As I look ahead, I consider, "What can I do to help tomorrow?" "What initiatives will make the biggest difference while remaining fiscally sound?"

This is our answer. This report reflects the accomplishments of our Department over the past year, as well as our mission and vision as we move forward to the next generation of growth. This answer demonstrates the value of the work on a daily basis, not only in terms of economics, but also in terms of hope, and the quality of life for the citizens of Pennsylvania. This report answers the persistent questions: "What needs to be done?" and "What can we do to help?" In these pages, I hope you may find these answers as well, as we continue our partnership for the growth of Pennsylvania.

I'm reminded of the woman I met, with tears in her eyes as she told me, "I've been clean for 25 years since I got treatment when I was pregnant with my baby. My baby's grown now and we work together, giving back to others who need help like I did." I still remember her smile as she proudly pulled out the picture of her grandbaby. A priceless example of how treatment can change the future for not just one person, but for generations to come.

Sincerely,

A handwritten signature in black ink that reads "Gary Tennis". The signature is written in a cursive, flowing style.

Gary Tennis
Secretary, Pennsylvania Department of Drug and Alcohol Program

THE NEED FOR THE DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

The establishment of the Department comes at a time of an unprecedented opioid epidemic occurring in Pennsylvania and across the country. It is so extreme that the Governor of Massachusetts recently declared a state of health emergency as a result of the rapid escalation of this issue. Over the past 20 years, there has been a steady rise in the rates of addiction and overdose death. Based on Pennsylvania Department of Health data, overdose deaths have been on the rise over the last two decades with an increase in the rate of death from 2.7 to 15.4 per thousand Pennsylvanians, with nearly 2,000 men, women and children dying annually in Pennsylvania due to overdose. In particular, there has been a sharp rise in the rate of heroin and other opiate abuse and overdose death. The situation has been further complicated by the high prevalence of multiple drug use.

Year	Number of Deaths	Population	Rate per 1,000
2011	1,909	12,742,886	15.4
2010	1,550	12,702,379	12.5
2008	1,522	12,448,279	12.6
2006	1,344	12,440,621	11.2
2004	1,278	12,406,292	10.6
2002	895	12,335,091	7.5
2000	896	12,281,054	7.4
1998	628	12,001,451	5.4
1996	630	12,056,112	5.4
1994	596	12,052,410	5.1
1992	449	11,995,405	3.8
1990	333	11,881,643	2.7

Cause of Death Statistics provided by the Department of Health, Bureau of Health Statistics and Research

The data from 2012 and later are preliminary; however, there clearly seems to be a strong, recent trend upward in heroin use since 2011. The federal Substance Abuse and Mental Health Services Association (SAMHSA) also reports that there has been a doubling of the number of heroin users between 2007 and 2012 (SAMHSA, 2012).

Among a sample of misusers of prescription drugs who used heroin, 82% started with prescription drugs before transitioning to heroin (SAMHSA, 2013). Anecdotally, we are hearing from all over the state that heroin use is still on the rise among our youth, often in communities that have not experienced heroin at such levels before.

In response to this epidemic, Pennsylvania has had a broad response including initiatives detailed in this report such as the Overdose Rapid Response Task Force, adoption of prescribing guidelines for opioids, and unused Prescription Drug Take Back initiatives. Governor Corbett’s Healthy Pennsylvania program, starting January 2015, will increase access to needed treatment services for our citizens struggling with addiction. At Governor Corbett’s direction, the Heroin and Other Opioid Workgroup was established to develop a coordinated and robust response to the epidemic, with collaboration from a broad range of commonwealth agencies and input from key community stakeholders (see p. 22).

From a broader perspective on a healthier Pennsylvania, substance abuse prevention, intervention, and treatment services have a profound beneficial impact on society. These services make our streets and homes safer from crime, improve our health, increase our employment (turning tax burdens into taxpayers), make us better parents, make us safer drivers, lower the number of unwanted pregnancies, reduce our workmen’s compensation claims and increase our overall social functioning. At the state government level, when the Department succeeds in its mission, other departments will find greater success in their missions as well (e.g. Department of Corrections, Department of Human Services, Department of Health, Department of Economic Development, Department of Transportation, Department of Labor and Industry, as well as State Police).

This results in extraordinary cost savings. For every dollar invested in addictions treatment, the taxpayer saves \$7.00 in costs to society (Rand Drug Policy Research Center, 2007), primarily in reduced criminal justice costs. Furthermore, research on the Pennsylvania system finds that effective treatment not only reduces recidivism dramatically, but also leads to increased employment rates, at higher rates of pay so that it is good for our economy as well as our families (Villanova University, 1995).

In 2007, it was estimated that the national cost to society of drug abuse alone, not including alcohol abuse, was \$193 billion (National Drug Intelligence Center [NDIC], 2011), a substantial portion of which—\$61 billion—is associated with drug related crime, including criminal justice system costs and costs borne by victims of crime. The national cost of drug abuse breaks down as follows:

Over \$61 Billion in Substance Abuse Related Costs Involve The Criminal Justice System

Crime includes three components: criminal justice system costs (\$56,373,254,000), crime victim costs (\$1,455,555,000), and other crime costs (\$3,547,885,000). These subtotal \$61,376,694,000.

Health includes five components: specialty treatment costs (\$3,723,338,000), hospital and emergency department costs for non-homicide cases (\$5,684,248,000), hospital and emergency department costs for homicide cases (\$12,938,000), insurance administration costs (\$544,000), and other health costs (\$1,995,164,000). These subtotal \$11,416,232,000.

Productivity includes seven components: labor participation costs (\$49,237,777,000), specialty treatment costs for services provided at the state level (\$2,828,207,000), specialty treatment costs for services provided at the federal level (\$44,830,000), hospitalization costs (\$287,260,000), incarceration costs (\$48,121,949,000), premature mortality costs (non-homicide: \$16,005,008,000), and premature mortality costs (homicide:\$3,778,973,000). These subtotal \$120,304,004,000.

The cost of treating drug abuse on the other hand, (including health costs, hospitalizations, and government specialty treatment) is estimated to be \$14.6 billion, a mere 7.56% of these overall societal costs (NDIC, 2011). If you add alcohol abuse to these figures, these costs multiply.

Drug and alcohol treatment also restores physical health, and therefore is extraordinarily cost effective in reducing use of, and bringing about related savings in health care. Treatment reduces the costs associated with lost productivity, crime, and incarceration across various settings and populations. The largest economic benefit of treatment is in avoided costs of crime (incarceration and victimization costs). In the California Alcohol and Drug Treatment Assessment (CALDATA) study, the cost of treating approximately 150,000 substance users was \$209 million, but the savings during treatment and in the first year afterward amounted to \$1.5 billion. The largest savings were related to reductions in crime. CALDATA also confirmed

that health during and after treatment improved significantly, with corresponding reductions in use of health services.

Pennsylvania has a current population of nearly 13 million and according to the most recent (2010-2011) National Survey on Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), within this population there is an estimated prevalence of 900,000 cases of substance use disorder.

This latest NSDUH survey indicates that 8% of individuals 12 years of age and older in PA have used an illicit drug in the past month. Binge drinking for individuals age 12 and older in the past month was 25%. Alcohol use for adolescents age 12-20 for the past month was at 28%. Additionally, the survey indicates that for those needing treatment, less than 10% get the services they need. Pennsylvania does significantly better than the rest of the nation: one out of eight in need of treatment receive it, so clearly we still have far to go.

A total of \$5.3 billion of Pennsylvania's state budget is spent addressing the effects of untreated or under treated alcohol, tobacco and other drug abuse through justice, education, health, child and family assistance, mental health and developmental disabilities, public safety and state workforce programs. Pennsylvania taxpayers spend \$429.59 per capita on problems from alcohol, tobacco, and other drug abuse; that is about 15.9% of the state budget; \$15.13 per capita of this amount is spent actually solving the problem through prevention, treatment, and/or research. The rest covers the burden of alcohol, tobacco, and other drug abuse on justice, education, health, child and family assistance, mental health and developmental disabilities, public safety and state workforce programs. And this is state funds only - federal and local costs are not included (National Center on Addiction and Substance Abuse, 2009).

The huge cost-benefits from treatment arise not just from decreased crime and its attendant expenses (prisons and jails, costs of time in court, etc.), but also increased employment, fewer medical expenses, reduced child protective services costs, and a number of other substantial expenses. For example, substance abuse treatment for Medicaid patients reduced total medical costs 30% in a comprehensive health maintenance organization (from \$5,402 per treated member in the year prior to treatment to \$3,627 in the year following treatment). The reductions were in all major areas of health care utilization (hospital stays, emergency visits and clinic visits), and did not reflect shifts in costs from one area to another. (Robert Wood Johnson Foundation, May 2007) Additional resources for substance abuse services will only increase the benefits accrued for society as a whole.

The treatment needs can be seen across a range of special populations including:

Criminal Justice: In Pennsylvania, of 51,319 total offenders in state corrections, approximately 70% or 35,923 of offenders need drug and alcohol treatment. This does not include the untold number in the county criminal justice system also in need.

Veterans: Of the approximately 995,135 Pennsylvania Veterans, an estimated 11% or 109,464 veterans have a substance abuse problem needing treatment.

Pregnant Women: Of the approximately 142,370 births, in the state about 5% or 7,118 are women who are struggling with an alcohol or drug problem.

Adolescents: In Pennsylvania, an estimated 68,000 children aged 12-17 have abused drugs or alcohol in the past year.

The Department will enhance the current substance abuse service system through a continual review of policies, procedures, and regulations that impact the delivery of prevention, intervention, and treatment services in the Commonwealth. Accountability and measurement of effectiveness of services is a standard business expectation of any publicly-funded system.

The Department will conduct a comprehensive Needs Assessment within a year to determine as accurately as we possibly can the exact nature of substance abuse problems within the state; this information is critical to inform policy at the state level and programming at the local level. With the continuing development of research in Pennsylvania on substance abuse issues, the field will become more knowledgeable and therefore more effective. A large component of furthering substance abuse knowledge and research will be realized as our data systems are matured.

Although the Department has experienced considerable challenges in implementation of both the Performance Based Prevention System (PBPS) and the Strengthening Treatment and Recovery (STAR) Data Systems. We are working through those challenges and our expectation is that these systems will continue to be further implemented, increasing in ease of usability and ultimately that each system will enhance strategic planning at both the state and county level.

The substance abuse service system in PA is entering an era of possibilities and promise. With the Department in place, coordinated, systematic strategies for improvement will be implemented to address the effectiveness of services provided, lower the incidence of substance abuse, and reduce the disparity that exists between need and services. This State Plan will be a continually evolving document that addresses the needs of the Department and other state agencies, as well as the SCAs and local provider agencies. It will inform decision making and strategic planning at the state and local levels. Most importantly, this document is designed to help prevent as many Pennsylvanians as possible from becoming addicted and help those who are suffering from the disease of addiction. The Department is committed to ensuring that quality prevention,

intervention, treatment and recovery support services are provided to the citizens of our Commonwealth.

A \$7 return on investment for every drug and alcohol program dollar spent.

DEPARTMENTAL ACCOMPLISHMENTS

In the past two years, the Department has had several significant accomplishments, never before possible. Highlights include:

- *Awarded three local and federal grants providing funding for prevention and treatment services for homeless individuals and permanent Prescription Drug Take Back Boxes.*
- *Partnered with Pennsylvania Commission on Crime and Delinquency and the Pennsylvania District Attorneys Association to expand the Prescription Drug Take Back process with over 200 permanent collection boxes across the commonwealth and over 8,000 pounds of drugs collected and destroyed.*
- *Established the Overdose Rapid Response Task Force, to facilitate interagency coordination for communication and response to overdoses and to establish hospital emergency department procedures for warm hand-off of overdose survivors to treatment.*
- *Founded and co-chaired the Safe and Effective Prescribing Practices and Pain Management Task Force with DOH, with cross agency collaboration to adopt Pennsylvania Guidelines for Treatment of Chronic Non Cancer Pain and Emergency Department Pain Treatment Guidelines.*
- *Established and ran Methadone Death and Incident Review team to create recommendations for best practices in the safe and effective use of Methadone (2013 Report Published).*
- *Initiated the Building Bridges to Recovery Event to encourage communication of our recovery community with medical providers.*
- *Completed streamlining and updating of first program licensure regulations which had not previously been updated for over 40 years.*
- *Expanded Medicaid Pilot project coordinating the Department and DHS staff to provide federally funded services to offenders returning from jail who are in need of SUD treatment. (effective July 2014)*

OUR DEPARTMENT HISTORY

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 PA Drug and Alcohol Abuse Control Act, Act 1972-63. This law established the Governor's Council on Drug and Alcohol Abuse. The Council was subsequently transferred through Reorganization Plan 1981-4, which placed its responsibilities and its administrative authorities within the Department of Health. 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.

Recognizing that substance abuse affects a huge segment of our population and is a major cost driver in our criminal justice, health care, children and youth, workmen's compensation and other taxpayer-funded systems, the Pennsylvania General Assembly enacted [Act 50 of 2010](#). Act 50 amends Section 201 of the Administrative Code of 1929 by adding the Department of Drug and Alcohol Programs (DDAP) to the other Commonwealth departments performing the executive and administrative work of the Commonwealth. The Act also defines the organizational structure, as well as the powers and duties of the Department.

As of July 1, 2012, the Department, formerly under the Department of Health as the Bureau of Drug and Alcohol Programs and the Division of Drug and Alcohol Program Licensure, became a Department in its own right. This change reflects a strong commitment by the General Assembly and the Commonwealth to provide education, intervention and treatment programs to reduce the drug and alcohol abuse and dependency for all Pennsylvanians. The Department is now capable of establishing relationships with state and community agencies at a level previously unavailable, to impact more effectively on this issue that devastates individuals and families, destroys communities, and drives many of the costs in our state budget.

In line with Act 50, the Department is tasked with the following:

- Developing and implementing programs designed to reduce substance abuse and dependency through quality prevention, intervention, rehabilitation and treatment programs;
- Educating all Pennsylvanians on the effects and dangers drugs and alcohol abuse and dependency, and the threat they pose to public health; and,
- Mitigating the economic impact of substance abuse for the citizens of Pennsylvania.

In addition, Act 50 requires the Department to develop a State Plan encompassing the entire state government for the control, prevention, intervention, treatment, rehabilitation, research, education, and training related to drug and alcohol abuse and dependence problems.

As acknowledged at the highest levels of government, evidenced by the General Assembly's creation of the Department, mitigating the devastating consequences of drug and alcohol abuse and addiction is a priority, even in challenging economic times. As we move toward fully resourcing treatment and prevention, crime rates will plummet and we will begin to closing down prisons and jails.

With the passage of Act 50 and the establishment of the Department, has led to a dramatic increase in coordination of efforts between state agencies within Pennsylvania. The Department has collaborated with the Pennsylvania Department of Human Services (DHS), Commission on Crime and Delinquency (PCCD), Department of Health (DOH), Department of Education (PDE), Board of Probation and Parole (PBPP), and the Department of Corrections (DOC). The Department also collaborates with various county and provider organizations, including the Drug and Alcohol Services Providers Organization of Pennsylvania (DASPOP), the Rehabilitation and Community Providers Association (RCPA), Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA), Pennsylvania Recovery Organizations-Alliance (PRO-A), and the Pennsylvania Association for Treatment of Opioid Dependence (PATOD) as well as individual Single County Authorities (SCAs), treatment and prevention providers, and recovery organizations. The Department will continue to collaborate and provide guidance and technical assistance to these other entities about the prevention and treatment of substance abuse.

Act 50, has led to a dramatic increase in coordination of efforts between state agencies within Pennsylvania.





MISSION

The Department of Drug and Alcohol Programs mission is to engage, coordinate and lead the Commonwealth of Pennsylvania's effort to prevent and reduce drug, alcohol and gambling addiction and abuse; and to promote recovery, thereby reducing the human and economic impact of the disease.

VISION

Pennsylvanians living free, or in recovery, from the disease of drug, alcohol and gambling addiction, resulting in safer, healthier, more productive and fulfilling lives.

OUR CORE VALUES

Effective Decision Making – We value decision making that is outcome-focused and quality-informed, that reflects an understanding of costs and benefits and maximizes the impact of available resources.

Collaboration – We value and respect the expertise and experience of stakeholders, and we reach out to develop effective partnerships with individuals and agencies across the Commonwealth that can benefit from and assist us in successfully achieving our mission.

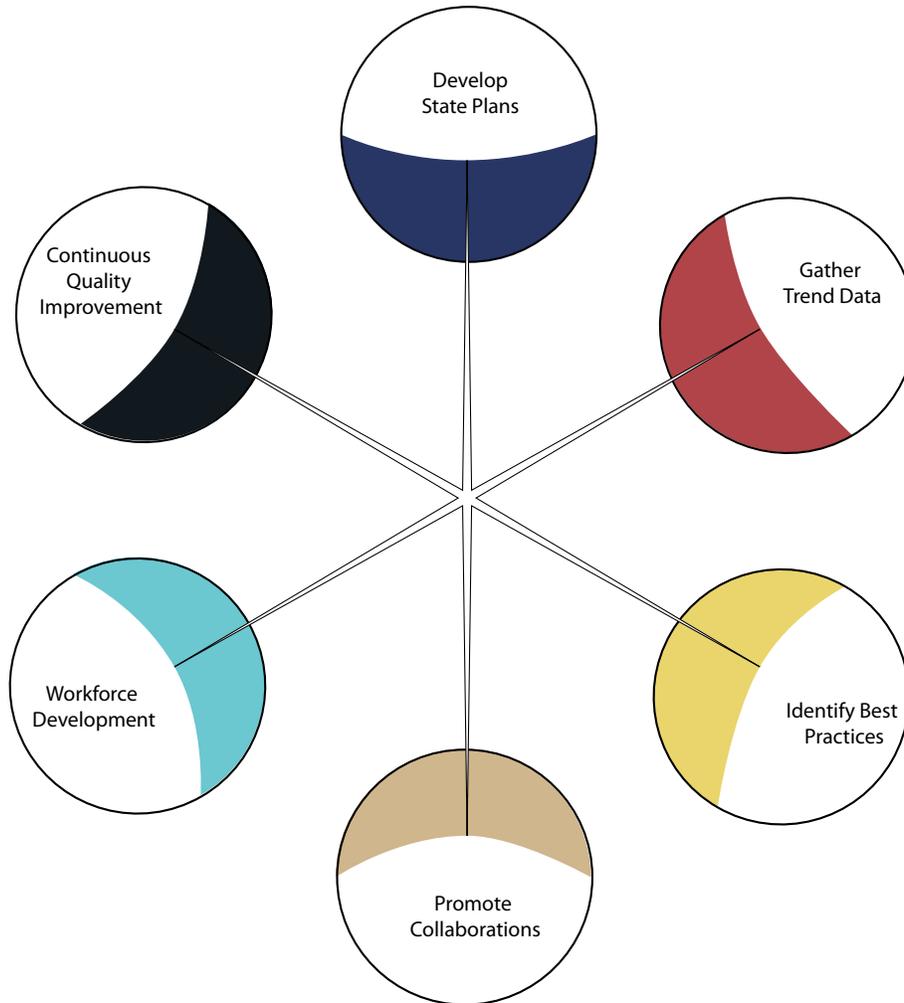
Hope – We know that change and recovery is attainable, yielding life changing benefits for individuals, family members and communities through their commitment to prevent, and achieve freedom from addiction through recovery.

Ethics – We do the right thing for the right reasons, demonstrating integrity in every action that we take, including doing no harm.

Diversity – We value diversity in the workforce – including diversity in gender, age, race, religion, sexual orientation, recovery and other related experiences – so that it reflects the various strengths and gives a voice to the needs of the diverse communities we serve.



OUR GOALS AND STATE PLAN



Goal // 1 - Develop State Plans for substance use disorders and problem gambling.

Goal // 2 - Gather and analyze trending data in order to maximize the effectiveness of our efforts in prevention, intervention, treatment and recovery.

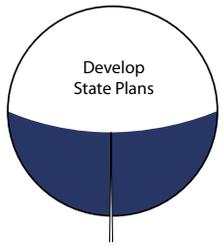
Goal // 3 - Identify and promote best practices and policies to ensure full access to high quality and cost effective prevention, intervention, treatment and recovery support services.

Goal // 4 - Increase Pennsylvania's effectiveness of its drug, alcohol and gambling prevention and treatment efforts by promoting and establishing federal, state and local collaboration.

Goal // 5 - Develop, and expand, a highly competent dedicated and efficient workforce and infrastructure to ensure the Department can accomplish its mission and achieve its goals.

Goal // 6 - Ensure a system of continuous quality improvement (CQI).

Objectives associated with each of these major goals are listed below. Detailed progress for these priorities will be explained later in the plan document. This is a robust and ambitious plan, targeting the needs of the Commonwealth and its citizens.



Develop State Plans For Substance Use Disorders And Problem Gambling.

A. Create a State Plan that responds to needs assessment data using Act 50 as the framework.

B. Ensure that cost benefit analysis is present in the plan structure for all appropriate plan elements.

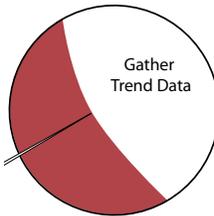
C. Gather input from expert opinion, research and community stakeholders.

D. Create a project plan for the State Plan, including a timeline for milestones.

E. Analyze SCA documents for promising features that may be incorporated into the State Plan.

F. Establish plan guidelines for the SCAs to use in development of their local plans, that is consistent with State Plan priorities

Gather And Analyze Trending Data In Order To Maximize The Effectiveness Of Our Efforts In Prevention, Intervention, Treatment And Recovery.



A. Ensure the coordination of research on drug and alcohol abuse and dependence (see p. 53, Act 50 of 2010 Section 2301-A, 1(vii)).

1. Establish needs assessment framework, including baseline data sets by January 2015.
2. Organize data for review and analysis by field experts, stakeholders and others.

B. Improve treatment, prevention, intervention and most importantly recovery outcomes through data-driven management (see p. 34 and p. 55).

1. Establish processes for routine updating of data sets to include state and county level indicators.
 - a. Update reporting requirements for SCAs and providers.
 - b. Monitor reporting of prevention services in the Performance Based Prevention Data System (PBPS) and treatment services in the Strengthening Treatment and Recovery (STAR) Data System.

2. Establish guidelines for completion of local needs assessments by SCAs, including identification of consistencies and differences with state level data.
3. Continue to identify and obtain data sets to be used in assessing need, including collaboration with other state agencies that have information related to drug and alcohol problems, as well as their prevention and treatment.
4. Work with SCAs and providers to identify enhancements or changes needed to PBPS and STAR data systems.
5. Communicate findings to SCAs, prevention providers and the general public.

C. Analyze other sources of data and trend analyses available through federal, state, and stakeholder sources inform and support the State Plan and other special initiatives, including overdose prevention and response activities.

D. Coordinate with all Departments and government agencies by offering technical assistance on best practices in addressing SUD prevention, education, and treatment needs.

Identify And Promote Best Practices And Policies To Ensure Full Access To High Quality And Cost Effective Prevention, Intervention, Treatment, And Recovery Services.



A. Addressing behavioral health risks within substance abuse special populations by substance of abuse (Note: While other populations are addressed, priority is emphasized with these populations due to prevalence, harm associated, as well as cost related issues.)

1. Prescription drugs: Increase statewide awareness and prevent the misuse/abuse of prescription drugs (see p. 32).

a) Overdose Prevention:

- (i) Develop overdose prevention resources for use in community, prevention, and treatment settings.
- (ii) Continue to work collaboratively with The Statewide Injury Prevention and Control Plan Injury Community Planning Group (ICPG) to prevent prescription drug injury and incidents.

b) Prevention:

- (i) Identify effective programs and

prescribing guidelines for prevention of prescription drug misuse/abuse/addiction.

- (ii) Develop and implement strategy to increase education and outreach dissemination of these programs.
- (iii) Monitor adoption of these effective programs through PBPS data reporting.
- (iv) Maintain data on the prevalence of prescription drug misuse/abuse/addiction as well as attitudes about use at the national, state and local level.
- (v) Develop and maintain up to date fact sheet on prescription drug misuse/abuse/addiction and consequences.
- (vi) Expand prescription drug disposal availability, through offering mobile incineration options, and bringing on additional pharmacy partners.
- (vii) Support state and national efforts on prescription drug monitoring programs and tamper resistant medications.
- (ix) Physician training (see p. 22).
- (ix) The Department will coordinate with PDE to provide support in the implementation of the Student Assistance Program.
- (x) The Department will coordinate with PDE to provide technical assistance and training in best practices for Alcohol and Other Drugs (AOD) education programs as required annually in grades K-12 by (Section 1547 of the PA School Code, enacted as Act 211 of 1990)

c) Treatment:

- (i) Require clinical integrity in assessments and referrals.
- (ii) Seek resources to expand treatment availability, through expanded use of Medicaid Health Choices, reduced criminal justice costs and other means.
- (iii) Identify primary populations in need of treatment and best practice models for responding.
- (iv) Identify and disseminate best practices via Methadone Death and Incident Review Team to reduce dangerous drug interactions with methadone.

2. Marijuana: Increase statewide awareness of latest medical research about the impact of marijuana

(THC) on the brain, particularly among adolescents (see p. 35).

- a. Identify effective programs for prevention of marijuana use.**
- b. Develop and implement strategy to increase use of these programs.**
- c. Monitor adoption of these effective programs through PBPS data reporting.**
- d. Maintain data on the prevalence of marijuana use as well as attitudes about use at the national, state, and local level.**
- e. Develop and maintain up to date fact sheet, with the latest medical research on marijuana use and consequences.**

B. Addressing substance abuse special populations affected by demographic.

1. Adolescence/Underage Drinking: Increase the statewide awareness and reduce the incidence of underage drinking, as well as drinking and driving (see p. 30).

- a. Identify effective programs for prevention of underage drinking.**
- b. Develop and implement strategy to increase use of these programs.**
- c. Monitor adoption of these effective programs through PBPS data reporting.**
- d. Maintain accessible database on the prevalence of underage drinking and its consequences at the national, state, and local level.**
- e. Work in partnership with other agencies and other state efforts to prevent underage drinking.**
- f. Continue to work on statewide multi agency safety team to implement comprehensive strategic highway safety improvement plan, through enforcement of statutory treatment requirements in Pennsylvania's DUI law.**

2. Pregnant Women and Women with Children: Increase access to care, to reduce burden, and to foster care system (see p. 63).

- a. Work with the Office of Children, Youth and Families to maximize women and children's drug and alcohol treatment program resources as a more effective alternative solution to breaking up families and placing children in foster care.**
- b. Decrease the risk of addicted babies or**

fetal alcohol affected babies by increasing use of women and children's drug and alcohol treatment programs for pregnant women in need of residential drug and alcohol treatment.

c. Implement and evaluate FASD State Plan.

d. Develop and implement programming during FASD Awareness Month to raise awareness of FASD prevention and consequence.

e. Develop and maintain training and educational resources, including those focused on relevant healthcare providers.

3. Older Adults: Seek coordination of efforts to deal with the problems including those relating to senior citizens substance abuse and depression (see p. 51).

a. Collaborate with Department of Aging and Pennsylvania Behavioral Health and Aging Coalition to assess the drug and alcohol prevention and treatment needs of older adults.

b. Monitor national, state, and local trends for the needs of older adults.

c. Promote programs which educate older adults on issues related to the incorrect use of prescribed and over-the-counter medications.

4. Veterans: Seek collaboration and coordination for access to care, and support veterans who deal with the post-traumatic problems including needs relating to substance abuse.

a. Collaborate with Veterans Administration and Department of Military and Veterans Affairs as well as other state, county and private providers to increase access to care and services.

b. Monitor national, state and local trends to better assess the needs of veterans.

C. Addressing substance abuse special populations affected by medical complications

1. Hepatitis C: Provide screening, testing, referral, and case management services for individuals at risk for hepatitis C (see p. 45).

a. Continue to collaborate with the Department of Health, Bureau of Epidemiology, on best practices with this population.

b. Continue to host annual meetings of Hepatitis C initiative including physicians, pharmaceutical companies, and SCAs to

examine emerging trends in management of Hepatitis C.

c. Promote public awareness on the impact of Hepatitis C and availability of testing.

2. Medical practice: Collaborate with organized medicine to disseminate medical guidelines for the use of drugs and controlled substances in medical practice (see p. 24, Act 50 of 2010 Section 2301-A, 1(vi)).

a. Work with the medical community to develop trainings regarding safe and effective pain management, and prescribing of drugs to be completed by June 30, 2015.

b. Develop and implement plan for expansion of SBIRT services.

c. Utilize findings from Methadone Death and Incident Review Team to establish the best, safest practices for use of methadone and disseminate as appropriate to addiction treatment and medical community.

d. Encourage use of tamper resistant opioids.

e. Coordinate with DOH on the implementation of SYNAR tobacco compliance checks and other research such as Behavioral Risk Factor Surveillance System.

3. FASD: Develop and implement a statewide plan to reduce the incidence of Fetal Alcohol Spectrum Disorders (FASD)(see p. 38).

4. Coordinate with DOH regarding development and implementation of training for physicians and other medical personnel regarding the PDMP, particularly to include identification of substance abuse and referral to treatment.

D. Inform and disseminate best practices:

1. System of Care: Maintain a Recovery-Oriented Systems of Care (ROSC) within the Commonwealth that supports a recovery management model through coordinated networks of community-based services and supports that are person-centered and strength-based (see p. 44).

a. Develop and implement strategy for the provision of a comprehensive continuum of care that supports individuals and families from prevention and outreach to initial access through support for sustained recovery.

b. Identify and strengthen use of natural community based recovery management and support resources.

c. Increase professional staff understanding and use of existing and future community based recovery supports including 12-step and other support systems.

d. Seek and utilize feedback from individuals in recovery in strategy development and implementation.

2. Prevention: Continue to support SCAs in the development and evaluation of innovative prevention programs. Those programs showing success will be recommended to the Service to Science national initiative (supported and spearheaded by SAMHSA/CSAP) with the goal of helping promising programs move toward becoming evidence-based programs.

E. Fostering collaboration with leading experts in their respective fields: The formation of local agencies and local coordinating councils, promotion of cooperation and coordination among such groups, encouragement of communication of ideas, and recommendations from such groups to the Pennsylvania Advisory Council on Drug and Alcohol Abuse (see p. 71, Act 50 of 2010 Section 2301-A, 1(iii)).

1. Develop, Cultivate and Sustain Clinical Standards:

a. Maintain and leverage the Clinical Standards Committee (CSC) to make recommendations to the Department regarding best practices for the identification, assessment, placement and treatment of alcohol and other drug problems (see p. 48).

(i) Charge CSC with the review of medication assisted treatment (MAT) standards as well as drug and alcohol peer recovery support.

b. Complete update of the Pennsylvania Client Placement Criteria (PCPC) by CSC and test the update by December 2014.

2. Develop model curriculum that utilizes pertinent data and information that improves substance abuse prevention (see p. 36, Act 50 of 2010 Section 2301-A, 1(xi)).

a. Identify evidence based curriculums for different populations served.

b. Develop and implement strategy, including developing tool kits as appropriate, to increase use of these curriculums in school and community settings.

c. Collaborate with the Pennsylvania Commission on Crime and Delinquency,

Department of Human Services, and the Department of Education in program identification and strategy development.

d. Collaborate with these agencies above to develop plan to strengthen fidelity to program design and monitor fidelity and adaptations.

e. Collaborate with these agencies above to develop and implement evaluation strategy for funded programs.

F. Development/Implementation of Standards

1. Local Government: Develop model drug and alcohol abuse and dependence control plans for local government, utilizing the concepts incorporated in the State Plan (see p. 71, Act 50 of 2010 Section 2301-A, 1(iv)).

a. Continue to contract with Single County Authorities for the provision of local needs assessments, plans, and service provision and management.

b. Identify high need areas based on data analysis and pursue strategies and resources for local responses.

c. Review availability of service continuum within local resources and develop strategies to provide services not available within local programming.

2. Treatment Facilities: In collaboration with treatment providers and other stakeholders, identify and initiate regulatory change needed to reduce unneeded administrative burden, promote best clinical practices, and ensure health and safety (see p. 59).

3. Contracting: Continue to provide grants and contracts to local governments and public and private agencies, institutions and organizations for the prevention, intervention, treatment, rehabilitation, research, education and training aspects of drug and alcohol dependence (see p. 86, Act 50 of 2010 Section 2301-A, 1(xix)).

4. Detection methods: Investigate methods for more precise detection and determination of alcohol and controlled substances in urine and blood samples, and by other means; and publish the current basis of uniform methodology for such detections and determinations (see p. 72, Act 50 of 2010 Section 2301-A, 1(viii)).

a. Meet with the Department of Health, Bureau of Laboratories to further review and revise testing methodology, as needed.

b. Utilize Listserves, Policy Bulletins,

Informational Bulletins, and the Department's website to publicize best practice in detecting controlled substances and testing methods.

c. Consult with the Clinical Standards Committee, as appropriate, to help disseminate this information.

d. Training will continue to be offered on the synthetic drug use.

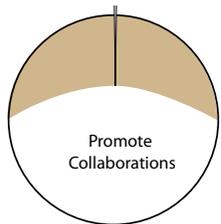
5. Intervention:

a. Assess current intervention services identifying strengths, gaps, and outcomes.

b. Identify best practices for intervention and develop plan to increase their use.

c. Work with other stakeholders including Department of Education, the Department of Human Services Office of Mental Health and Substance Abuse Services and practitioners to strengthen Student Assistance Services.

Increase Pennsylvania's Effectiveness Of Its Drug, Alcohol And Gambling Prevention And Treatment Efforts By Promoting And Establishing Federal, State And Local Collaboration.



A. Law enforcement collaborations

1. Criminal offenders: Development of treatment and rehabilitation services with clinical integrity, for male and female juveniles and adults who are charged with, convicted of or serving a criminal sentence in this Commonwealth (see p. 56, Act 50 of 2010 Section 2301-A, 1(xv)).

a. The Department will develop and provide a cross-system training in partnership with probation and parole representatives designed to maximize the resources of both systems by developing an understanding of how each add a value to the other's roles. The training will be delivered to a minimum of 100 individuals by June 30, 2015.

b. Support PCCD in the development of performance measures for the individuals diverted from incarceration through the restrictive intermediate punishment program.

c. Work with SCAs to ensure statewide implementation of Medicaid coverage for all county jail releases in need of drug and

alcohol treatment by July 1, 2015.

d. Collaborate with Administrative Offices of Pennsylvania Courts to develop Alcohol and Other Drugs (AOD) guidelines for PA courts

e. Provide periodic training in AOD issues for the judiciary and the legal communities.

2. Crime prevention: Coordinate all health and rehabilitation efforts to deal with the problem of drug and alcohol abuse and dependence, including, those relating to law enforcement assistance, highway safety, parole and probation, and children, youth and family systems (see p. 68, Act 50 of 2010 Section 2301-A, 1(ii)).

a. Implement collaborative pilot project with DHS, DOC, and PBPP to assess inmates drug and alcohol needs while in transition units and have medical assistance application completed pre-release so those individuals eligible for MA have Health Choices coverage available for needed treatment services upon release.

b. Continue to provide information and technical assistance to other agencies as requested.

c. Offer technical support to DOC staff training in AOD issues.

d. Collaborate with DOC entities seeking to provide AOD related efforts so that they are able to meet or exceed accepted clinical treatment standards, and make recommendations for improvements.

e. Collaborate with DOC and PBPP in the training of the intersection between SUD and criminogenic risk factors as related to SUD treatment.

3. Emergency medical assistance: (see Act 50 of 2010 Section 2301-A, 1(xvii))

a. Continue to support the availability of medically monitored and medically managed detoxification.

b. Maintain requirement that overdose survivors in need of SCA funded detoxification be admitted within 24 hours of identification.

4. Identify overlap with other agencies including, but not limited to the areas of impact from drug and alcohol problems and/or policy, program, oversight, and workforce in health, mental health, education and Commonwealth employees. (Act 50 of 2010 Section 2301-A, 1(vii))

a. Develop and implement strategies to avoid duplicative efforts and/or add value.

b. Collaborate as appropriate on the development of programs, policies and training.

c. Continue to partner with PCCD, OCYF, OMHSAS, PBPP, DOC, PDE, DOT, the Juvenile Court Judges Commission and others, to ensure that the most cost effective, efficient services with clinical integrity, are provided for the prevention and treatment of drug and alcohol problems.

d. Explore opportunities to meet with various employee unions and the Civil Service Commission, to collaborate on issues surrounding substance abuse, prevention, intervention, and treatment.

B. Encourage collaborations between stakeholders: Develop community-based drug or alcohol abuse treatment and ensure access to services in a cooperative manner among State and local governmental agencies and departments and public and private agencies, institutions and organizations (see p. 56, Act 50 of 2010 Section 2301-A, 1(xvi)).

1. Governor's Heroin and Other Opioid Workgroup: Support the recommendations of the workgroup by providing oversight and technical assistance for implementation of the action steps identified by this multi agency, stakeholder supported initiative

2. Drug and Alcohol Advisory Coalition: Enhance statewide collaboration by reinstating the Drug and Alcohol Advisory Coalition Parent Panel: Maintain a panel of parents to study family and community access to alcohol and drug abuse information, intervention and treatment services and make recommendations (see p. 43).

a. Support Parent Panel initiative to increase physician and emergency department staff knowledge and sensitivity regarding drug and alcohol problems, and referral to treatment.

3. Pennsylvania Association of County Drug and Alcohol Administrators

a. The Department senior management staff will continue to closely partner with SCA and the PACDAA leadership team.

b. PACDAA representation and/or input will continue to be sought in the development of policy and best practices for drug and alcohol services.

4. Collaborate with Provider Associations:

a. Representation and/or input will be sought from relevant provider organizations in the development of policies and/or best practices for drug and alcohol. These organizations include, but are not limited to:

(i) Drug and Alcohol Service Providers of PA

(ii) Commonwealth Prevention Alliance

(iii) Pennsylvania Association for Treatment of Opioid Dependence

(iv) Pennsylvania Prevention Directors Association

(v) Rehabilitation & Community Providers Association

5. Individuals in Recovery

a. Continue to support the work of the Pennsylvania Recovery Organization Alliance in the development and provision of recovery focused training, as well as the development of recovery informed practices and policies.

b. Representation and/or input will be sought from individuals in recovery through PRO-ACT, RASE and other recovery organizations in the development of policies and/or best practices for drug and alcohol.

6. Education/Research: Look for opportunities to reach out to appropriate universities and research institutes (where most studies are conducted) to discuss how best to coordinate activities related to research and studies. Develop working relationships with these universities and institutes.



Develop, And Expand A Highly Competent And Efficient Workforce And Infrastructure To Ensure The Department Can Accomplish Its Mission And Achieve Its Goals.

A. Establish and maintain effective and relevant training for individuals working in the drug and alcohol field. (Act 50 of 2010 Section 2301-A, 1(xiv))

1. Assess current training needs and resources: Work to address those identified needs through collaboration with other state and local resources. Identify potential trainings that are skill/competency based, provide expert level information/skills, measure learning and are sustainable.

2. Professional Training: Facilitate training programs

for professional and nonprofessional personnel with respect to drug and alcohol abuse and dependence, including the encouragement of such programs by local governments (see p. 43, 55).

a. Continue to provide training through mini-regionals, regional training institutes, and on-site trainings.

b. Collaborate with the Northeast Center for Application of Prevention Technologies and the Addiction Technology Transfer Center to incorporate competency based trainings for the prevention and treatment workforce and internal staff development.

c. Implement on line video based trainings for prevention.

3. Stakeholder Training: To offer educational courses for law enforcement officials, including prosecuting attorneys, court personnel, the judiciary, probation and parole officers, correctional officers and other law enforcement personnel, welfare, vocational rehabilitation and other State and local officials who come in contact with drug abuse and dependence problems (see p. 57, Act 50 of 2010 Section 2301-A, 1(xiii)).

4. Staff development :

a. Establish evaluation method for trainings and include benchmarks in the The Department CQI plan.

b. Identify training needs for internal staff development, as well as educational opportunities that will foster learning/growth at an expert level.

5. Develop Recommendations: Identify and implement realistic recommendations to positively impact workforce issues within the Commonwealth. Re-assess required credentials and work with stakeholders to promote pathway for recovery alumni to become credentialed clinical staff (see p. 50).

Establish A System Of Continuous Quality Improvement (CQI).

A. Licensure: Maintain licensing process that ensures quality standards of practice, protects health and safety, while avoiding unnecessary regulatory burdens.

1. Continue review and identification of needed changes to licensing regulations.
2. Ensure consistency of application of standards by all Licensing Specialists.
3. Support development of best practices for program, health and safety by providers.

4. Redesign the licensing and tracking business process to increase efficiencies.
5. Incentivize safest and most effective provider practices by providing extended-period licenses.

B. Contracted Services: Develop and implement quality assurance assessment process for SCA and provider contracted services that assesses compliance with required standards and includes performance measures.

1. Work with relevant Bureaus and stakeholders, including PACDAA, providers, community partners, families and individuals in recovery in the development of performance measures for Department and SCA contracts, including use of data systems and their continued enhancements.

2. Maintain annual SCA monitoring.

C: Quality assurance: Develop and implement practices to ensure compliance with quality standards.

1. Coordinate with DOI and health insurers to identify best practices in implementation of Alcohol and Other Drugs (AOD) benefits in compliance with all state and federal regulations including Act 106 of 1989, Mental Health Parity and Addiction Equity Act, and Patient Protection and Affordable Care Act.

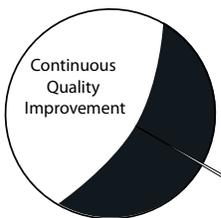
2. Offer technical support to DOI Bureau of Licensing and Enforcement to ensure compliance with current evidence based practices in industry standards for clinical integrity in the treatment of AOD.

3. Coordinate with DHS to identify key quality measures to be reported to the Department from Behavioral Health Managed Care Organizations (BHMCOs) biannually. These should include at minimum, rates of denials, breakdown of reasons for denial, rate of appeals, and rate of cases who were denied the requested level of care, average length of stay at each level of care, rate of individuals accessing a continuum of care (defined as 3 or more levels of care), rate of AMA discharges in less than 2 weeks of treatment engagement, and any other measures identified by the Department, DHS or BHMCOs.

4. The Department will provide technical assistance to DHS Bureau of Hearings and Appeals to update on the implementation of the Third Edition of the Pennsylvania Client Placement Criteria (PCPC 3), and ensure consistency with the medical necessity guidelines for clinical integrity.

5. The Department will make available training to BHMCOs managing Medicaid clients regarding medical necessity guidelines in the PCPC 3 via trainings and technical support.

6. The Department will coordinate with DHS for the review and implementation of best practices in the services in Healthy PA and Medicaid services for AOD clients.



PENNSYLVANIA ADVISORY COUNCIL ON DRUG AND ALCOHOL ABUSE RECOMMENDATIONS

The following recommendations were identified at the May 28, 2014 Governor's Advisory Council Meeting as actions to consider in addressing the heroin and other opioid epidemic. They may be considered in the coming year for feasibility and implementation strategies. To find out more about the Pennsylvania Advisory Council On Drug and Alcohol Abuse Recommendations, please visit www.ddap.pa.gov, Your Department link.

- Address the under-funding for treatment which limits the ability to provide proper length of stay with clinical integrity. Consider ways to more effectively fund quality treatment.
- Recommend that clients receive the proper level and duration of treatment.
- Strategize ways to achieve better access, and meaningful access to treatment so that access can be converted to utilization.
- Expand the use of naloxone expansion such as in-home use.
- Work with lawmakers to allow police to use naloxone.
- Expand availability of effective SUD training for physicians.
- Adjust distribution and management of PA state funds for the purpose of drug and alcohol such that all state funds are monitored and overseen by the Department of Drug and Alcohol Programs.
- Improve access to parent education of school age children through school districts. Specifically including stigma training, warning signs of a child using drugs/alcohol and strategies for what to do when substance use is identified.
- Recommend the declaration of a public health state of emergency in response to the heroin and opioid epidemic, to include mandating immediate changes in schools and prisons.
- Appoint an ombudsman to ensure Pennsylvanians access to treatment and treatment benefits.
- Create a "No Wrong Door" policy for access to treatment.
- Address stigma and fear in a person with addiction coming forward.
- Enact and implement Good Samaritan protections so an individual cannot be arrested if seeking help.
- Consider a \$1 tax on driver's license renewals with money to go towards drug and alcohol treatment, or related tax on alcohol sales.
- Consider a 5 cent tax on every prescription filled in PA with money to go towards drug and alcohol treatment.
- Explore improved Suboxone clinic monitoring and oversight to reduce "pill mills."
- Educate general public to increase public awareness of addiction as a disease.
- Continue to streamline regulations.
- Identify and implement the most effective prevention programs.
- Improve client's ability to navigate the funding and treatment system.
- Consider special needs of rural areas for access to care.
- Expand available continuing medical education in SUD treatment issues.

GOVERNOR'S HEROIN AND OTHER OPIOIDS WORKGROUP RECOMMENDATIONS

SEPTEMBER 2014

Similar to rising trends across the nation, overdose deaths in Pennsylvania have been on the rise over the last two decades. To strengthen and expand current initiatives, Governor Corbett held a press conference on May 9, 2014, calling for a unified and concerted effort across all of state government to deal with these issues. Stemming from this event, Governor Corbett then convened the Governor's Heroin and Other Opioids Workgroup, with the Department of Drug and Alcohol Programs appointed as the lead agency for this initiative. All cabinet-level agencies and other state offices under the Governor's jurisdiction were directed to recommend multi-disciplinary initiatives to effectively combat opioid abuse and the loss of life by drug overdose in the commonwealth. The workgroup first convened in June 2014 and met on various occasions throughout the process. Five strategic subcommittees were formed to specifically address the most critical areas of concern.

On September 30, 2014, the recommendations were presented to the Governor and accepted. The recommendations which follow are the collective result of this effort. The plan provides a comprehensive approach with the over arching goal of increasing public and private collaboration to stop the cycle of addiction and stem the growing heroin and opioid abuse and overdose epidemic statewide.

A. SAFE AND EFFECTIVE USE OF PRESCRIPTION OPIOIDS

Mis-prescribing and overprescribing opioid analgesics too often lead to the illicit use of prescription opioids and, ultimately, heroin. Because of this, specific strategies for prescribing and dispensing prescription medications have been considered as an effective mechanism for reducing excessive availability of substances that are abused.

Recommendation A.1 Support Pennsylvania Guidelines on the Use of Opioids to Treat Chronic Non-Cancer Pain and the Pennsylvania Emergency Department Pain Treatment Guidelines and encourage adoption of prescribing guidelines for other healthcare contexts by taking all necessary steps to educate all prescribers across the commonwealth.

Recommendation A.2 Establish a public-private partnership between the insurance industry and appropriate state agencies to reduce opioid misuse and overdose.

Recommendation A.3 Encourage and support legislative efforts to address unsafe and excessive prescribing practices in the context of Workers' Compensation.

Recommendation A.4 Encourage and support legislative efforts regarding expansion of access to the existing Prescription Drug Monitoring Program database and prepare for enactment.

B. ACCESS TO TREATMENT

Like diabetes, hypertension, asthma and other chronic illnesses, substance use disorders are progressive, chronic, and eventually fatal if not treated. Individuals who have a substance use disorder should have adequate access to clinically appropriate care.

Recommendation B.1 Increase healthcare provider education and awareness by encouraging appropriate training for physicians and other healthcare providers regarding substance use disorders, screening and expeditious referral to treatment.

Recommendation B.2 Increase education and awareness to the commonwealth workforce and their family members about substance use disorders, including access to care via the State Employee Assistance Program and the Pennsylvania Employees Benefit Trust Fund.

Recommendation B.3 Increase public-private partnerships to adequately and appropriately address substance use disorders via:

- a) Cross-agency training to increase awareness about drug addiction, including the dangers of opioid misuse, overdose prevention and appropriate overdose response methods;
- b) Establishing collaborative partnerships with third party insurers including HealthChoices Managed

Care Organizations, Medicare, and Pharmacy Benefit Managers to improve awareness of treatment benefits and access to care to ensure timely assessment, referral and engagement in the clinically appropriate intensity and duration of care; and,

c) Addressing the drug addiction and overdose issue through the State Healthcare Innovation Plan.

Recommendation B.4 Work in collaboration with the Pennsylvania District Attorneys Association, appropriate state agencies and other entities to expand availability of Restrictive Intermediate Punishment treatment diversion sentences for offenders currently being sentenced to county jail or to low-level state prison sentences, and explore appropriate ways of effectuating the diversion post-arrest rather than at sentencing.

C. LICENSING: PROFESSIONAL INTERVENTIONS

In order for substance use disorders to be treated in a similar fashion as other chronic illnesses, it is necessary for healthcare and other licensed professionals to have an understanding about the disease of addiction, as well as the recovery process. Most individuals in the early stages of the disease are in the workforce. Therefore, strategies to address substance use and abuse with these individuals have greater efficacy and are more cost effective.

Recommendation C.1 Develop and implement an education program for the health-related boards administered by the Department of State's Bureau of Professional and Occupational Affairs.

Recommendation C.2 Develop an education and engagement program, coordinating with Department of Drug and Alcohol Programs, Department of State's Bureau of Professional and Occupational Affairs, Division of Professional Health Monitoring Programs and the Department of Labor and Industry that has maximum impact on the overall lost productivity and profits aspects of drug addiction.

D. EDUCATION: PREVENTION, INTERVENTION AND OUT-REACH

It is necessary for everyone in Pennsylvania, professionals and citizens alike, to be made aware of the dangers of medication misuse, addiction and recovery, and how to prevent and respond to overdose.

Recommendation D.1 Establish an informal, internal Executive Prevention Council of the top prevention experts from the Pennsylvania Commission on Crime and Delinquency and the Departments of Drug and Alcohol Programs, Education, and Public Welfare, to identify best practices and evidence-based substance use disorder prevention programs and establish sound parameters for

the utilization and funding of such programs to ensure that taxpayer dollars are spent wisely and effectively.

Recommendation D.2 Distribute information internally to employees and externally to the general public through all commonwealth agencies that engage in information dissemination (Department of Drug and Alcohol Programs will help to identify brochures, web-based, social media, and other resources to be effective, based on up-to-date research).

E. OVERDOSE RESPONSE

While most of the initiatives identified in this report will likely take time to actually impact overdose rates, there are immediate, life-saving measures that can be implemented on the scene of an overdose, such as increased access to Narcan (naloxone hydrochloride). Furthermore, individuals are not likely to receive necessary emergency help if others present at the scene are fearful of legal ramifications should they make a call to 911.

Recommendation E.1 Support and anticipate current legislative efforts aimed to prevent opioid-related overdose deaths by expanding access to naloxone for concerned third parties, in conjunction with appropriate training, and by permitting limited legal protections for witnesses seeking medical help at the scene of an overdose.

To download and view the full recommendations, please visit www.ddap.pa.gov/reports

CHAPTER 2

Annual Report 2012-13 and Progress Report 2013-14

THIS CHAPTER REVIEWS PROGRESS MADE ON GOALS/PRIORITIES ESTABLISHED BY THE DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS IN THE 2014-2015 STATE PLAN. THE CHAPTER INCLUDES THE ANNUAL REPORT FOR FY 2012-2013 AND THE PROGRESS REPORT FOR FY 2013-2014. IN ADDITION, THIS CHAPTER CONTAINS NEW AREAS OF INTEREST SINCE THE IMPLEMENTATION OF ACT 50 OF 2010.



SUBSTANCE ABUSE PREVENTION

The Department of Drug and Alcohol Programs, Bureau of Treatment, Prevention and Intervention, Division of Prevention and Intervention (Division), is responsible for the development, oversight and management of substance abuse prevention and intervention services throughout Pennsylvania. The Division of Prevention and Intervention strives to increase the implementation of prevention programs, age-appropriate strategies, policies and practices that are 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 to promote the development of healthy lifestyles that positively impact individuals across the lifespan, in their communities, families and schools.

The Department 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 entities funding or delivering drug and alcohol prevention services work with their local SCA to assure that their prevention activities fit the local strategic plan. All data collected on these services is reported to the local SCA and the Department. The data reported must incorporate the data elements collected in the PBPS.

SIX FEDERAL STRATEGIES

The six (6) Federal Strategies, based in 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. Some examples of services captured under the Information Dissemination Strategy include: media campaigns, health promotions and newsletters.

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. Some examples of programs that are captured under the Education Strategy include: Celebrating Families, Girl Power and Life Skills Training.

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. Some examples of programs captured under the Alternative Activities Strategy include: youth/peer mentoring programs, Nurse Family Partnership and Big Brother/Big Sister.

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. Some examples of services/programs captured under the Problem Identification and Referral Strategy include: SAP Core Team Meetings, DUI/DWI Programs and Employee Assistance Programs.

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 substance use disorders. Activities include organizing, planning, enhancing efficiency and effectiveness of services, inter-agency collaboration, coalition building and networking. Some examples of services captured under the Community-Based Process Strategy include: technical assistance, multi-agency coordination and collaboration and assessing community needs.

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. 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. Some examples of services captured under the Environmental Strategy include: counter-advertising printed materials, social norms marketing and changing policies.

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 which does not yet meet diagnostic levels.

STRATEGIC PREVENTION FRAMEWORK (SPF) MODEL

SCAs must ensure that all five steps of SPF are adhered to in the implementation of performance-based prevention: Needs Assessment, Capacity, Planning, Implementation and Evaluation. Cultural competency 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 SCAs 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 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 determine 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 through positive, healthy outcomes.

PROGRAMS AND STRATEGIES

The Department encourages SCAs and prevention providers throughout the Commonwealth to utilize evidence-based and Evidenced Informed Programs as a part of their comprehensive approach within their counties. Each SCA is required to deliver at least 25% of services through a combination of evidence-based and evidenced-informed programs.

Using a combination of evidence-based and evidenced-informed programs and strategies, based on local community needs, have 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 concerning consumption and by tracking social indicator data.

Evidence-based, evidenced-informed programs and state 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.
- Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals.
- Replicated and have produced desired results in a variety of settings.

Evidenced-Informed Programs meet the following minimum criteria:

Characteristics of evidence-informed prevention strategies, activities, approaches and programs include:

- Program is based on a theory of change that is documented in a clear logic or conceptual model, or is based on an established theory that has been tested and supported in multiple studies.
- Program may be similar in content and structure to interventions that appear in registries and/or peer-reviewed literature.
- Program is based on published principles of prevention.

- Program is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a pattern of credible and positive effects.
- Program may have appeared in a peer reviewed professional publication or journal.
- Program may have been identified or recognized publicly and may have received awards, honors or mentions.
- Program must have an evaluation that includes, but is not limited to, a pre/post test and/or survey.

State Approved Effective Strategies are defined as programs which:

- Capture activities that utilize methods of best practice.
- Provide basic ATOD awareness/education, as well as everyday alternative prevention activities.
- Captures strategies that address population-level change.
- Captures activities necessary to implement or enhance evidence-based and state approved programs.

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 PBPS. SCAs are required to provide 20% 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, including, but not limited to, Pre/Post Test and/or survey. (examples: Classroom Education, Peer Leadership/Mentoring, and ATOD Free Activities Recurring). Recurring services also cover certain, limited types of meetings and activities that are not structured lessons and may not have measurable outcomes. (Examples: coalition meetings, technical assistance meetings, Core Team recurring meetings)

There are approximately 44 evidence-based and 42 evidenced informed programs that are currently being delivered

throughout the Commonwealth that address drug use. Some of these programs include, but are not limited to:

- 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 issues within local schools;
- Girls Circle – a structured support group for girls that is designed to increase positive connection, personal and collective strengths and competencies;
- Life Skills Training – a school-based program that works with elementary to high school students to assist them in developing the necessary skills to resist social pressures to use alcohol, tobacco and other drugs;
- 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;
- 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; and,
- Project Lead and Seed – a structured leadership program in which adults, such as parents, youth pastors, youth-serving civic organization facilitators or teachers are trained to return to their schools or communities to provide training to their own youth leaders (in middle or high school); and whom implement action plans to reduce and prevent underage drinking, tobacco and other drugs.

The Department also collaborates with and supports other state agencies and organizations in their efforts to reduce substance use/abuse and promote health and rehabilitation efforts.

- Department of Human Services, Office of Mental Health and Substance Abuse Services (OMHSAS)
- Pennsylvania Youth Suicide Prevention Monitoring Committee – The Pennsylvania Youth Suicide Prevention initiative is a multi-system collaboration to reduce youth suicide.

Substance Abuse and Mental Health Services Administration (SAMHSA)

- ♦ Support SAMHSA prevention initiatives such as the National Town Hall Meetings
- Pennsylvania Liquor Control Board (PLCB)
 - ♦ Contribute to the mandated Act 85 Legislative Report coordinated by the Pennsylvania Liquor Control Board.
- Pennsylvania Commission on Crime and Delinquency (PCCD)
 - ♦ Disproportionate Minority Contact Committee – Provides technical assistance and information to ensure that individual communities are providing the necessary drug and alcohol prevention supports to disproportionately burdened minorities.
 - ♦ Balanced and Restorative Justice in Pennsylvania Committee – The committee supports the juvenile justice system in working with children that have committed delinquent acts and supports their care and rehabilitation to include, but not limited to, substance abuse issues.
- Department of Health
 - ♦ Statewide Injury Prevention & Control Plan Injury Community Planning Group (ICPG) – Falls Prevention in Older Adults Workgroup – Mission is to develop a comprehensive and coordinated plan that focuses on preventing injuries and violence across the lifespan by empowering state and local partners through the collection and analysis of data and the leveraging of resources for injury prevention programs to recapture lost human potential. Workgroups have been formed for three main injury topics: motor vehicle crashes, unintentional falls and unintentional poisonings.
 - ♦ Sexual Violence Primary Prevention Planning Committee – Addresses sexual violence prevention throughout the commonwealth.
 - ♦ Pennsylvania Coalition Against Domestic Violence – Assist in the development of a statewide prevention plan to support communities throughout Pennsylvania to prevent domestic violence before it occurs.
- Department of Education
 - ♦ Pennsylvania School Wide Positive Behavior Support State Leadership Team - Through training and technical assistance, supports

schools and their family and community partners to create and sustain comprehensive school based behavioral health support systems in order to promote the academic, social and emotional well-being of all Pennsylvania's students.

- ◆ Youth and Family Training Institute Advisory Board - To achieve quality family and youth driven outcomes by advancing the philosophy, practices and principles of High Fidelity Wraparound through training, coaching, credentialing and ensuring fidelity to the process.
- ◆ Safe and Supportive Schools (SAS) Student Interpersonal Skills Development Committee - To develop social and emotional standards that educators and teachers will utilize for instructions with students Pre-K to 12.
- ◆ Student Assistance Program Commonwealth Interagency Committee – Provides leadership for developing a safe and drug-free environment and mental health wellness in schools and communities across the commonwealth.

■ Department of Transportation

- ◆ Multi Agency Safety Team (MAST) – Assist in the development and implementation of the Comprehensive Strategic Highway Safety Improvement Plan.

■ Commonwealth Prevention Alliance (CPA)

- ◆ Representative to the Board of Directors
- ◆ Conference Planning Committee – Provide trainers and staff support for the annual conference.

■ Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA)

- ◆ Provides information and support for grantees related to adherence to requirements and implementing best practices.

■ Pennsylvania Prevention Director's Association (PPDA)

- ◆ Provides informational updates regarding the Department's prevention relevant matters to PPDA members as well as provides meeting space for their quarterly meetings.

■ Drug Free Pennsylvania

- ◆ Develops and disseminates media literacy curriculums for middle and high school students; provides training on the curriculums; and, oversees an annual Public Service Announcement contest in schools across the Commonwealth.

PREVENTION ANNUAL REPORT AND PRIORITIES

The Department has determined several key issues as priorities in the drive to prevent alcohol, tobacco and other drug use. Each priority was chosen based on local, state and national initiatives. The prevention priorities include:

PRIORITY: INCREASE THE STATEWIDE AWARENESS AND REDUCE THE INCIDENCE OF UNDERAGE DRINKING, UNDERAGE DRINKING AND DRIVING, AND DRINKING AND DRIVING.

Background: The Department recognized the need to increase awareness of alcohol related incidents based on local, state and national data and initiatives. According to the Administrative Office of Pennsylvania Courts (APOC), there was an 8% increase in offenses for driving under the influence between 2010 and 2011. National Outcome Measure (NOMS) survey data collected for the past 5 years shows that alcohol is the substance most commonly reported to have ever been used by youth respondents. For FY 2012-2013, 30.7% of youth respondents reported ever drinking alcohol. Among just those respondents who were age 15-17, the percentage of those having ever used is 55%. According to the Department of Transportation, alcohol-related crashes were 4.2 times more likely to result in death than those not related to alcohol.

ANNUAL REPORT FY 2012-2013

The Department assisted the Substance Abuse and Mental Health Services Administration (SAMHSA) in supporting national initiatives to prevent underage drinking. The Department worked collaboratively with SAMHSA to assist in the development, implementation and monitoring of the National Town Hall Meetings Program, which provides public education and awareness on underage drinking in the Commonwealth. The Department coordinated and oversaw the county projects, provided technical assistance to county teams, and coordinated funding for various projects associated with underage drinking.

The Strategic Prevention Framework State Incentive Grant (SPF SIG) was a five-year grant from SAMHSA's Center for Substance Abuse Prevention (CSAP). The lead agency, the Department of Drug and Alcohol Programs was awarded this \$10,465,000 grant in October 2006 and the funding came to an end in September

2012. The Department completed the final evaluation for the SPF-SIG grant in September of 2012. A total of 96 programs were assessed during the five year period. The 17 grantees expressed a common accomplishment of strengthening local networks/coalitions/partnerships to address underage drinking and drinking and driving.

The following highlights were obtained from the Executive Summary of the grant's final evaluation report prepared by the University of Pittsburgh's School of Pharmacy, Department of Pharmacy and Therapeutics.

The PA SPF SIG was intended to reduce alcohol use and alcohol-related consequences in selected communities in the commonwealth. The sub recipient delivered direct and/or environmental programming in order to address three main target priorities related to the prevention and reduction of alcohol as well as alcohol related problems:

1. Early initiation and regular use of alcohol in 12-17 year-olds,
2. Reduce drinking and driving in 16-21 year olds,
3. Reduce alcohol misuse in 18-21 year olds.

Project outcomes were assessed on two broad levels: community outcomes and participant level outcomes.

Community outcome measures are indirectly related to the target priorities listed above, but were established at the beginning of the project as initial and secondary indicators of alcohol and alcohol-related problems. These measures indicate the following:

1. A small reduction in arrest rates from 12.6% to 11.9% respectively for alcohol-related offenses in 12-17 year olds between 2007 and 2011.
2. Past 30 Day alcohol use decreased from 16.3% to 15% from 2006 to 2009, as reported in the National Survey on Drug Use and Health (NSDUH).
3. DUI arrest rates (in terms of total number of arrests) for 16-21 year olds have slightly decreased between 2007 and 2011, from 6.63% to 6.41% following a slight increase to 8.03 in 2009. Alcohol-related traffic deaths for all ages showed an initial precipitous decrease between 2007 and 2008 (40.01% to 19.25% respectively). The alcohol-related fatalities compared to all fatalities trend between 2007 and 2011 showed a relative decrease from 40.01% to 37.25%. Rates above are calculated as alcohol-related fatalities divided by all fatalities multiplied by 100.
4. Liquor law and drunkenness arrest rates showed a small decline between 2007 and 2011, from 29.82% to 28.2%. The rate is calculated as the combined arrests divided by all arrests and multiplied by 100.
5. Alcohol use in the past 30 days, as measured by the NSDUH was steady at 29.4% between 2006 and 2009.

Participant level outcomes are more directly related to the target priorities listed above and were collected using a Federally-developed survey called the National Outcomes Measures (NOMs) as it relates to direct service activities.

For Priority 1, participant level data show a majority of participants in the 12-17 age range, have not used alcohol in the past 30 days, and this was maintained following the provision of a prevention program. For those program participants who did use alcohol in their lifetime, average age of first use was approximately 13 years old, which is consistent with normative data for alcohol initiation. In terms of risk and protective factors related to alcohol consumption, as measured through the NOMs at one data collection point (early 2011), participants also had strong unfavorable attitudes against regular alcohol use (approximately 76% at pretest and 78% at posttest) and well as high perceived risk of harm for binge drinking (78% at pretest and 76% posttest). Of those in the 12-17 age range, the vast majority (approximately 96%) reported not driving under the influence of alcohol. However, this figure may be biased because of participants not being old enough to have a driver's license. In sum, though, for youth ages 12-17, these consumption patterns (no use) and attitudes (unfavorable) are positive strengths to continue to maintain.

Priority 2 focused on drinking and driving in 16-21 year olds, and Priority 3 focused on alcohol misuse in 18-21 year olds. For these priorities, there were limited data sets for adults over the age of 18, for two reasons. First, there were only three grantees who focused on Priority 2 and three who focused on Priority 3. Second, when programs were implemented, they were typically environmental strategies, which did not allow for participant surveying using the NOMs.

Process evaluation measures assessed the degree to which sub recipient grantees implemented the SPF model with a reasonable degree of fidelity to the model. Process measures were evaluated by conducting site visits at the beginning of the project and then conducting exit interviews at the end. Results from the exit interviews indicated both accomplishments and obstacles with the SPF implementation. Accomplishments typically common across sub recipient grantees were increased understanding of epidemiological assessment and data-driven decision making, strengthened collaborative efforts among partners, delivered or maintained programs in the community, and increased community awareness of alcohol and alcohol related issues. Challenges or barriers were related to data collection processes, technical system issues (for example, both Federal and Commonwealth reporting systems), and uncertainty about operational definitions and reporting requirements at the beginning of the project.

Overall, the SPF SIG was an ambitious, commonwealth-wide prevention project that resulted in significant accomplishments, areas for further growth and opportunity for improvement. The project was implemented during a general context of economic decline, with its consequent challenges for effective and efficient programming. Overall, accomplishments included

the institution of the SPF model on a commonwealth-wide level, with emphasis on the need for data-driven decision making and evidence-based outcomes. Sub recipients unfamiliar with these processes showed improvements in their understanding of the process, and more sophisticated grantees refined their understanding of the process, as measured by their self-report upon the conclusion of the grant. Significant community changes may not have been observed in the relatively short time frame in which sub recipient communities were actively implementing direct service activities or environmental strategies. Nonetheless, nearly all grantees reported some measurable positive outcome related to primary or secondary consumption indicators, primary or secondary consequence indicators, or in risk or protective factors believed to contribute to alcohol use in persons under the age of legal consumption.

Another SAMSHA initiative included the Department being approached during mid FY 2012-2013 to work with a federal contractor to create a Public Service Announcement (PSA) related to preventing underage drinking. A workgroup consisting of other state partners and substance abuse prevention advocates was formed in January 2013 to determine the target audience, message and distribution of the underage drinking video. The decision was made to focus on parents as the target audience and the message was "Talk to Your Kids at Every Age – They Are Listening."

PROGRESS REPORT FY 2013-2014

The Department continues to assist the SAMHSA in supporting national initiatives on underage drinking through distribution of list serves and informational resources. When requested, the Department will provide the SAMHSA with community contacts regarding the National Town Hall Meetings Program.

The Department continues to work on the statewide Multi Agency Safety Team (MAST), to implement the Comprehensive Strategic Highway Safety Improvement Plan, which will include a focus on highway safety issues, including underage drinking and driving.

The Department continues its efforts to prevent under age drinking (UAD) with the finished production of a under age drinking public service announcement (PSA) funded by a grant from SAMSHA. The UAD Video workgroup completed scripting, coordinated the shoot, and produced two – 30 second PSAs. Then provided the SAMSHA contractor with final approval to do post production work on the PSAs. The completed PSA will be posted on SAMSHA's website (http://www.samhsa.gov/samhsanewsletter/Volume_18_Number_1/StateVideos.aspx) with other states and territories that have produced videos related to the prevention of underage drinking. The workgroup will use the remainder of FY 2013-2014 to determine how to effectively distribute the PSAs to their grantees, state partners, prevention providers, and substance abuse advocates.

The Pennsylvania Strategic Prevention Framework Partnership for Success (SPF PFS) Project proposes to reduce underage drinking among 12-20 year olds and reduce prescription drug misuse and abuse among 12-25 year olds in five (5) high-need counties throughout the state: Blair, Bucks, Delaware, Lackawanna and Westmoreland, through a comprehensive approach that includes public awareness, education, and environmental change strategies. The Department has identified several project goals:

- 1) Increase awareness/knowledge of the consequences of underage drinking and prescription drug misuse/abuse;
- 2) Increase awareness of effective strategies to prevent underage drinking and prescription drug misuse/abuse;
- 3) Reduce risk factors related to underage drinking and prescription drug misuse/abuse;
- 4) Improve collection of and access to local data that can be used to identify and monitor underage drinking and prescription drug misuse/abuse related trends;
- 5) Reduce availability and accessibility of prescription drugs for misuse/abuse;
- 6) Increase proper disposal of expired, unused and unwanted prescription drugs;
- 7) Increase awareness among prescribers of prescription drug abuse and the role they can play in reducing prescription drug misuse and abuse.

The Department, as the designated lead agency, will coordinate with county subrecipients and other partners to assess need, build capacity and infrastructure, create strategic plans, implement prevention strategies, and evaluate the effectiveness of strategies implemented. Best practices, including public awareness campaigns, educating youth, parents, prescribers, and other stakeholders, relationship-building with pharmacists and other health care providers, will be used in combinations that will approach these populations from a variety of directions. The SPF-PFS grant is projected to reach/serve approximately 362,000 people living in the five identified high need counties.

PRIORITY: INCREASE STATEWIDE AWARENESS AND PREVENT THE MISUSE/ABUSE OF PRESCRIPTION DRUGS AND RELATED DRUG OVERDOSES.

Background: Prescription drug misuse/abuse is a growing concern across the nation. Based on state, local and national research and data, the Department began monitoring and addressing the priority.

According to the Partnership Attitude Tracking Study conducted

by The Partnership at Drugfree.org, one in four teens reports having misused or abused a prescription drug at least once in their lifetime. According to National Outcome Measure Surveys (NOMs) that were administered in 2012 in Pennsylvania, 12% of youth surveyed took prescription drugs that were not prescribed to them. In 2012, 15% of youth surveyed felt that prescription drugs were not harmful.

ANNUAL REPORT FY 2012-2013

The Department worked to identify services provided by the Single County Authorities that specifically address the misuse/abuse of prescription drugs. There were several programs used by the SCAs to address this priority, including R.E.A.L, Too Good For Drugs (TGFD), and Leadership/Mentoring Activities.

The Department monitored national trends to ensure the Commonwealth is provided with up-to-date data, research and information.

The Department worked in partnership with the Pennsylvania Commission on Crime Delinquency (PCCD) and the Pennsylvania District Attorney's Association (PDAA) to increase the availability of permanent prescription repositories in the Commonwealth. The intent of this initiative was to reduce the amount of prescription drugs available for potential misuse/abuse.

The Department was able to draft a Prescription Drug Take Back Box Grant Program application that was used by PCCD to apply and receive a federal grant of \$100,000 for the purchase of 250 permanent prescription repositories.

The Department staff worked collaboratively with the Statewide Injury Prevention and Control Plan Injury Community Planning Group (ICPG) – Falls Prevention in Older Adults Workgroup to develop a comprehensive and coordinated plan. The plan focused on preventing injuries and violence across the lifespan by empowering state and local partners, through the collections and analysis of data and the leveraging of resources for injury prevention programs, to recapture lost human potential. One of the topics related to unintentional poisonings of older adults, which includes prescription drugs.

PROGRESS REPORT FY 2013-2014

The Department continues to identify services provided by the Single County Authorities that specifically address the misuse/abuse of prescription drugs. There are several programs being used by the SCAs to address this priority, including R.E.A.L, Too Good For Drugs (TGFD), and Leadership/Mentoring Activities.

The Department is monitoring national trends to ensure the Commonwealth is provided with up-to-date data, research and

information.

The Department continues to work in partnership with the Pennsylvania Commission on Crime Delinquency (PCCD) and the Pennsylvania District Attorney's Association (PDAA) to increase the availability of permanent prescription repositories in the Commonwealth. The PDAA sent the Prescription Drug Take Back Box Grant Program application to each District Attorney in PA's 67 counties in July 2013. Since that time, 169 MedReturn Prescription Drug Take Back boxes have been requested/placed in 169 secured local law enforcement locations in 30 counties. In addition to the units obtained through our partnership with PCCD and PDAA, there have also been 106 take-back boxes identified in 18 counties that have been purchased by other community organizations and agencies, thus making a total of 275 collection boxes that are located throughout the commonwealth. An updated list of available Prescription Drug Take Back box locations can be found on the Department's website at: <http://www.ddap.pa.gov/drugtakeback>. SCAs will be able to work with their local District Attorney to utilize media created through the initiative to provide awareness about drug take back box locations and the dangers of prescription drug abuse.

The Department staff works collaboratively with the Statewide Injury Prevention and Control Plan Injury Community Planning Group (ICPG) – Falls Prevention in Older Adults Workgroup to develop a comprehensive and coordinated plan. This plan focuses on preventing injuries and violence across the lifespan by empowering state and local partners, through the collections and analysis of data and the leveraging of resources for injury prevention programs, to recapture lost human potential. One of the topics relates to unintentional poisonings of older adults, which includes prescription drugs.

The Pennsylvania Strategic Prevention Framework Partnership for Success (SPF PFS) Project proposes to reduce underage drinking among 12-20 year olds and reduce prescription drug misuse and abuse among 12-25 year olds in five (5) high-need counties throughout the state: Blair, Bucks, Delaware, Lackawanna and Westmoreland, through a comprehensive approach that includes public awareness, education, and environmental change strategies. The Department has identified several project goals:

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- 2) Increase awareness of effective strategies to prevent underage drinking prescription drug misuse/abuse;
- 3) Reduce risk factors related to underage drinking and prescription drug misuse/abuse;
- 4) Improve collection of and access to local data that can be used to identify and monitor underage drinking and prescription drug misuse/abuse related trends;
- 5) Reduce availability and accessibility of prescription drugs for misuse/abuse;

6) Increase proper disposal of expired, unused and unwanted prescription drugs;

7) Increase awareness among prescribers of prescription drug abuse and the role they can play in reducing prescription drug misuse and abuse.

The Department is the designated lead agency for the SPF-PFS grant to coordinate with county sub recipients and other partners to assess need, build capacity and infrastructure, create strategic plans, implement prevention strategies, and evaluate the effectiveness of implemented strategies. A variety of best practices in building public awareness: including campaigns, educating youth, parents, prescribers, and other stakeholders, relationship-building with pharmacists and other health care providers. These campaigns will be used in combinations that will target these populations from a variety of delivery/communication vehicles. The SPF-PFS grant is projected to reach/serve approximately 362,000 people living in the five identified high need counties.

PRIORITY: IMPROVE PREVENTION OUTCOMES THROUGH DATA-DRIVEN MANAGEMENT.

Background: As the Department has increased its capacity to collect and analyze data through the PBPS data system and other sources, the importance of and ability to utilize data-driven management has grown. The Department has utilized and promoted several strategies for collecting and analyzing data that can be used to guide prevention efforts and improve prevention outcomes. Data driven management has primarily focused on the collection and utilization of needs assessment data, prevention service data and evaluation/outcome data.

ANNUAL REPORT FY 2012-2013

Data-driven planning of drug and alcohol prevention services was completed by SCAs. Those funding or delivering drug and alcohol prevention services were required to have anticipated measurable outcomes when providing recurring prevention activities. To measure outcomes, recurring services were required to include pre/post tests and/or surveys.

The Department worked with the established Prevention Data Workgroup to enhance the usage of the PBPS data system to allow for better collection and analysis of prevention data which leads to improved data-driven management.

The Department was awarded a one year no-cost extension for the State Prevention Enhancement (SPE) Grant. The Department worked with KIT Solutions to implement the enhancements to PBPS that were proposed and defined in SFY 2011/2012.

PROGRESS REPORT FY 2013-2014

The Department requires SCAs to administer pre/post tests and/or surveys for evidence-based and evidence informed programs as a method of collecting outcomes for these programs/activities.

The Department is analyzing the data collected in PBPS to examine questions such as:

- What programs and services are being implemented, and where and to what extent are these programs/services being implemented?
- Who and how many people are being served by various types of programs?
- How are programs and services implemented to address a specific need/issue in a targeted community potentially impacting that need/issue?

This analysis can provide information to better determine potentially underserved populations, and where gaps in service may exist. It can also be used to better coordinate and plan services.

The Department continues to work with the established Prevention Data Workgroup to enhance the usage of the PBPS data. Also discussed with the workgroup is the plan for future needs assessments that will identify state and local priorities. Discussion is taking place about ways to provide each SCA with more statewide data to combine with local data.

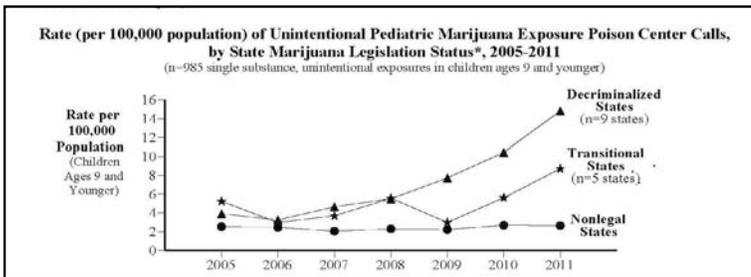
Current service data entered in PBPS and needs assessment data is being reviewed in order to identify potential service gaps. Greater breadth and quality of prevention services targeting adults, especially the high risk 18-25 age group, is one such service gap. Many of the current prevention services being delivered to adults are focused on parenting and family management topics. Additional prevention services for adults outside of parenting/family management topics are needed. Another identified service gap is the provision of services that fall under the Environmental Federal Strategy. Services focused on environmental level change have the ability to reach/impact a large segment of the population and are key in producing changes in policies, communities, etc., that support and reinforce the individual level behavior change strategies that are implemented. In SFY 2010/2011, 2011/2012 and 2012/2013 only 1-2% of all prevention services entered into PBPS fell under the environmental federal strategy.

With the receipt of a Strategic Prevention Framework – Partners for Success (SPF-PFS) grant that began October 1, 2013, the Department’s State Epidemiological Outcomes Workgroup (SEOW) will be revitalized. SEOWs are a network of people and organizations that bring analytical and other data competencies to prevention. Their mission is to integrate

data about the nature and distribution of substance use and related consequences into ongoing assessment, planning, and monitoring decisions at state and community levels. The overall goal for SEOWs is to use data to inform and enhance state and community decisions regarding substance abuse prevention programs, practices, and policies, as well as promote positive behavioral and mental health over the lifespan. Guided by the steps of SAMHSA's SPF, SEOWs examine, interpret, and use data to inform prevention planning and decision-making.

PRIORITY: INCREASE STATEWIDE AWARENESS AND PREVENT THE USE OF MARIJUANA.

Background: In SFY 2010/2011, marijuana was the primary drug of choice for 67% of SCA paid treatment admissions reported into the Department's Client Information System (CIS) for individuals age 15-17. For SCA paid treatment admissions reported into CIS for those over age 18, marijuana was the primary drug of choice for 12.5%. For SFY 2012/2013, 15% of respondents on the Youth NOMs survey reported ever using marijuana. Among just those respondents who were age 15-17, 36% reported ever using marijuana. In addition, for the past 5 years approximately 23% of youth respondents reported no or slight risk from smoking marijuana once or twice a week. Of the five questions on the Adult NOMs survey regarding the potential harm posed by use of certain substances (i.e. cigarettes, marijuana, alcohol, prescription drugs and synthetic drugs), the question on marijuana use had the highest percentage of respondents reporting no or only slight risk of harm from use (22% in SFY 2012/2013).



*Decriminalized States: passed marijuana decriminalization legislation (for medical and/or recreational purposes) before 2005 (AK, CA, CO, HI, ME, NV, OR, VT, and WA). Transitional States: Enacted legislation between 2005 and 2011 (AZ, MI, MT, NM, RI). Nonlegal States: Had not passed legislation as of December 31, 2011.

NOTES: Data are from the National Poison Data System (NPDS), which contains information from the human poison exposure case phone calls taken by all 56 poison centers across the country. Single-substance, unintentional exposures in children aged 9 years and younger from January 1, 2005, to December 31, 2011 were included as cases. The authors suggest that the increased call rate may be related to increased use by family members, increased likelihood of ingestion, increased potency of the ingestion, and/or increased likelihood of caregivers calling poison centers or presenting to health care facilities for help.

SOURCE: Adapted by CESAR from Wang, G.S., Roosevelt, G., Le Lait, M-C, Martinez, E.M., Bucher-Bartelson, B., Bronstein, A.C., and Heard, K., "Association of Unintentional Pediatric Exposures with Decriminalization of Marijuana in the United States," *Annals of Emergency Medicine*, In Press, 2014. For more information, please contact Dr. George Wang at george.wang@childrenscolorado.org.

The Department believes that decisions about medicine including medical marijuana, should be made by scientists and physicians rather than legislation. There has been consideration of cannabidiol oil which has offered some anecdotal support for Dravet syndrome, which causes severe seizures and death in affected children. The US Food and Drug Administration (FDA) is the agency responsible for determining the delivery system, dosage, recommended frequency of use, therapeutic dosage levels, identification of side effects, and safety of medications. Currently, the FDA not supported the medical use of opium, although there are several pill forms of opiate derivatives such as OxyContin and morphine. Similarly, while the FDA has not approved marijuana for any medicinal use, they have approved derivatives such as Marinol and Cesamet, with a third medicine (Sativex) in stage three trials.

Based on local, state and national data and initiatives, increasing the statewide awareness and preventing the use of marijuana in youth was chosen as a priority. Given the legality of medical marijuana in several states and the recent legalization of recreational marijuana use in other states, The Department will be cognizant of changing attitudes toward the perceived risk/harm of marijuana. The Department will use data, research and programs to address and prevent the use of marijuana, and correct the perception that it is harmless. Perception of risk is directly related to the rate of marijuana use among children and adolescents, with increasing use of marijuana as the perception of risk decreases.

ANNUAL REPORT FY 2012-2013

The Department worked to identify services provided by the Single County Authorities that specifically address marijuana use. The goal was to increase prevention services provided that address marijuana use. There were several programs that have been used by the SCAs to address this priority, including, Too Good for Drugs (TGFD), Project ALERT and Leadership/Mentoring Activities.

The Department monitored national trends to ensure the commonwealth is provided with up-to-date data, research and program information.

PROGRESS REPORT FY 2013-2014

The Department continues to work to identify services provided by the Single County Authorities that specifically address marijuana use. The goal remains to increase prevention services that address marijuana use. The programs being used by the SCAs to address this priority include, Too Good for Drugs (TGFD), Project ALERT and Leadership/Mentoring Activities.

The Department continues to monitor national trends to

ensure the Commonwealth is provided with up-to-date data, research and program information. The revitalizing of the State Epidemiological Outcomes Workgroup through receipt of the SPF-PFS grant this FY will be instrumental in helping the Department identify needs and programs to reduce substance abuse concerns.

The Department is working to educate the field regarding the latest research on the consequences of marijuana use including addiction, psychosis, and schizophrenia, as well as risk of lowered IQ, drugged driving and related accidents.

PRIORITY: ENHANCE THE DEVELOPMENT OF A MODEL CURRICULUM THAT UTILIZES PERTINENT DATA AND INFORMATION THAT IMPROVES SUBSTANCE ABUSE PREVENTION.

Background: In Pennsylvania, the model program for prevention follows the Strategic Prevention Framework (SPF) that ensures SCAs adhere to the five steps of the SPF model: Needs Assessment, Capacity, Planning, Implementation, and Evaluation. Cultural competency and sustainability are also incorporated in these five steps.

In 2000, transition toward the use of prevention programs that showed evidence of effectiveness resulting in a change in individuals' substance use and abuse took place. These evidence-based programs were reviewed by Center for Substance Abuse Prevention (CSAP) and listed as model programs that showed individual change. As the number of these evidence-based programs began to grow, SCAs and prevention providers were encouraged to utilize those programs that addressed areas of need in their local communities. To help ensure further use of programs that show evidence of effectiveness, the Department requires SCAs to deliver at least 25% of services through a combination of evidence-based and evidence informed programs.

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The Department developed a process to examine programs submitted by the SCAs to determine appropriate utilization at the county level. The program review process serves as a formalized method to review prevention programs in order to determine whether they should be added to the Department's list of evidence-based programs and/or evidence-informed programs, as well as to determine if certain Department funding sources can/should be used to fund the programs. The approval process is based on review of the program and whether it utilizes evidence-based practices that have been found to reduce drug and alcohol use, as well as other related risk factors.

The Department nominated the CHOICES program in Lehigh

County for the Service to Science Program. Service to Science is a national initiative to increase the array of evidence-based substance abuse prevention programs.

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The Department continues to review programs per the outlined process and support increased use of evidence-based and evidence informed programs.

The Department will continue to provide nominations to Service to Science as appropriate.

PRIORITY: FACILITATE COLLABORATION OF EFFORTS RELATING TO EDUCATIONAL ASSISTANCE, EDUCATION PROFESSIONS DEVELOPMENT, HIGHER EDUCATION, ELEMENTARY AND SECONDARY EDUCATION FOR THOSE WITH SUBSTANCE USE DISORDERS.

In that underage drinking (28% prevalence rate for past month alcohol use in individuals aged 12-20 in PA) and prescription drug abuse (6% prevalence rate of non-medical use of pain relievers in individuals aged 12-17 and drug overdose deaths at 1,946 for the year 2010, which translates into a rate of 15.5 per 100,000 population) are significant issues that directly impact youth, the Department is making a concentrated effort to address these issues. According to a 2011 survey in Pennsylvania, 14 percent of youth surveyed admitted to taking prescription drugs that were not prescribed to them and 18 percent felt that prescription drugs were not harmful. Through the use of drug take back programs and offering the evidence based LifeSkills Training (LST) Programs to school districts throughout the state the Department is using its influence as a department to impact the use of prescription drugs by youth. The Department, in collaboration with PDE, PCCD, and the BLUEPRINTS, was able to make the LST program available to all Pennsylvania school districts in the commonwealth. This resulted in the implementation of the LST Program in 76 school districts.

Additionally, through the use of the SCA Needs Assessments The Department is able to determine the issues and concerns at the local level relative to the use of substances by adolescents and thus plan accordingly to address them. With the use of the Student Assistance Program (SAP) in school districts across the commonwealth, adolescents are able to be identified and services can begin at the earliest possible moment to lessen the impact of substance use.

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The Department of Drug and Alcohol Programs (DDAP) in partnership with the Pennsylvania Commission on Crime and Delinquency (PCCD) and the Pennsylvania District Attorneys Association (PDAA), has collaborated with local communities to provide grants that facilitate the installation of hundreds of secure and permanent Prescription Drug Take Back boxes installed throughout Pennsylvania.

The Opening Doors initiative, spearheaded by First Lady Susan Corbett, is intended to prevent high school dropouts. Division staff began a collaborative effort with the PDE to support that department's implementation of an Early Warning System that captures information on students related to five predictors of dropout rates that include 1.) daily attendance 2.) code of conduct violations, 3.) state reportable offense violations 4.) failing math grade and 5.) failing English language arts. The Department recognizes that students with these types of predictors often have, or are at risk for, substance use disorders and worked with PDE to identify services appropriate for the system's intervention catalog. The Department worked with their grantees to support collaborative efforts in the four pilot school districts that include Erie City, Harrisburg, Albert Gallatin, and Lancaster. Division of Prevention staff will continue to work at the state level with PDE to support their efforts to implement this system which can support The Department efforts to identify students as early as possible who have, or are at risk for, substance use disorders.

INTERVENTION

The Department of Drug and Alcohol Programs, Bureau of Treatment, Prevention and Intervention, Division of Prevention and Intervention (Division) is responsible to provide for the development, oversight and management of substance abuse prevention and intervention services throughout Pennsylvania. Through programs such as Prime for Life and the Brief Alcohol Screening and Intervention for College Students, the Department addresses individuals that have used illicit substances and provides them the necessary skills to avoid further use. The major focus is to identify and address individuals currently struggling with substance use and to provide them with the skills to develop healthy lifestyles.

In addition, the Department requires grantees called Single County Authorities (SCAs) to implement Student Assistance Programs (SAP) that utilize a systematic team approach comprised of professionals from various disciplines within the school districts that may include but not be limited to guidance counselors, teachers, principals, and SAP liaisons from community agencies. The team identifies barriers to learning, and, in collaboration with families, identifies

students in need of assistance to enhance their school success. Further, as representatives of the county drug and alcohol service system, professionally trained SAP liaisons provide consultation to teams and families regarding the need for referral to community-based and school-based assessment and intervention for drug and alcohol related problems.

The federal strategy 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 the ability to change the thinking/behaviors of the individual.

Current Initiatives

- Prime For Life
- Brief Alcohol Screening and Intervention for College Students (BASICS)
- Youth and Family Training Institute Board
- Balanced and Restorative Justice in Pennsylvania
- Pennsylvania School Wide Positive Behavior Leadership Team

PRIORITY: ENHANCE STRATEGIES AND PROGRAMS THAT PROVIDE INDIVIDUALS WITH THE NECESSARY SKILLS TO REFRAIN FROM FUTURE SUBSTANCE USE.

Background: In July 2012, the Bureau of Drug and Alcohol Programs became the Department of Drug and Alcohol Programs and the Division of Treatment, Prevention and Intervention was created. The Division is working to enhance knowledge regarding intervention as well as starting to provide technical assistance. Intervention strategies attempt to address those individuals that have experimented with alcohol, tobacco and other drugs (ATOD) to modify their behaviors and thoughts.

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The Department maintained up-to-date information through webinars, articles and studies to ensure the Single County Authorities (SCAs) are apprised of pertinent information.

The Department supported the SCAs in the assessment if individuals at-risk for ATOD use. The risk screening assessments may lead to referral for further evaluation and/or assessment.

The Department supported departments throughout the Commonwealth that focus on intervention strategies and

addressing individuals at risk of substance abuse. Some examples are as follows:

- The Youth and Family Training Institute Advisory Board strives to achieve quality family and youth driven outcomes by advancing the philosophy, practices and principles of High Fidelity Wraparound through training, coaching, credentialing and ensuring fidelity.
- The Disproportionate Minority Contact Committee provides technical assistance and information to ensure that communities are providing substance abuse prevention to at risk minorities.
- The Balanced and Restorative Justice in Pennsylvania Committee works to support the mission of the juvenile justice system.
- The Pennsylvania School Wide Positive Behavior Support State Leadership Team creates and sustains a comprehensive school based behavioral health support system in order to promote the academic, social and emotional well-being of all Pennsylvania's students.

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The Department maintains knowledge through webinars, articles and studies to ensure the Single County Authorities (SCAs) are apprised of pertinent information.

The Department continues to support the SCAs in the assessment of individuals at-risk for Alcohol Tobacco and Other Drugs (ATOD) use. The risk screening assessments may lead to referral for further evaluation and/or assessment.

The Department continues to support departments throughout the commonwealth that focus on intervention strategies and addressing individuals at risk of substance abuse.

PRIORITY: DEVELOP AND IMPLEMENT A STATEWIDE PLAN TO INCREASE AWARENESS REGARDING FETAL ALCOHOL SYNDROME (FASD).

FASD is a set of mental, physical and neurobehavioral birth defects that are the direct result of alcohol use during pregnancy. FASD is estimated to occur in 1 in 100 live births in the United States annually. Although FASD is 100% preventable, more than 50% of women of childbearing age drink alcohol and 1 in 8 pregnant women drink alcohol. Each year, taxpayers spend an estimated \$6 billion nationally to treat children and adults diagnosed with FASD. Substance abusing pregnant women and women with children are an identified priority population for those receiving services through the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant.

According to the Institute of Medicine, "Of all the substances of abuse (including cocaine, heroin, and marijuana), alcohol produces by far the most serious neurobehavioral effects in the fetus." For all of these reasons, FASD has been identified as a state priority through the development and implementation of the state FASD Action Plan.

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By a proclamation issued by Governor Tom Corbett, September is observed as FASD Awareness Month. This coincides with national observances also held during the month. Various activities were supported directly by the Department. This included the annual Kickoff Event, which was held on September 9, 2013, at the Butler Memorial Hospital in Butler, PA, and it featured the reading of the Governor's FASD Awareness Month Proclamation, remarks made by Cheryl Dondero, Deputy Secretary of the Department of Drug and Alcohol Programs, and a keynote presentation by Dianne O'Connor and Jasmine Suarez-O'Connor. Mrs. O'Connor explained the joys and challenges of raising children with FASD and Jasmine spoke of what it is like to live with FASD. Various area service providers had display tables featuring their agencies and services. The Department worked with partners from the Western PA FASD Planning Committee to present the FASD Awareness Month Kickoff Event.

The Department also implemented The Baby Bottle Distribution Project in which women's health care providers distributed 3,888 baby bottles with prevention message inserts to expectant mothers across the commonwealth.

The Department required SCAs to provide two community activities related to FASD prevention during the state fiscal year.

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The Department is in the process of reconvening the FASD Task Force to update the FASD State Plan for Pennsylvania.

The Department will continue to require SCAs to provide two community activities related to FASD prevention during the state fiscal year.

OTHER AREAS OF IMPORTANCE

The Department of Drug and Alcohol Programs is designated as the lead agency under Act 1 of 2010 for the management of the Compulsive and Problem Gambling Program. The Department is tasked with providing programs for public education, awareness and training surrounding compulsive and problem gambling.

With the increased availability of legalized gambling in Pennsylvania comes increased concern about individual and social costs of problem gambling. The Department will address this concern by increasing problem gambling prevention, education and outreach efforts.

In 2010, a problem gambling prevention needs assessment was conducted by all 47 Single County Authorities (SCA) to profile population needs, resources and readiness to address needs and gaps. The process involved the collection and analysis of data to define problems within each SCA's geographic area. Each subsequent fiscal year, SCAs have the opportunity to apply for a problem gambling funding initiative. Funds are awarded to the SCAs to develop and implement a comprehensive system of problem gambling prevention strategies, and programs. These problem gambling prevention services are provided either directly by the SCAs or their contracted provider(s). Problem gambling prevention program activities are delivered in a variety of settings and, when appropriate, to communities affected by risk factors associated with problem gambling.

The SCAs utilize the Performance Based Prevention System (PBPS) to plan, monitor, evaluate and analyze problem gambling prevention services in order to effectively administrate prevention programming. Additionally, PBPS will assist with directing prevention-related policy and funding (see Annual Gambling Report for additional detail: <http://www.ddap.pa.gov/reports>).

PROBLEM GAMBLING

The Department of Drug and Alcohol Programs (DDAP) implements a comprehensive, coordinated and effective compulsive and problem gambling program for the commonwealth. The Department is tasked with providing programs for public education, awareness and training surrounding compulsive and problem gambling.

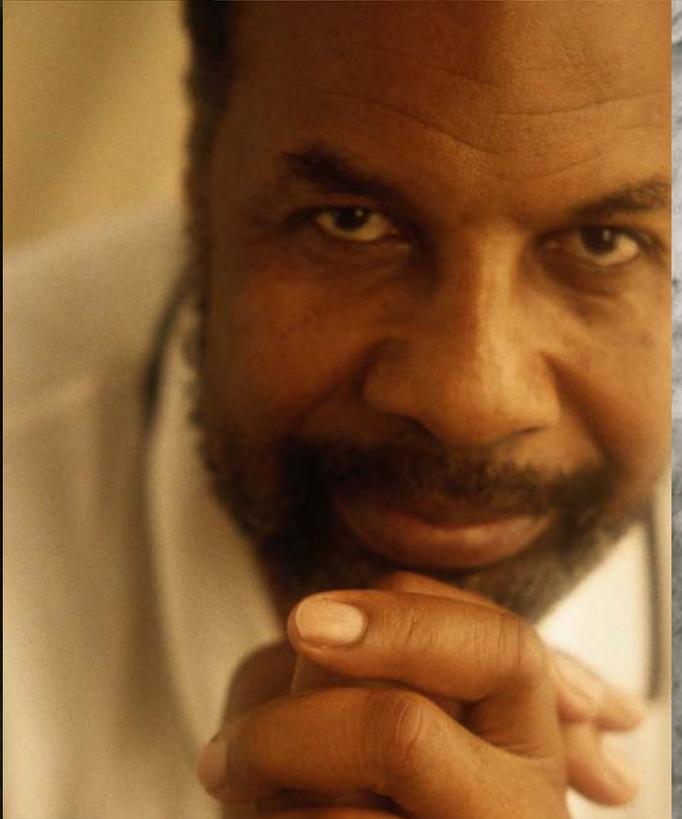
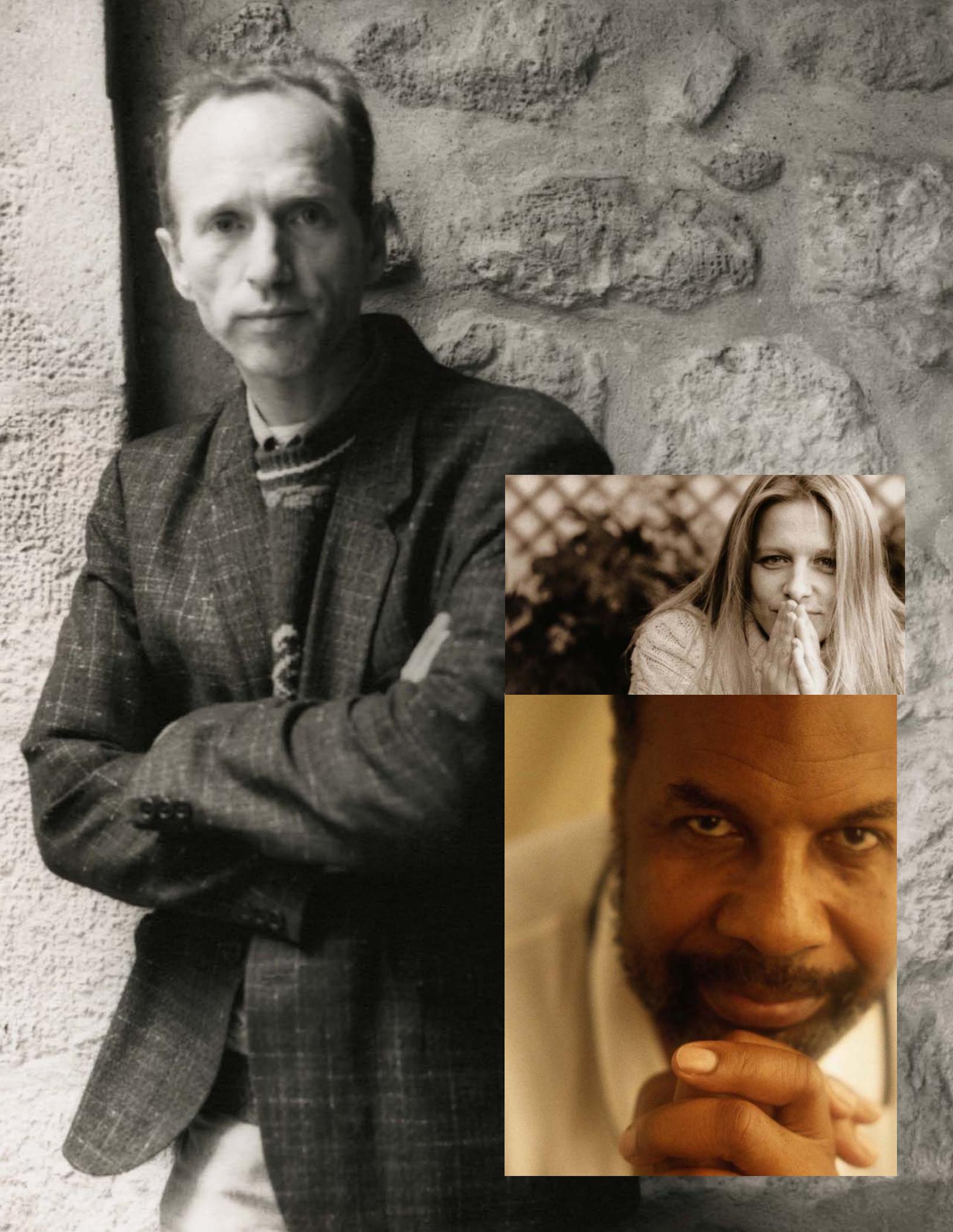
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The SCAs utilize the Performance Based Prevention System (PBPS) to plan, monitor, evaluate and analyze problem gambling prevention services. Additionally, PBPS will assist with directing prevention-related policy and funding.





SUBSTANCE ABUSE TREATMENT

The Treatment Division is responsible for program planning and development of standards, policies, guidelines, service descriptions and measuring outcomes for the clinical functions of case management and treatment of drugs, alcohol and problem gambling. A separate report for the compulsive and problem gambling program is developed annually and can be found at: <http://www.ddap.pa.gov/gamblingaddiction>.

The Division responds to the needs of treatment professionals and publicly funded clients by facilitating program development; evaluating data and conducting research surrounding the development, promotion and implementation of treatment services; assessing the training needs; and collaborating with local providers, counties and other state agencies to develop programming and coordinate systems, to ensure the diverse needs of substance use disorder throughout the commonwealth are met.

PRIORITY: IMPLEMENT A MEDICAL ASSISTANCE (MA) PILOT PROGRAM IN PARTNERSHIP WITH THE DEPARTMENT OF HUMAN SERVICES (DHS), SINGLE COUNTY AUTHORITIES (SCAs), COUNTY ASSISTANCE OFFICES (CAOs) AND COUNTY CRIMINAL JUSTICE OFFICIALS TO INCREASE OFFENDER ACCESS TO ADDICTION TREATMENT SERVICES.

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The Department meets with various criminal justice system agencies to address the drug and alcohol needs of individuals in the criminal justice system. With 70% of incarcerated individuals having substance abuse issues, it is vital that the Department works closely with agencies that support criminal justice initiatives. There is a significant overlap in clientele between criminal justice agencies and the Department, and by working together, collective best practices can be instituted to reduce redundancies and duplication of services, and conserve scarce resources.

The Department implemented several pilot programs this year in partnership with the Department of Human Services (DHS), Single County Authorities (SCAs), local County Assistance Offices (CAOs) and local criminal justice officials, designed to increase offender access to needed addiction treatment services. The pilots include a full assessment and expedited enrollment (MA) so that benefits can begin upon release (for eligible offenders). A plan is in place to implement this pilot with state corrections in SFY 2013-2014.

The following SCAs implemented pilots during SFY 2012-2013:

Armstrong/Indiana/Clarion – Armstrong & Clarion started in December 2012, Indiana in May 2013. Overall, there were 136 referrals with 85 eligible for the program, saving an estimated \$527,985.

Armstrong had 72 referrals, with 47 eligible for the program, and saved an estimated \$233,156 from December 1, 2012 to December 31, 2013.

Clarion had 34 referrals with 18 eligible for the program during the same time period, saving \$135, 892. **Indiana** had 30 referrals with 20 eligible for the program, and saved \$158,937 from May 1, 2013 to December 31, 2013.

Lycoming/Clinton – Lycoming started in March 2013, with 15 offenders entering treatment and 3 pending (Clinton started in December 2013).

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The following SCAs implemented pilots during SFY 2013-2014:

Berks – started August 2013, collaborating with DOC/SCI-Graterford on returning Berks Co. offenders. Overall, from August to December 2013, 58 were released directly from jail to treatment, saving the SCA 2,398 bed days and \$526,675. 20 individuals were discharged from treatment, 16 (80%) of those discharged had successful outcome discharges.

Clinton - started their pilot in December 2013.

Dauphin - started their pilot program on January 1, 2014.

As data is collected on the effectiveness of the pilot, it is anticipated that additional counties will take steps to implement this program. Blair, Centre, Northumberland and Venango counties have expressed interest in implementing a pilot program during this SFY.

PRIORITY: DEVELOPMENT OF 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 OFFENSE OF THIS COMMONWEALTH. PROVISION OF SIMILAR SERVICES SHALL BE MADE FOR JUVENILES ADJUDGED TO BE DELINQUENT, DEPENDENT OR NEGLECTED.

PRIORITY: TO DEVELOP COMMUNITY-BASED DRUG OR ALCOHOL ABUSE TREATMENT SERVICES IN A COOPERATIVE MANNER AMONG STATE AND LOCAL GOVERNMENTAL AGENCIES AND DEPARTMENTS AND PUBLIC AND PRIVATE AGENCIES, INSTITUTIONS AND ORGANIZATIONS.

The Department collaborates with various county, provider and client advocacy organizations including but not limited to the SCAs, Rehabilitation & Community Providers Association (RPCA), Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA), Pennsylvania Recovery Organization Alliance (PRO-A), Parent Panel Advisory Council (PPAC), Drug and Alcohol Advisory Council (DAAC), and the Drug and Alcohol Services Providers Organization of Pennsylvania (DASPOP). With input from these organizations, as well as the Clinical Standards Committee, the Department will continue to ensure development and implementation of effective evidence based programs. This ensures individuals in need of drug and/or alcohol treatment; access to services and continued recovery, while maximizing our limited resources.

The cost and community safety benefits of providing treatment for individuals in the criminal justice system have been well documented in the research. The Department believes that the most effective treatment services are ones that are implemented by trained personnel in an appropriate manner, in the correct duration, and in the right setting. Thus, the Department requires the use of PCPC for adults and ASAM for adolescents as placement criteria. The Department considers the use of a full continuum of care to be the most effective means to combat drug and alcohol abuse. The Department partners with PCCD, OCYF, OMHSAS, PBPP, DOC, the Juvenile Court Judges Commission and others to ensure that the most cost effective, efficient services are provided to individuals suffering from substance use disorders. This allows for individuals to invest more fully in their recovery and become productive members of society.

The PCPC is currently being revised through the Clinical Standards Committee (CSC) and will include updated information on criminality as it relates to substance use treatment needs.

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Community based treatment exists at all levels of care and types of services throughout the commonwealth. SCAs are required to contract with at least one licensed treatment provider for each level of care and type of service. The Department has and will continue to collaborate with stakeholders on the implementation of evidence based programming and the development of new programs. Additionally, the Department has begun the process of reviewing information on the implementation of the Affordable Care Act and Telehealth services to determine how these initiatives may impact substance abuse services throughout the commonwealth. The Department also monitors contract compliance and licensure standards for these programs as described (see p. 59) to assist in the maintenance of service quality.

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The Department continues to collaborate with PCCD, OCYF, OMHSAS, PBPP, DOC, the Juvenile Court Judges Commission and others to ensure that Evidence Based Practices are being implemented throughout the substance use services system in relation to adults and juveniles who are involved in the criminal justice or juvenile justice/dependency systems. The CSC, through the Department, has released the PCPC that provides information on criminality as it pertains to substance use services.

The ASAM's 3rd edition was released in 2013 and has the most updated information concerning substance use placement and juvenile justice/dependency issues. The Department anticipates providing training to the field on the ASAM in 2014.

The Department continues to review reports, white papers, research articles etc. on adolescent and adult criminal/juvenile/dependency justice issues. The information provided informs the Department on issues surrounding adults and juveniles who have become involved in the criminal/juvenile/dependency justice systems.

PRIORITY: TO OFFER EDUCATIONAL COURSES FOR LAW ENFORCEMENT OFFICIALS, INCLUDING PROSECUTING ATTORNEYS, COURT PERSONNEL, THE JUDICIARY, PROBATION AND PAROLE OFFICERS, CORRECTIONAL OFFICERS AND OTHER LAW ENFORCEMENT PERSONNEL, WELFARE, VOCATIONAL REHABILITATION AND OTHER STATE AND LOCAL OFFICIALS WHO COME IN CONTACT WITH DRUG ABUSE AND DEPENDENCE PROBLEMS.

The Department places emphasis on this priority, which reflects the need for collaboration and training across a broad range of related agencies. The Department has developed positive working relationships with various entities (e.g., DOC, PBPP, Judges and OCYF), providing them with technical assistance and a variety of trainings surrounding matters involving drug and alcohol use. These training are designed to expand their knowledge of effectively working with individuals with who use drug and/or alcohol. The Department will continue to explore the development of new courses that will be beneficial to its sister agencies.

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The Department developed various courses and continues to participate in diverse initiatives for professionals working with individuals with substance and/or alcohol related problems throughout the commonwealth. Included among these are an "Addictions 101" course for state/county parole agents and a Screening, Brief Intervention and Referral to Treatment (SBIRT) training for Children and Youth caseworkers. The Department staff have offered training and educational presentations on local and statewide venues for Crisis Intervention Team members, Office of General Counsel, Parole Commissioners, Parole and Probation Officers, Re-entry staff at the Department of Corrections, individuals working with service members/veterans, judges and professionals in the legal system.

PRIORITY: ESTABLISH AND MAINTAIN A PANEL OF PARENTS TO STUDY FAMILY AND COMMUNITY ACCESS TO ALCOHOL AND DRUG ABUSE INFORMATION, INTERVENTION AND TREATMENT SERVICES AND MAKE RECOMMENDATIONS.

One in four Pennsylvania families are affected by untreated alcohol and drug addiction, with many of those impacted being adolescents. Untreated substance use problems contribute to high dropout rates from school, teen suicide, unwanted teen

pregnancy, teen overdoses and crime. Despite the helpfulness of treatment, many teens may not access care because families do not know what services are available or how to access them. Additionally, our system may not have historically been "user friendly" for adolescents and their families. In order to give families a voice in making information and treatment more accessible, the Parent Panel Advisory Council (PPAC) was established in 2007, in accordance with House Resolution 585 of 2006. Representing parents across the commonwealth, individuals serving on this council advise and make recommendations to the department for system improvements in light of the personal experiences they have had with their sons and daughters. The top priority recommendation from PPAC was the establishment of the Department.

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Parent Panel Advisory Council (PPAC) continued to meet in an effort to provide feedback to the department. PPAC and the Pennsylvania Drug and Alcohol Advisory Council (DAAC) established a partnership to improve the substance use service system through the two groups collaborating as a whole, as well as through the formation of a separate collaborative workgroup. The Emergency Room / Healthcare Workgroup, comprised of members from both Advisory Councils, met by conference call on three occasions during this fiscal year to explore the possibilities and approaches for networking with physicians and emergency departments to improve their awareness of substance use disorders and services available, identify areas for improvement where healthcare and issues of substance abuse disorder intersect and identify possible solutions and action steps to address these needed improvements. In total, through its collaborative meetings with the DAAC, through the efforts of the Workgroup, and through assembling independently with its members, the PPAC met on 5 occasions this fiscal year. It provided feedback and input to the secretary regarding access to care, the need to "market" the SCAs and their delivery of services and the need for cross-systems education regarding substance use.

In addition to the members' participation in PPAC, many of the members are involved in local initiatives or are involved in other state affiliated committees which parallel or support their official recommendations made to the House Health and Human Services Committee. This group of individuals remains very active in providing input to the Department. Through interdepartmental collaboration between the Department and other state agencies, another priority of PPAC is being addressed through disseminating information on how to access treatment services. By providing this information through various meetings, conferences, etc., the Department has improved the knowledge base of both state and local agency personnel on how to access substance abuse treatment. Additionally, through collaboration with other agencies, the Department is able to explore accessing additional funding sources which may provide opportunities for more individuals to enter treatment.

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Parent Panel continues its collaborative efforts with the DAAC at large and through the efforts of the joint Emergency Room / Healthcare Workgroup. To date, PPAC members have participated in 3 meetings, have finalized a report on their findings through the Workgroup and made a formal presentation to the joint members of PPAC, DAAC and Department leadership. A meeting is currently being planned for the PPAC/DAAC and the Department leadership to meet with a group of physicians to further the discussion on how to improve healthcare providers' understanding of substance abuse and improve referral to treatment and access to care for individuals with a substance use disorder. Additionally, a second collaborative meeting is being planned for the spring of 2014 with the Governor's Drug and Alcohol Advisory Council of New Jersey. This will present the opportunity for a regional discussion of pertinent issues surrounding substance use as well as for sharing best practices.

In addition, a second workgroup of PPAC members has been established to determine how to bring additional parents together statewide for support and information, how to organize and assist parents with advocacy efforts and how to best query and address the needs of parents. The idea of a Statewide Parent Forum will be explored in greater detail by the Workgroup and, if feasible, planned by this particular Workgroup.

PRIORITY: MAINTAIN A RECOVERY-ORIENTED SYSTEMS OF CARE (ROSC) WITHIN THE COMMONWEALTH THAT SUPPORTS A RECOVERY MANAGEMENT MODEL THROUGH COORDINATED NETWORKS OF COMMUNITY-BASED SERVICES AND SUPPORTS THAT ARE PERSON-CENTERED AND STRENGTH-BASED.

A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families and communities to achieve abstinence and improved health, wellness and quality of life for those with or at risk of alcohol and drug problems. The central focus of a ROSC is to create an infrastructure or "system of care" with the resources to effectively address the full range of substance use problems within communities, in partnership with other disciplines that are individualized, strength-based and person-centered that is available pre-recovery engagement through long term recovery management. ROSC implementation and a focus on recovery is an identified item of importance by the Substance Abuse and Mental Health Services Administration (SAMHSA) through

inclusion of recovery in its identified initiatives, as well as its emphasis of ROSC and recovery in the Substance Abuse Prevention and Treatment (SAPT) Block Grant application, various discretionary grants offered by the agency and a vast array of SAMHSA sponsored webinars, trainings and technical assistance opportunities. This model of care has been substantiated by research indicating that fewer than 10% who need treatment obtain it; once people access treatment, retention and continuing care may be limited. Additionally, it takes 4 to 5 years to reach stability of alcohol recovery and longer for other substances. Most individuals who resume their use of AOD will do so in the first 90 days following treatment. These factors further substantiate the principles and elements of ROSC which encourage continual peer based recovery supports across the lifespan, self-management, warm linkages within the individual's community, etc.

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In determining its involvement in the implementation of ROSC, the Department has taken the approach that the elements and principles of ROSC should be and are imbued into all aspects of the existing service system, and it has therefore been identified as such, rather than as a separate initiative. The Department continued to have key staff participate in trainings offered by SAMHSA relevant to this topic and to provide continued leadership to the Persons In Recovery (PIR) Subcommittee of OMHSAS's Advisory Council. The Department continued its partnership with the PA Recovery Organization Alliance which provided a variety of ROSC-related trainings throughout the state. Additionally, the Department initiated statewide training availability on the effective use of community based recovery resources such as 12 step programs.

In December 2012, various Department staff met with and observed staff and operations from Pennsylvania Recovery Organization – Achieving Community Together (PRO-ACT) and Northeast Treatment Centers (NET) in Philadelphia to obtain information about their delivery of recovery support services and data collection process within the setting of a Recovery Center. Direct observation of service delivery and data processing provided greater insight regarding implementation options, strategies and data processing that can be adopted by service providers in other areas of the commonwealth. Both site visits included interviews with participants who gave testament to the benefits of recovery supports and how involvement as a peer allowed them personal opportunities in their own recoveries as well as the ability to assist others with theirs, thus substantiating the benefits of these services and a ROSC. In addition to this particular site visit, other information gathering activities were done by Department staff, including participation in various nationally supported webinars on the topic.

In April 2013, by invitation from SAMHSA, Department staff attended a federal Dialogue Meeting held in Rockville, Maryland

to further the objectives of advancing an understanding of the intersection and interaction of prevention on recovery, identifying areas of commonality for developing collaborative efforts and assisting SAMHSA in developing a set of action steps necessary for implementation of wellness and recovery initiatives across stakeholder groups.

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The Department continues its partnership with the PA Recovery Organization Alliance which provides a variety of ROSC-related trainings throughout the state. Additionally, the Department is continuing the establishment of statewide training availability on the effective use of community based recovery resources such as 12 step programs. Department key staff continues to participate in trainings offered by SAMHSA relevant to this topic and to provide continued leadership to the PIR Subcommittee of OMHSAS's PIR Advisory Council. Staff has also maintained involvement with the SAMHSA initiative noted in the Annual Report Section above through participation in the Conceptual Alignment Workgroup which is working to bridge the gap between prevention, recovery and other wellness providers.

substance using individuals. The Project is a collaborative effort between the Department of Drug and Alcohol Programs, the Department of Health's Bureaus of Communicable Diseases and Epidemiology and Genentech, a Member of the Roche Group.

In State Fiscal Year 2006-2007 the Hepatitis C Project became entirely commonwealth funded and was expanded to include four additional projects: Allegheny, Blair, Clearfield/Jefferson and Northampton, which continued through State Fiscal Year 2007-2008. Blair County discontinued the program during State Fiscal Year 2008-2009, while the other counties have continued.

In 2005, the first year of the project's operation, the rate of reported cases of Hepatitis C in Pennsylvania was 1 per 100,000 population and this rate trended significantly lower in 2006 (.4 per 100,000 population), 2007 (.3), 2008 (.2), 2009 (.3) and the most recent calendar year reported by the Centers for Disease Control, 2010 (.2).

The Pennsylvania Hepatitis C Project is making a difference by relieving the suffering caused by Hepatitis C, removing obstacles to patient recovery and reducing healthcare costs downstream through education, testing and referral to treatment.

PRIORITY: PROVIDE SCREENING, TESTING, REFERRAL AND CASE MANAGEMENT SERVICES FOR INDIVIDUALS AT RISK FOR HEPATITIS C.

Hepatitis C virus (HCV) infection is the most prevalent chronic blood-borne infection in the United States. People who inject drugs are at high risk for becoming infected with HCV from sharing needles and drug use paraphernalia. The majority of people with Hepatitis C are asymptomatic. Without diagnosis and treatment, 15% - 40% of those persons living with viral Hepatitis will eventually develop liver cirrhosis or hepatocellular carcinoma.

Because of the high burden of chronic Hepatitis C virus infection in the United States and because no vaccine is available for preventing infection, national recommendations emphasize other primary prevention activities, including screening and testing blood donors, inactivating HCV in plasma-derived products, testing persons at risk for HCV infection, providing them with risk-reduction counseling and consistently implementing and practicing infection control in healthcare settings.

Pennsylvania's Hepatitis C Outreach, Education and Screening/Detection Project was initiated in Philadelphia in the latter part of State Fiscal Year 2005-2006 through special provisions from the Center for Substance Abuse Treatment in which the HIV set-aside funds from the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) were used to support outreach, education and screening/detection of Hepatitis C in

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The Department of Drug and Alcohol Programs provided a total of \$564,000 in state funding to Allegheny, Clearfield/Jefferson, Northampton and Philadelphia SCAs for the provision of screening, testing, counseling and case management services for clients at risk for contracting Hepatitis C. All sites were fully operational and compliant with all reporting requirements. Through its annual meeting in May 2013 with all the Hepatitis C Project sites, the Department of Health's Bureaus of Communicable Diseases and Epidemiology, Genentech Inc. and the Philadelphia Department of Public Health, the Department continued to ensure that sites in the Commonwealth of Pennsylvania adhered to established Hepatitis C service protocols.

The Hepatitis C Project continued to encompass three service areas: Outreach, Testing and Case Management. The following State Fiscal Year 2012-2013 data is inclusive of all four projects with the exception of the outreach component, which only includes performance measurement data from Allegheny, Clearfield/Jefferson and Northampton SCAs. Outreach data indicates that 3,750 persons were contacted, reflecting a decrease of 142 clients when compared to the previous year. Clearfield-Jefferson's number of outreach contacts was reduced due to staff transition but its testing and case management services remained robust. There were 1,390 clients referred for testing through the three SCAs, 322 more clients than the previous year.

Over 37% of outreach contacts were referred for testing,

which was an increase of 10% from the previous year. Pre-test counseling was provided to 11,267 clients, an increase of 1,526 clients when compared to the previous year; 1,296 of the 1,526 increase were in Philadelphia. 11,188 clients were tested, 15% more tests than last year's 9,741.

Overall, 6,656 individuals or 59% tested positive, including 6,454 in Philadelphia, 63% more than the 4,162 individuals who tested positive in the Philadelphia project's previous year. Also, 7,137 persons or 64% received post-test counseling, comparable to the previous year's 68%.

Case management data indicate that 6,663 individuals were referred for medical evaluation in State Fiscal Year 2012-2013, 2,386 more clients than in 2011-2012. Since the Philadelphia SCA does not currently report treatment and vaccination related case management data, the following is based only on the other three SCAs' data. Overall, 195 clients accepted treatment this year through the Allegheny, Clearfield/Jefferson and Northampton SCAs, an increase over 178 in the previous year. In addition, 289 persons received Hepatitis A and B vaccines, representing an increase of 87 clients compared to the previous year, with Allegheny's outcome increasing to 235 clients compared to 62 clients in the previous year.

All four SCAs provided testing and case management services in 2012-2013. The Allegheny, Clearfield/Jefferson and Northampton SCAs conducted many outreach activities to promote their projects within their service areas. Allegheny SCA opened a viral Hepatitis drop-in center, attended health fairs, coordinated guest speakers from the American Liver Foundation and received a waiver to offer rapid Hepatitis C virus antibody tests at screening sites, reducing the cost per test from \$55 to \$20 and determining the results of tests in 20 minutes as opposed to the previous time frame of two to three weeks. Clearfield/Jefferson hired a new Rural Health Outreach Coordinator, developed HCV testing awareness radio and print advertisements, created a Facebook page for its Hepatitis C program, made plans to develop a Hepatitis C Advisory Committee and met with Orasure Technologies, Inc. regarding rapid testing. Northampton collaborated with partner organizations to provide HCV prevention, education, counseling, testing and case management. They focused their efforts into educating Hepatitis C positive patients and worked to link them with appropriate resources.

The Department also collaborated with Department of Health Epidemiologist Sameh Boktor, MD, MPH in support of the Federal Centers for Disease Control and Prevention (CDC) Viral Hepatitis Prevention and Surveillance funding opportunity that Dr. Boktor was awarded in the fall of 2012 (Agency Funding Opportunity Number CDC-RFA-PS13-1303). The purpose of the one-year funding award was to support activities intended to improve the delivery of viral Hepatitis prevention in healthcare settings and public health programs and support active, enhanced surveillance to monitor the burden of acute and chronic viral Hepatitis.

Dr. Boktor directed the development and delivery of high risk adult Hepatitis prevention webinars and educational booklets to educate public health nurses employed by the Department of Health and substance use case managers associated with the Department of Drug and Alcohol Programs through the provision of Pennsylvania's CDC grant. Dr. Boktor also conducted active, enhanced surveillance for viral Hepatitis and collected more extensive and complete surveillance information than was possible through the passive National Notifiable Disease Surveillance System (NNDSS). The Department reviewed and provided input regarding project materials, served as the liaison between the project and participating substance use case managers and incorporated the results of Dr. Boktor's enhanced surveillance into its executive decision making process.

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The Department of Drug and Alcohol Programs is once again providing \$564,000 in state funding to Allegheny, Clearfield/Jefferson, Northampton and Philadelphia SCAs for the provision of screening, testing, counseling and case management services for clients at risk for contracting Hepatitis C. All sites are fully operational and compliant with all reporting requirements. Through its annual meeting scheduled for May 14, 2014 with all the Hepatitis C Project sites, the Department of Health's Bureaus of Communicable Diseases and Epidemiology, Genentech Inc. and the Philadelphia Department of Public Health, the Department continues to ensure that sites in the Commonwealth of Pennsylvania adhere to established Hepatitis C service protocols.

The Department also continues its collaboration with Department of Health Epidemiologist Sameh Boktor, MD, MPH in support of the Federal Centers for Disease Control and Prevention (CDC) Viral Hepatitis Prevention and Surveillance funding opportunity that Dr. Boktor was awarded in the fall of 2012 and was approved for continuation in 2013-2014 (Agency Funding Opportunity Number CDC-RFA-PS13-130302CONT14). The purpose of the one-year funding continuation award is to support activities intended to improve the delivery of viral Hepatitis prevention in healthcare settings and public health programs and support active, enhanced surveillance to monitor the burden of acute and chronic viral hepatitis.

Dr. Boktor will increase the proportion of persons living with HCV infection who are made aware of their HCV infection through testing and are linked to prevention and clinical care services (in people with substance use disorders and people born from 1945 to 1965) and decrease the number of new HCV cases, particularly among adolescents and young adults who inject drugs through 5 activities:

1. Refresher training for Department staff, including a survey to collect information on the use of the materials

distributed during the preceding training conducted in 2013. Funding opportunities from SAMHSA and other federal organizations will be discussed to request funds for Hepatitis prevention activities.

2. Analysis of HCV screening and treatment data for the Department of Corrections to identify possible areas for improvements. In addition, the results of this analysis will be used to improve the department's HCV screening and treatment protocols.

3. Education of Rotary Club members and "baby boomers" in the area of Montgomery County, including a free screening event in May 2014.

4. Staff education of the Gaudenzia, Inc. community-based drug and alcohol treatment program serving south-central Pennsylvania, including monthly educational sessions to the program's clients.

5. Participation in the monthly meetings of the HCV Pittsburgh Coalition, which provides awareness campaigns, free screening events and discussions of important community needs, for example linkage to care for HCV patients.

The Department will continue to review and provide input regarding project materials, serve as the liaison between the project and participating substance use case managers and incorporate the results of Dr. Boktor's educational and analytical efforts into its executive decision making.

PRIORITY: HOMELESS PREVENTION AND HOUSING SUPPORT: TO PREVENT PA FAMILIES AND INDIVIDUALS SUFFERING FROM SUBSTANCE USE DISORDERS AND CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS FROM BECOMING HOMELESS OR RETURNING TO HOMELESSNESS AND EXPAND ACCESS TO AND AVAILABILITY OF RESOURCES TO SUPPORT HOMELESS FAMILIES AND INDIVIDUALS SUFFERING FROM SUBSTANCE USE DISORDERS AND CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN OBTAINING AND MAINTAINING THE AFFORDABLE HOUSING OF THEIR CHOICE THROUGH THE COOPERATIVE AGREEMENT TO BENEFIT HOMELESS INDIVIDUALS (CABHI)– STATES GRANT.

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Supports for obtaining and maintaining permanent housing are being addressed through the Department, which identified a source of federal grant funding for support services to assist persons with substance use disorders and co-occurring substance use and mental health disorders to develop the skills

and resources necessary to obtain and maintain permanent housing. The department was awarded a Cooperative Agreement to Benefit Homeless Individuals – States grant (CABHI-States Grant Number 1H79TI025346-01) in September 2013. Offered through the Substance Abuse and Mental Health Services Administration (SAMHSA), the three-year, \$1.7 million grant enables the Department and its collaboration partners, The Mental Health Association of Southeast Pennsylvania (MHASP), the Homeless Advocacy Project (HAP) and the City of Philadelphia, to enhance the infrastructure of the treatment service system to provide accessible, effective, comprehensive, coordinated/integrated and evidence-based treatment services; permanent supportive housing; peer supports and other critical services to persons who experience chronic homelessness with substance use disorders or co-occurring substance use and mental health disorders.

Called the Homeless 2 Home Behavioral Health Project for Pennsylvania, the first of three Recovery Coaches were hired by MHASP for the Project in January 2013, and a Representative Payee will also be hired by MHASP to provide further staff support. The Department submitted a Continuation Application for the Project to SAMHSA in January 2013 and coordinates monthly meetings of the Homeless 2 Home Project Team to receive input and provide guidance in support of the Project's outcomes, which include the development of strategies associated with addressing the needs of individuals experiencing chronic homelessness and increasing the number of individuals placed in permanent supportive housing and enrolled in Medicaid and other mainstream benefits e.g., Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI), Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP).

Additionally, to prevent homelessness among individuals with substance use disorders and co-occurring substance use and mental health disorders in Pennsylvania, the Department also participates in monthly meetings of the Pennsylvania Homeless Steering Committee, an interagency committee sponsored by the Department of Community and Economic Development. In addition to developing and administering the Pennsylvania Agenda for Ending Homelessness, the Steering Committee serves as a forum for information sharing, assesses and formulates state homelessness policy and priorities, reviews and develops procedures for the Regional Homeless Assistance Process' Continuum of Care application process, facilitates the collection of data on homelessness and directs and provides technical assistance to Regional Homeless Advisory Boards and individual project applicants. The Department has provided specific input regarding the goals and objectives of the Agenda for Ending Homelessness to ensure that persons with substance use disorders and co-occurring substance use and mental health disorders are included in the Agenda and recognized as populations of particular concern.

PRIORITY: MAINTAIN THE CLINICAL STANDARDS COMMITTEE (CSC) TO MAKE RECOMMENDATIONS TO THE DEPARTMENT REGARDING THE BEST PRACTICES AND THE IDENTIFICATION, ASSESSMENT, PLACEMENT AND TREATMENT OF ALCOHOL AND OTHER DRUG PROBLEMS FOR CITIZENS OF PENNSYLVANIA.

The Clinical Standards Committee advises the Department to ensure the use of best practices within the commonwealth. The CSC's primary task for the past three years was to review the Pennsylvania Client Placement Criteria (PCPC) regarding implementation, utilization, content, and structure; and to identify, review and recommend evidence based practices that may benefit the substance use treatment field. The PCPC is the medical necessity criteria utilized by the Department and DHS, as designated in Act 152 of 1988.

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The Clinical Standards Committee (CSC) was reconvened in February 2009 and consists of representatives from treatment providers, Single County Authorities (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 (SBIRT); Pharmacotherapy; Women/Women with Children; and PCPC Utilization. Each subcommittee was tasked with reviewing and revising the special considerations papers that are included in The Second Edition of the PCPC.

The Department successfully secured a technical writer, and contracted with the University of Pittsburgh's Program Evaluation and Research Unit (PERU) beginning July 1, 2012, to complete a systematic revision of the PCPC based on the work of the CSC. Significant revisions comprised of a synopsis of each special population paper, the development of "Principles of Treatment" and the creation of a Do's/Don'ts section for each level of care. Additional responsibilities assigned to PERU included; developing criteria for an Intervention level of care. designing and testing the PCPC revisions with a small focus group, revising the PCPC based on focus group feedback and development of the PCPC training and dissemination strategy. The CSC did not convene during much of fiscal year 2012-2013, due to the extent of the work being completed by PERU; however, documents were shared electronically throughout the revision process, allowing the CSC to review the edits and

provide feedback to the Department and PERU.

The special population papers, which were historically included in Appendix A: Special Needs and Considerations, were revised and updated. In the development of the special topic papers, each of the subcommittees strived to make the papers more culturally aware and responsive to the needs of individuals seeking SUD treatment services. In light of the revisions to the papers, the CSC and Department recommended placing the full papers on the Department's website, and including a synopsis of each paper in the PCPC. An explanation of changes to each special considerations paper is summarized below.

The Pharmacotherapy paper nomenclature was changed to Medication Assisted Treatment (MAT) and includes an expanded discussion of medications typically used in MAT, a list of considerations for determining the appropriateness of MAT for an individual and an emphasis that MAT is a comprehensive treatment approach.

The Co-Occurring paper eliminated "dual diagnosis" terminology; included assessment considerations, co-occurring treatment principles, placement considerations; and incorporated a number of resources for additional information about treating individuals with co-occurring substance use and mental health disorders.

Women and Women with Children can face a variety of issues that have an impact on their ability to attend and participate in SUD treatment, and the paper was revised to include new emphasis on barriers to treatment, gender-specific needs and the importance of trauma-informed care. It was also recommended that changes to the PCPC to ensure the language is non-judgmental.

The Cultural and Ethnic Considerations and Sexual Orientation papers were expanded to ensure the emphasis on the importance of cultural sensitivity in SUD treatment, whether the considerations are cultural, ethnic or sexual orientation/identity in nature. Individuals involved in SUD treatment need to feel safe and free from discrimination based on their culture, race, ethnicity or sexual orientation.

The Criminal Justice paper was not included in the previous version of the PCPC because it was not completed until July 2004. The criminal justice paper was published as a Research to Practice Brief: *Understanding and Treating Substance Use Disorders Among the Criminal Justice Population*. All sections of the original paper were revised and now include emphasis on assessment and placement considerations and challenges, systems collaboration and recovery considerations. The Criminal Justice paper has been included in the PCPC, rather than in a separate publication.

The "Principles of Treatment" were developed by a small group of CSC members to serve as a set of guiding principles for SUD treatment in Pennsylvania and were included in the Introduction section of the PCPC. Two platforms in

SUD treatment and intervention form the foundation of the treatment principles: the science of SUD treatment and intervention and the whole-person and community-based paradigm of recovery. Principles derived from the platform of the science of SUD treatment and interventions aspire to implement research-based elements of effective treatment directly into practice. Principles based on the platform of recovery focus on the strengths of the person and his or her connections within a community of recovery supports.

A set of overall placement considerations, or a “Do’s and Don’ts” list, was added to the PCPC. These general placement considerations serve as guidance for the application of the PCPC in areas such as: a recommended type of service is unavailable; an individual declines the recommended level of care; an individual is in a controlled environment; the role of prior treatment in placement decisions; understanding available resources; and so on. PERU developed these considerations and they are included in the “How to Use the Criteria” section and also follow placement criteria for each type of service in the PCPC.

The recommendation made by the SBIRT subcommittee was to develop and include an Intervention level of care in the PCPC. PERU worked in coordination with the Department to begin development of this set of criteria for the CSC. Development of the Intervention level of care continued to be an ongoing endeavor for PERU and the Department throughout the course of the year. Once the Intervention level of care was drafted, a new subcommittee of the CSC was created to provide further guidance and development of the service description and criteria.

Based on the preliminary timeline developed by PERU, it was anticipated that revisions of the PCPC document would be completed by June 2013 with testing and training completed by December 2013. The timeline was extended into the next fiscal year in order to accommodate operational demands of the Department.

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The Department has continued to engage PERU as the technical writer for the revision of the PCPC. Although the CSC continued its work in revising the PCPC, it met less frequently, as the largest part of the work became the responsibility of PERU. The primary role of the members of the CSC over the past year has been that of reviewing and providing feedback regarding PERU’s edits to the PCPC.

The Intervention subcommittee has been working to further develop criteria for this new level of care. The term “Early Intervention” has been chosen as the name for this service level and is defined by the subcommittee as: *organized psychoeducational sessions designed to help individuals identify and reduce risky substance use behaviors that could lead to the*

development of a substance use disorder. Intervention is not substance use disorder treatment. There is recognition in the SUD field that educational and motivational approaches serve as viable methods to address the needs of individuals exhibiting problematic patterns of substance use that do not meet diagnostic criteria for a substance use disorder. Early Intervention is designed to focus on individuals who are engaging in hazardous substance use and provide them with education to develop the skills necessary to reduce his or her substance use risk.

A Training subcommittee of the CSC has been created with the responsibility of recommending to the Department suggestions for revising the current PCPC training program so that it consistently results in practitioners who have been trained to apply the revised PCPC in a valid and reliable manner for every individual with whom the trainee may apply the criteria. The Training Committee is comprised of past and current PCPC trainers and current substance use disorder treatment providers. Minor revisions to the PCPC Summary Sheet have been made and Principles of Training have been developed. Training principles include items such as minimum participant status, course objectives and format, participant certification standards, course prerequisites and skills targets. The Training subcommittee continues its efforts to revise and enhance the PCPC training curriculum.

Based on the existing timeline, The Third Edition of the PCPC will likely be released and implemented during FY 2014-2015.

PRIORITY: COLLABORATE WITH 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.

The Department meets regularly and on an as needed basis with state agencies for the purpose of collaboration on issues surrounding substance use. These relationships allows for candid conversations with leaders in the commonwealth regarding the impact of drug and alcohol use on their agencies and clientele. The Department provides training and education surrounding substance use issues to state agencies and their local constituencies. The Department will provide technical assistance to these agencies on best practices in the field, optimizing resources.

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The Department staff have been meeting with various

Pennsylvania state agencies (i.e., Commission on Crime and Delinquency; Department of Human Services, Office of Mental Health and Substance Abuse Services and the Office of Medical Assistance Programs; Attorney General's Office; Department of Education; Department of Health, Bureau of Health Statistics and Research; Department of Health, Bureau of Health Planning; Department of Health, Bureau of Communicable Diseases; Department of Health, Bureau of Epidemiology; Department of Military and Veterans Affairs; Department of Transportation; Department of Corrections; State Police; Pennsylvania Board of Probation and Parole, Department of Aging, Pennsylvania Civil Service Commission, etc.), to discuss the coordination of substance use services throughout the commonwealth. Cross system initiatives have been implemented with the Commission on Crime and Delinquency, Department of Human Services, Department of Corrections, Pennsylvania State Probation and Parole, Department of Health and the Department of Education.

PRIORITY: COORDINATION OF EFFORTS RELATING TO VOCATIONAL REHABILITATION, WORKFORCE DEVELOPMENT AND TRAINING.

Workforce development is a key area to the success of effective prevention, intervention and treatment of substance use disorders. This includes a number of areas of need such as training, job satisfaction, and reduced administrative burdens. These are some of the elements of a comprehensive recruitment, training and retention strategy to support employment in the field.

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One of the specific goals of the SPE Grant was to improve the knowledge and capacity of the prevention workforce. Under the SPE, several video-based trainings were created.

The Department was closely involved with the Commonwealth Prevention Alliance 23rd Annual Prevention Conference to assist in the training and development of professionals in the prevention field.

PROGRESS REPORT FY 2013-2014

The Department staff continues to meet with the Institute for Research, Education and Training in Addictions (IRETA) regarding a variety of health research projects including, but not limited to, the development of problem gambling performance measures for both prevention and treatment and development of clinical consultation services for clinicians certified in problem gambling. Through coordination with IRETA, training on Screening, Brief Intervention and Referral to Treatment (SBIRT)

has been presented to case managers, clinicians and healthcare providers throughout the commonwealth. The Department has supported trainings on evidence based practices through the PA Certification Board (PCB) and the PA Recovery Organizations Alliance (PRO-A). Through these trainings, workforce development has been sustained and improved. Additionally, the Department supports the use of surveys to determine training, development and resource needs in the field.

The Department continues to work with the University of Pittsburgh to assist in revising the Pennsylvania Client Placement Criteria (PCPC). The University of Pittsburgh will also be testing the revised instrument for validity, as well as developing and providing training on the areas of the instrument that have been updated.

The Department plans to implement training to the field on the PCPC, DSM 5 and the ASAM, 3rd edition. This will allow substance use service providers to have the most up to date information relevant to diagnosis and placement tools. This knowledge will lead to improved services to their clientele.

The Division of Prevention and Intervention has initiated contact with the Office of Vocational Rehabilitation to provide a linkage to educational information about substance abuse through the Department's clearinghouse as well as information that can link their clients to resources for drug and alcohol assessment and treatment. Updating this information will occur at least annually with the Office of Vocational Rehabilitation.

The Department continues to be closely involved with the Commonwealth Prevention Alliance in the planning of their Annual Prevention Conference each June to assist in the training and development of professionals in the prevention field. In addition, the Department maintains a relationship the Northeast Collaborative for the Application of Prevention Technologies (CAPT) to assist with the creation and implementation of training needs that will positively impact the prevention field.

The Division of Prevention and Intervention is working with the Training Section as well as the Prevention Workgroup to identify training needs for the field and update prevention courses as needed.

The Department recognizes that prescription drug abuse is a significant issue in PA. One component of the issue involves prescriber practices and the need to educate stakeholders in the medical field about best practices in order to reduce prescription drug abuse and overdoses while maintaining effective pain management. The Department initiated a workgroup consisting of medical stakeholders and co-chaired by the Department's Secretary Gary Tennis and the Department of Health's Physician General, Dr. Carrie DeLone. The focus of this group is (i) to identify and find consensus on best and safest prescribing and pain management practices, and (ii) to identify ways that the stakeholders (representing various state Departments and private organizations) can most effectively

promote those practices.

PRIORITY: COORDINATE ALL HEALTH AND REHABILITATION EFFORTS TO DEAL WITH THE PROBLEM OF DRUG AND ALCOHOL ABUSE AND DEPENDENCE, INCLUDING, THOSE RELATED TO SENIOR CITIZENS AND DEPRESSION.

As the “baby boomer” generation ages, the Department expects more older adults in need of substance use services. The number of older adults with substance use problems is estimated to increase from 2.5 million in 1999 to 5.0 million in 2020. As people age, they will place increasing demands on the substance use treatment system and this will require a shift in focus to address the special needs of an older population of individuals with substance use disorders. There is also a need to develop improved tools for measuring substance use among older adults. With 367,586 Pennsylvanians receiving Social Security and a substance use problem prevalence rate of 4.5% for individuals aged 50 and over, the number of Pennsylvanians on Social Security with a substance use problem is over 16,500. Additionally, because the older population is more likely to be on prescription medications, it is imperative that they understand the dangers involved when combining an opioid pain reliever with some prescription medications.

PROGRESS REPORT FY 2013-2014

The Department staff continues to work with various Pennsylvania agencies (i.e., Pennsylvania Behavioral Health and Aging Coalition, Department of Aging, Office of Mental Health and Substance Abuse Services, etc.) throughout the state to discuss ways to collaborate and provide services to senior citizens affected by substance use. The Department representatives attend OMHSAS Older Adults Planning Council meetings to provide input on substance use issues affecting older adults. The Department also developed a substance use disorder guide for the OMHSAS Older Adults Planning Council. The Department worked closely with the Pennsylvania Behavioral Health and Aging Coalition to provide information to the substance use field on older adults and suicide risk. Prescription take-back efforts are particularly important with this population since leftover medications may be inappropriately accessed by others in the household.

From a prevention perspective, the Division of Prevention and Intervention attends quarterly meetings with the Injury Community Planning Group to provide support to this population regarding risk factors associated with substance use disorders.

PRIORITY: COORDINATION OF ALL HEALTH AND REHABILITATION EFFORTS TO DEAL WITH THE PROBLEM OF DRUG AND ALCOHOL ABUSE AND DEPENDENCY, INCLUDING, THOSE RELATED TO LAW ENFORCEMENT ASSISTANCE, HIGHWAY SAFETY, PAROLE AND PROBATION SYSTEMS, JAILS AND PRISONS, AND JUVENILE DELINQUENCY.

The Department collaborates with PCCD, OCYF, OMHSAS, PBPP, DOC, the Juvenile Court Judges Commission, etc. to ensure that quality services are being provided to individuals involved with the criminal/juvenile/dependency justice systems. With 70% of individuals incarcerated having substance use issues it is particularly vital that the Department works closely with agencies that support criminal justice initiatives. There is a significant overlap in clientele between criminal justice agencies and the Department and by working together best practices can be instituted by all parties that effectively address the offender’s drug and alcohol problem, reducing recidivism and increasing community safety.

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The Department expanded a pilot program this year in partnership with the Department of Human Services, Single County Authorities, local County Assistance Offices, local criminal justice officials and the Department of Corrections designed to increase offender access to needed addiction treatment services. The pilot includes a drug and alcohol assessment completed at the jail/prison and an application for Medical Assistance (MA) being submitted for those in need of treatment prior to release so that MA can be started at time for release for MA eligible offenders.

Additionally, the Department has worked with the Clinical Standards Committee’s Criminal Justice Subcommittee to clearly define standards for assessment of individuals leaving correctional settings. This subcommittee includes representatives from State Probation and Parole, Department of Corrections and treatment providers that have specialized expertise with criminal justice populations.

The Department has collaborated with many components of the criminal justice system including local judiciary, Pennsylvania Commission on Crime and Delinquency (PCCD), PA Board of Probation and Parole (PBPP) and the Department of Corrections to discuss best practices in developing a comprehensive strategy on the issue of substance use as it impacts the adult and juvenile justice systems. Through these newly developed partnerships the Department expects to avoid duplication in resources and time while implementing best practices. Additionally, the Department will partner with these and other

criminal justice agencies to implement research and education that will inform quality services to individuals involved in the criminal justice system.

The Department participates on various workgroups with the DOC, OMHSAS, PCCD, and OCYF to provide feedback and information on initiatives implemented by these agencies.

The Department collaborated with PDAA to implement a grant proposal for installation of Prescription Drug Take Back boxes in local law enforcement offices. The Division of Prevention and Intervention maintains a webpage listing the permanent Prescription Drug Take Back Box locations (<http://www.ddap.pa.gov/>) throughout the Commonwealth.

Highway safety issues are being addressed through the Division's quarterly participation on the statewide Multi Agency Safety Team (MAST), which is tasked with the development and implementation of the Comprehensive Strategic Highway Safety Improvement Plan. In addition to other highway safety issues, this group focuses on underage drinking and driving. The Department provided the following data collected in PBPS to the MAST for their annual report: number of people receiving alcohol related education, and the results from the annual youth and adult National Outcome Measure surveys administered to those receiving prevention services for the question – During the past 12 months, have you driven a vehicle while you were under the influence of alcohol only?

Division staff maintained ongoing participation on PCCD's Disproportionate Minority Committee (DMC) with a role for the Department to advise the group members on interventions for youth who commit delinquent acts. The DMC state committee approved new DMC sites for providing interventions and the DMC Youth Law Enforcement curriculum was approved.

PRIORITY: ENCOURAGE COLLABORATION OF EFFORTS RELATING TO HEALTH PROFESSIONALS, HOSPITAL AND MEDICAL FACILITIES.

The Affordable Care Act, or federal health reform, will most likely have a profound effect on the way people receive health care. The Department has taken steps to initiate relations with various healthcare professionals who come in contact with substance using individuals. In 2010, there were 1,946 overdose deaths in Pennsylvania, which translates into a rate of 15.5 per 100,000. It is imperative that collaborations and relationships be enhanced, including working with the Pennsylvania Medical Society to help physicians better understand prescription abuse issues, the development of tamper resistant opioids, and drug take back programs.

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The Department remains committed to having physicians trained on Screening, Brief Intervention and Referral to Treatment (SBIRT), especially Emergency Room physicians who come in contact with many individuals who have health related problems and are without healthcare coverage. Examples of this can be seen in our collaborations with the University of Pittsburgh and IRETA, two key leaders in the field of SBIRT, as well as attempts to gain additional federal grant funding to expand SBIRT. Additionally, through the Department's Hepatitis C Project and the Methadone Death and Incident Review Team, physicians are providing direct input on substance use issues that are adversely affecting commonwealth residents. The Department continually investigates funding opportunities to ensure additional physician education can take place.

To address the high number of overdose deaths in the commonwealth, the Department has formed an Overdose Rapid Response Task Force whose ultimate goal is to prevent overdose deaths. Various health professionals participate on the workgroup including representatives from the PA Coroner's Association, Public Health Physicians, Department of Health, SAMHSA, OMHSAS, etc.

PRIORITY: ENCOURAGE COLLABORATION OF EFFORTS RELATING TO MENTAL HEALTH PROFESSIONALS AND COMMUNITY MENTAL HEALTH CENTERS.

There is little research on the characteristics of individuals with intellectual disabilities (IDs) who misuse substances and how such problems impinge upon their well-being. However, being male and young, having a borderline/mild ID, living independently and having a mental health problem were found to be risk factors for developing a substance related problem (Journal of Intellectual Disability Research 2006, 50(8), 588-597). Approximately 8.9 million adults have co-occurring disorders; however, only 7.4% of individuals receive treatment for both conditions with 55.8% receiving no treatment at all (SAMHSA website 2014). As such, co-occurring disorders should be considered an expectation and not an exception.

Individuals with substance use disorders are also commonly diagnosed with other mental health disorders. Therefore, it is important to maintain collaboration with other mental health professionals as part of a comprehensive system of assessment and treatment.

PROGRESS REPORT FY 2013-2014

The Department has continued its collaboration with DHS staff to develop strategies for working with those individuals affected by developmental disabilities and mental health issues.

Through regular meetings and participation on various DHS initiatives including the PA Military and Family Behavioral Health Coalition, PA Systems of Care, PA CARES Task Force, Healthcare Workgroup Steering Committee, Older Adults Behavioral Health Planning Council, Persons in Recovery Subcommittee, OMHSAS Executive Committee, etc., the Department has maintained and improved working relationships with our sister agency.

The Division of Prevention and Intervention initiated contact with the six District Health Offices to provide a linkage to educational information about substance abuse through the Department's clearinghouse as well as information that can link their clients to resources for drug and alcohol assessment and treatment. Updating this information will occur at least annually with the District Health Offices.

The Department coordinated the FASD Awareness Month with a kickoff on September 9, 2013 at the Butler Memorial Hospital that included an FASD proclamation from Governor Corbett. The keynote speakers were a mother and her daughter diagnosed with FASD. In addition, the Department implemented its annual Baby Bottle Project that included sending almost 3900 baby bottles with educational inserts about the dangers of FASD to 50 health professionals who disseminated those baby bottles to their pregnant patients. Those receiving the bottles provided positive feedback about this initiative.

PRIORITY: SUPPORT SUBSTANCE-RELATED EFFORTS RELATED TO COMMONWEALTH EMPLOYEES BENEFITS AND CIVIL SERVICE LAWS.

The Department is committed to ensuring that quality prevention, intervention and treatment services are available for all citizens of the commonwealth. By working together, all entities in Pennsylvania can craft a benefit package that will improve the health and work performance of commonwealth employees.

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The Department was available to provide input and technical assistance to the various unions and health plans in crafting their benefit packages. The Department has been available to the State Civil Service Commission to provide feedback on laws that impact individuals with substance use issues.

PRIORITY: THE FORMATION OF LOCAL AGENCIES AND LOCAL COORDINATING COUNCILS, AND PROMOTION OF COOPERATION AND COORDINATION AMONG SUCH GROUPS, AND ENCOURAGEMENT OF COMMUNICATION OF IDEAS AND RECOMMENDATIONS FROM SUCH GROUPS TO THE PENNSYLVANIA ADVISORY COUNCIL ON DRUG AND ALCOHOL ABUSE

It is the position of the Department that no central authority can determine precisely what services are necessary in each of the 67 counties of the commonwealth. Therefore, 47 Single County Authorities (SCAs) have been established so that local input can be provided to the Department in a logical and coordinated manner. Advisory councils at the state and local level have been established so that input can be provided by consumers of drug and alcohol services, family members and treatment providers on policy, procedure, evidence based practices, research, regulation and training matters.

PROGRESS REPORT FY 2013-2014

The Department continues to meet regularly with the SCAs individually and through their organization, the Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA), to discuss issues of importance related to substance use services. Their concerns are addressed on an individual basis or as appropriate through PACDAA meetings and at Advisory Council meetings. Representatives from PACDAA have regularly attended Advisory Council meetings.

PRIORITY: DEVELOPMENT OF MODEL DRUG AND ALCOHOL ABUSE AND DEPENDENCE CONTROL PLANS FOR LOCAL GOVERNMENT, UTILIZING THE CONCEPTS INCORPORATED IN THE STATE PLAN.

The development of the state needs assessment and plan will provide a model for local planning. At the local level, the use of advisory councils and stakeholder workgroups to assess local data enables each SCA to obtain information about prevention, intervention, treatment and recovery issues that directly impact their community.

The Department has continued to work on a state needs assessment and plan which will provide guidance to SCAs for local planning. The Department anticipates completing the state needs assessment and plan during FY 2014-2015.

Medical providers play a key role in prevention, problem

identification and referral for treatment. Physician prescribing practices for controlled substances can impact the prevention or development of drug problems. The Department will work with the medical community to disseminate best practices related to frequently abused drugs.

PROGRESS REPORT FY 2013-2014

To address the high number of overdose deaths in Pennsylvania, the Department has formed an Overdose Rapid Response Task Force whose ultimate goal is to prevent overdose deaths. The Methadone Death and Incident Review Workgroup was created by Act 148-2012 to review and examine the circumstances surrounding methadone-related deaths and methadone-related incidents in the commonwealth for the purposes of promoting safety, reducing methadone-related deaths and methadone-related incidents and improving treatment practices.

The Department has been committed to having physicians trained in Screening, Brief Intervention and Referral to Treatment (SBIRT), especially Emergency Room physicians who come in contact with many individuals who have health related problems and are without healthcare coverage.

Prevention staff was part of the Department's effort to initiate a Task Force consisting of medical stakeholders and co-chaired by the Department's Secretary Gary Tennis and Physician General, Dr. Carrie DeLone. This group was formed in response to concerns regarding prescribing practices that resulted in the overprescribing of opiate medications. The focus of this group is:

- to identify and find consensus on best and safest prescribing and pain management practices, and
- to identify ways that the stakeholders at the table (representing various state Departments and private organizations) can most effectively promote those practices.

The initial meeting of this group was in December 2013; a second meeting occurred in April 2014 where the members unanimously approved prescriber guidelines for chronic, non-cancer pain.

PRIORITY: TO ENSURE COORDINATION OF RESEARCH, SCIENTIFIC INVESTIGATIONS, EXPERIMENTS, AND STUDIES RELATED TO THE CAUSE, EPIDEMIOLOGY, SOCIOLOGICAL ASPECTS, TOXICOLOGY, PHARMACOLOGY, CHEMISTRY, EFFECTS ON HEALTH, DANGERS TO PUBLIC HEALTH, PREVENTION, DIAGNOSIS AND TREATMENT OF DRUG AND ALCOHOL DEPENDENCE AND TO ENSURE CONFIDENTIALITY OF THE INDIVIDUALS WHO ARE THE SUBJECT OF SCIENTIFIC INVESTIGATION OR RESEARCH IS MAINTAINED.

Given our growing dependence on computers and the need for databases and registries, protection of an individual's privacy is paramount. A breach of confidentiality violates a person's rights and poses a risk of dignitary harm to the research participant ranging from social embarrassment and shame to stigmatization. Participation in research is voluntary and the Department fully recognizes its obligation to protect confidentiality. Written by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, the Belmont Report (1979) is the major ethical statement guiding human research in the United States and is the basis for U.S. federal research protections. The report sets out three fundamental ethical principles: respect for persons, beneficence and justice.

PROGRESS REPORT FY 2013-2014

Through cooperative activities with IRETA, the Department continues to investigate how best to maximize the potential for research and scientific activities that will impact the substance use field. Working with the University of Pittsburgh's Program Evaluation and Research Unit (PERU), the PCPC has been revised to more fully meet the needs of clinicians in the state. The PCPC has a full continuum of care (outpatient through residential care options) and allows for special needs considerations (Medication Assisted Treatment, co-occurring disorders, criminal justice, etc.) when a clinician is working with a person to make a level of care determination. With PA having the full continuum of care, which encompasses evidence based practices, it is possible for research to begin on how best to utilize funding for all levels of care.

The Department continually explores funding opportunities for research that may be available and has received several grants including the Strategic Prevention Framework-Partnerships For Success (SPF-PFS) and the Cooperative Agreement to Benefit Homeless Individuals (CABHI) for states.

PRIORITY: INVESTIGATE METHODS FOR THE MORE PRECISE DETECTION AND DETERMINATION OF ALCOHOL AND CONTROLLED SUBSTANCE IN URINE AND BLOOD SAMPLES, AND BY OTHER MEANS, AND PUBLICATION ON A CURRENT BASIS OF UNIFORM METHODOLOGY FOR SUCH DETECTIONS AND DETERMINATIONS

The Department encourages the sharing of information around drug testing developments and technologies through the use of its Listserve and website. As information is gathered, this material is passed to the field in an expeditious manner. Trainings on drug testing are reviewed for possible inclusion

in an educational curriculum to the field. Specific trainings on synthetic drugs will be offered so that the field is informed on the detection of and the effects of these drugs.

PROGRESS REPORT FY 2013-2014

As appropriate, the Department and staff from the Pennsylvania Department of Health, Bureau of Laboratories review best practices in testing methodology and provide information to the substance use field. The Department staff are monitoring trends in the area of effective drug testing, and support training in these best practices. Current trends include the development of strategies related to the detection of synthetic drugs.

PRIORITY: FACILITATE TRAINING PROGRAMS FOR PROFESSIONAL AND NONPROFESSIONAL PERSONNEL WITH RESPECT TO DRUG AND ALCOHOL ABUSE AND DEPENDENCE, INCLUDING THE ENCOURAGEMENT OF SUCH PROGRAMS BY LOCAL GOVERNMENTS.

The Department offers a robust training program that includes courses for the professional and non-professional alike. It is the Department's belief that a well-educated workforce can best provide quality services in a cost efficient manner and thus improve outcomes for individuals impacted by drug and alcohol use.

PROGRESS REPORT FY 2013-2014

The Department continues to offer trainings to the substance use field through mini-regionals, regional training institutes, and on-sites. Specialty courses such as SBIRT, Women and Children Issues, FASD, STAR, Underage Drinking, etc. were provided to varying stakeholder audiences/professionals and the Department continues to encourage the development of new courses that may be offered in its curriculum.

By providing training to the community, the Department continues its commitment to better provide knowledge and information to individual citizens who can impact substance use in their locality.

PRIORITY: SUPPORT A SYSTEM OF COLLABORATIVE EMERGENCY MEDICAL SERVICES FOR PERSON'S VOLUNTARILY ENTERING TREATMENT.

The Department is committed to ensuring that all individuals seeking treatment are able to access it in a timely manner. When an individual is screened through the SCA system, emergent care needs that are identified must be addressed immediately. Emergent care needs consist of detoxification, prenatal care, perinatal care and psychiatric care. Individuals seeking drug and alcohol treatment services may be assessed at detox facilities, hospitals, correctional facilities and/or mental health facilities.

PROGRESS REPORT FY 2013-2014

The Department continues to support the availability of medically monitored and medically managed detoxification. The Department requires that individuals in need of detox be admitted to such services within 24 hours. Training is available on emergent care needs as well as on the areas of screening and assessment. The Department also requires that the SCAs prioritize many populations; individuals who overdose, are pregnant, women with dependents, and intravenous drug use, so that they may be able to access services in a timely manner.

PRIORITY: TO GATHER AND PUBLISH STATISTICS PERTAINING TO DRUG AND ALCOHOL ABUSE AND DEPENDENCE AND PROMULGATE REGULATIONS, SPECIFYING UNIFORM STATISTICS TO BE OBTAINED, RECORDS TO BE MAINTAINED AND REPORTS TO BE SUBMITTED BY PUBLIC AND PRIVATE DEPARTMENTS, AGENCIES, ORGANIZATIONS, PRACTITIONERS AND OTHER PERSONS WITH RESPECT TO DRUG AND ALCOHOL ABUSE AND DEPENDENCE, AND RELATED PROBLEMS.

The Department gathers statistical information on the prevalence and incidence of substance use throughout the commonwealth with both STAR and PBPS data systems. The information obtained by the Department is used to drive decision making relative to the drug and alcohol service system.

PROGRESS REPORT FY 2013-2014

The Department mandates that certain information be collected by the SCAs and their providers in compliance with federal reporting requirements. Through the use of STAR, information is collected that provides specific details related to gender, age, substance use, employment, education, criminal justice activity, referral source, marital status, etc., on individuals involved in the publicly funded drug and alcohol service system. Additionally, prevention related activities are collected through PBPS. Reports are then generated to give a snapshot of the status of drug and alcohol use within the commonwealth.

The Department continues to offer training on the use of STAR and PBPS so that SCAs and providers can provide the most accurate data for reporting purposes.

PRIORITY: INCREASE ACCESS TO SUBSTANCE ABUSE TREATMENT AND RECOVERY SUPPORT SERVICES THROUGH THE EXPANSION OF CONSUMER CHOICE AND INCREASE SERVICE CAPACITY THROUGH A NETWORK OF COMMUNITY AND FAITH-BASED PROVIDERS WITHIN THE PHILADELPHIA SERVICE REGION THROUGH IMPLEMENTATION OF THE ACCESS TO RECOVERY (ATR) GRANT.

Access to Recovery (ATR) is a four year, federal, discretionary grant that was awarded to the Department and its project partner, Philadelphia SCA, in 2010. The project supports SAMHSA's initiatives to build capacity for the delivery of services, both treatment and recovery support services at the community level, thus providing individuals with access and choice. These concepts are foundational to ROSC and recovery principles. As research continues to be done on successful recovery maintenance, the delivery of services through a ROSC is being substantiated as both supportive of recovery and cost effective. The ATR program is assisting Philadelphia with its implementation of ROSC. It is hoped that lessons learned from the project might be useful for system implementation elsewhere in the commonwealth.

ANNUAL REPORT FY 2012-2013

The Department partnered with the Philadelphia Single County Authority (SCA) which is the Department of Behavioral Health and Intellectual Disability Services (DBHIDS) Office of Addiction Services (OAS) to implement this four year project. The project was designed to provide uninsured or underinsured adults with alcohol or other drug challenges an array of options and choices of providers to obtain clinical treatment and enhanced recovery support services through a voucher system. Within the uninsured or underinsured target population, the project prioritized several sub-populations for inclusion through specific eligibility criteria which includes people experiencing homelessness, individuals re-entering society from the criminal justice system, pregnant or parenting women and veterans.

In September 2010, the Department was awarded a four year grant totaling \$11,889,262 for the period of September 30, 2010 to September 29, 2014 from the Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Treatment (CSAT) to implement an Access to Recovery (ATR) program in Philadelphia County. The focus of the grant is to expand access to recovery through the provision of an array of treatment and recovery supports at the local level by

traditional, as well as faith-based and grass root organizations in its provider network, with an emphasize on participant choice. The grant requires a specific number of clients to be served with designated annual funding amounts that vary for each year of the project. Funding by year for the four year project includes \$2,617,201 for the first year which began September 30, 2010 and ended September 29, 2011. The project received continuation funding for the second year which included \$3,249,418 from September 30, 2011 through September 29, 2012. Continuation funding for the third year was secured in the amount of \$3,221,322 for the period of September 30, 2012 through September 29, 2013. If the project continues to be funded, the fourth year would include \$2,801,321 from September 30, 2013 through September 29, 2014. Throughout the entire four year project 10,705 clients will receive ATR services with this grant funding.

The project was fully operational on January 31, 2011 as required by the notice of grant award. During the initial implementation period the project focused on staff and provider recruitment and training, client enrollment and enhancements to the voucher management system (VMS). The provision of recovery support services continued to be the key focal point during the year. These services were aimed at helping individuals engage in recovery, enable them to obtain or remain in treatment, help them transition their lifestyles away from addiction and provide recovery coaching to maintain a life in recovery.

During the second year, the SCA provider network was expanded to 57 recovery support service providers; 22 of which are ATR evaluation sites. This expanded provider network is comprised of additional faith-based and community-based providers aimed at reaching individuals that might not otherwise receive treatment or recovery support services. This expansion facilitated the inclusion of additional recovery support services which currently includes an assortment of fifteen services. In addition, unexpended funds from the first year were transferred to the second year via an approved carryover plan, thus facilitating new service categories including: Enhanced Educational Support, Employment/Vocational Training Expansion, and Clinical Assessments in non-traditional settings. Also during the second grant year, project advancements were made to improve training and service structures, voucher and fiscal management, assertive outreach and engagement as well as collaborative partnership development.

PROGRESS REPORT FY 2013-2014

Services in the third year of the grant have continued as described, with the addition of vouchered care coordination services. The project concluded the third year on September 29, 2013 having served 3,038 participants. In this fourth and final year of the project 1621 individuals have been served since September 30, 2013 to date, with a total of 11,063 individuals

having received services since the inception of the project. Staff is engaging in strategic planning to continue the provision of services through the life of the grant while winding down services overall. The provider network continues to have 48 providers of recovery support services, as well as the option to include treatment services as necessary.

PRIORITY: To DECREASE THE OCCURRENCE OF OVERDOSE BY IMPLEMENTING MULTIFACETED, COLLABORATIVE APPROACHES.

Background: As is summarized by the CDC in its “Prescription Drug Overdose in the United States Fact Sheet”, drug overdose was the leading cause of injury death in 2011. Among people 25 to 64 years old, drug overdose caused more deaths than motor vehicle traffic crashes. Drug overdose death rates have been rising steadily since 1992 with a 118% increase from 1999 to 2011 alone. In 2011, 33,071 (80%) of the 41,340 drug overdose deaths in the United States were unintentional, 5,298 (12.8%) of suicidal intent, and 2,891(7%) were of undetermined intent. In 2011, drug misuse and abuse caused about 2.5 million emergency department (ED) visits. Of these, more than 1.4 million ED visits were related to pharmaceuticals. In 2011, of the 41,340 drug overdose deaths in the United States, 22,810 (55%) were related to pharmaceuticals. Of the 22,810 deaths relating to prescription drug overdose in 2011, 16,917 (74%) involved opioid analgesics (also called opioid pain relievers or prescription painkillers), and 6,872 (30%) involved benzodiazepines. In the United States, prescription opioid abuse costs were about \$55.7 billion in 2007. Of this amount, 46% was attributable to workplace costs (e.g., lost productivity), 45% to healthcare costs (e.g., abuse treatment), and 9% to criminal justice costs.

PROGRESS REPORT FY 2013-2014

An Overdose Rapid Response Task Force (ORRTF) was convened by the Department of Drug and Alcohol Programs (DDAP) comprised of a wide range of stakeholder representatives including, but not limited to: Office of the Governor, Attorney General’s Office, Pennsylvania Coroner’s Association, Drug and Alcohol Service Providers Organization of Pennsylvania, Drug Enforcement Administration, Department of Health, Department of Human Services, Capitol Police/State Police, Pennsylvania Association of County Drug and Alcohol Administrators, Pennsylvania Association for the Treatment of Opioid Dependence, Pennsylvania District Attorneys Association, Philadelphia/Camden High Intensity Drug Trafficking Areas, as well as representatives from the federal Substance Abuse and Mental Health Administration.

The ORRTF was convened in response to a possible upsurge

in the use of Fentanyl with the first meeting having occurred on July 22, 2013, with seven subsequent meetings held during the fiscal year. Given the overall increase in overdose in general, the consensus of the group was to focus on overdose prevention and response in general, rather than to focus on one particular substance of abuse. The objectives of the Task Force are: 1) Determine particular Overdose Trends as a proactive/preventative measure; 2) Determine what avenues exist or can be established to communicate trends between state agencies/organizations; 3) Determine cross-system collaborative efforts for addressing identified trends/issues; 4) Deter an upsurge in use of a particular trending substance, and 4) To ultimately prevent overdose deaths.

There are five workgroups that have been established including the Coroner’s Workgroup, the Health Department Workgroup, the Treatment/Warm Hand-off Workgroup, the Information Sharing Workgroup, and the Naloxone Workgroup. Each workgroup has been tasked with addressing particular objectives. Achievements to date include, but are not limited to: the creation of a unified report form to be completed by coroners and submitted to the Department for the timely collection of overdose data and occurrence, ongoing assessment of existing data bases that currently collect overdose information to determine usefulness of information and how to best share for the purposes of overdose prevention and response, the requirement of Single County Authorities to create overdose policies and establish relationships with local healthcare providers and to facilitate referral to substance abuse treatment for survivors of overdose, the creation of an information portal through a Homeland Security Information Network portal, collaboration and partnership among state stakeholders involved in the various aspects of overdose, and the potential for increasing naloxone access for use in responding to overdose, expedient response to overdose; appropriate and increased overdose training and awareness, etc.

As has been described, in May 2014, Governor Corbett established The Governor’s Heroin and Other Opioid Workgroup comprised of representatives from all agencies in state government to develop a comprehensive, multi-faceted approach to address the problem of heroin and other opioid use and overdose death. By its very nature, this initiative was and is not the Department’s alone, but is a collaborative effort for which the department has been tasked to facilitate and provide oversight and assistance with implementation of the various strategies. Governor Corbett unveiled his recommendations as directed by this workgroup in September 2014. Throughout the upcoming year, the Department will collaborate with the necessary state agencies and other stakeholder groups necessary for moving the identified recommendations forward. This cross-agency initiative to address and reduce overdose deaths in the Commonwealth supplements and strengthens previously implemented initiatives intended for this purpose.

EVALUATION & CONTRACT COMPLIANCE

The Department of Drug and Alcohol Programs (DDAP), Bureau of Quality Assurance for Prevention and Treatment, Evaluation and Contract Compliance Division¹ has the primary responsibility to oversee the Single County Authorities' (SCAs) adherence to grant agreement requirements and to evaluate the SCAs' efficacy in carrying out their administrative functions, 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, 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 Division staff, in collaboration with the Department'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 quality in the local drug and alcohol service delivery system; 2) addresses emergent care needs; 3) ensures timely access to assessment and treatment services and appropriate utilization of 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) ensures the implementation of 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.

PRIORITY: ON-SITE QUALITY ASSURANCE ASSESSMENT REVIEW MONITORING OF SINGLE COUNTY AUTHORITIES (SCAs).

ANNUAL REPORT FY 2012-2013

The Department's five-year grant agreement began July 1, 2010. The onsite monitoring for FY 2011-2012 began in March 2012 and ended in October 2012. For FY 2012-13 the Division began onsite monitoring of all 47 SCAs in June 2013. The Department implemented a 12-month monitoring process incorporating the annual onsite review with an in-depth interoffice review to verify adherence to Department grant agreement requirements. The Department continued to focus the review from a management perspective, as well as adherence to compliance of the grant agreement requirements.

PROGRESS REPORT FY 2013-2014

In October, 2013, the Division completed the monitoring review process of all SCAs that began in June 2013. The Division's process not only reviews compliance with Grant Agreement requirements, but also evaluates the overall effectiveness of the SCA's management of the service delivery system. The purpose of the on-site portion of the QAA process focuses primarily on

ensuring timely access to, and retention in, the appropriate level of service. In addition, the Division reviews the SCA's process for tracking of funding sources and payment to providers. In order to make effective use of the amount of time spent on-site, the Division incorporated the use of pre-submitted materials, conference calls, technical assistance, and in-house review and evaluation.

In collaboration with the Bureau of Administration, the Division is developing its web-based application, currently utilized by the SCAs for reporting of contract data, to include a fiscal reporting component. The modifications to the web-based application, known as the SCA Data Site (SDS), will replace a portion of the Department's hardcopy fiscal reporting package. In addition, beginning with the fiscal reporting for state fiscal year ending June 30, 2014, SCAs will be required to enter more detailed information into the SDS related to the expenditure of Department funds as well as other funding sources. This will allow the Department to more accurately report on the use of state and federal funds for the delivery of substance use and gambling disorder services. The Division intends to incorporate the remainder of the fiscal reporting package into the SDS prior to the implementation of the next Grant Agreement, in July 2015.

(1.) Fall 2014, Evaluation and Contract Compliance (Division) was changed to Accountability and Program Improvement (Division) as part of the agencies overall restructuring plan.

PROGRAM LICENSURE

The Program Licensure Division in the Bureau of Quality Assurance for Prevention and Treatment is responsible for licensing free-standing drug and alcohol treatment facilities. These responsibilities are carried out pursuant to the powers 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 of Drug and Alcohol Programs (DDAP) by Act 50 of 2010. The Division is responsible for the licensure of any partnership, corporation, proprietorship, or other legal entity intending to provide drug and alcohol treatment services. The Department has regulatory responsibility through its licensure authority over both public and private drug and alcohol treatment facilities.

Drug and alcohol treatment activities which are a part of a health care facility are also subject to the requirements under 28 Pa. Code, Part IV. The facility receives a license under the Health Care Facility Act, 35 P.S. § 448.101 et. seq., which covers the general operations of that facility. The Department also issues a certificate of compliance to the drug and alcohol component within the facility which certifies that program areas meet the minimum standards germane to drug and alcohol treatment under the Pennsylvania Drug and Alcohol Abuse Control Act (71 P.S. §§ 1690.101-1690.115).

Facilities which use methadone in the treatment of narcotic abuse are subject to the regulations in 4 Pa. Code, Chapter 715 and must be approved by the Department.

PRIORITY: TO PROVIDE STANDARDS FOR THE APPROVAL BY THE RELEVANT STATE AGENCY FOR ALL PRIVATE AND PUBLIC TREATMENT AND REHABILITATIVE FACILITIES.

procedures to reduce the administrative burden and redundant inspections experienced by the providers. The Department has reviewed relevant regulations, along with feedback from community providers and has developed changes that will streamline regulations and has streamlined the inspection process and reduced redundancy. The pre-survey application process has been streamlined, effectively reducing the time for completion from a six month average to a 60 day average. The time spent on site by Drug and Alcohol Licensing Specialists has been reduced the amount of time that was previously spent on site. The use of written facility attestations and pre-submission of licensure materials has also saved the Department on travel expenses and human resources. Finally the General Standards for Free Standing Treatment Facilities have been revised and updated and will be published as final early in FY 2014 – 2015.

ANNUAL REPORT FY 2012-2013

The Department continually reviews policies, procedures, and regulations to determine their effectiveness in providing and implementing quality and evidence based programming. The Department has worked with provider associations to review regulations and offer recommendations to help reduce redundancy and administrative burden while still ensuring that quality services are provided in a safe and confidential manner.

PROGRESS REPORT FY 2013 -2014

Licensing standards and regulations exist for those facilities that provided drug and alcohol treatment within the Commonwealth. The Division will continue to work with the office of General Counsel to revise the activity specific regulations, staffing requirements and the standards for approval of Narcotic Treatment Programs.

The Bureau of Quality Assurance for Prevention and Treatment, Program Licensure Division, is responsible for ensuring that facilities providing drug and alcohol treatment services meet minimum standards for patient care and safety based on the current regulations.

The Department, acting on the recognition that facilities have been made to undergo multiple inspections throughout the year, has revised and implemented internal policy and

BUREAU OF QUALITY ASSURANCE, OVERVIEW OF REVIEWS YEAR TO DATE	
Requests for applications/standards processed	170
Initial and renewal licensing inspections conducted	749
Incident reports received and evaluated	609
Complaints investigated	173
Presurvey Manuals Reviewed	86
Narcotic Treatment Program monitoring inspections conducted	104

BUDGETS & GRANTS MANAGEMENT

The Budget and Grants Management Division is contained within the Bureau of Administration and Program Support. This Division is responsible for fiscal management and the procurement and contractual needs of the Department of Drug and Alcohol Programs (DDAP). The Division is the liaison for the receipt of federal and state funds and is responsible for the appropriate distribution of these funds to the Single County Authorities (SCAs), the local administrative entities responsible for the management of services at the local level, as well as for goods and services directly administered at the state level. Specific roles of the staff in this Division include, but are not limited to, budget development, fund allocation, contract development, payment processing, financial reporting, and audit management functions.

PRIORITY: TO PROVIDE GRANTS AND CONTRACTS TO LOCAL GOVERNMENTS AND PUBLIC AND PRIVATE AGENCIES, INSTITUTIONS AND ORGANIZATIONS FOR THE PREVENTION, INTERVENTION, TREATMENT, REHABILITATION, RESEARCH, EDUCATION AND TRAINING ASPECTS OF SUBSTANCE USE DISORDERS.

The Department contracts with the SCAs for the provision of prevention, intervention, treatment, and recovery support services in their respective communities. The Department also provides funding to various entities throughout the Commonwealth for treatment, prevention, recovery, education and training related services. These agencies include Pennsylvania Recovery Organizations Alliance (PRO-A), Department of Corrections (DOC), Department of Human Services (DHS), and Gaudenzia, Inc. Additionally, the Department partners with local agencies for the administration of federal discretionary grants that it receives such as the Access To Recovery (ATR) and the Strategic Prevention Framework-State Incentive (SPF SIG) grants. The Department issues Requests for

Proposals and reviews these requests for funding and issues awards as deemed appropriate.

The Department also monitors for federally funded and other grant opportunities which could be sought to increase funding and collaboration with community partners. The Department has supported Pennsylvania Commission on Crime and Delinquency (PCCD) granting of funds to the Pennsylvania District Attorney's Association to increase the availability of permanent drug take-back repositories. The Department has submitted applications for a range of potential opportunities.

TRAINING

The Department of Drug and Alcohol Programs' (DDAP) training system provides continuing education and skill-building courses in order 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. The Department 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 (MRTR's) are one-day events containing up to four core or basic courses. The MRTR's 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 MRTR's.

On-Site Trainings

The on-site trainings allow service providers and 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 the Department 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.

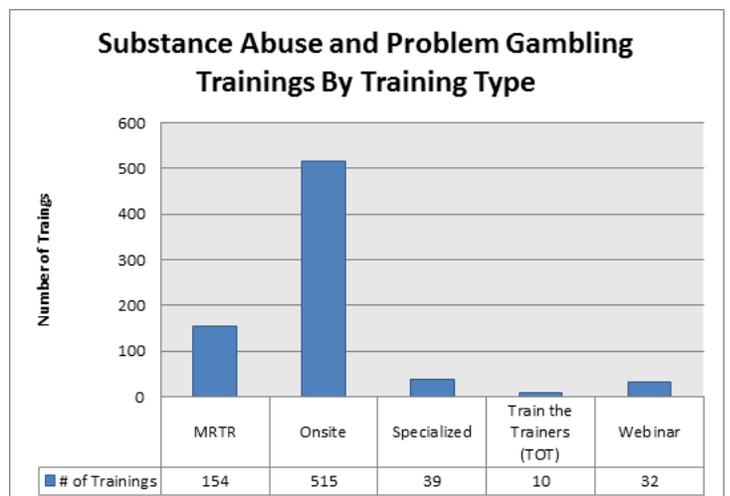
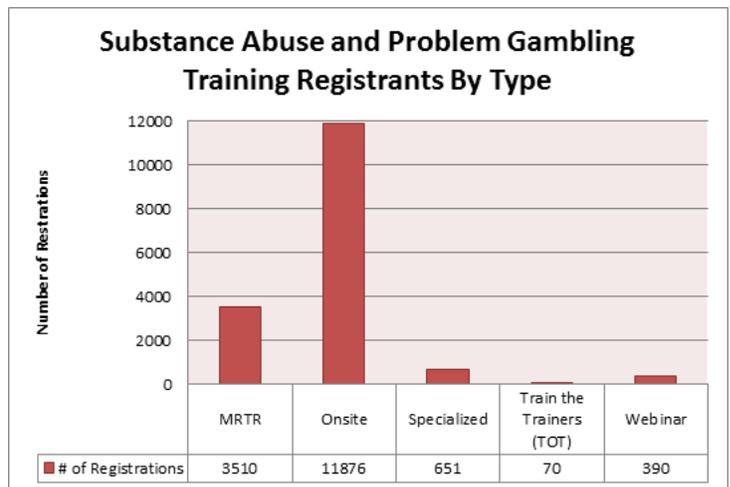
Regional Training Institutes

The Regional Training Institute is a five-day event designed to offer higher level courses to the substance abuse field. This event was not held during this reporting year 2012-2013 and is typically held once each year. As with all our trainings, courses offered in the Regional Training Institutes offer Certified Addiction Counselor and NASW credits so that employees can maintain their PCB and/or NASW certifications.

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 <https://apps.ddap.pa.gov/clearinghouse>.





WOMEN AND CHILDREN'S ANNUAL REPORT

STATE FISCAL YEAR 2012-2013

Act 65 of 1993 authorizes the DOH to establish and fund residential drug and alcohol treatment programs for pregnant women and women with dependent children. This responsibility was transferred to the Department pursuant to Act 50 of 2010. The Department contracts with Single County Authorities (SCAs) who authorize 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 offer specific services to this population. Such services are SAPT Block Grant requirements.

Consistent with that mandate, the Department 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 or 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 2012-2013, service capacity for women and women with children was as follows (Note: The following numbers are conditional upon space and the number of people residing at each facility at any given time):

Programs providing residential treatment services exclusively for pregnant women or women with dependent children

- Total Capacity for Women = 266
- Total Capacity for Children = 442
- Residential Programs for Women = 10
- Total Capacity = 174

Halfway House Programs, one of which allows women to bring their children

- Total Capacity for Women = 348
- Total Capacity for Children = 28+

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 as through agreements with prevention providers or

specially trained child development staff.

Expected outcomes for 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 and 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 2012-2013, the following residential women with children programs were in operation:

- Abstinent Living at the Turning Point at Washington (Women with Children) Julie's House
- Family Links, Inc. in Allegheny County
- Family Links - Family Treatment Center Frankstown in Allegheny County
- Gaudenzia, Inc. - Fountain Springs in Schuylkill County
- Gaudenzia, Inc., Vantage House in Lancaster County
- Gaudenzia, Inc. Winner Co-occurring Women and Children Program in Philadelphia County
- Gaudenzia Kindred House in Chester County
- Gaudenzia New Image in Philadelphia County
- Genesis II, Inc. DBA Caton Village in Philadelphia County
- Interim House West in Philadelphia County
- Libertae Family House Libertae, Inc. in Bucks County
- My Sister's Place, Thomas Jefferson University in Philadelphia County

- RHD Family House in Montgomery County
- RHD Family House NOW (New Options For Women) in Philadelphia County
- Samara House of CYWA in Chester County
- Sojourner House, Inc. in Allegheny County
- Mary E. Steratore Addiction Treatment Center in Fayette County
- Mirmont Treatment Center in Delaware County
- RHD – Womanspace in Montgomery County
- RHD – Womanspace in Philadelphia County
- Turning Point Chemical Dependency Treatment Center (Freedom Center) in Venango County

In addition, there were 16 halfway house programs that specifically provided services to women. Some of these facilities can accommodate pregnant women and two facilities are able to accommodate women with their children:

- Abstinent Living at the Turning Point at Washington, Inc. in Washington County
- Another Way in Fayette County
- Catholic Charities Diocese of Harrisburg, PA, Inc. (Evergreen House) in Dauphin County
- Clem-Mar House, Inc. in Luzerne County
- Cove Forge Renewal Center in Cambria County
- Gaudenzia - New Destiny in Schuylkill County
- Gaudenzia Erie Inc., Community House in Erie County
- Libertae, Inc. in Bucks County
- Pyramid Healthcare – Belleville in Mifflin County
- Pyramid Healthcare, Inc., Pine Ridge in Pike County
- Pyramid Healthcare, Inc., Tradition House in Blair County
- PA Organization for Women in Early Recovery (POWER) in Allegheny County
- The Gate House for Women in Lancaster County
- The Highland House, Inc. in Lawrence County
- The Lighthouse for Women of Greenbriar Treatment Center in Washington County
- Myah's House of Hope in Armstrong County

There were 10 facilities across the Commonwealth that provided residential treatment programs for women:

- Eagleville Hospital in Montgomery County
- Gaudenzia, DRC, Inc. in Philadelphia County
- Gaudenzia Together House in Philadelphia County
- Greenbriar Treatment Center in Washington County
- Interim House, Inc. in Philadelphia County

The Department continued to support the provider organization, Women and Their Children Heal (WATCH). WATCH consists of residential and outpatient treatment providers statewide who provide drug and alcohol treatment services to women, pregnant women and women with children, particularly serving women within a gender-specific model of care. Their 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. Department staff continued to serve as a liaison to WATCH, attended meetings, provided administrative support and facilitated collaboration between this group and other state agencies. The Department continued to utilize this group's expertise as a resource as they provided feedback regarding the provision of women's treatment services, best practices, provider education and other needs facing this population. WATCH developed a training comprised of best practices for the provision of treatment services to women. This gender-responsive training entitled "Gender-Responsive: Treatment that Matters for Women with Substance Use Disorders," has been available since October 2011. The Department will continue to provide technical assistance to WATCH as they continue to facilitate this training throughout the Commonwealth and modify the curriculum as needed. The Department will continue to support WATCH and utilize this resource to ascertain feedback relative to women's treatment services, best practices, provider education and other needs facing this population.

In addition, the Department continued to host the Women's Treatment Forum, a venue designed to educate and inform drug and alcohol treatment providers about the current gender-specific needs and issues surrounding the women they serve as well as possible resources to assist with such practices. It is an opportunity to bring treatment providers together annually to discuss women-centered and need-specific programming for women and children, as well as share best practices for the provision of treatment services to women. This year's speaker was Super Star, and the event was entitled "Living a Life with Purpose: Rebranding Sobriety, Personal Responsibility, & Dream Catching". Super Star is a musician, author, and motivational speaker. He was a former owner of a successful, cutting-edge computer consulting firm and lost it to drug addiction. He shares his message with school, community, treatment and church groups, and hosts a Rockin' Recovery Tour for National Recovery Month each September at venues across the country. Plans are underway for the upcoming women's treatment forum to occur in May 2014.

PART 2: PROGRAM DATA AND FINANCIAL INFORMATION



CHAPTER 1

Overview of Program Data

THIS CHAPTER PROVIDES COLLECTED PROGRAM DATA BY THE
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS. THE CHAPTER INCLUDES ALL
SYSTEM AND FISCAL DATA COLLECTED FOR FY 2012-2013.



Prevention Data Analysis State Fiscal Year 2012-2013

To help Pennsylvanians lead healthier and longer lives, the Department promotes a structured, community-based approach to substance abuse prevention through prevention and intervention policies and practices that are based on the latest research within the substance abuse field. The framework aims to promote youth development, reduce risk-taking behaviors, build assets and resilience and prevent problem behaviors across the individual's life span. This report approach provides information that can be used by communities to build an effective and sustainable prevention infrastructure. 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 services reported through the PBPS. The total number of prevention services has continued to increase over the past five years. State Fiscal Year 2012-2013's increase of 8,692 services overall is mainly attributed to an increase in additional recurring services across Pennsylvania.

Prevention Services by Single and Recurring Type

Figure 2 details all single and recurring services across the state with the move towards a more recurring reinforcement approach to service delivery. This increase in the number of recurring services is in part due to a more defined policy requirement, specifically, 20 percent of all prevention services provided must be recurring in nature. The commonwealth, 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 increased over the last five State Fiscal Years (SFYs). 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 SFYs following the new policy, total attendees and total participants numbers have been increasing steadily.

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 2008-2009 through 2012-2013

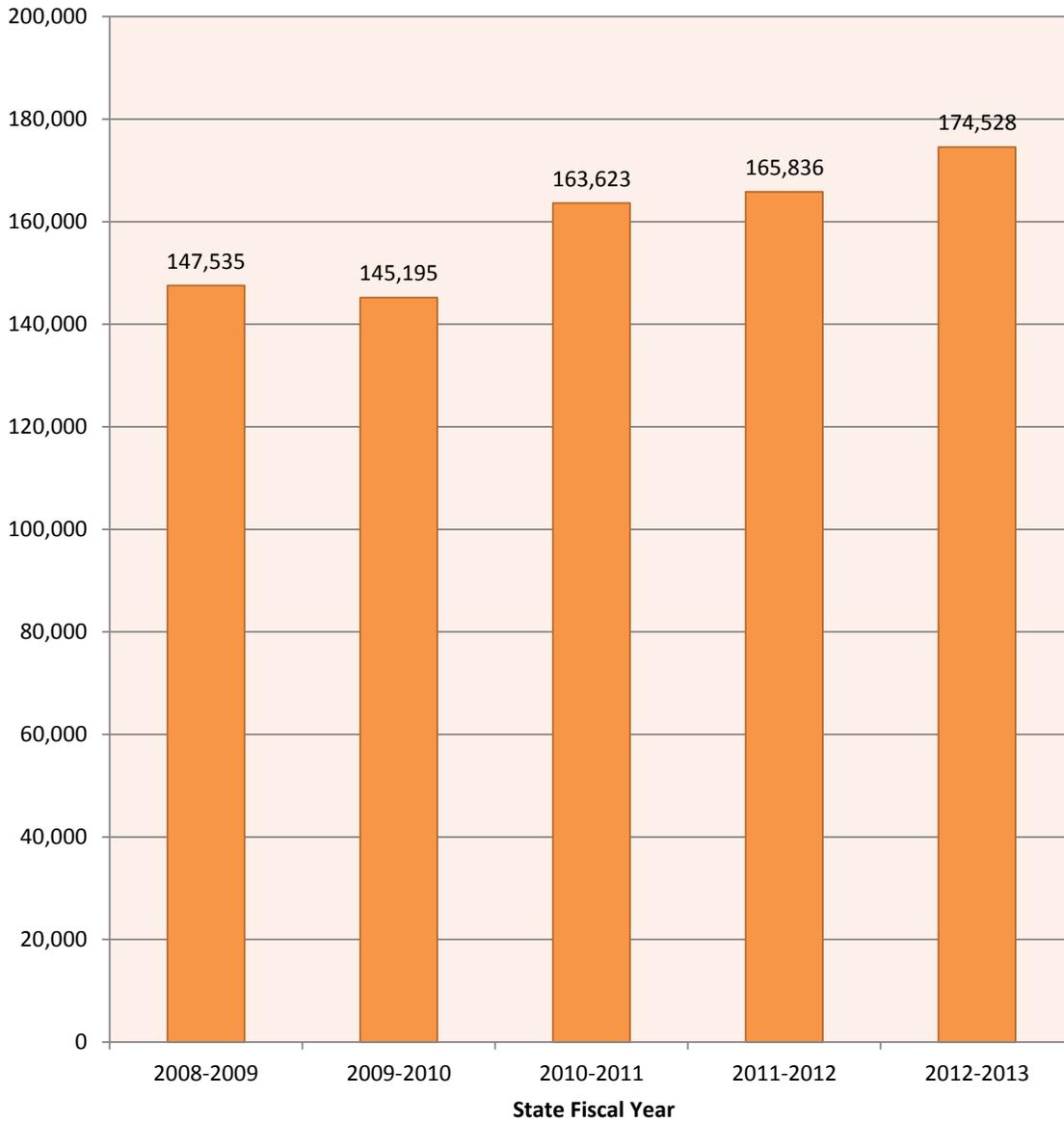


Figure 2

Single and Recurring Prevention Services as Reported to PBPS State Fiscal Years 2008-2009 through 2012-2013

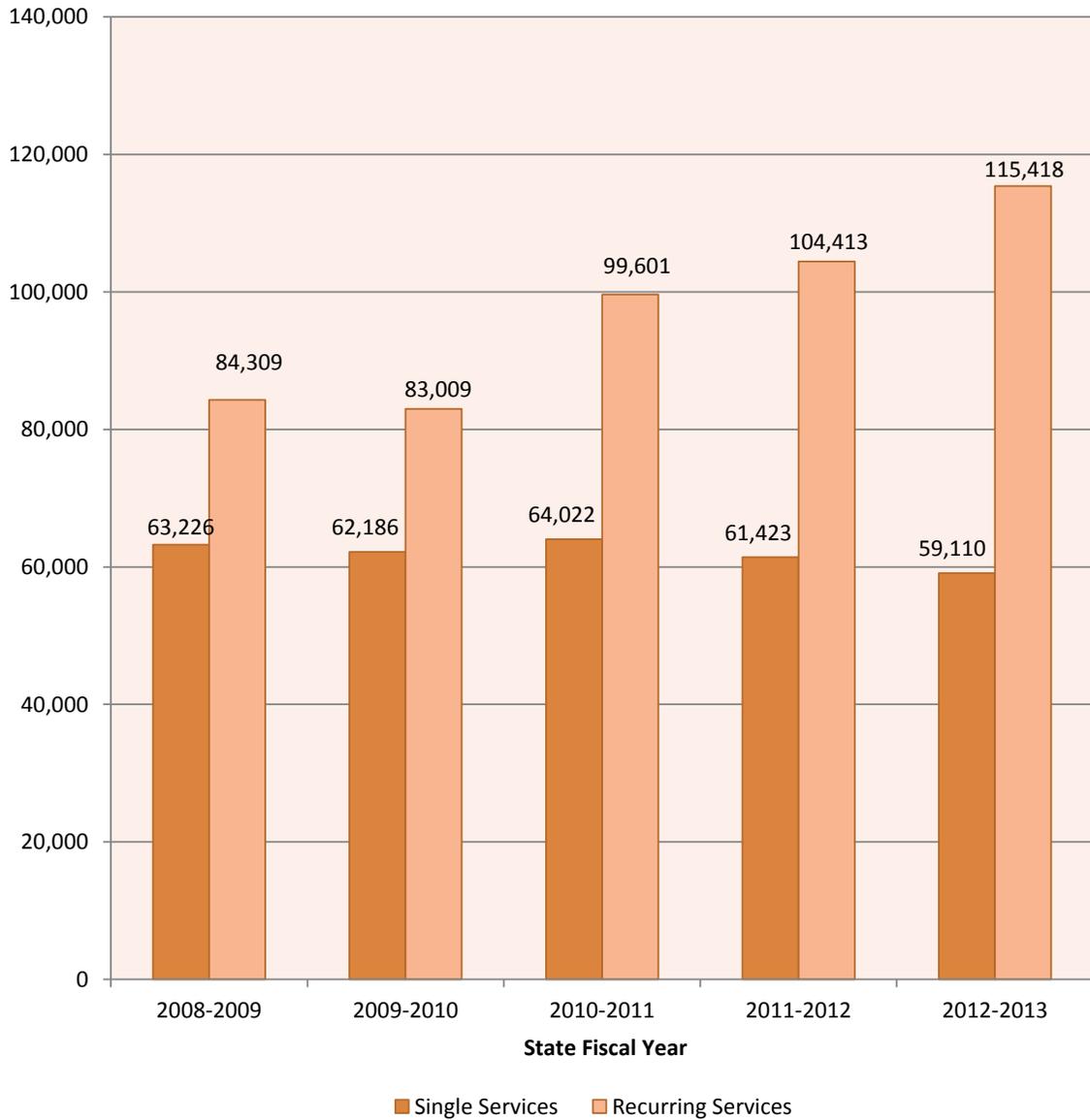
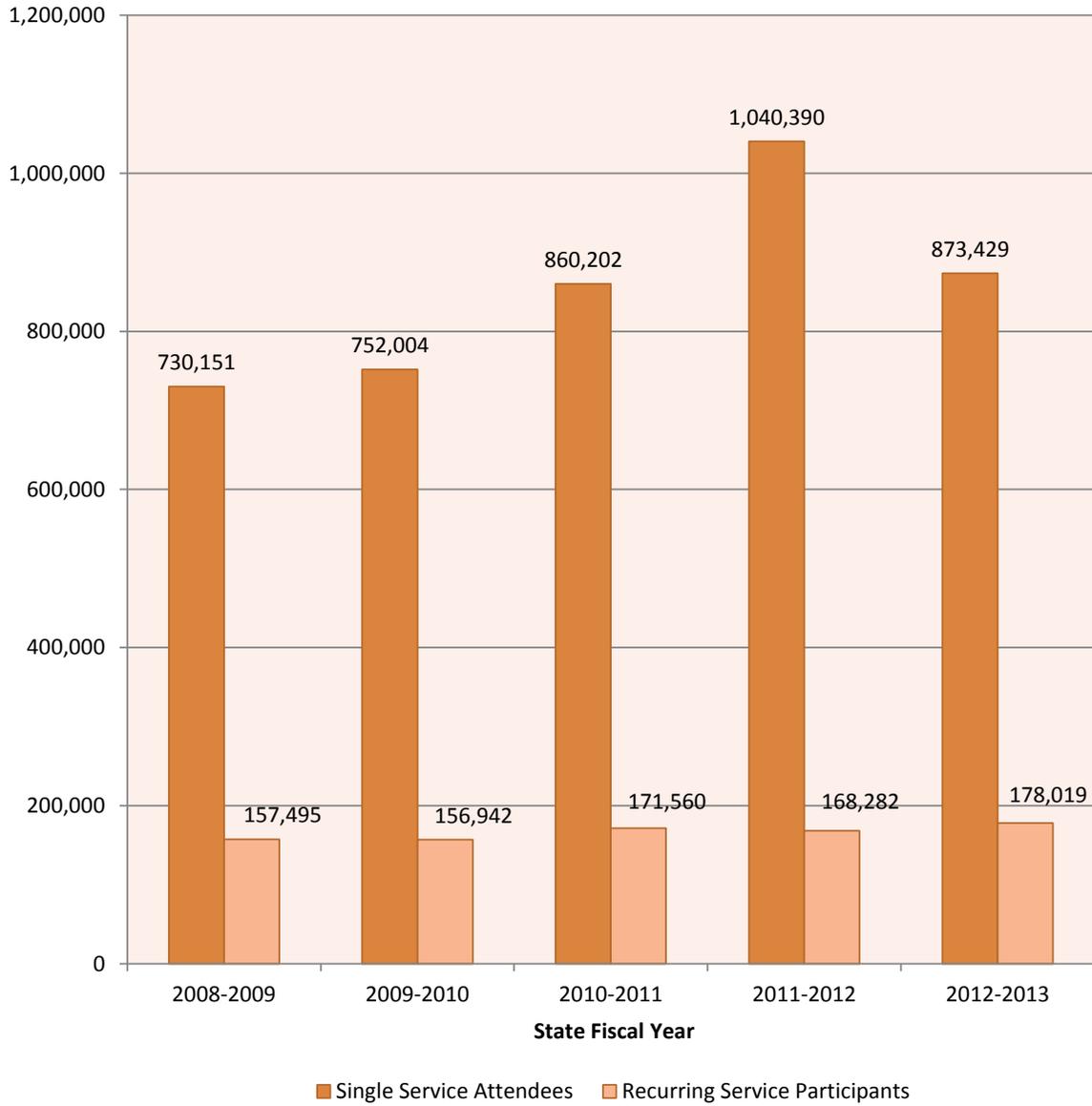


Figure 3

Prevention Service Attendees and Participants State Fiscal Years 2008-2009 through 2012-2013



Evidence-based Programs, State Approved Programs, and State Approved Strategies

The graph in Figure 4 demonstrates a five-year trend of the three prevention service categories: Evidence-Based Programs, State Approved Programs, and State Approved Strategies. In a move towards a more accountable approach, the Department required a minimum of 25 percent of services through Evidence-Based Programs and State Approved Programs. There has been an increase in Evidence-Based and State Approved Program services. Evidence-Based and State Approved programs provide more rigor and effectiveness than State Approved Strategies.

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
- Evaluation findings have been subjected to critical review by other researchers
- Replicated and produced desired results in a variety of settings

State Approved Programs meet the following criteria:

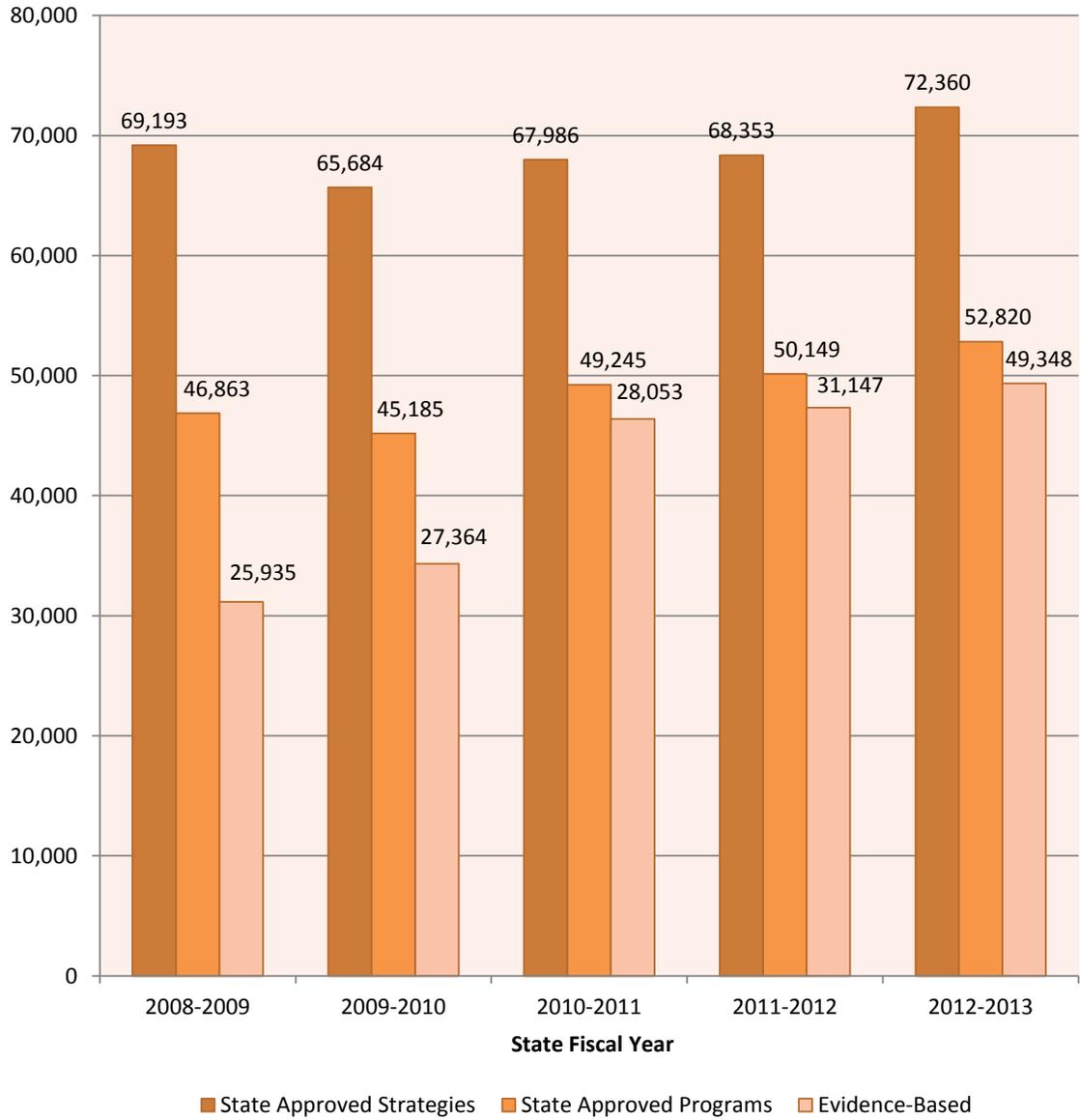
- Program/principle has been identified or recognized publicly and has received awards, honors or mentions
- Program/principle has appeared in a non-referred professional publication or journal
- Programs/Principle must have an evaluation that includes, but is not limited to, a pre/posttest and/or survey.

State Approved Strategies are defined as programs which:

- Capture activities that utilize methods of best practice
- Provide basic alcohol, tobacco and other drug awareness/education, as well as everyday alternative prevention activities
- Captures strategies that address population-level change
- Captures activities necessary to implement or enhance evidence-based and state approved programs

Figure 4

Prevention Services by Program Category as Reported to PBPS State Fiscal Years 2008-2009 through 2012-2013



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:

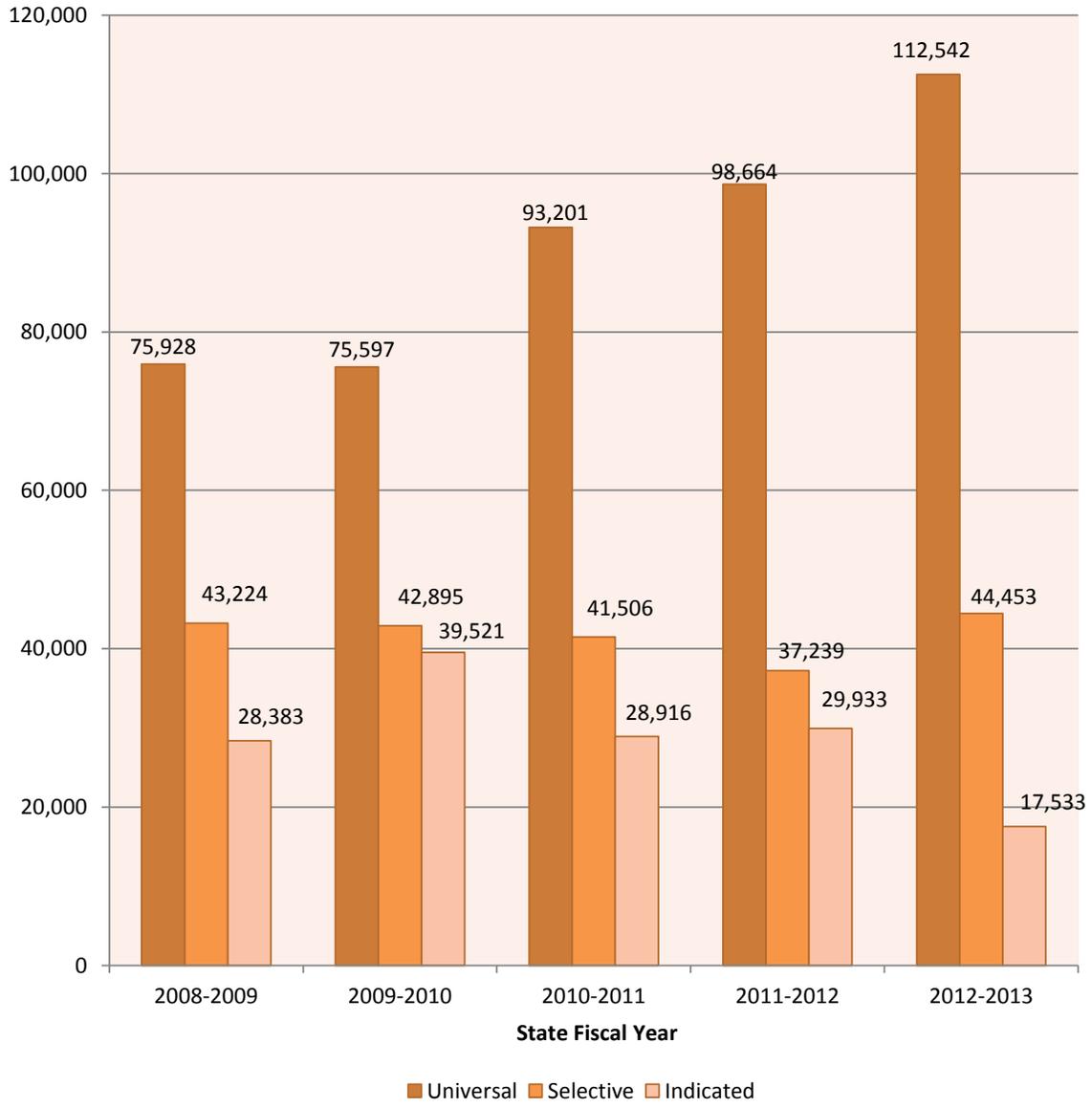
- Universal strategies address the entire population.
- Selective strategies focus on subsets or subgroups of the population exposed to greater levels of risk.
- Indicated strategies are designed to prevent the onset of substance abuse in individuals who have initiated the use of alcohol or other drugs.

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

Figure 5 shows a five-year trend of reporting data under the IOM classifications. The trend data shows Universal populations with an increase of 13,878 services from SFY 2011/2012. Services to Selective populations also increased from 2011/2012 to 2012/2013, but services to Indicated populations decreased.

Figure 5

Prevention Services by Institute of Medicine Population Categories as Reported to PBPS State Fiscal Years 2008-2009 through 2012-2013



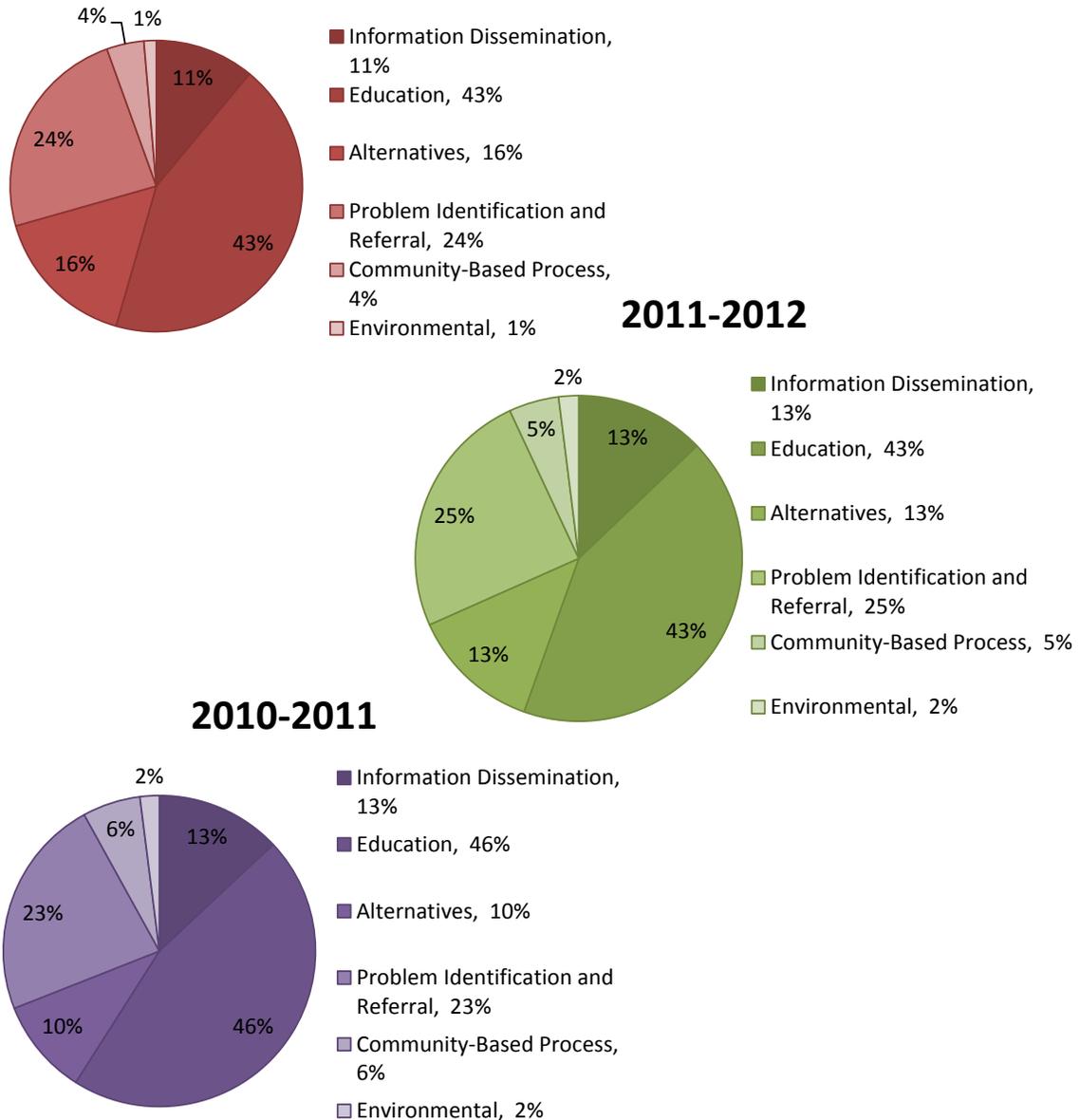
Federal Strategies in Prevention

Figure 6 demonstrates a three-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 increase in the Community-Based Processes indicating a more holistic approach thus fulfilling a previous goal. 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 2010-2011 through 2012-2013



IOM Population Categories

The six Federal Strategies are applicable and are utilized by each IOM population category. Figure 7 shows these population categories broken out by Federal Strategy for state fiscal year 2012-2013. Defined below are the three IOM population categories. 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. While Education services play a large role in all Universal prevention service activities to large diverse groups, the indicated target population covering high-risk individuals is now showing over 50 percent Problem Identification and Referral services. Based on Federal guidelines this makes for more effective prevention programs statewide.

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.

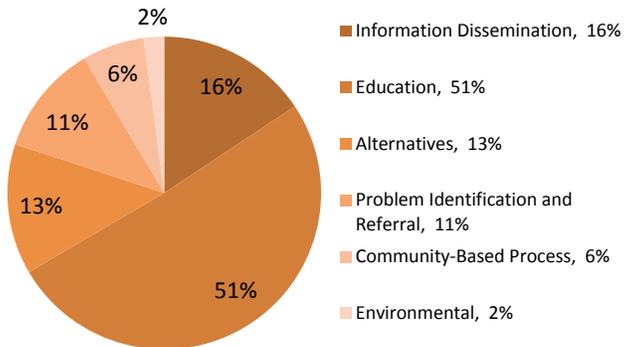
Selective Prevention Interventions are activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than the universal population. Education and Problem Identification/Referral are a large part of successfully providing service to this 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 sensitive balance of services to meet this population's need 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.

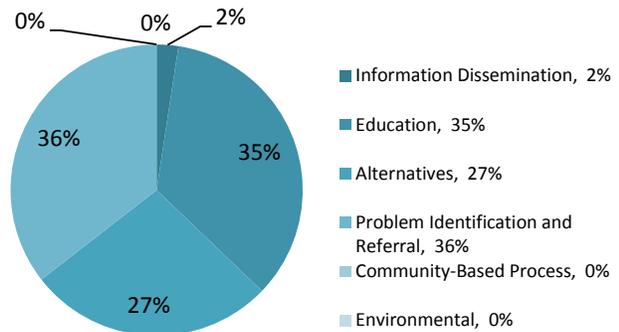
Figure 7

Institute of Medicine Population Categories by Federal Strategy Prevention Services as Reported to PBPS in 2012-2013

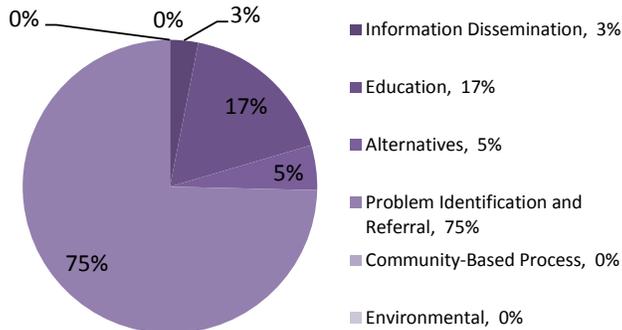
Universal



Selective

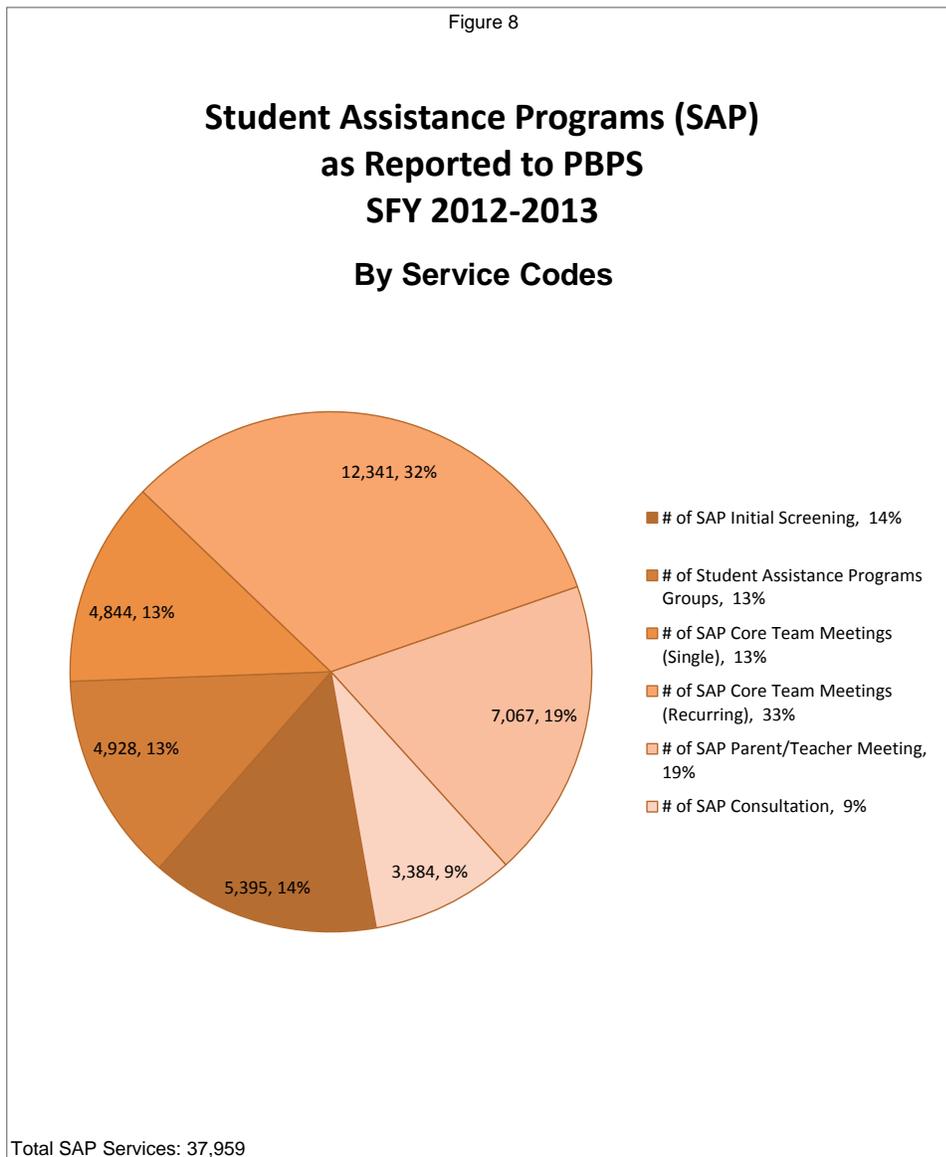


Indicated



Student Assistance Data

The Student Assistance Program (SAP) is an important intervention for the youth in Pennsylvania. Figure 8 shows a total of 37,969 SAP services for Fiscal Year 2012-2013 broken down into their specific approach (service code). The SAP 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 SCAs to complement their prevention initiatives.

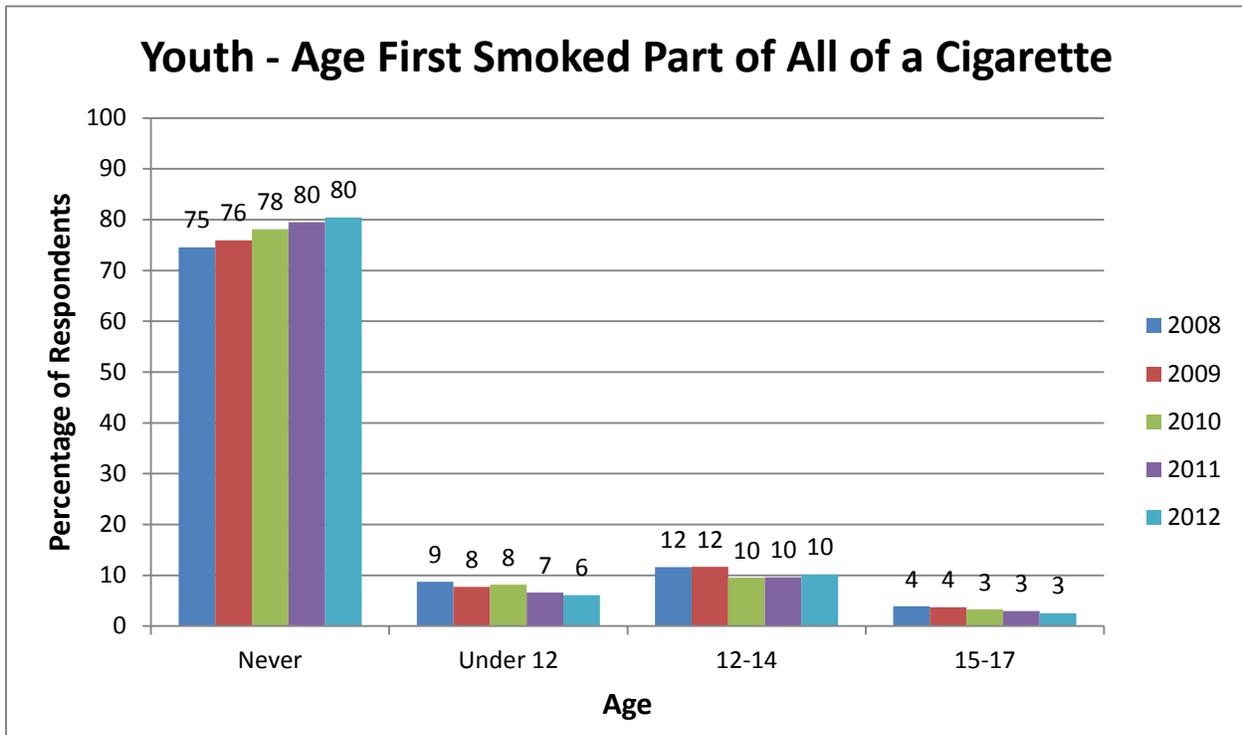


Youth National Outcome Measures (NOMs) Survey Results as Reported to the Performance Based Prevention System (PBPS)

The following surveys were gathered from Pennsylvania youth who attended selected single prevention services and recurring prevention services from October 1st to November 30th of 2008 (n=10,993), 2009 (n=11,226), 2010 (n=14,312), 2011 (n=12,635), and 2012 (n=10,687). The October to November timeframe helps provide some consistency to these survey results from year to year. Because service participants or attendees are not necessarily representative of the general population, please consider this a convenience sample. Survey respondents from 2011 and 2012 are very similar demographically. The only significant difference between the two years is that in 2012 there were fewer respondents under age 12 and more respondents age 12-14.

Demographic Breakdown Respondents		
	2011	2012
Sex		
Male	49%	50%
Female	51%	50%
Age		
Under 12	15%	6%
12-14	61%	68%
15-17	22%	23%
18-21	2%	3%
Race		
White	78%	80%
Black	10%	10%
Other*	7%	7%
Unknown	4%	3%
Ethnicity		
Hispanic or Latino	10%	11%
Not Hispanic or Latino	90%	89%
* Category of Other includes the following: American Indian and Alaska Native, Asian, Native Hawaiian and Other Pacific Islander, and More than One Race		

Question 01T: How old were you the first time you smoked part or all of a cigarette?

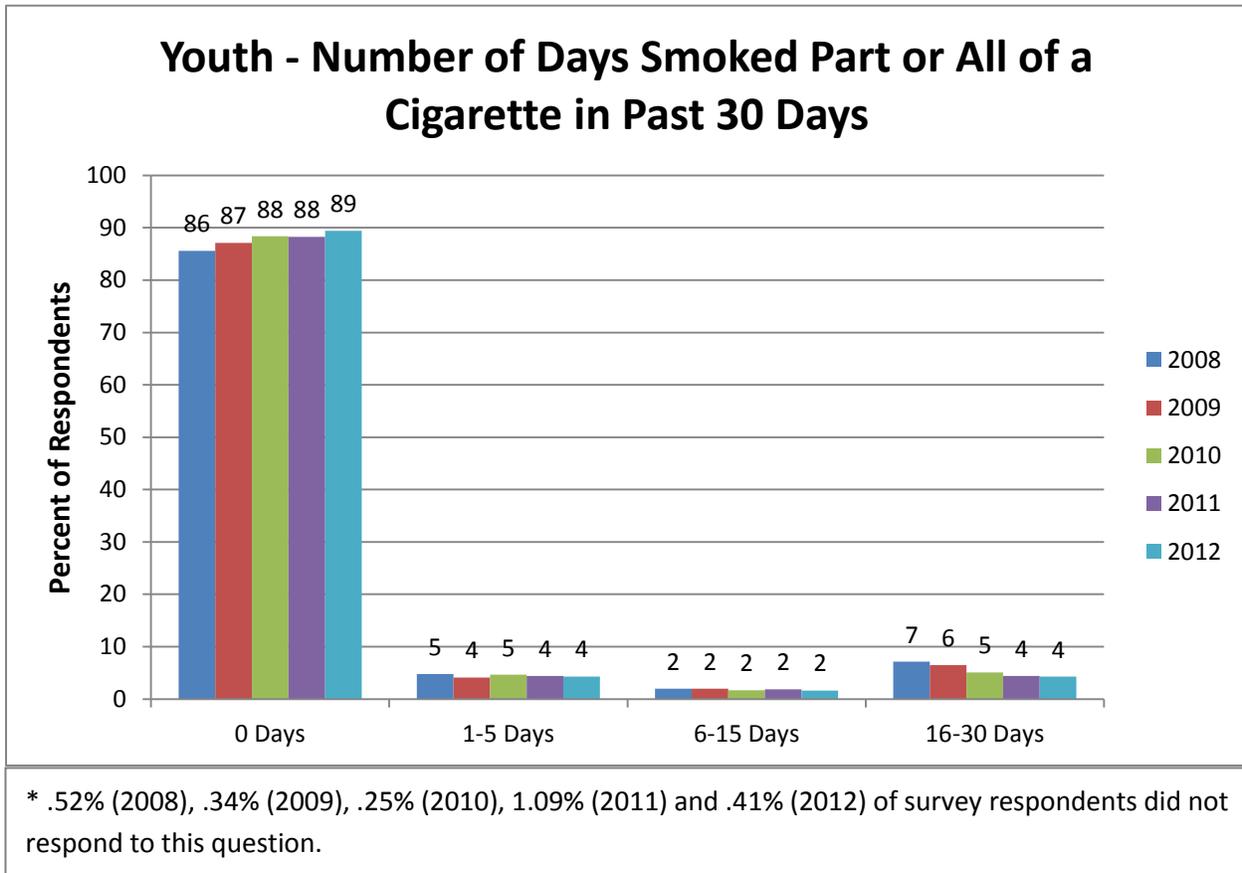


* The graph above shows only three of the categories of responses to the question. The table below shows the percent of respondents who selected 18-21 and who did not respond. Note that the Youth NOMs Survey is designed to survey individuals under age 18. Since the NOMs survey is often administered in schools and some high school students may be age 18, this survey has captured data from some respondents who were 18 years old. The small percentages for the 18-21 category in the table below are due in large part to the very small number of respondents who were 18 or older and therefore able to respond that they had their first drink at that age.

	2008	2009	2010	2011	2012
18-21	0.38%	0.34%	0.36%	0.16%	0.24%
No Response	0.81%	0.57%	0.52%	1.11%	0.46%

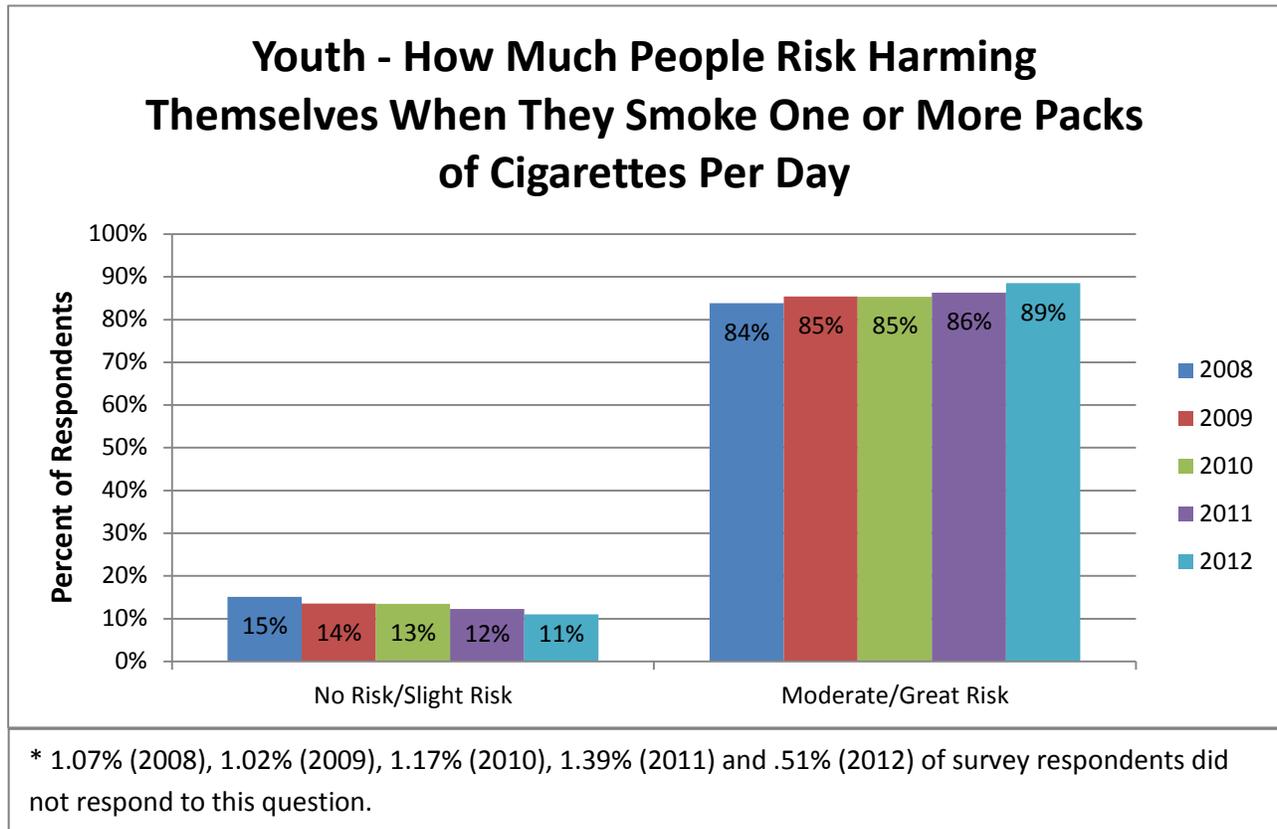
Age at first use of cigarettes among youth respondents has shown positive trends over the past five years. The percent reporting no lifetime use has increased every year from 2008-2012 with an overall increase of 5.9% from 2008 to 2012.

Question 02T: During the past 30 days, on how many days did you smoke part or all of a cigarette?



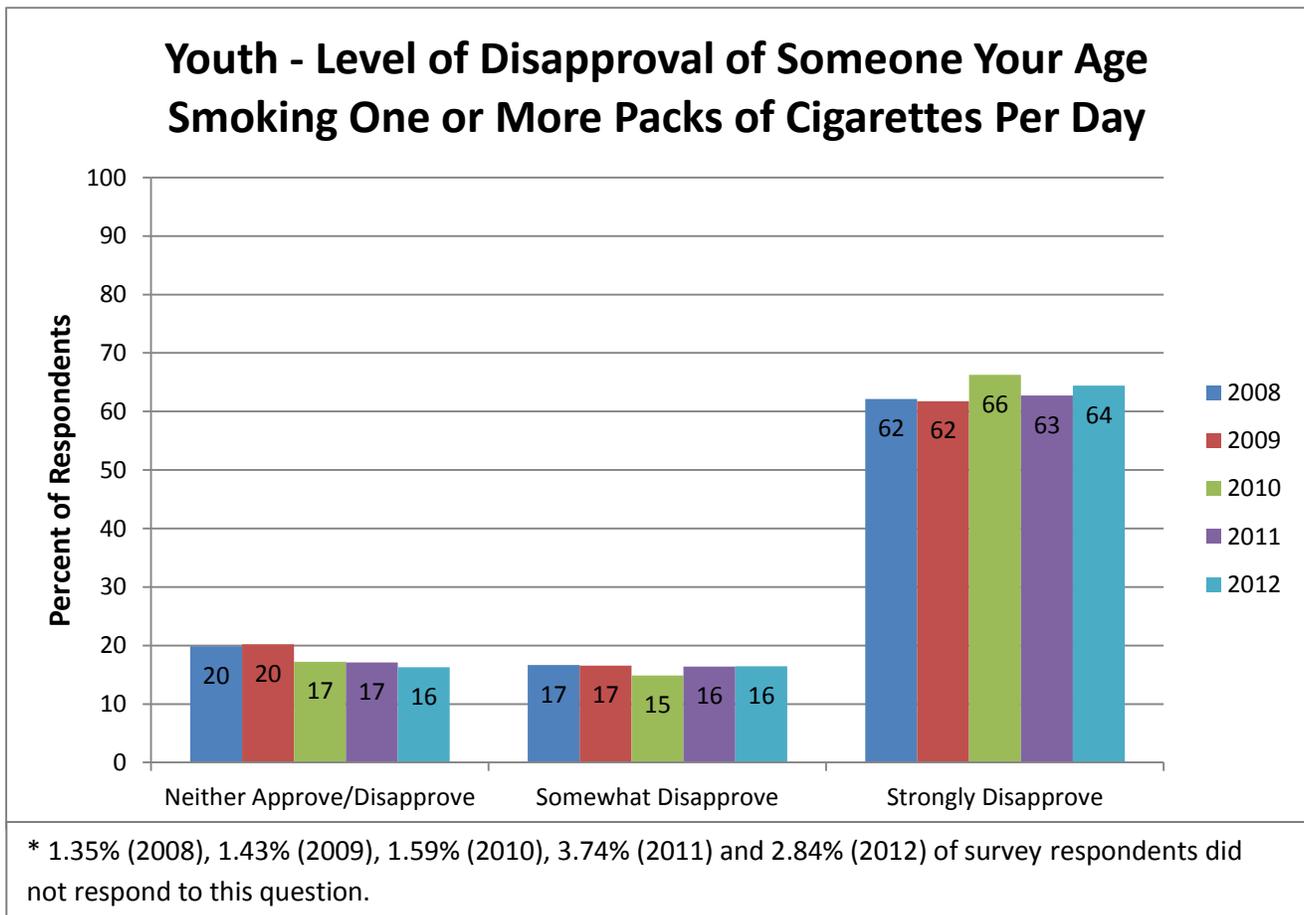
Past 30 day cigarette use among youth respondents has shown positive trends over the five years depicted above. The percent reporting no past 30 day use has increased 3.9% from 2008-2012. This increase has been accompanied by a 2.9% decrease from 2008 to 2012 in the number of respondents reporting cigarette use on 16-30 days out of the past 30 days. Declines in past 30 day cigarette use were also reported on the National Survey on Drug Use and Health for youth aged 12-17 for every year from 2002-2012.

Question 03T: How much do people risk harming themselves physically and in other ways when they smoke one or more pack of cigarettes per day?



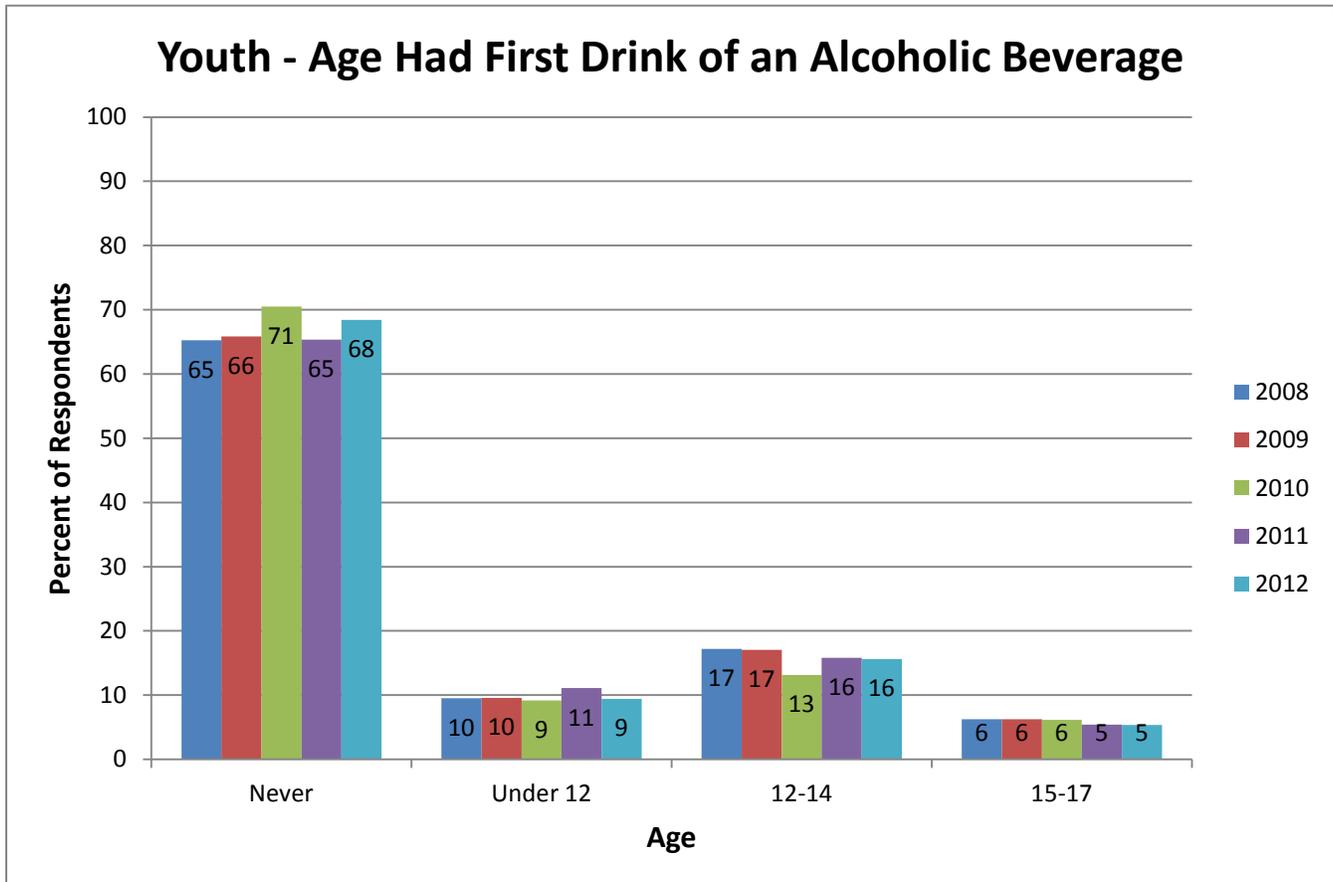
The percent of youth respondents reporting that smoking one or more packs of cigarettes per day poses a moderate or great risk of harm has increased slightly from 2008-2012. Each year more respondents reported that smoking one or two packs of cigarettes per day posed a moderate or great risk of harm than reported that smoking marijuana and drinking alcohol posed a moderate or great risk of harm. In 2012 67.7% of respondents reported great risk of harm which is close to the national percentage of 65.7% reported on the 2012 National Survey on Drug Use and Health for youth aged 12-17.

Question 04T: How do you feel about someone your age smoking one or more packs of cigarettes a day?



The percent of youth respondents who reported that they strongly disapproved of someone their age smoking one or more packs of cigarettes per day has fluctuated slightly from 2008-2012, but the percent of youth reporting they neither approved nor disapproved has decreased by 3.6% from 2008-2012.

Question 01A: How old were you the first time you had a drink of an alcoholic beverage?

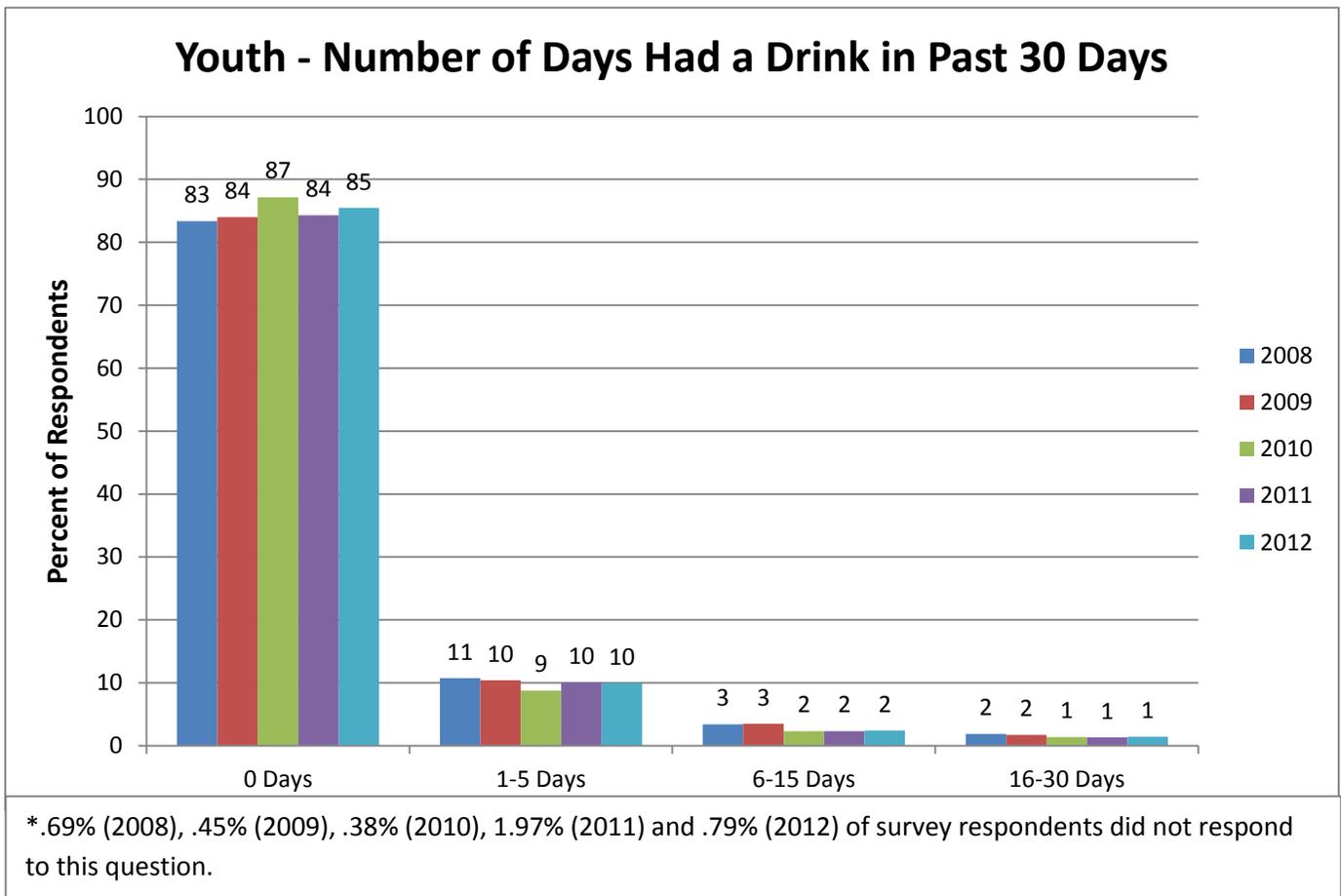


* The graph above shows only three of the categories of responses to the question. The table below shows the percent of respondents who selected 18-21 and who did not respond. Note that the Youth NOMs Survey is designed to survey individuals under age 18. Since the NOMs survey is often administered in schools and some high school students may be age 18, this survey has captured data from some respondents who were 18 years old. The small percentages for the 18-21 category in the table below are due in large part to the very small number of respondents who were 18 or older and therefore able to respond that they had their first drink at that age.

	2008	2009	2010	2011	2012
18-21	0.55%	0.45%	0.36%	0.28%	0.31%
No Response	0.86%	0.82%	0.64%	2.06%	0.84%

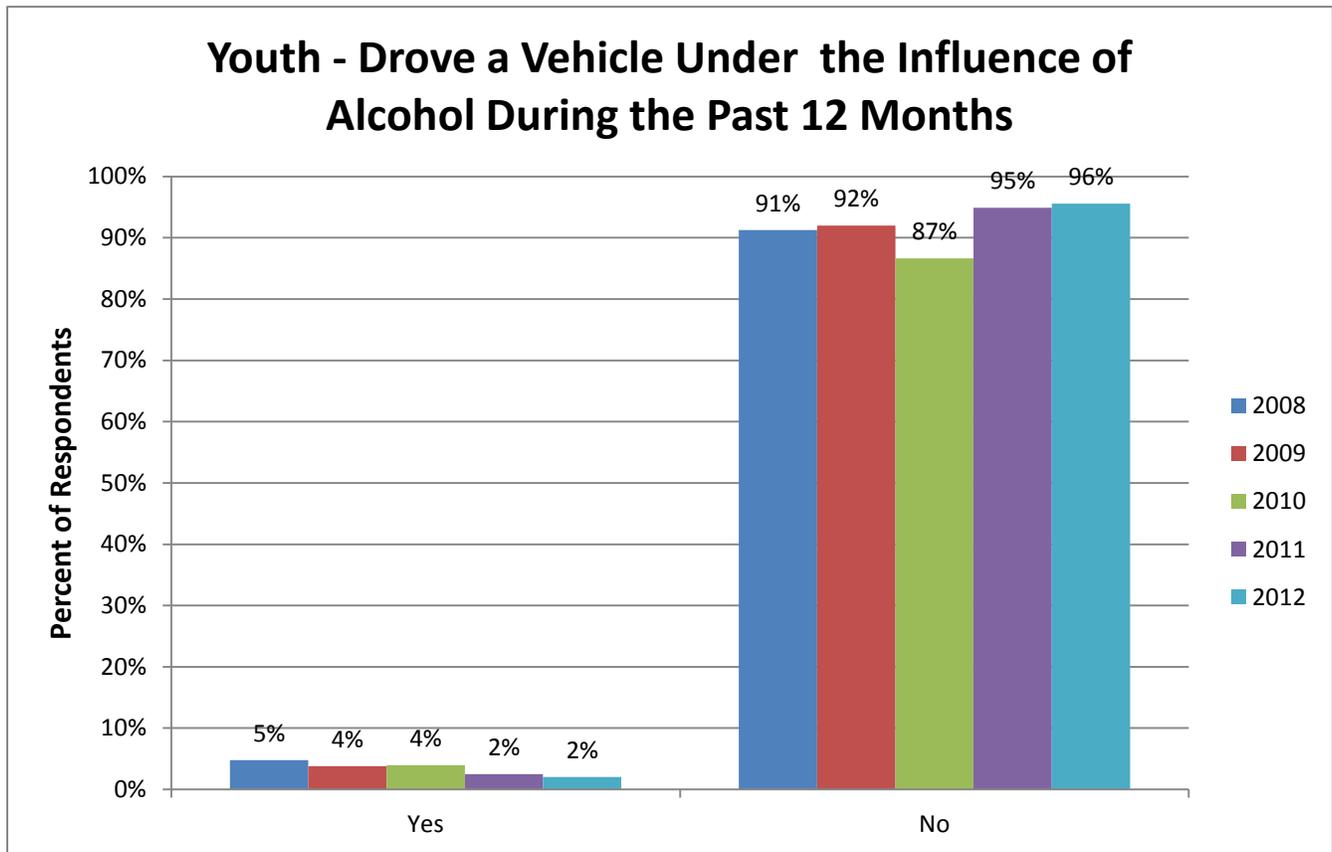
The percent of youth respondents reporting they never drank alcohol increased from 2008-2010, decreased by 5% in 2011, and then increased by 3% in 2012. Alcohol is the substance that was most commonly reported to have ever been used by youth respondents.

Question 02A: During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?



The percent of youth reporting no use of alcohol in the past 30 days increased by 2% from 2008-2012. Alcohol is the substance that was most commonly reported to have been used in the past 30 days by youth respondents. In 2012 13.7% of respondents reported past 30 day use which is similar to the national percentage of 12.9% reported on the 2012 National Survey on Drug Use and Health for youth aged 12-17.

Question 03A: During the past 12 months, have you driven a vehicle while you were under the influence of alcohol only?

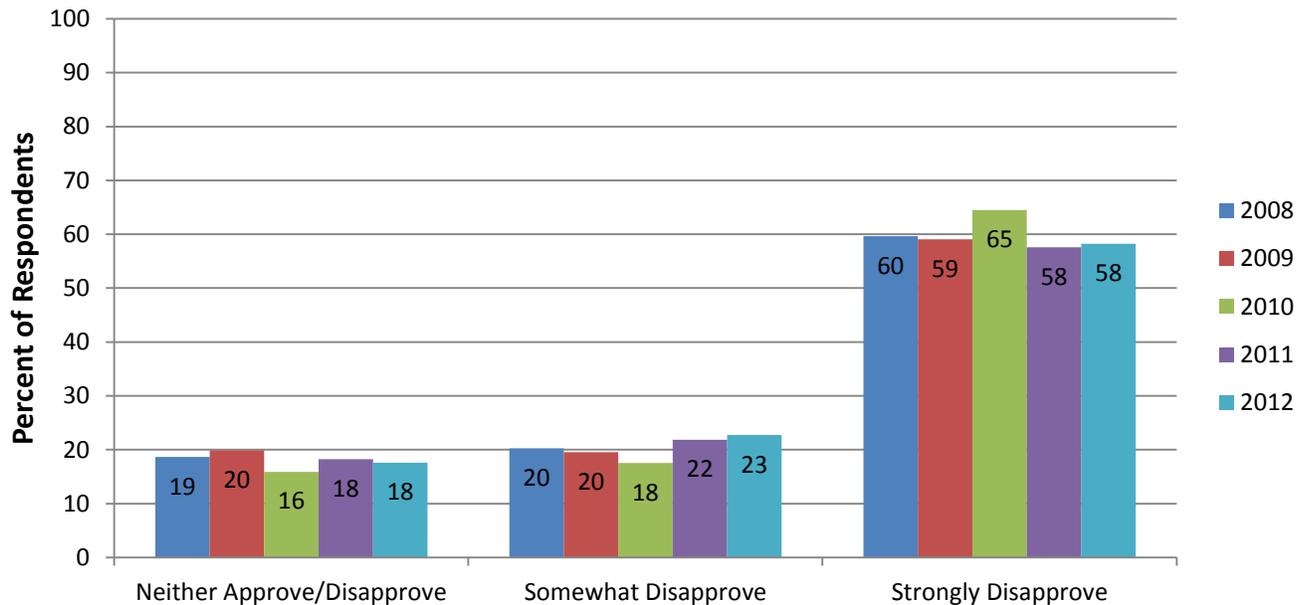


* 3.95% (2008), 4.21% (2009), 9.32% (2010), 2.60% (2011) and 2.37% (2012) of survey respondents did not respond to this question.

The percent of youth reporting that they drove under the influence has decreased from 5% in 2008 to 2% in 2012. In 2012 looking at only those respondents that were 16 or older (n=1580), 5.2% reported that they drove under the influence in the past 12 months.

Question 04A: How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?

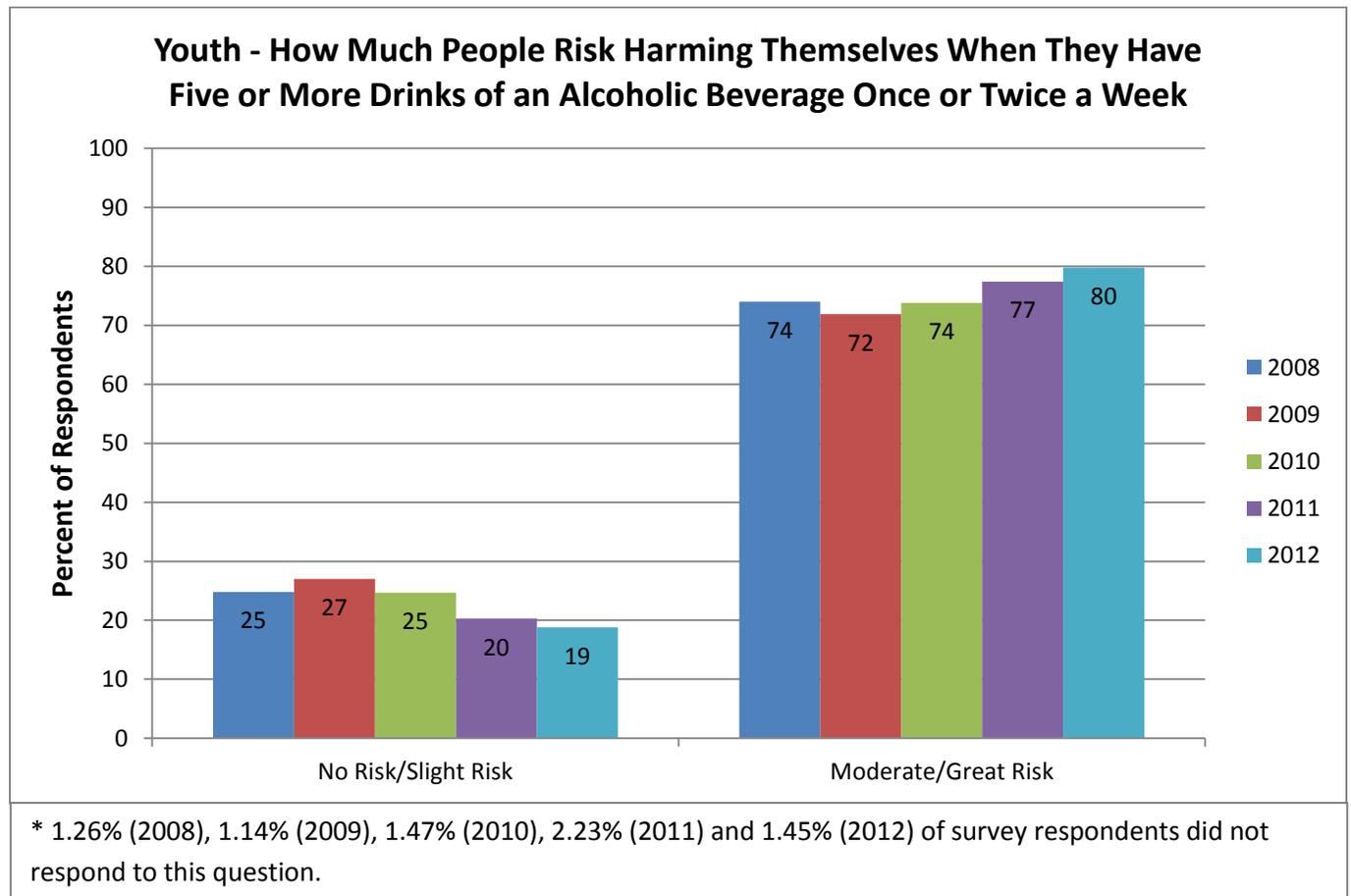
Youth - Level of Disapproval of Someone Your Age Having One or Two Drinks of an Alcoholic Beverage Nearly Every Day



* 1.48% (2008), 1.47% (2009), 1.94% (2010), 2.34% (2011) and 1.48% (2012) of survey respondents did not respond to this question.

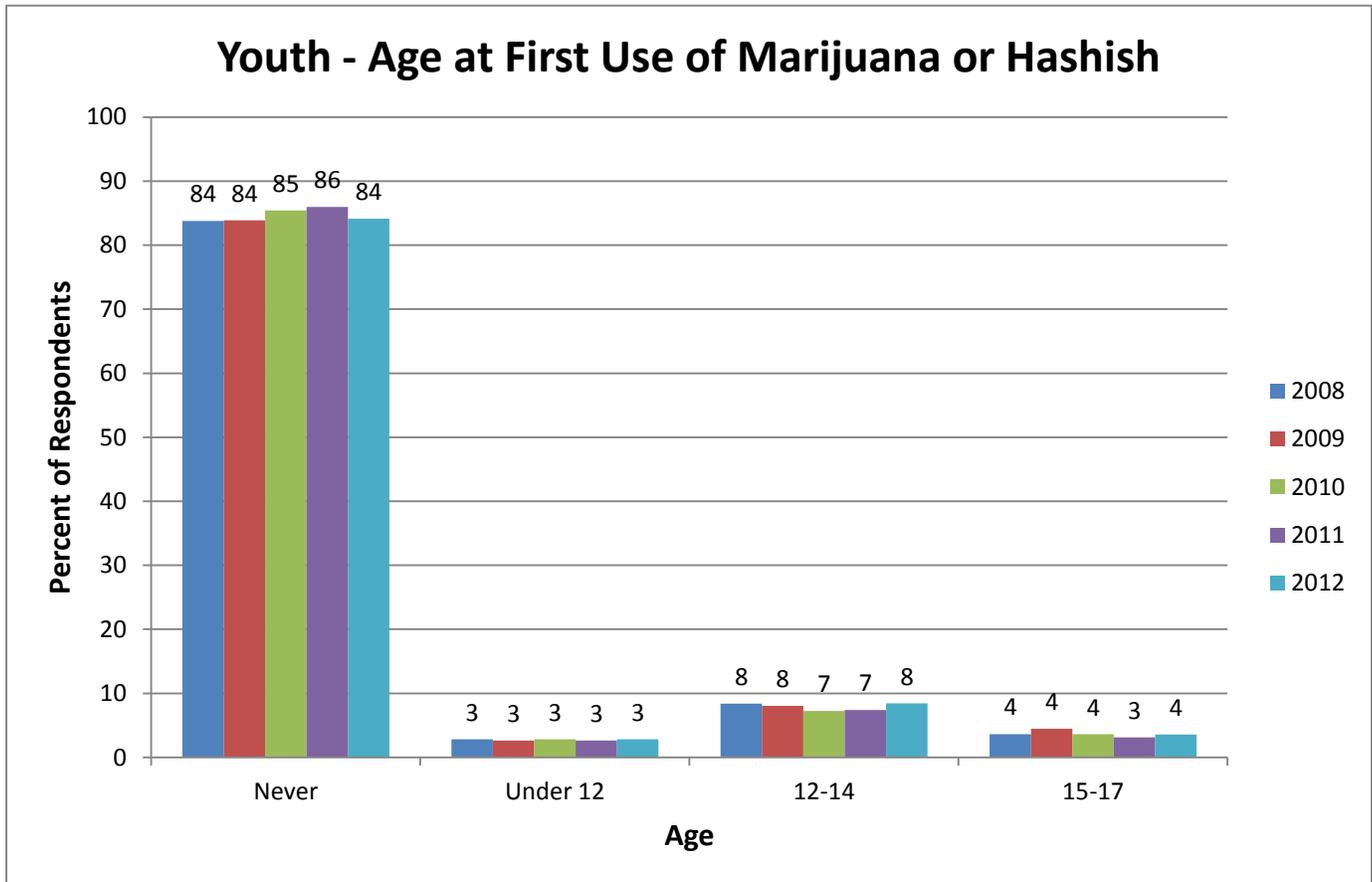
The percent of youth respondents who reported that they strongly disapproved of someone their age having one or two drinks of an alcoholic beverage nearly every day has fluctuated over the past 5 years, but shows an overall downward trend. This decrease in strong disapproval was accompanied by an increase in those reporting that they somewhat disapproved.

Question 05A: How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?



The percent of youth respondents reporting that having five or more drinks of an alcoholic beverage once or twice a week poses a moderate or great risk of harm has increased 6% from 2008-2012. Of the questions on the survey regarding the potential harm posed by use of certain substances, this question on alcohol use had the highest percent of respondents reporting no or only slight risk for 2008-2010. In 2011 and 2012 it was second highest after marijuana. In 2012 46% of respondents reported great risk. This is higher than the national percentage of 40% reported on the 2012 National Survey on Drug Use and Health for youth aged 12-17.

Question 01M: How old were you the first time you used marijuana or hashish?



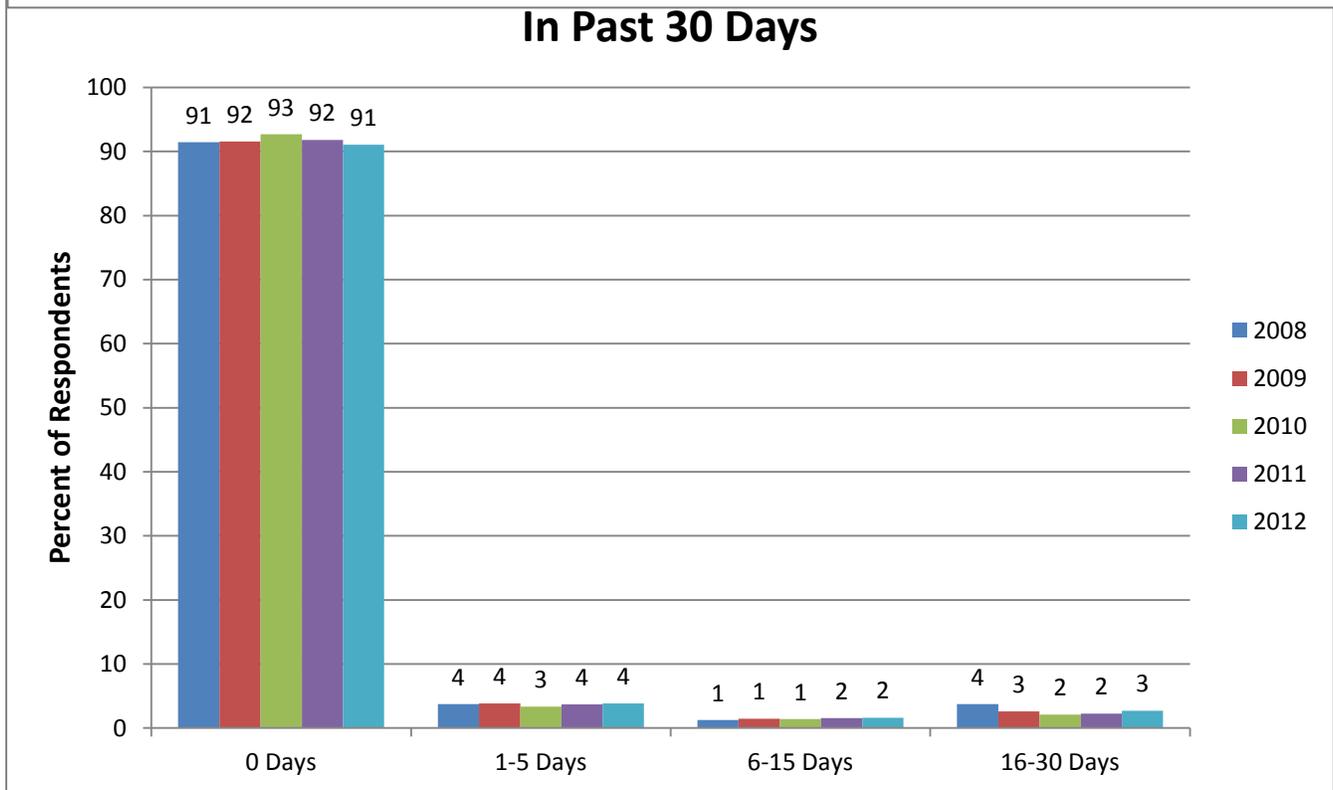
* The graph above shows only three of the categories of responses to the question. The table below shows the percent of respondents who selected 18-21 and who did not respond. Note that the Youth NOMs Survey is designed to survey individuals under age 18. Since the NOMs survey is often administered in schools and some high school students may be age 18, this survey has captured data from some respondents who were 18 years old. The small percentages for the 18-21 category in the table below are due in large part to the very small number of respondents who were 18 or older and therefore able to respond that they had first used marijuana at that age.

	2008	2009	2010	2011	2012
18-21	0.45%	0.29%	0.31%	0.17%	0.22%
No Response	0.93%	0.67%	0.64%	0.69%	0.82%

In 2012 the percent of youth reporting that they have never used marijuana or hashish decreased for the first time in the past 5 years. In 2012 15% reported using marijuana or hashish at least once in their lifetime.

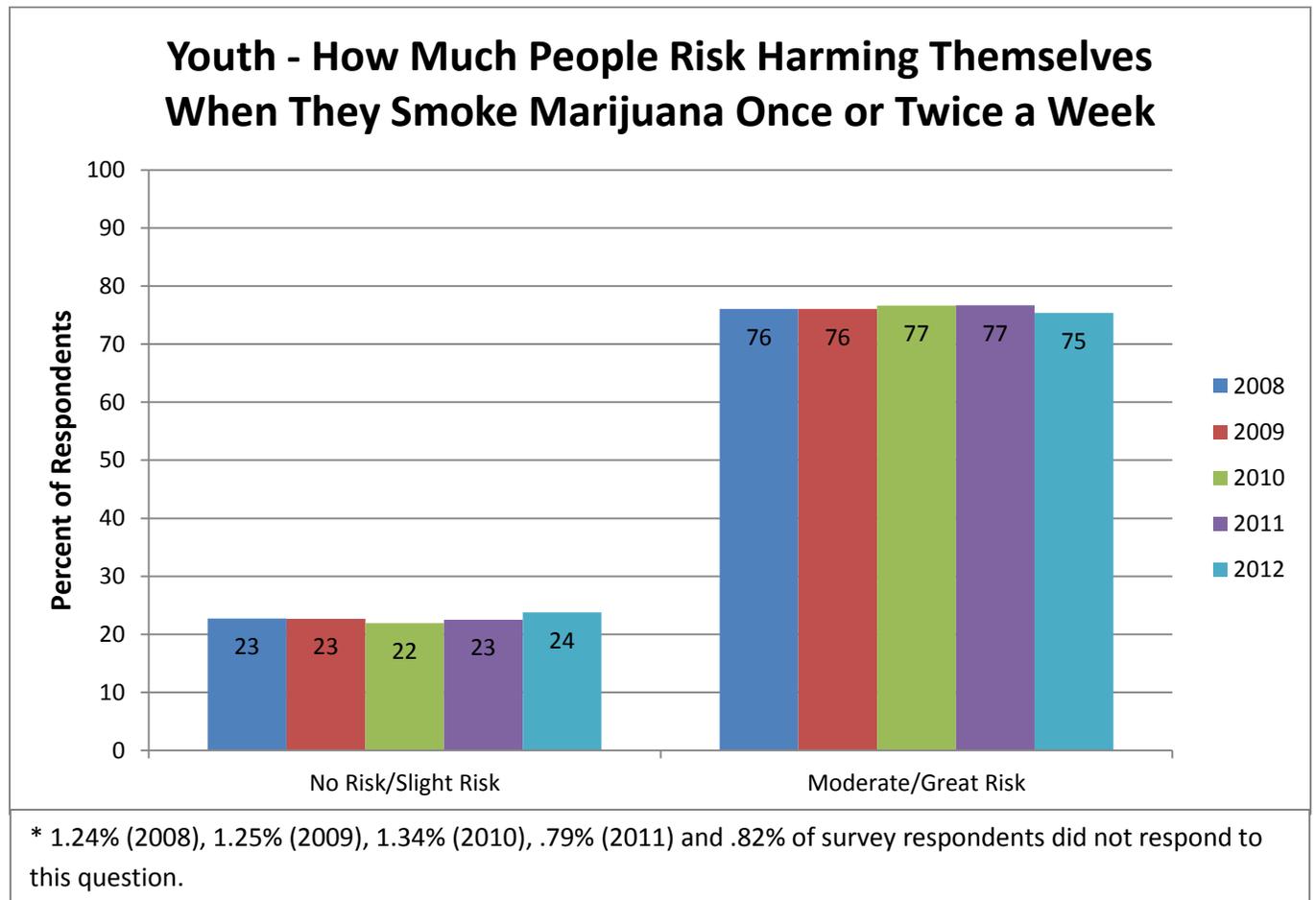
Question 02M: During the past 30 days, on how many days did you use marijuana or hashish?

* .73% (2008), .52% (2009), .41% (2010), .68% (2011) and .78% (2012) of survey respondents did not respond to this question.



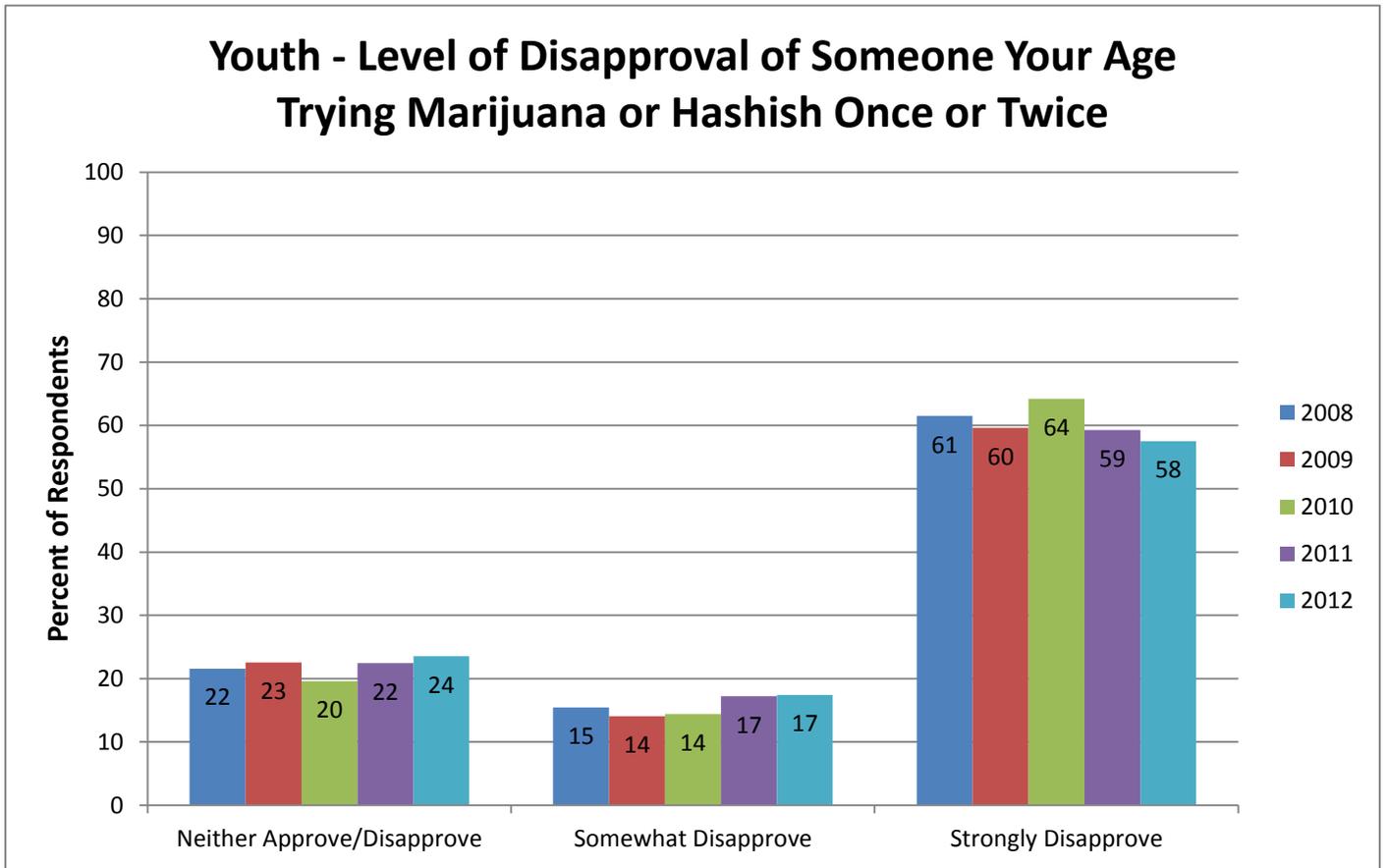
From 2008 to 2010 there was a very slight increase in the percent of youth respondents reporting no use of marijuana or hashish in the past 30 days. However, from 2010-2012 the percent reporting no use decreased slightly (1.6%). In 2011 7.5% of youth respondents reported past 30 day use and in 2012 8.2% reported past 30 day use. National data from the National Survey on Drug Use and Health reveals that past 30 day marijuana use among youth aged 12-17 increased from 6.7% in 2008 to 7.9% in 2011 and then decreased to 7.2% in 2012.

Question 03M: How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?



The percent of youth respondents reporting that smoking marijuana once or twice a week poses a moderate or great risk of harm has remained nearly the same every year from 2008-2011, but decreased slightly in 2012. In 2012, 10.4% of youth respondents reported no risk of harm from smoking marijuana once or twice a week. In 2012 51.6% of respondents reported great risk which is higher than the national percentage of 43.6% reported on the 2012 National Survey on Drug Use and Health for youth aged 12-17.

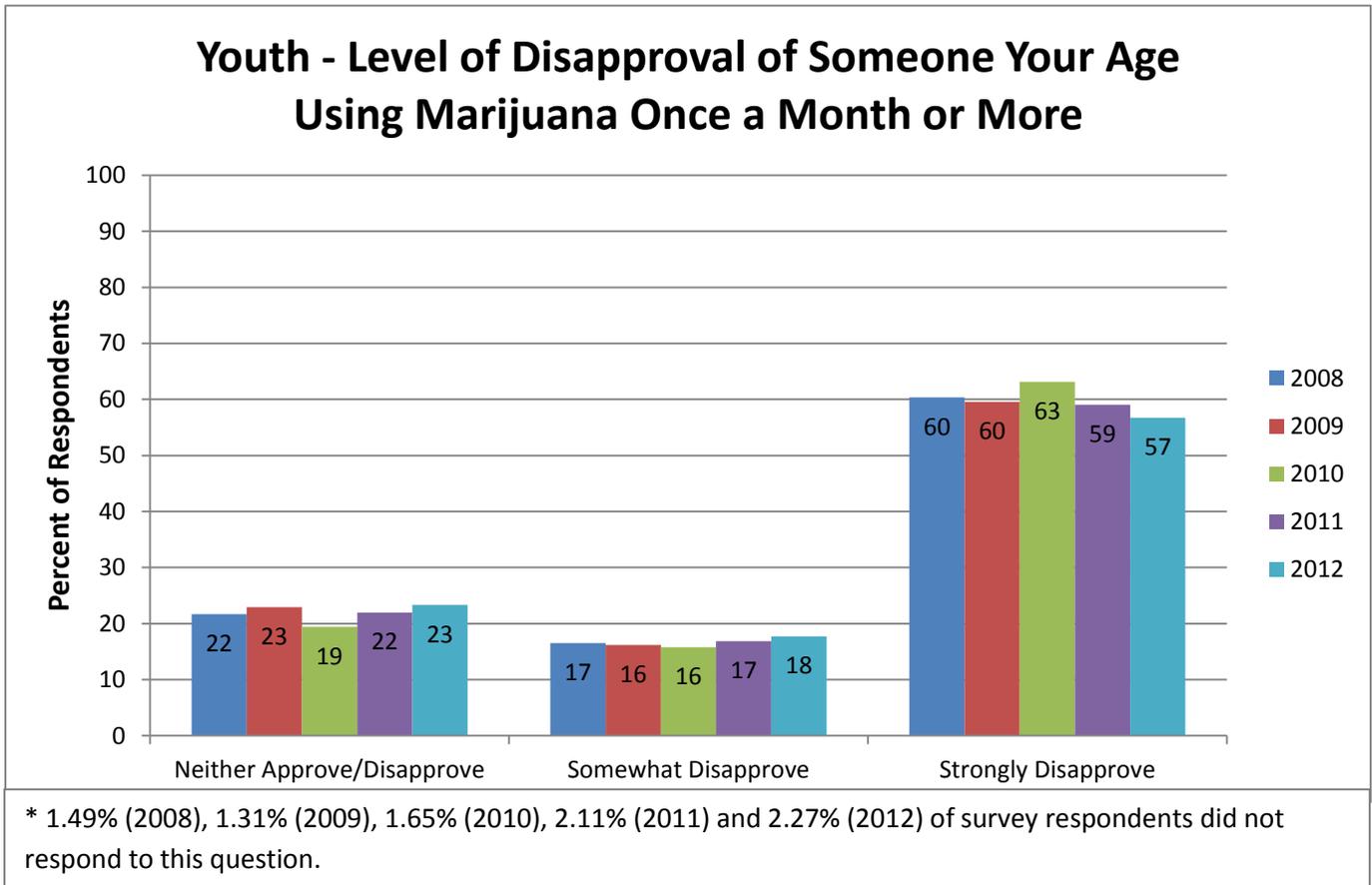
Question 04M: How do you feel about someone your age trying marijuana or hashish once or twice?



* 1.48% (2008), 3.72% (2009), 1.72% (2010), 1.07% (2011) and 1.51% (2012) of survey respondents did not respond to this question.

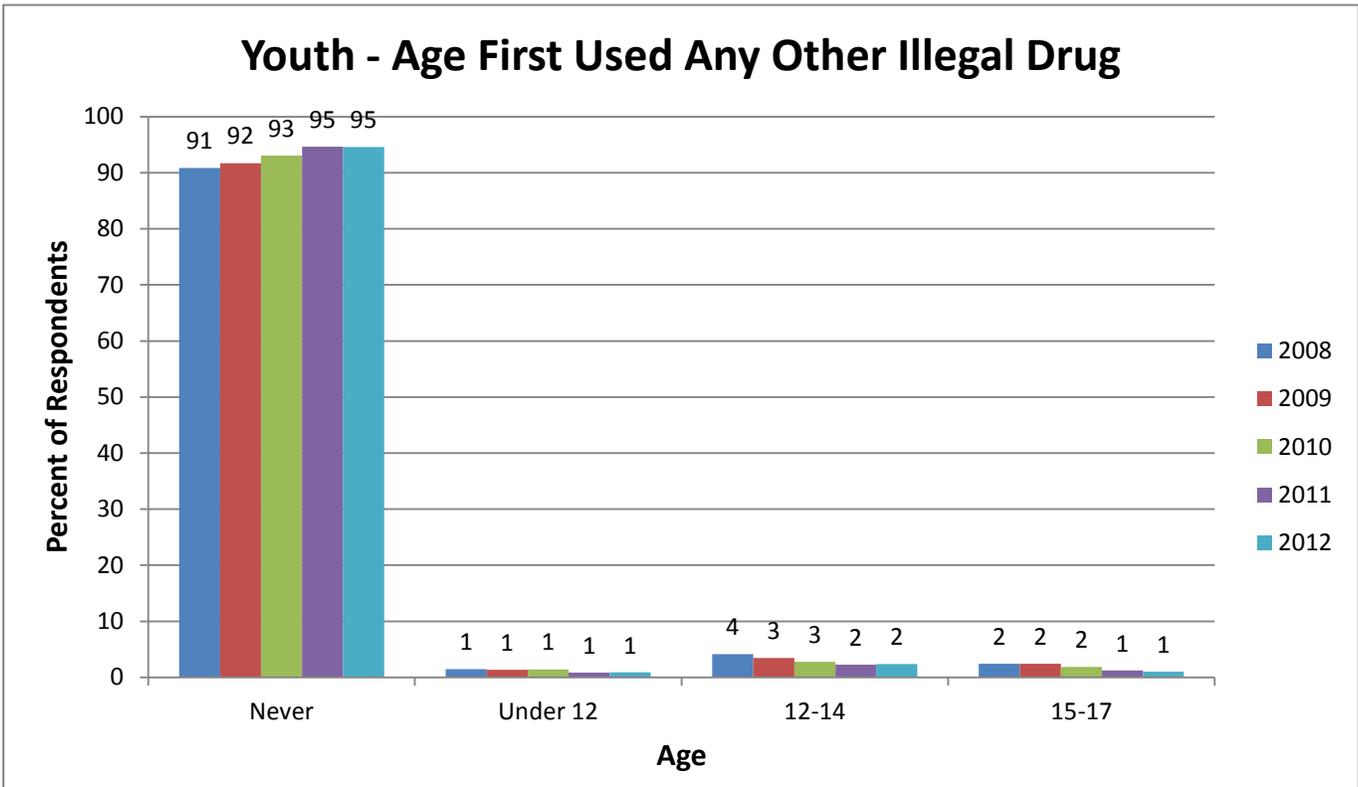
The percent of youth respondents who reported that they strongly disapproved of someone their age trying marijuana or hashish once or twice has shown an overall downward trend from 61% in 2008 to 58% in 2012. The only disruption in this trend was an increase in strong disapproval in 2010.

Question 05M: How do you feel about someone your age using marijuana once a month or more?



The percent of youth respondents who reported that they strongly disapproved of someone their age using marijuana once a month or more has shown an overall downward trend from 60% in 2008 to 57% in 2012. When comparing this table to the previous table on disapproval of trying marijuana once or twice the percents in all categories for all years are very similar. This may indicate that respondents' disapproval of use was not related to how frequent the use was.

Question 010: How old were you the first time you used any other illegal drug? Other illegal drugs include substances like: Heroin, crack or cocaine, methamphetamine, Hallucinogens (such as LSD, Ecstasy, PCP or peyote).

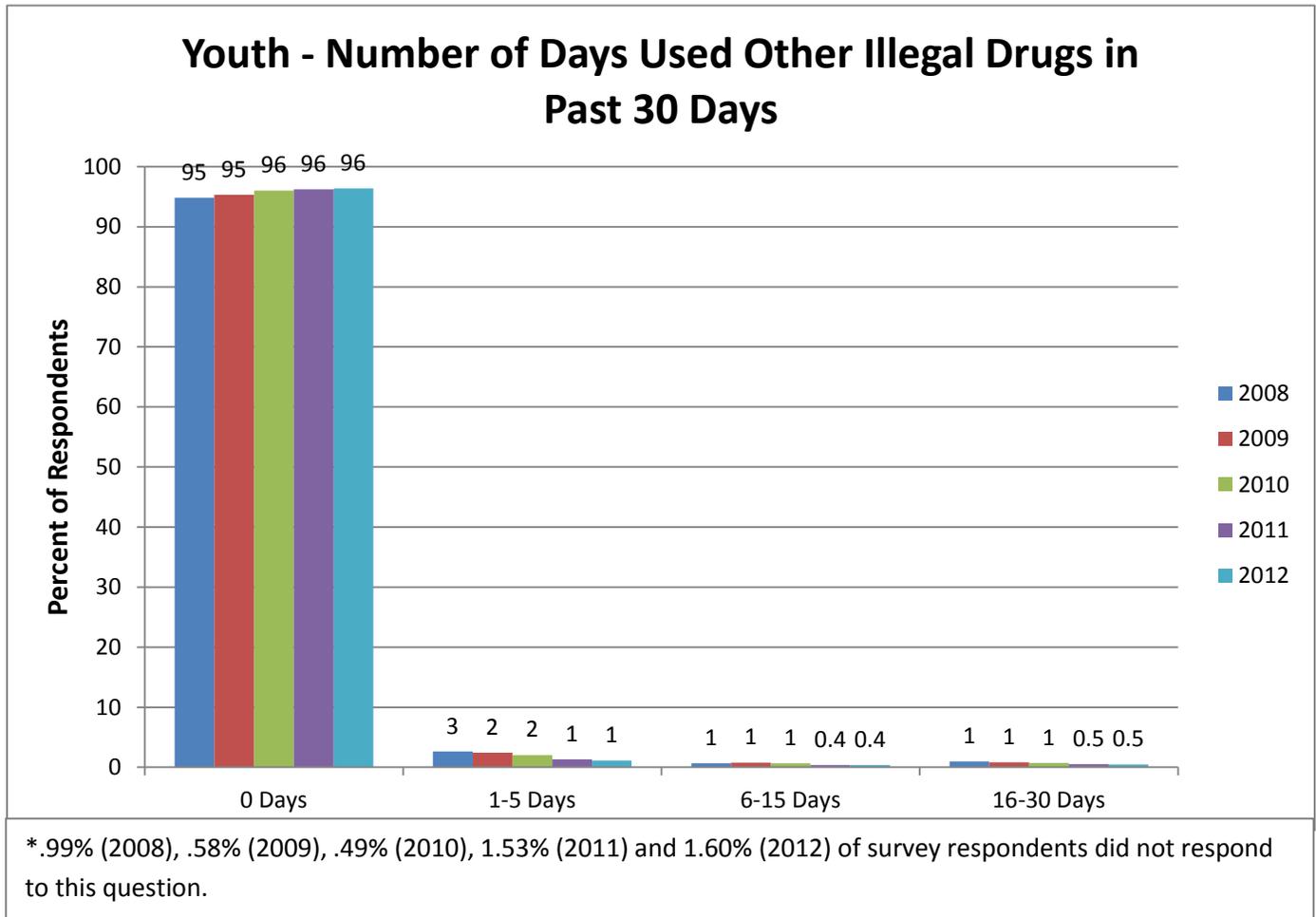


* The graph above shows only three of the categories of responses to the question. The table below shows the percent of respondents who selected 18-21 and who did not respond. Note that the Youth NOMs Survey is designed to survey individuals under age 18. Since the NOMs survey is often administered in schools and some high school students may be age 18, this survey has captured data from some respondents who were 18 years old. The small percentages for the 18-21 category in the table below are due in large part to the very small number of respondents who were 18 or older and therefore able to respond that they had first used drugs at that age.

	2008	2009	2010	2011	2012
18-21	0.30%	0.34%	0.22%	0.17%	0.14%
No Response	0.80%	0.70%	0.61%	0.88%	1.01%

The percent of youth reporting that they have ever used any other illegal drug has decreased each year from a high of 8.4% in 2008 to a low of 4.4% in 2012.

Question 020: During the past 30 days, on how many days did you use any other illegal drug? Other illegal drugs include substances like: Heroin, crack or cocaine, methamphetamine, Hallucinogens (such as LSD, Ecstasy, PCP or peyote).



The percent of youth reporting no use of other illegal drugs during the past 30 days has stayed consistently high at 95-96%. In 2012, 2% of youth reported past 30 day use which is less than the national percentage of 3.9% reported on the 2011-2012 National Survey on Drug Use and Health for youth aged 12-17.

Question 01P: Have you ever taken prescription medications that were not prescribed specifically for you?

This question was added to the youth NOMs survey in 2011.

Year	Yes	No	Did Not Answer
2011	14%	12%	2.6%
2012	12%	85%	3.1%

Question 02P: How much do people risk harming themselves physically and in other ways when they take prescription medications not specifically prescribed for them?

This question was added to the youth NOMs survey in 2011.

Year	No Risk/Slight Risk	Moderate Risk/Great Risk	Did Not Answer
2011	18%	79%	2.9%
2012	15%	81%	3.5%

Question 01I: How much do people risk harming themselves physically and in other ways using inhalants or sniffing substances?

This question was added to the youth NOMs survey in 2011.

Year	No Risk/Slight Risk	Moderate Risk/Great Risk	Did Not Answer
2011	16%	81%	2.7%
2012	15%	81%	4.0%

Question 02I: Have you ever snorted, sniffed, or huffed on a substance for the purpose of experiencing a high?

This question was added to the youth NOMs survey in 2011. The percent of youth in 2012 reporting lifetime use of inhalants is almost the same as the national percentage of 6.5% reported on the 2012 National Survey on Drug Use and Health for youth aged 12-17.

Year	Yes	No	Did Not Answer
2011	8%	88%	3.6%
2012	7%	88%	4.5%

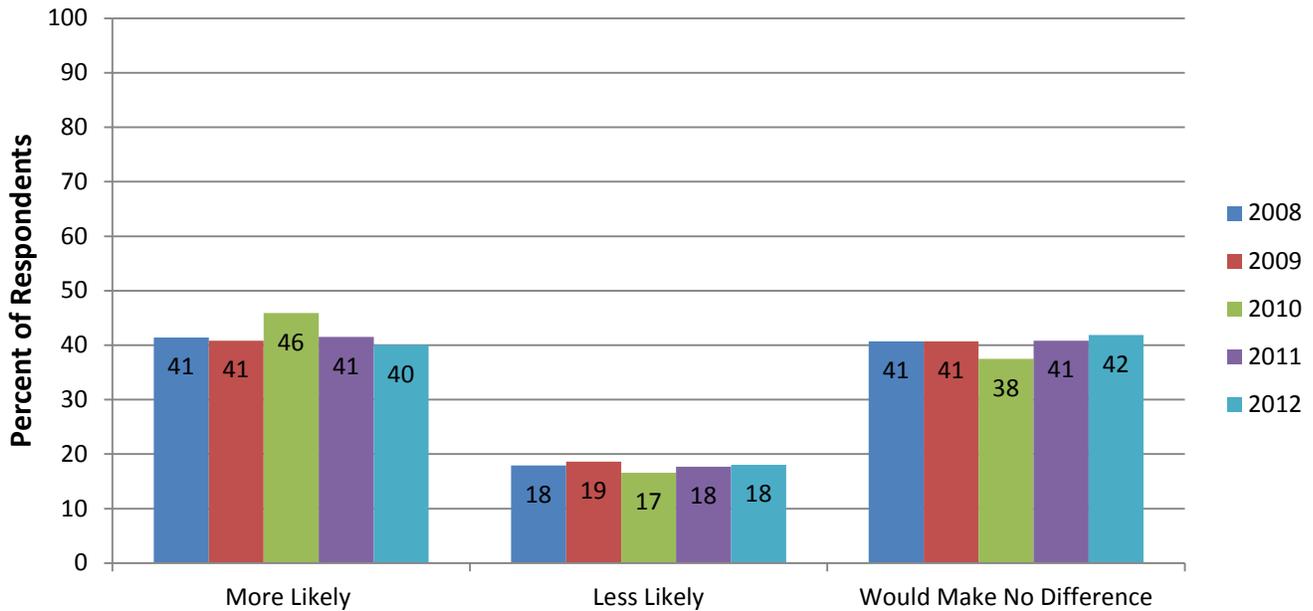
Question 01S: How much do people risk harming themselves physically and in other ways using synthetic drugs?

This question was added to the youth NOMs survey in 2011.

Year	No Risk/Slight Risk	Moderate Risk/Great Risk	Did Not Answer
2011	14%	84%	2.6%
2012	10%	86%	3.5%

Question 01Z: Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis?

Youth - Likelihood of working for an employer that tests its employees for drug or alcohol use on a random basis? (Only if Working)

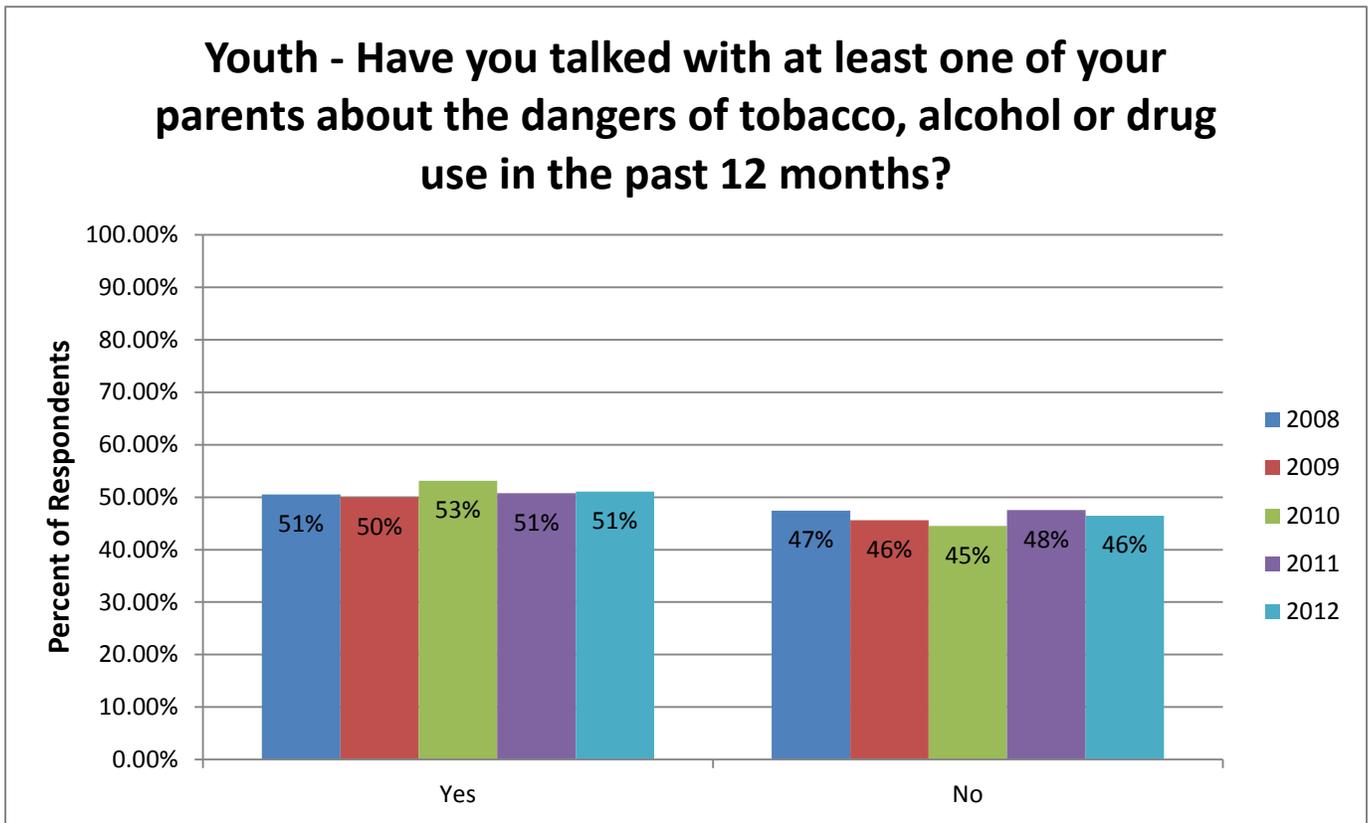


* The percentages in the graph above were calculated out of the total number of respondents who chose one of the three answer choices shown (n=7293 for 2007, n=7135 for 2008, n=6965 for 2009, n=9325 for 2010, n=7575 for 2011). Those who selected not applicable or did not answer this question were not included in the denominator when calculating the percentages. The percent who selected Not Applicable or who did not respond, calculated out of the total number of respondents, is shown in the table below.

	2008	2009	2010	2011	2012
Not Applicable	27.88%	30.38%	24.94%	35.41%	35.24%
No Response	7.23%	7.56%	9.83%	4.64%	5.09%

The percent of youth reporting that they would be more likely to work for an employer that randomly tests its employees for drug and alcohol use remained nearly the same from 2008-2012 (approximately 40-41%), except for an increase to 46% in 2010.

Question 02Z: During the past 12 months, have you talked to your parents about the dangers of tobacco, alcohol or drug use?

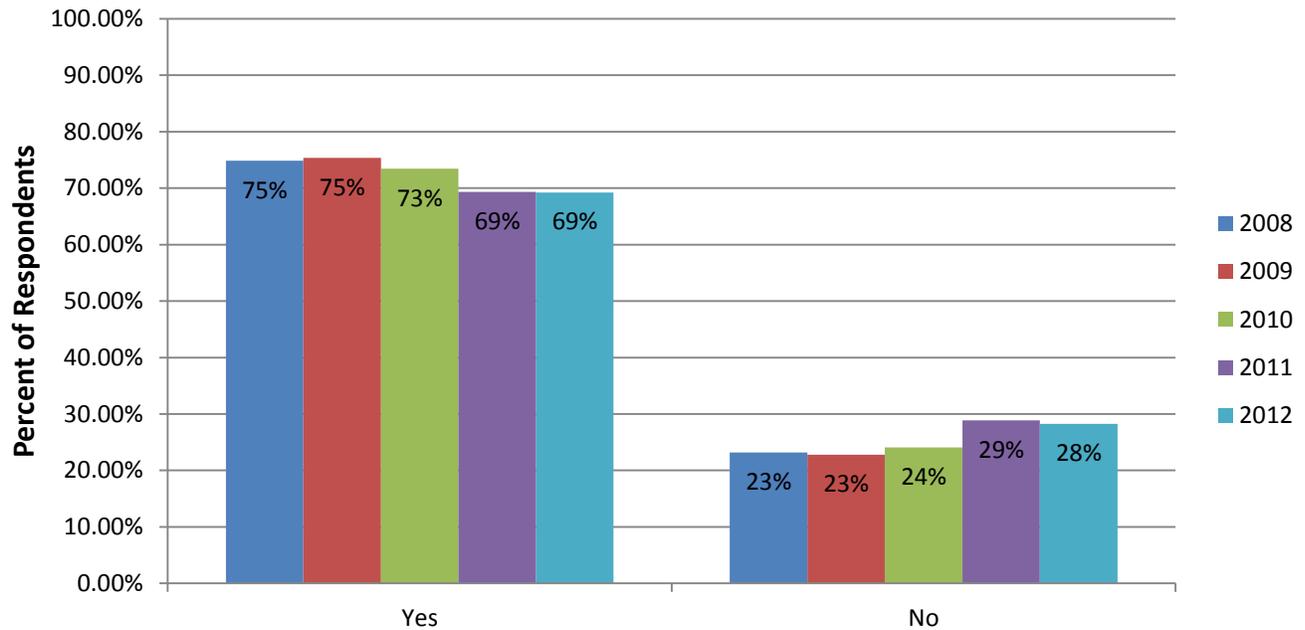


* 2.02% (2008), 4.37% (2009), 2.20% (2010), 1.72% (2011) and 2.47% (2012) of survey respondents did not respond to this question.

The percent of youth reporting they have talked with their parents about the dangers of tobacco, alcohol, or drug use has remained at approximately 50% over the past 5 years.

Question 03Z: During the past 12 months, do you recall hearing, reading, or watching an advertisement about the prevention of substance use?

Youth - Heard, Read, or Watched an Advertisement about the Prevention of Substance Use During the Past 12 Months



* 2.00% (2008), 1.84% (2009), 2.31% (2010), 1.84% (2011) and 2.50% (2012) of survey respondents did not respond to this question.

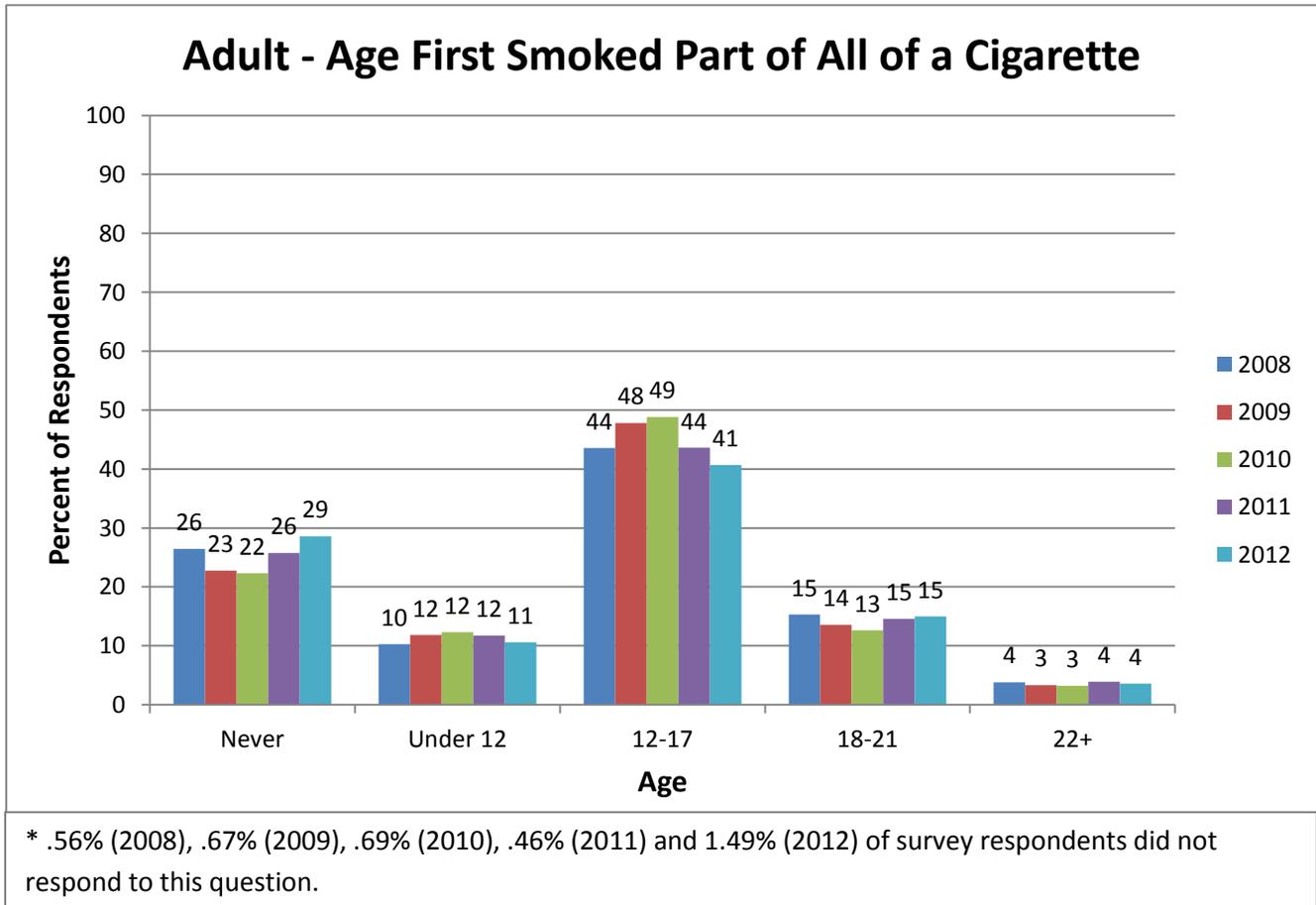
The percent of youth reporting hearing, reading, or watching an advertisement about the prevention of substance use has decreased over the past 5 years from 75% to 69%. The National Survey on Drug Use and Health (NSDUH) asks a similar question. Youth aged 12-17 were asked if they had seen or heard drug or alcohol prevention messages from sources outside of school. According to NSDUH 78% of youth reported they had seen or heard a prevention message in 2008, but this decreased to 76% in 2012.

Adult National Outcome Measures (NOMs) Survey Results as Reported to the Performance Based Prevention System (PBPS)

The following surveys were gathered from Pennsylvania adults who attended selected single prevention services and recurring prevention services from October 1st to November 30th of 2008 (n=3558), 2009 (n=4765), 2010 (n=5537), 2011 (n=4989) and 2012 (n=3091). The October to November timeframe helps provide some consistency to these survey results from year to year. Because service participants or attendees are not necessarily representative of the general population, please consider this a convenience sample. There are several differences between the demographics of survey respondents in 2011 compared to 2012. A greater percentage of the 2012 respondents are female, white, and age 41-59. Changes in the demographic make-up of the survey respondents each year, limits the ability to compare across years.

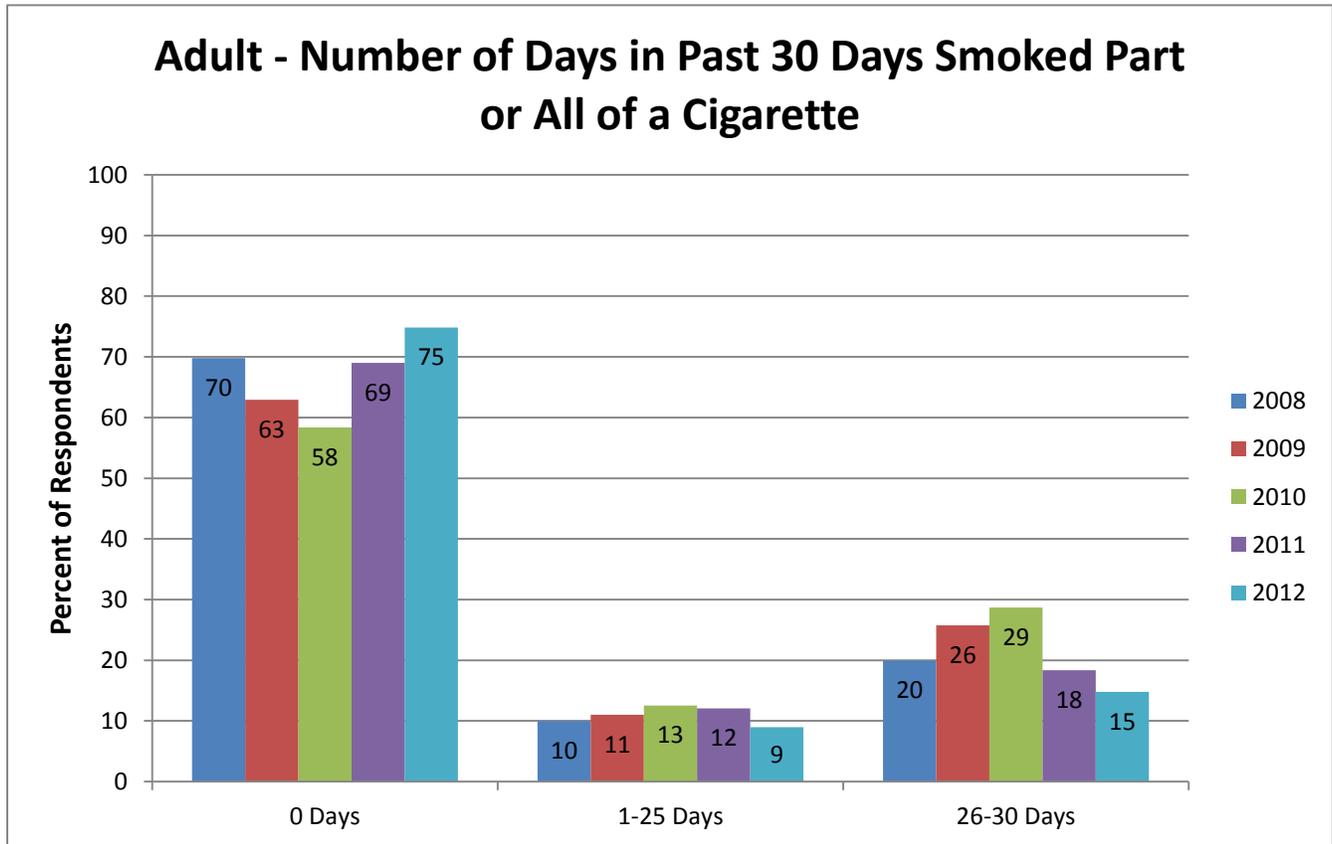
Demographic Breakdown of 2011 Respondents		
	2011	2012
Sex		
Male	37%	32%
Female	63%	68%
Age		
18-25	20%	15%
26-40	37%	38%
41-59	34%	39%
60+	10%	8%
Unknown	0.18%	0%
Race		
White	78%	89%
Black	15%	6%
Other*	4%	4%
Unknown	3%	1%
Ethnicity		
Hispanic or Latino	5%	5%
Not Hispanic or Latino	95%	95%
* Category of Other includes the following: American Indian and Alaska Native, Asian, Native Hawaiian and Other Pacific Islander, and More than One Race		

Question 01T: How old were you the first time you smoked part or all of a cigarette?



Each year 40-50% of the adult respondents reported that they first smoked a cigarette between the ages of 12 and 17. The percent of adults reporting that they have never smoked has ranged from 22% in 2010 to 29% in 2012.

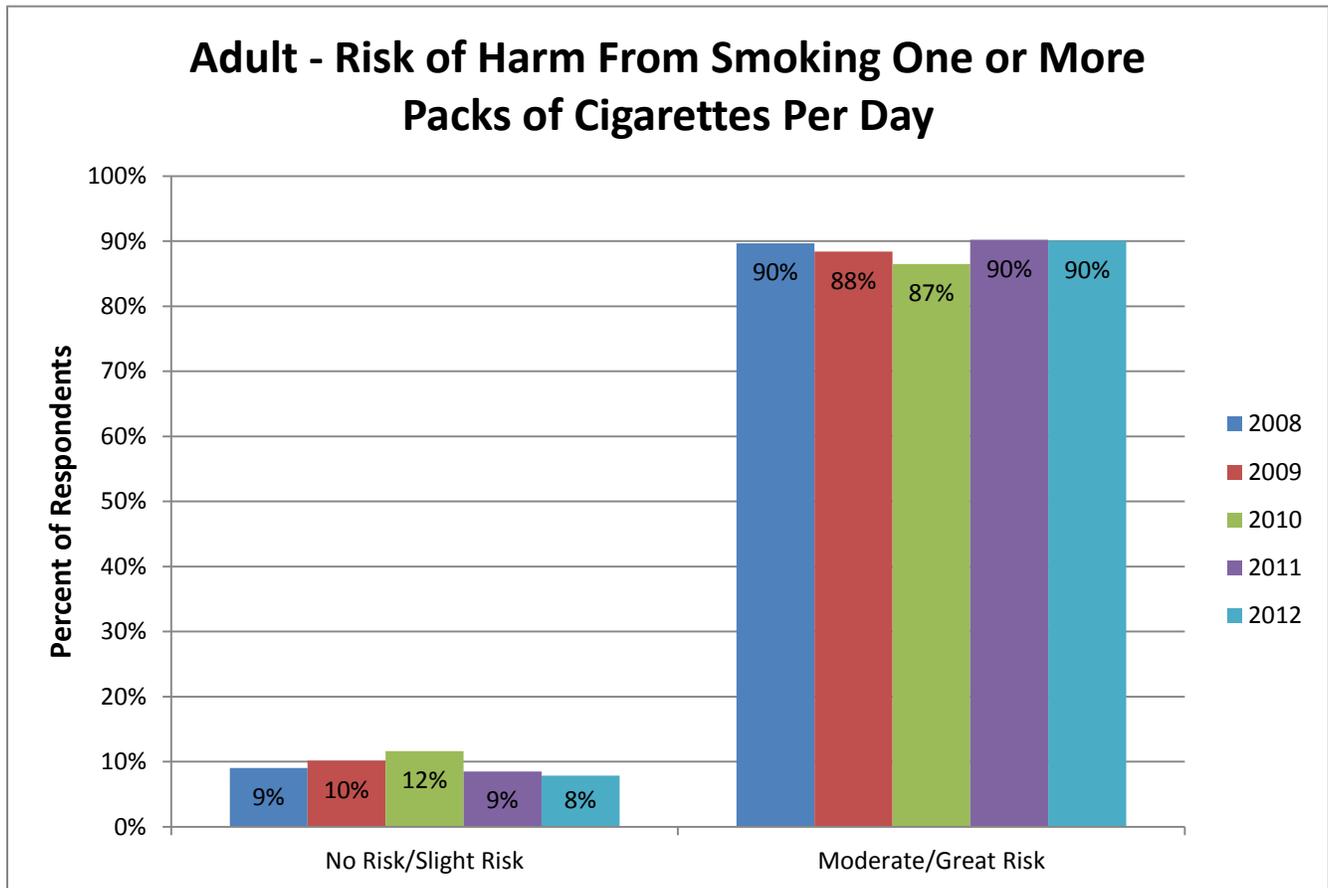
Question 02T: During the past 30 days, on how many days did you smoke part or all of a cigarette?



* .34% (2008), .38% (2009), .49% (2010), .54% (2011) and 1.42% (2012) of survey respondents did not respond to this question.

Past 30 day cigarette use among adult respondents has ranged from a low of 24% in 2012 to a high of 41% in 2010. In 2012 24% of adults reported past 30 day use of cigarettes. This is the same as the national percentage of 24% reported on the 2012 National Survey on Drug Use and Health for adults age 18+.

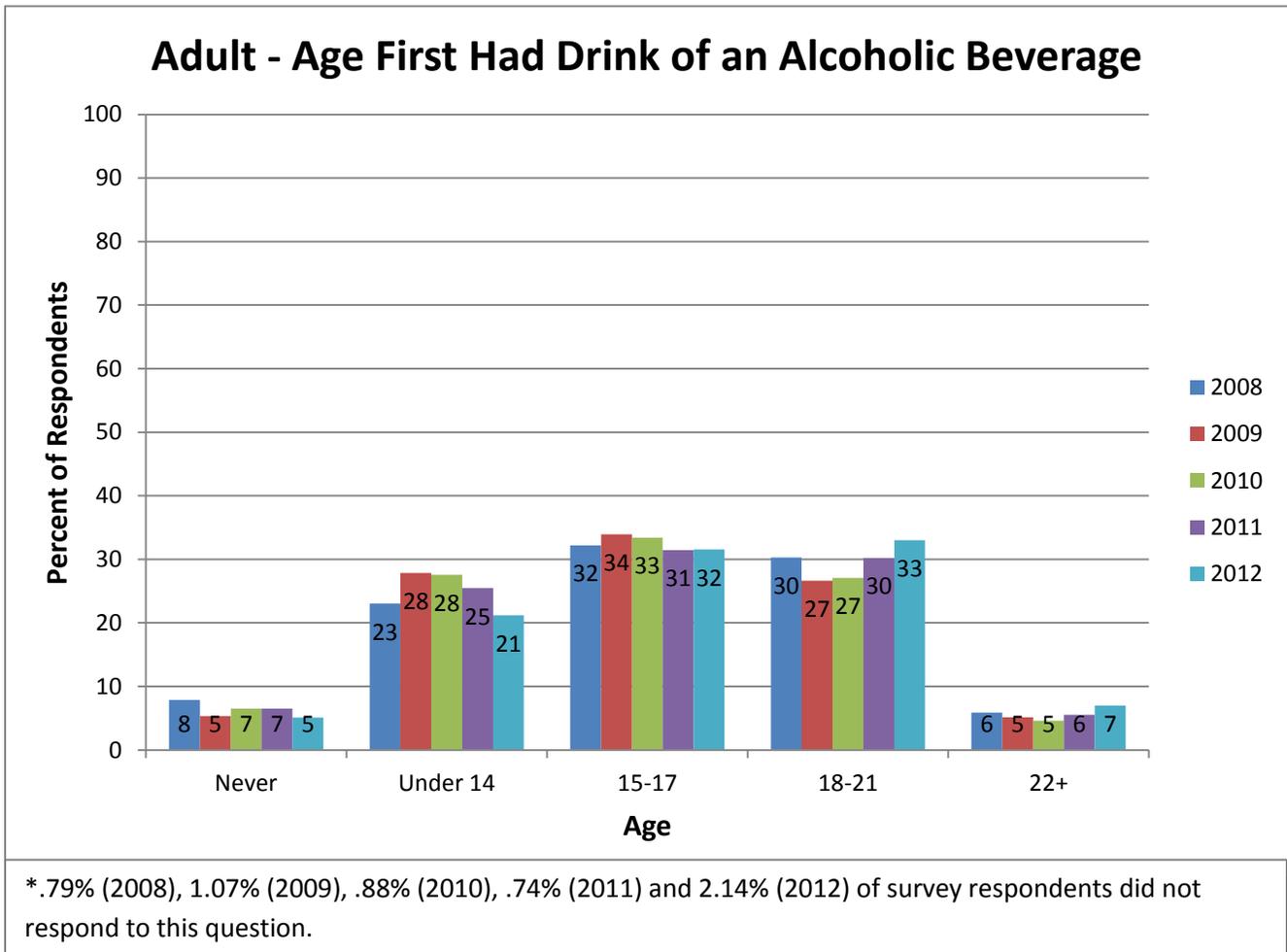
Question 03T: How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?



* 1.29% (2008), 1.43% (2009), 1.82% (2010), 1.22% (2011) and 2.10% (2012) of survey respondents did not respond to this question.

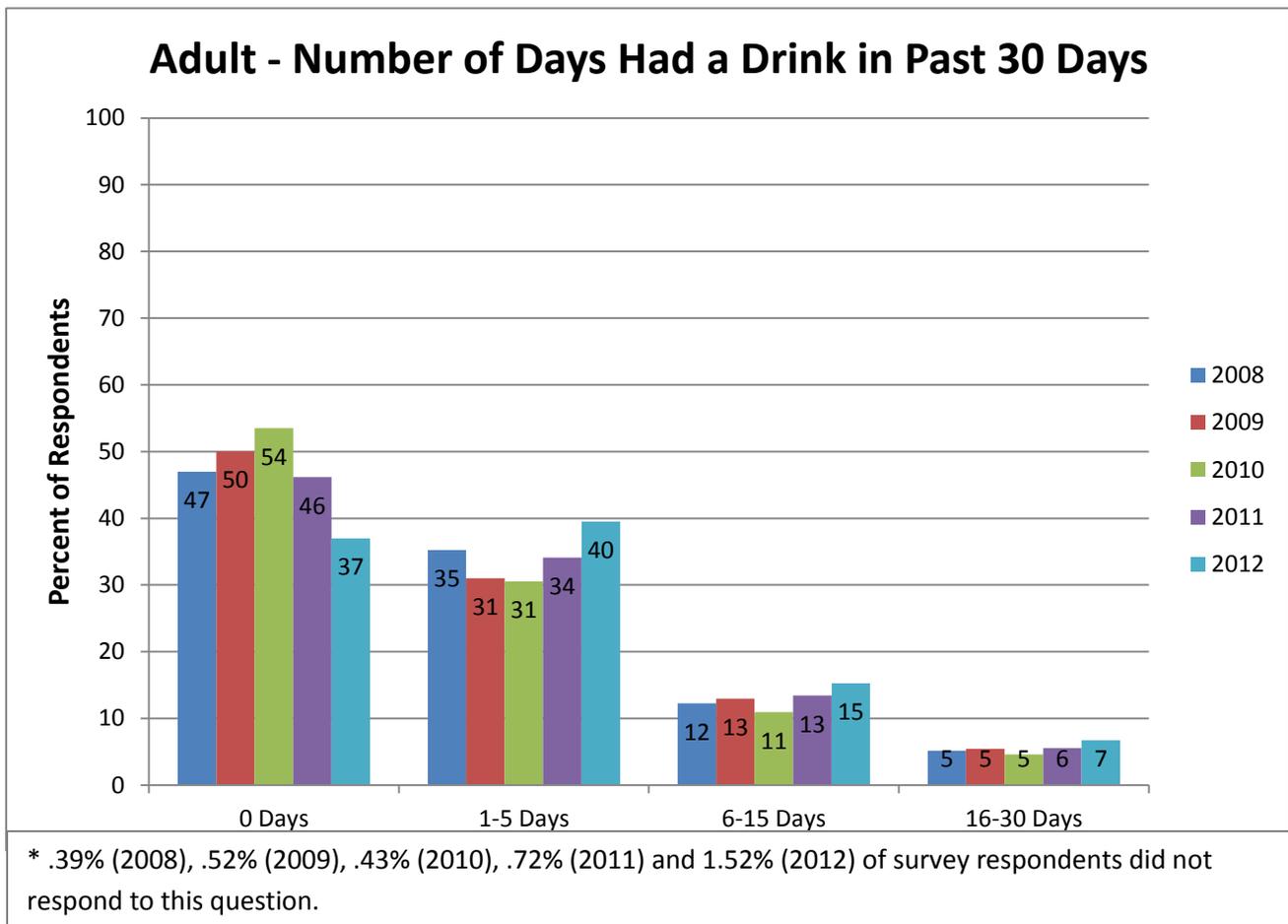
The number of adults reporting moderate or great risk of harm from smoking one or more packs of has remained close to 90% for the past 5 years. Each year more adults reported that smoking one or two packs of cigarettes per day posed a moderate or great risk of harm than reported that smoking marijuana and drinking alcohol posed a moderate or great risk of harm. In 2012 74.5% of adults reported great risk of harm. This is similar to the national percentage of 73.2% reported on the 2012 National Survey on Drug Use and Health for adults age 26+.

Question 01A: How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink.



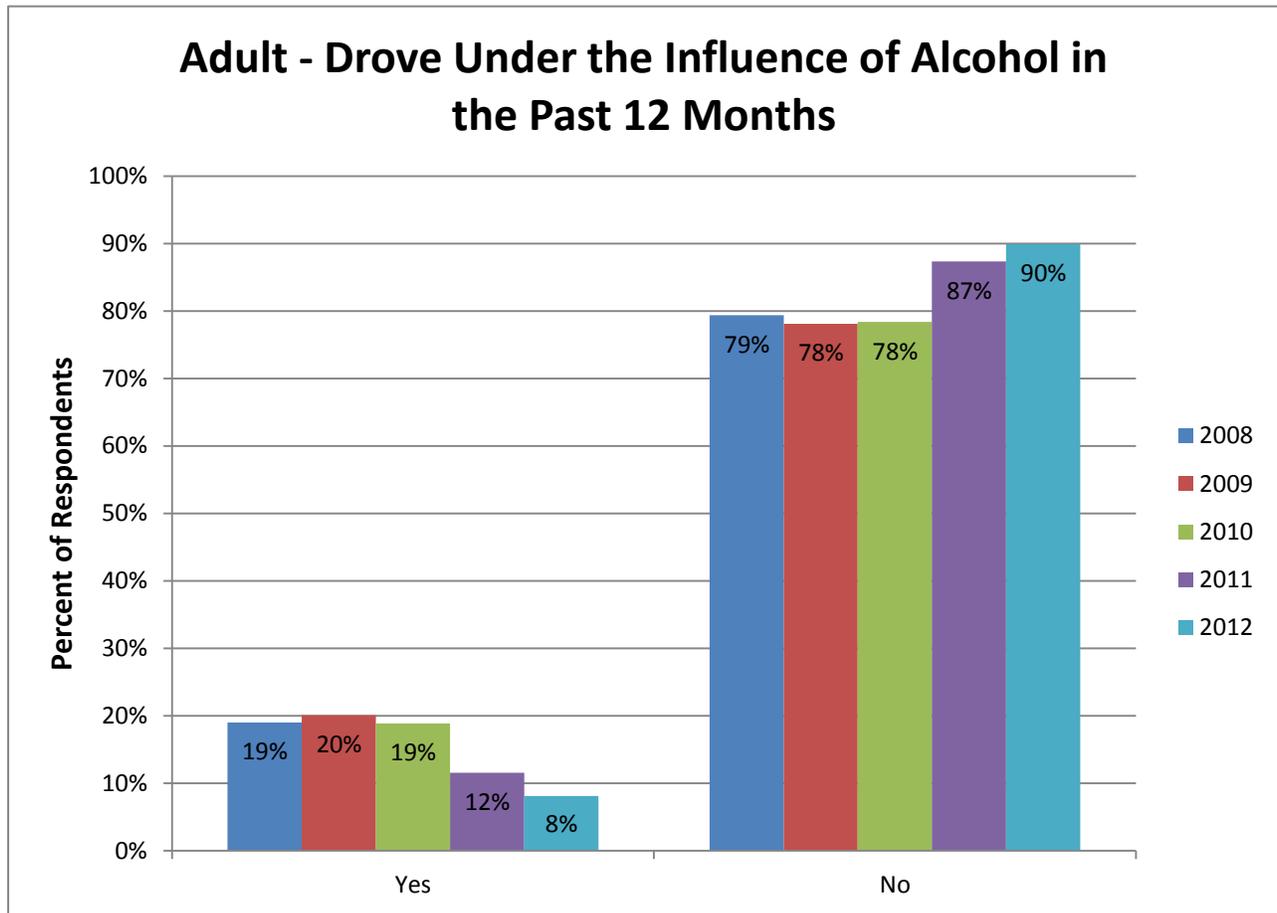
For each of the past five year just over 30% of adult respondents reported that they had their first drink of an alcoholic beverage between the ages of 15 and 17.

Question 02A: During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?



The percent of adults reporting that they had a drink on 5 or less days out of the past 30 days has remained above 75% for 2008-2012 with a high of 84% in 2010 and a low of 77% in 2012. In 2012 61.5% of adults reported past 30 day alcohol use. This is higher than the national percentage of 56% reported on the 2012 National Survey on Drug Use and Health for adults age 18+.

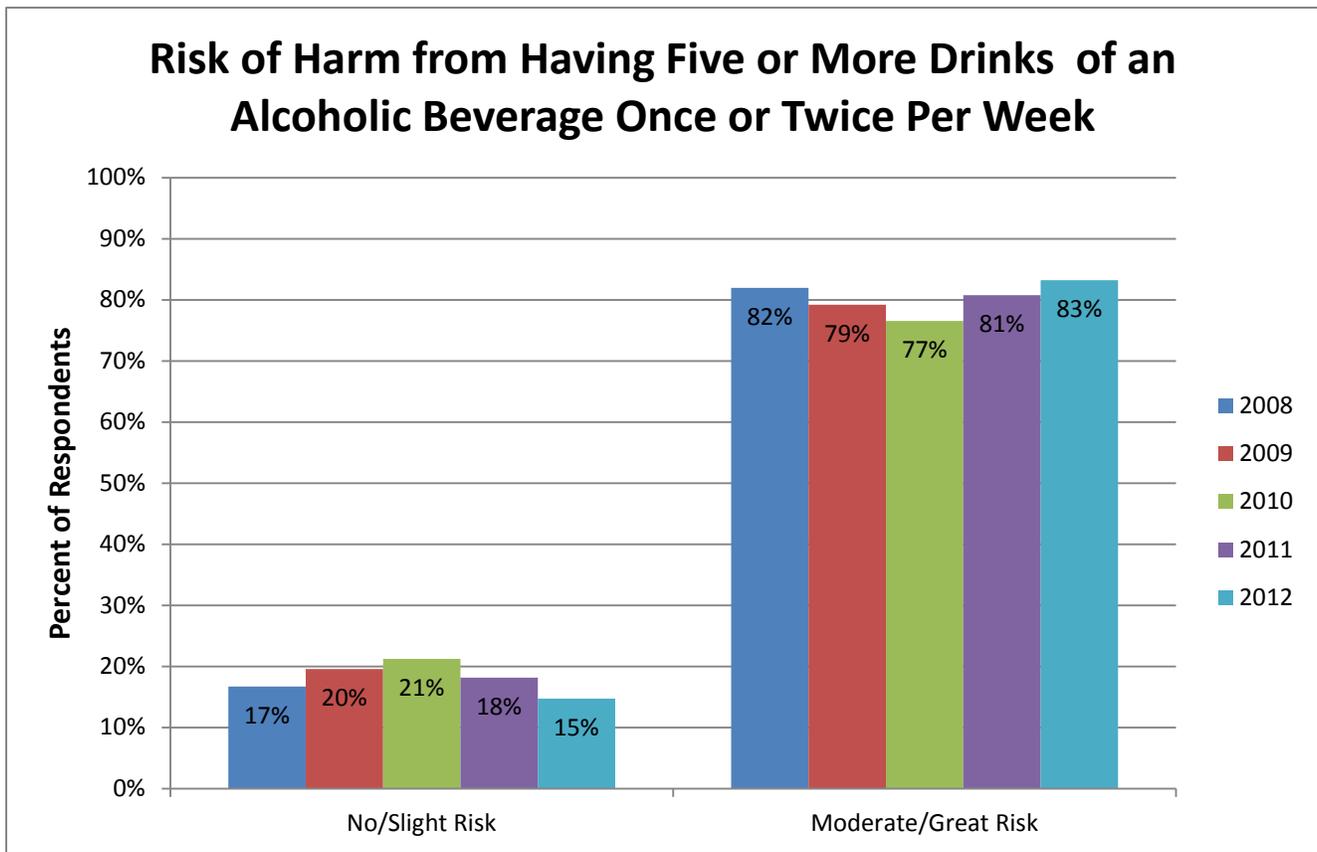
Question 03A: During the past 12 months, have you driven a vehicle while you were under the influence of alcohol only?



*1.63% (2008), 1.76% (2009), 2.65% (2010), 1.08% (2011) and 2.01% (2012) of survey respondents did not respond to this question.

The percent of adults reporting that they drove under the influence has shown an overall downward trend. In 2012 8% of respondents reported that they drove under the influence in the past 12 months.

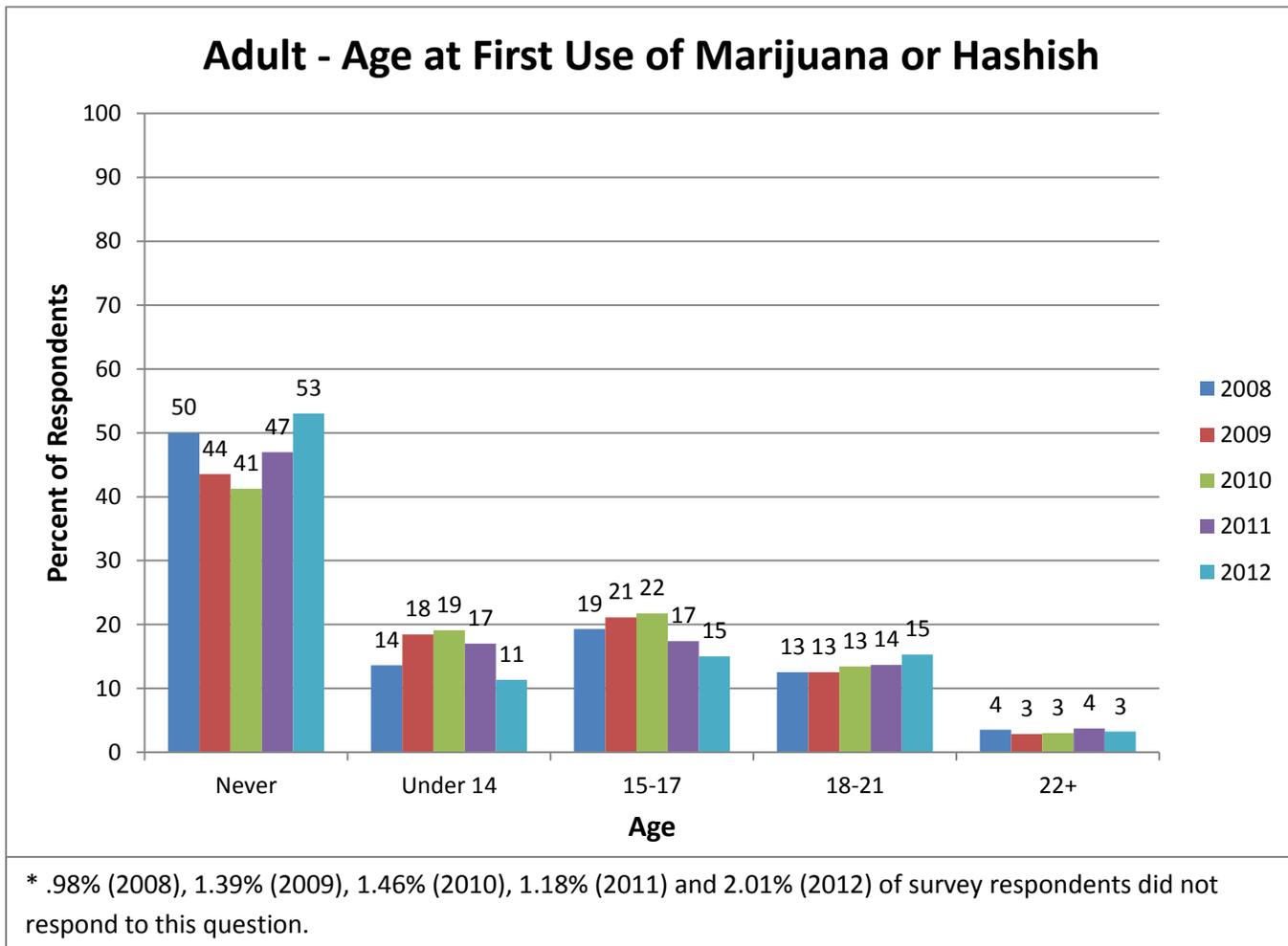
Question 04A: How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?



* 1.29% (2008), 1.22% (2009), 2.20% (2010), 1.00% (2011) and 2.01% (2012) of survey respondents did not respond to this question.

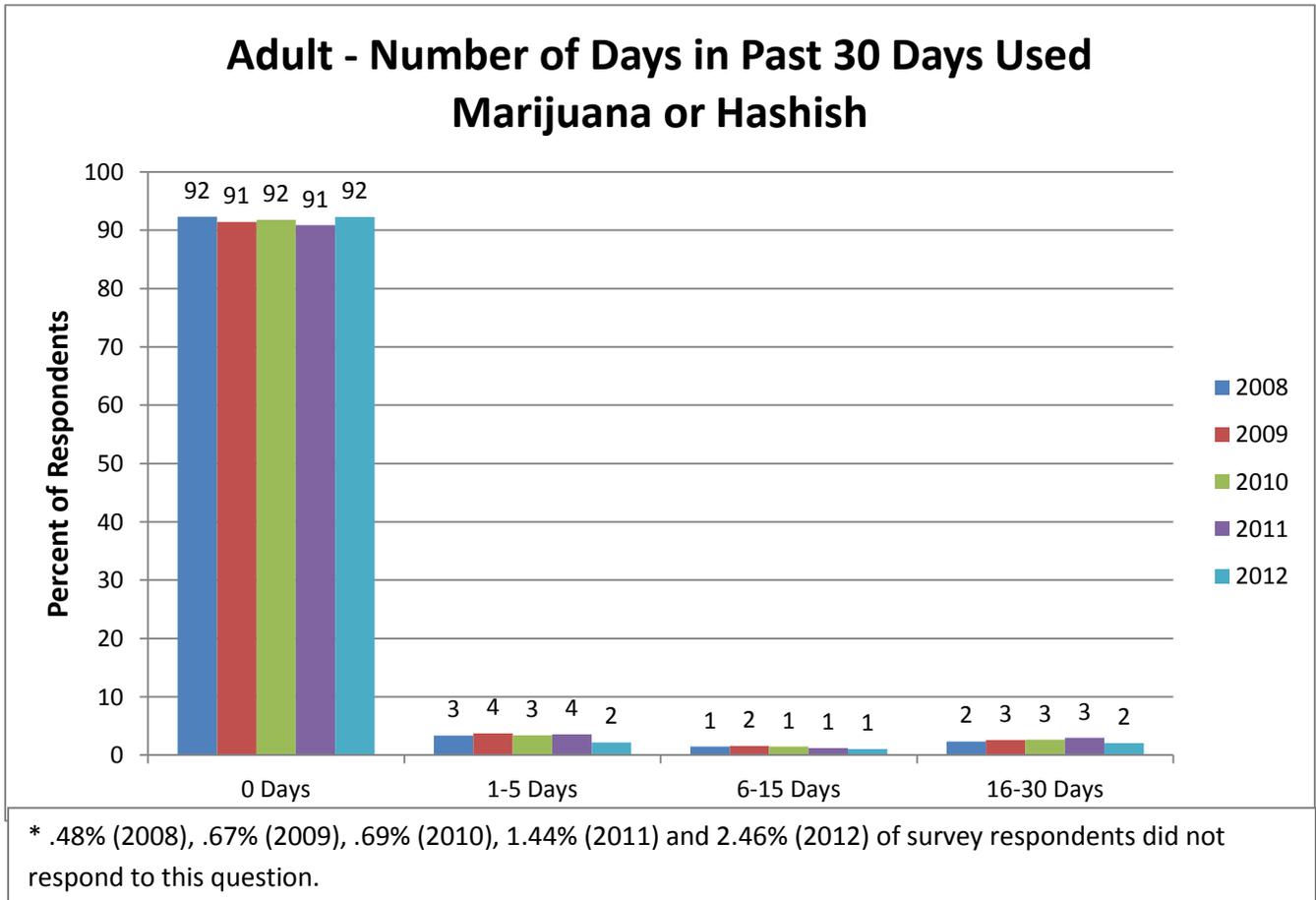
The percent of adults reporting moderate/great risk from having five or more drinks of an alcoholic beverage once or twice per week has ranged from a high of 83% in 2012 to a low of 77% in 2010. In 2012 52.6% of adults reported great risk of harm. This is higher than the national percentage of 44% reported on the 2012 National Survey on Drug Use and Health for adults age 26+.

Question 01M: How old were you the first time you used marijuana or hashish?



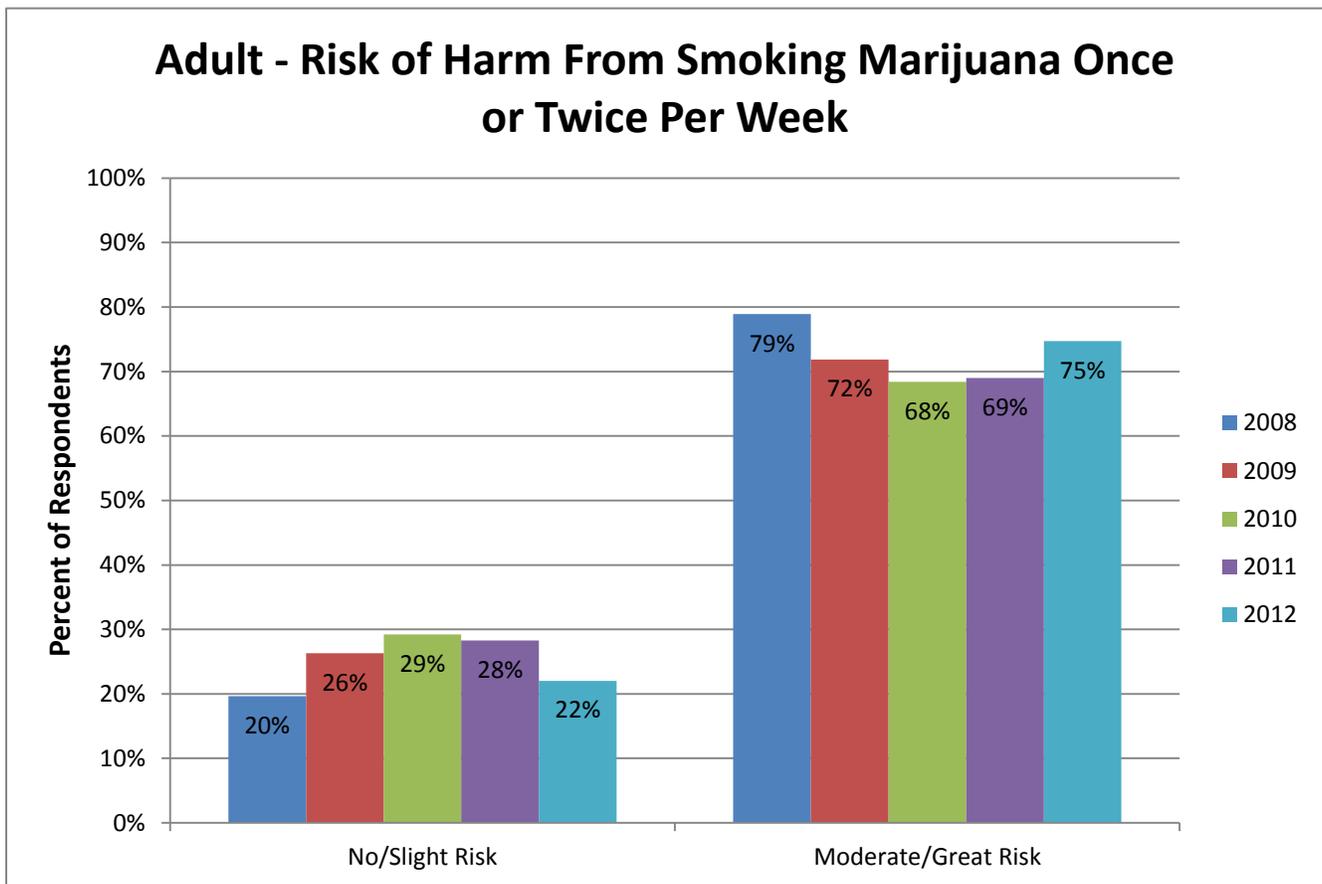
The percent of adults reporting that they have never used marijuana or hashish has ranged from a low of 41% in 2010 to a high of 53% in 2012. In 2012 approximately 45% of adult respondents reported that they had used marijuana or hashish. The most commonly reported age at first use was 15-17.

Question 02M: During the past 30 days, on how many days did you use marijuana or hashish?



The percent of adults reporting no past 30 day use of marijuana or hashish has remained slightly above 90% for every year from 2008-2012. In 2012 5.3% of adults reported past 30 day use of marijuana or hashish. This is lower than the national percentage of 7.3% reported on the 2012 National Survey on Drug Use and Health for adults age 18+.

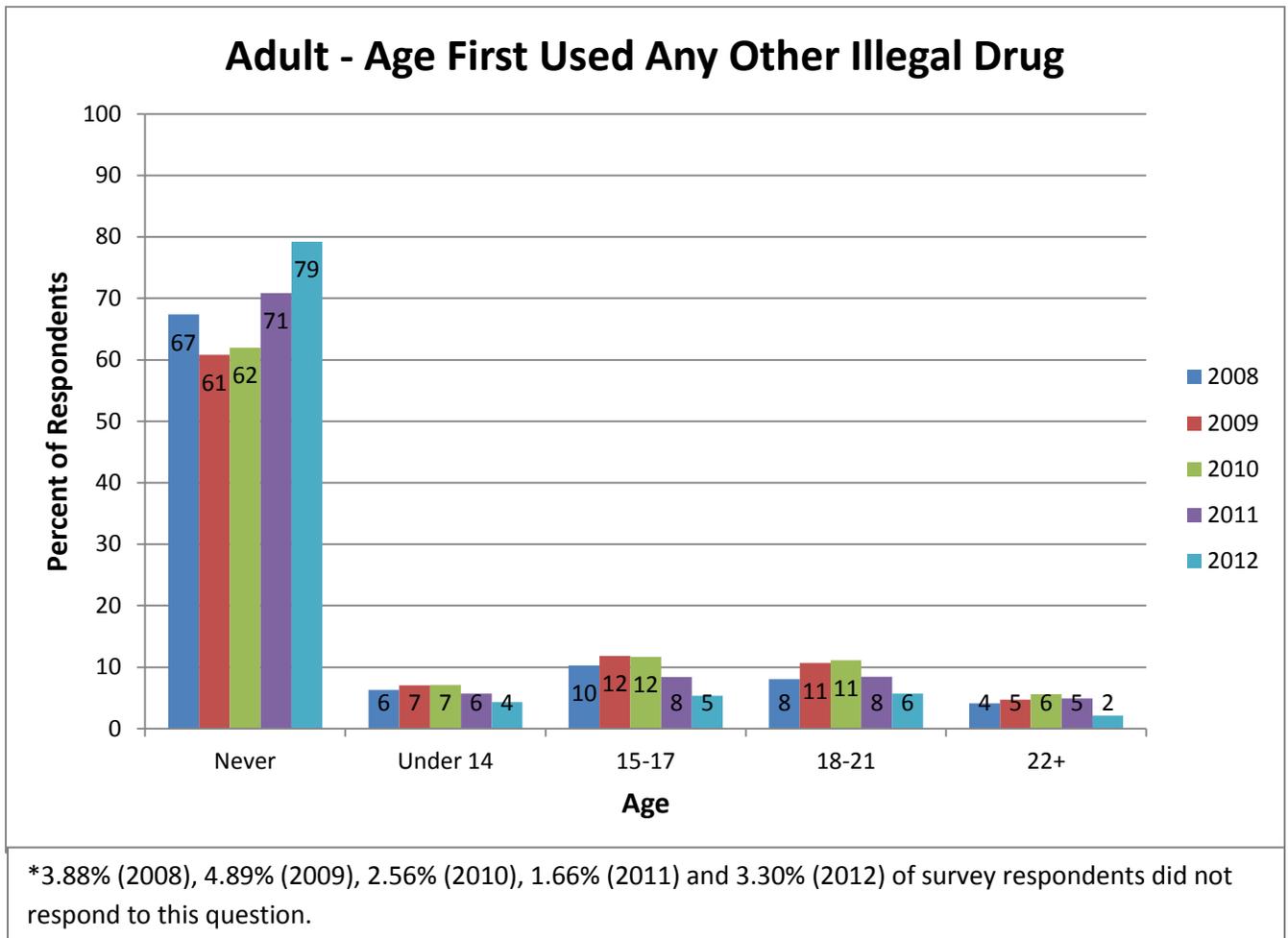
Question 03M: How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?



* 1.46% (2008), 1.78% (2009), 2.35% (2010), 2.67% (2011) and 3.24% (2012) of survey respondents did not respond to this question.

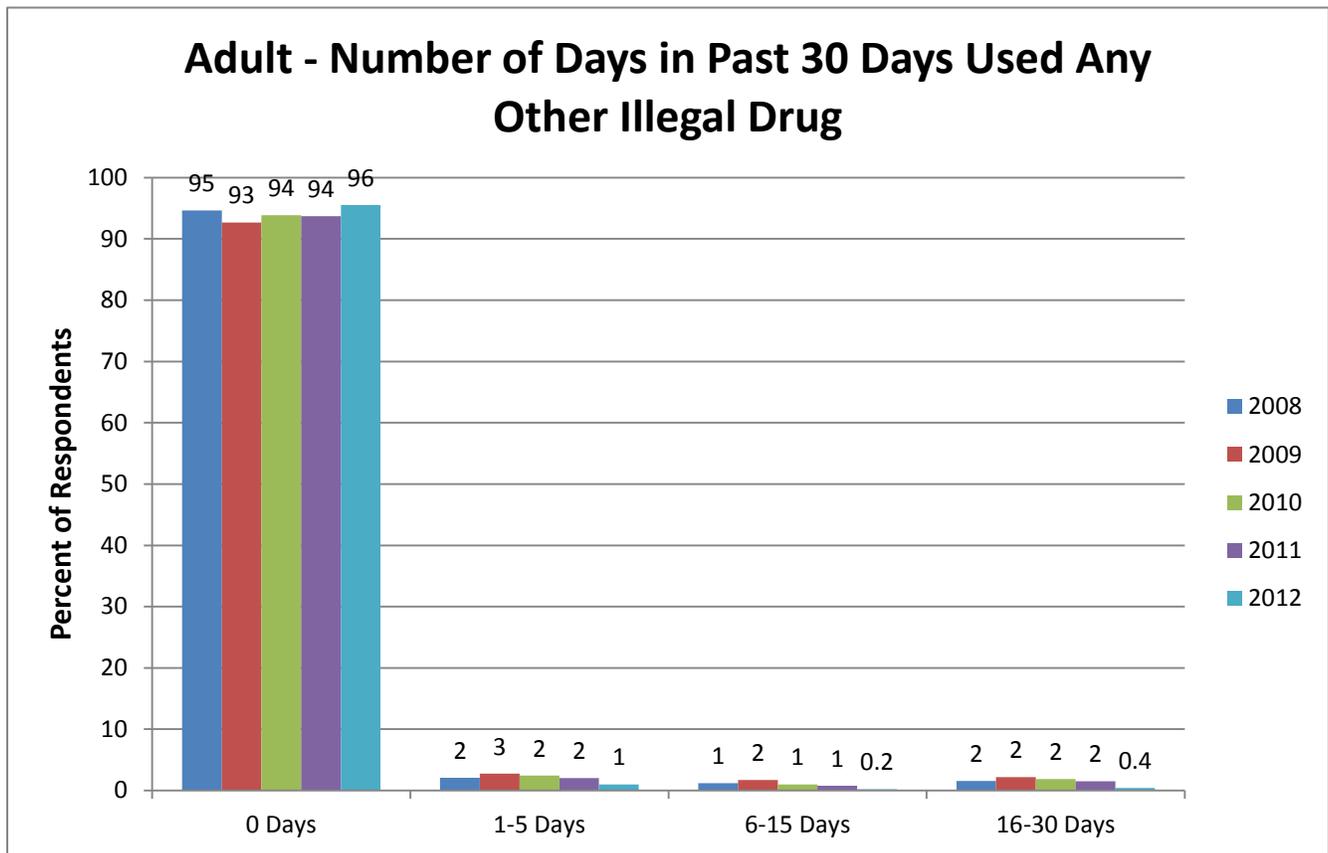
The percent of adults reporting moderate/great risk of harm from smoking marijuana once or twice a week has ranged from a low of 68% in 2010 to a high of 79% in 2008. Of the five questions on the survey regarding the potential harm posed by use of certain substances (i.e. cigarettes, marijuana, alcohol, prescription drugs and synthetic drugs), this question on marijuana use had the highest percent of respondents reporting no or only slight risk.

Question 010: How old were you the first time you used any other illegal drug? Other illegal drugs include substances like: Heroin, crack or cocaine, methamphetamine; Hallucinogens (such as LSD, Ecstasy, PCP or peyote); Inhalants or sniffed substances such as glue, gasoline, paint thinner, cleaning fluid or shoe polish.



The percent of adults reporting that they have never used any other illegal drug has ranged from a low of 61% in 2009 to a high of 79% in 2012. In 2012 approximately 17.5% of adults reported that they had used any other illegal drug. The most commonly reported age at first use was 15-17 for all years except 2012.

Question 010: During the past 30 days, on how many days did you use any other illegal drug? Other illegal drugs include substances like: Heroin, crack or cocaine, methamphetamine; Hallucinogens (such as LSD, Ecstasy, PCP or peyote); Inhalants or sniffed substances such as glue, gasoline, paint thinner, cleaning fluid or shoe polish.



*.56% (2008), .67% (2009), .83% (2010), 2.00% (2011) and 2.85% (2012) of survey respondents did not respond to this question.

The percent of adults reporting no past 30 day use of any other illegal drug has ranged from a low of 93% in 2009 to a high of 96% in 2012. In 2011 4% of adults reported past 30 day use of other illegal drugs. This is slightly higher than the national percentage of 3% reported on the 2010-2011 National Survey on Drug Use and Health for adults age 18+.

Question 01P: Have you ever taken prescription medications that were not prescribed specifically for you?

This question was added to the adult NOMs survey in 2011.

Year	Yes	No	Did Not Answer
2011	28%	68%	3.5%
2012	23%	73%	3.5%

Question 02P: How much do people risk harming themselves physically and in other ways when they take prescription medications not specifically prescribed for them?

This question was added to the adult NOMs survey in 2011.

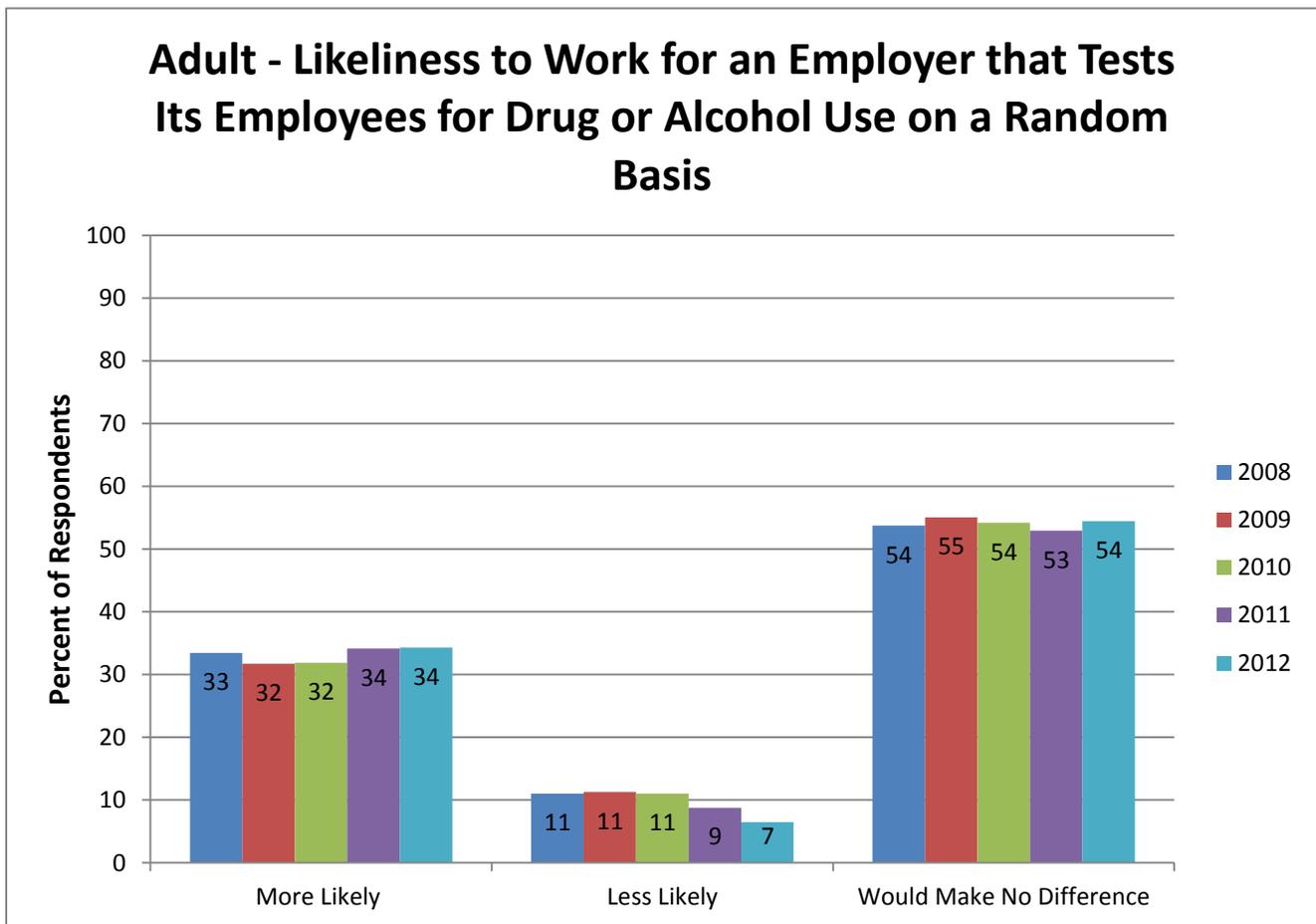
Year	No Risk/Slight Risk	Moderate Risk/Great Risk	Did Not Answer
2011	11%	85%	4%
2012	10%	86%	4%

Question 01S: How much do people risk harming themselves physically and in other ways using synthetic drugs?

This question was added to the adult NOMs survey in 2011. A question regarding perceived risk of harm was asked about five substances in 2012. Synthetic drugs had the second highest percentage (after cigarettes) of respondents selecting moderate or great risk.

Year	No Risk/Slight Risk	Moderate Risk/Great Risk	Did Not Answer
2011	9%	87%	4%
2012	7%	89%	4%

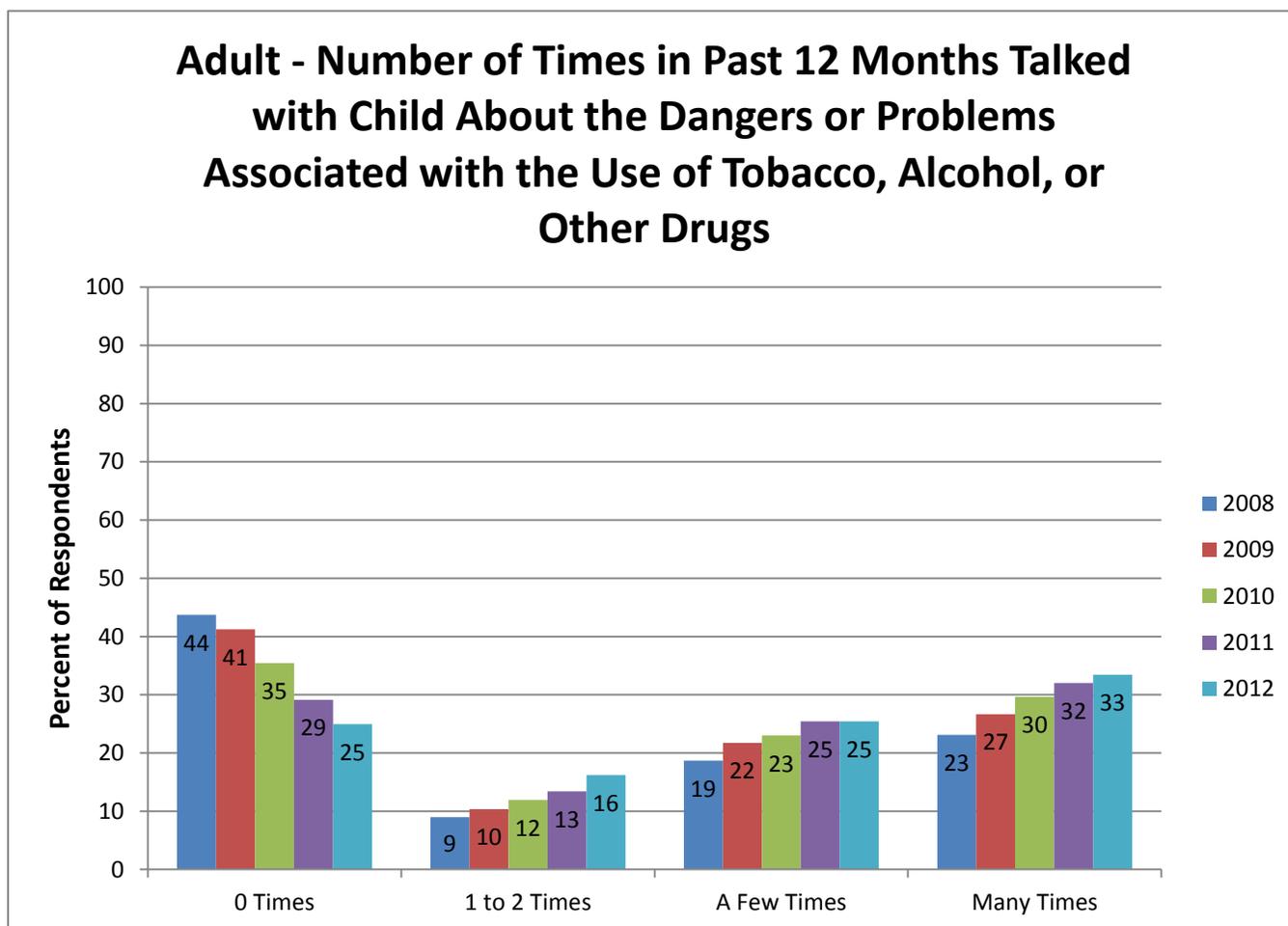
Question 01Z: Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis?



*.48% (2008), 1.89% (2009), 2.84% (2010), 4.13% (2011) and 4.72% (2012) of survey respondents did not respond to this question.

The percent of adults reporting that they would be more likely to work for an employer that tests its employees for drug or alcohol use on a random basis has remained just above 30% for the past five years.

Question 02Z: During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?



* The percentages in the graph above were calculated out of the total number of respondents who chose one of the four answer choices shown (n=3165 for 2008, n=3317 for 2009, n=3490 for 2010, n=2815 for 2011, n=1813 for 2012). Those who selected not applicable (no children or children are not age appropriate) or did not answer this question were not included in the denominator when calculating the percentages. The percent who selected Not Applicable and who did not respond, calculated out of the total number of respondents, is 5.90% (2008), 30.39% (2009), 36.84% (2010), 43.5% (2011) and 41.35% (2012).

The percent of adults reporting that they have not talked with their child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs in the past 12 months has decreased steadily from 2008-2012. This has been accompanied by an increase in the number reporting that they talked with their child many times. In 2012 75% of respondents reporting talking with their child at least once.

Treatment Data Analysis

State Fiscal Year 2012-2013

Current year treatment data is not available at this time. This year's data has been transitioned from the agency's historical CIS (Client Information System) application to our new STAR (Strengthening Treatment and Recovery) application. As part of this transition, we are now capturing more detailed data as required by the federal Treatment Episode Data Set (TEDS). Once we have submitted all information to TEDS and it has been accepted by SAMHSA, we will then be able to provide complete reporting of our data. We are projecting that this data will be available by late 2014/early 2015.

Single County Authority Expenditures for State Fiscal Year 2012-13 By Funding Source				
	Total	Total	Total	
	DDAP	County	Other SCA	Total
Single County Authority	Funds	Funds	Funds	Funds
Allegheny	\$ 11,581,574	\$ 160,414	\$ 7,939,560	\$ 19,681,548
Armstrong/Indiana/Clarion	\$ 1,441,531	\$ -	\$ 2,262,716	\$ 3,704,247
Beaver	\$ 1,251,466	\$ 80,000	\$ 614,982	\$ 1,946,448
Bedford	\$ 389,147	\$ -	\$ 341,344	\$ 730,491
Berks	\$ 3,058,713	\$ 1,872,127	\$ 2,654,450	\$ 7,585,290
Blair	\$ 1,092,343	\$ -	\$ 1,244,910	\$ 2,337,253
Bradford/Sullivan	\$ 535,633	\$ 24,414	\$ 148,169	\$ 708,216
Bucks	\$ 3,316,645	\$ 269,536	\$ 1,416,594	\$ 5,002,775
Butler	\$ 1,101,747	\$ 26,753	\$ 1,254,965	\$ 2,383,465
Cambria	\$ 1,003,411	\$ 28,304	\$ 500,062	\$ 1,531,777
Cameron/Elk/McKean	\$ 854,115	\$ 84,018	\$ 1,047,518	\$ 1,985,651
Carbon/Monroe/Pike	\$ 1,049,107	\$ 57,429	\$ 1,687,289	\$ 2,793,825
Centre	\$ 777,394	\$ 32,429	\$ 673,695	\$ 1,483,518
Chester	\$ 2,447,019	\$ 434,586	\$ 3,962,899	\$ 6,844,504
Clearfield/Jefferson	\$ 1,003,300	\$ -	\$ 851,692	\$ 1,854,992
Col/Montour/Snyder/Union	\$ 832,340	\$ 14,469	\$ 663,747	\$ 1,510,556
Crawford	\$ 709,363	\$ 19,331	\$ 1,088,129	\$ 1,816,823
Cumberland/Perry	\$ 1,633,810	\$ 194,315	\$ 1,114,303	\$ 2,942,428
Dauphin	\$ 2,484,323	\$ 224,701	\$ 1,098,052	\$ 3,807,076
Delaware	\$ 3,411,795	\$ 128,115	\$ 2,215,292	\$ 5,755,202
Erie	\$ 3,581,432	\$ 281,864	\$ 1,554,553	\$ 5,417,849
Fayette	\$ 1,077,539	\$ -	\$ 1,536,452	\$ 2,613,991
Forest/Warren	\$ 350,156	\$ 13,244	\$ 234,161	\$ 597,561
Franklin/Fulton	\$ 611,839	\$ 96,228	\$ 405,378	\$ 1,113,445
Greene	\$ 291,609	\$ 9,503	\$ 117,778	\$ 418,890
Huntingdon/Mifflin/Juniata	\$ 665,736	\$ -	\$ 317,077	\$ 982,813
Lackawanna/Susquehanna	\$ 1,690,987	\$ 82,500	\$ 898,285	\$ 2,671,772
Lancaster	\$ 2,517,771	\$ 160,465	\$ 1,725,228	\$ 4,403,464
Lawrence	\$ 804,424	\$ -	\$ 633,548	\$ 1,437,972
Lebanon	\$ 647,790	\$ 101,420	\$ 400,152	\$ 1,149,362
Lehigh	\$ 2,271,628	\$ 87,890	\$ 2,283,280	\$ 4,642,798
Luzerne/Wyoming	\$ 2,309,810	\$ 201,907	\$ 1,404,098	\$ 3,915,815
Lycoming/Clinton	\$ 1,138,997	\$ 111,343	\$ 1,176,472	\$ 2,426,812
Mercer	\$ 1,086,933	\$ 45,000	\$ 791,275	\$ 1,923,208
Montgomery	\$ 4,013,941	\$ 139,743	\$ 1,614,925	\$ 5,768,609
Northampton	\$ 1,657,435	\$ 120,772	\$ 1,343,194	\$ 3,121,401
Northumberland	\$ 534,443	\$ 22,834	\$ 305,842	\$ 863,119
Philadelphia	\$ 25,471,494	\$ 1,635,962	\$ 16,181,733	\$ 43,289,189
Potter	\$ 175,222	\$ 23,804	\$ 62,643	\$ 261,669
Schuylkill	\$ 1,163,583	\$ 29,319	\$ 798,112	\$ 1,991,014
Somerset	\$ 547,889	\$ 16,226	\$ 145,576	\$ 709,691
Wayne	\$ 298,402	\$ 95,395	\$ 237,399	\$ 631,196
Tioga	\$ 325,525	\$ 36,287	\$ 127,298	\$ 489,110
Venango	\$ 449,321	\$ 16,587	\$ 488,564	\$ 954,472
Washington	\$ 1,413,416	\$ -	\$ 945,596	\$ 2,359,012
Westmoreland	\$ 2,518,245	\$ 38,302	\$ 1,078,778	\$ 3,635,325
York/Adams	\$ 1,959,999	\$ 99,999	\$ 1,012,944	\$ 3,072,942
Total	\$ 99,550,342	\$ 7,117,535	\$ 70,600,709	\$ 177,268,586

Single County Authority Expenditures By Major Activity for State Fiscal Year 2012-13 (All Sources)

Single County Authority	Total Administration	Total Prevention	Total Intervention	Total Treatment	Total Expenditure
Allegheny	\$ 1,936,609	\$ 2,418,485	\$ 3,113,715	\$ 12,212,739	\$ 19,681,548
Armstrong/Indiana/Clarion	\$ 558,078	\$ 785,402	\$ 140,952	\$ 2,219,815	\$ 3,704,247
Beaver	\$ 388,905	\$ 325,625	\$ 5,388	\$ 1,226,530	\$ 1,946,448
Bedford	\$ 126,444	\$ 319,092	\$ 44,243	\$ 240,712	\$ 730,491
Berks	\$ 803,447	\$ 1,121,068	\$ 336,770	\$ 5,324,005	\$ 7,585,290
Blair	\$ 211,501	\$ 323,657	\$ 461,691	\$ 1,340,404	\$ 2,337,253
Bradford/Sullivan	\$ 108,900	\$ 108,136	\$ 54,201	\$ 436,979	\$ 708,216
Bucks	\$ 992,344	\$ 686,388	\$ 643,336	\$ 2,680,707	\$ 5,002,775
Butler	\$ 249,331	\$ 366,642	\$ 200,165	\$ 1,567,327	\$ 2,383,465
Cambria	\$ 236,122	\$ 147,225	\$ 48,386	\$ 1,100,044	\$ 1,531,777
Cameron/Elk/McKean	\$ 240,499	\$ 235,933	\$ 12,069	\$ 1,497,150	\$ 1,985,651
Carbon/Monroe/Pike	\$ 363,359	\$ 459,642	\$ 91,941	\$ 1,878,883	\$ 2,793,825
Centre	\$ 235,081	\$ 315,037	\$ 22,094	\$ 911,306	\$ 1,483,518
Chester	\$ 940,782	\$ 507,616	\$ 9,928	\$ 5,386,178	\$ 6,844,504
Clearfield/Jefferson	\$ 114,244	\$ 622,783	\$ 138,723	\$ 979,242	\$ 1,854,992
Col/Montour/Snyder/Union	\$ 207,654	\$ 160,127	\$ 126,442	\$ 1,016,333	\$ 1,510,556
Crawford	\$ 123,607	\$ 251,009	\$ 99,622	\$ 1,342,585	\$ 1,816,823
Cumberland/Perry	\$ 274,593	\$ 811,716	\$ 22,070	\$ 1,834,049	\$ 2,942,428
Dauphin	\$ 680,634	\$ 888,340	\$ 157,118	\$ 2,080,984	\$ 3,807,076
Delaware	\$ 679,916	\$ 642,076	\$ -	\$ 4,433,210	\$ 5,755,202
Erie	\$ 330,090	\$ 1,365,868	\$ 570,263	\$ 3,151,628	\$ 5,417,849
Fayette	\$ 244,028	\$ 439,285	\$ 257,139	\$ 1,673,539	\$ 2,613,991
Forest/Warren	\$ 122,960	\$ 98,412	\$ -	\$ 376,189	\$ 597,561
Franklin/Fulton	\$ 243,556	\$ 126,545	\$ 17,415	\$ 725,929	\$ 1,113,445
Greene	\$ 81,118	\$ 111,506	\$ -	\$ 226,266	\$ 418,890
Huntingdon/Mifflin/Juniata	\$ 205,214	\$ 181,480	\$ 25,075	\$ 571,044	\$ 982,813
Lackawanna/Susquehanna	\$ 223,729	\$ 453,311	\$ 235,119	\$ 1,759,613	\$ 2,671,772
Lancaster	\$ 470,827	\$ 1,313,856	\$ 49,304	\$ 2,569,477	\$ 4,403,464
Lawrence	\$ 215,297	\$ 273,760	\$ 10,495	\$ 938,420	\$ 1,437,972
Lebanon	\$ 227,242	\$ 175,463	\$ 98,528	\$ 648,129	\$ 1,149,362
Lehigh	\$ 418,412	\$ 600,923	\$ 285,450	\$ 3,338,013	\$ 4,642,798
Luzerne/Wyoming	\$ 264,654	\$ 652,147	\$ 82,388	\$ 2,916,626	\$ 3,915,815
Lycoming/Clinton	\$ 286,746	\$ 278,727	\$ 11,730	\$ 1,849,609	\$ 2,426,812
Mercer	\$ 296,524	\$ 467,370	\$ 22,984	\$ 1,136,330	\$ 1,923,208
Montgomery	\$ 799,973	\$ 493,900	\$ 332,635	\$ 4,142,101	\$ 5,768,609
Northampton	\$ 390,105	\$ 459,295	\$ 142,796	\$ 2,129,205	\$ 3,121,401
Northumberland	\$ 165,719	\$ 80,979	\$ 82,453	\$ 533,968	\$ 863,119
Philadelphia	\$ 10,296,916	\$ 4,611,224	\$ 1,959,505	\$ 26,421,544	\$ 43,289,189
Potter	\$ 61,968	\$ 57,119	\$ -	\$ 142,582	\$ 261,669
Schuylkill	\$ 275,322	\$ 423,399	\$ 26,396	\$ 1,265,897	\$ 1,991,014
Somerset	\$ 91,632	\$ 131,986	\$ 28,420	\$ 457,653	\$ 709,691
Wayne	\$ 156,903	\$ 108,540	\$ 57,735	\$ 308,018	\$ 631,196
Tioga	\$ 134,964	\$ 65,830	\$ -	\$ 288,316	\$ 489,110
Venango	\$ 175,655	\$ 133,136	\$ 9,400	\$ 636,281	\$ 954,472
Washington	\$ 315,358	\$ 501,116	\$ 4,218	\$ 1,538,320	\$ 2,359,012
Westmoreland	\$ 527,897	\$ 1,101,577	\$ -	\$ 2,005,851	\$ 3,635,325
York/Adams	\$ 407,416	\$ 438,589	\$ 14,970	\$ 2,211,967	\$ 3,072,942
Total	\$ 26,902,275	\$ 26,641,342	\$ 10,053,272	\$ 113,671,697	\$ 177,268,586

Appendix A: Resources and Contact Information

FOR IMMEDIATE HELP, CALL A HOTLINE OR CHECK THE PHONE BOOK UNDER "SUICIDE," "CRISIS" OR "MENTAL HEALTH." IN AN EMERGENCY, CALL 911. IF YOU CALL FOR SOMEONE ELSE, STAY WITH THE PERSON UNTIL HELP ARRIVES.

Prevention Web Sites

The Center for Communities That Care:
www.communitiesthatcare.net/gettingstarted

Social Development Research Group:
www.uwsrd.org/sdrg

Evidence-Based Prevention and Intervention Support Center (EPISCenter):
www.EPISCenter.psu.edu

Commonwealth Prevention Alliance:
www.commonwealthpreventionalliance.org

Youth Risk Behavior Surveillance System:
www.cdc.gov/HealthyYouth/yrbs/index.htm

National Survey on Drug Use and Health (NSDUH):
www.samhsa.gov/data/NSDUH.aspx

Monitoring the Future:
www.monitoringthefuture.org

The Partnership at DrugFree.org:
www.drugfree.org

MADD:
www.madd.org

Drug Free Pennsylvania:
www.drugfreepa.org

PA DUI Association:
www.padui.org

Guides to Prevention Programs

Blueprints for Healthy Youth Development:
www.blueprintsprograms.com

National Institute of Justice:
www.crimesolutions.gov

Federal OJJDP Model Programs Guide:
www.ojjdp.gov/mpg

SAMHSA Model Programs List:
www.nrepp.samhsa.gov

Washington State Institute for Public Policy (WSIPP):
www.wsipp.wa.gov

WSIPP Benefit/Cost Results:
www.wsipp.wa.gov/BenefitCost

State Resources

Pennsylvania General Assembly:
www.legis.state.pa.us

DDAP – PA Department of Drug and Alcohol Programs:
www.ddap.pa.gov

DOH – PA Department of Health:
www.health.state.pa.us

PLCB – PA Liquor Control Board:
www.lcb.state.pa.us/PLCB/index.htm

PCCD – PA Commission on Crime and Delinquency:
www.pccd.state.pa.us

PDE – PA Department of Education, Office of Safe Schools (Elementary and Secondary):
http://www.portal.state.pa.us/portal/server.pt/community/office_of_elementary_secondary_education/7209/office_for_safe_schools/1152067

Pennsylvania Student Assistance Programs (SAP):
<http://www.sap.state.pa.us>

County Commissioners Association of PA (CCAP):
www.pacounties.org

Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA):
www.pacdaa.org

Federal Resources

Office of National Drug Control Policy:
www.whitehouse.gov/ondcp

National Clearinghouse for Alcohol and Drug Information: www.ncadi.samhsa.gov

Substance Abuse and Mental Health Services Administration (SAMHSA):
www.samhsa.gov

National Institute on Drug Abuse (NIDA):
www.nida.nih.gov and www.drugabuse.gov

National Institute on Alcohol Abuse and Alcoholism (NIAAA):
www.niaaa.nih.gov

Centers for Disease Control (CDC):
www.cdc.gov/HealthyYouth/alcoholdrug/index.htm

National Centers for Chronic Disease Prevention/Health Promotion: www.cdc.gov/chronicdisease/index.htm

National Center on Addiction and Substance Abuse (CASA):
www.casacolumbia.org

With Bullying:

US Department of Health and Human Services:
www.stopbullying.gov

PA Center for Safe Schools:
www.safeschools.info/bullying-prevention

The Pennsylvania Safe Schools Act:
www.pasafeschoolsact.com

With Drugs and Alcohol:

Pennsylvanian's Needing Help Now:
www.ddap.pa.gov/needhelpnow

National Clearinghouse for Alcohol and Drug Information:
1-800-729-6686

National Alcohol and Drug Treatment and Referral Service:
1-800-662-HELP

Alcoholics Anonymous:
www.aa.org

Pennsylvania Area Al-Anon Web Site:
www.pa-al-anon.org

Check yellow pages under "Drugs" for the county D&A services available in your area.

With Smoking Cessation:

Pennsylvania Smoke Free Quitline
www.DeterminedToQuit.com or
1-800 QUIT NOW (784-8669)

With Depression or Suicidal Thoughts:

National Depression Hotline:
1-800-448-3000

National Hopeline Network:
1-800-442-HOPE (442-4673)

National Suicide Prevention Lifeline:
1-800-273-TALK (273-8255)

With Gambling:

Pennsylvania Gambling Addiction 24 Hour Hotline:
www.paproblemgambling.com
1-877-565-2112

Pennsylvania Council on Compulsive Gambling
www.pacouncil.com
1-800-GAMBLER (848-1880)

With Domestic Violence or Child Abuse:

National Resource Center for Domestic Violence and Child Abuse:
1-800-932-4632

Appendix B: State Plan Acronym List

AOD	Alcohol and Other Drugs	PBPP	PA Board of Probation and Parole
ASAM	American Society of Addiction Medicine	PBPS	Performance Based Prevention System
ATR	Access to Recovery Grant	PCB	PA Certification Board
BTP	Buprenorphine Treatment Program	PCCD	Pennsylvania Commission on Crime and Delinquency
CSAP	Center for Substance Abuse Prevention	PIR	Persons In Recovery
CSAT	Center for Substance Abuse Treatment	RCPA	Rehabilitation & Community Providers Association
CSC	Clinical Standards Committee	PATOD	Pennsylvania Association for Treatment of Opioid Dependence
DAAC	Drug and Alcohol Advisory Council	PCPC	PA Client Placement Criteria
DDAP	Department of Drug and Alcohol Programs	PDE	PA Department of Education
DOC	Department of Corrections	PERU	Program Evaluation and Research Unit (University of Pittsburgh)
DOH	Department of Health	PPAC	Parent Panel Advisory Council
DHS	Department of Human Services	PRO-A	PA Recovery Organizations Alliance
FASD	Fetal Alcohol Spectrum Disorder	ROSC	Recovery Oriented Systems of Care
FDA	US Food and Drug Administration	SAMHSA	Substance Abuse and Mental Health Services Administration
HCV	Hepatitis C Virus	SAPT	Substance Abuse Prevention and Treatment
H-OO	Heroin and Other Opioid Workgroup	SBIRT	Screening, Brief Intervention and Referral to Treatment
IRETA	Institute for Research, Education, and Training in Addictions	SCA	Single County Authority
MAT	Medication Assisted Treatment	SCI	State Correctional Institution
OCYF	Office of Children, Youth and Families	STAR	Strengthening Treatment and Recovery Data System
OMAP	Office of Medical Assistance Programs	VMS	Voucher Management System
OMHSAS	Office of Mental Health and Substance Abuse Services		
ORRTF	Overdose Rapid Response Task Force		
OTP	Opioid Treatment Program		
PACDAA	PA Association of County Drug and Alcohol Administrators		