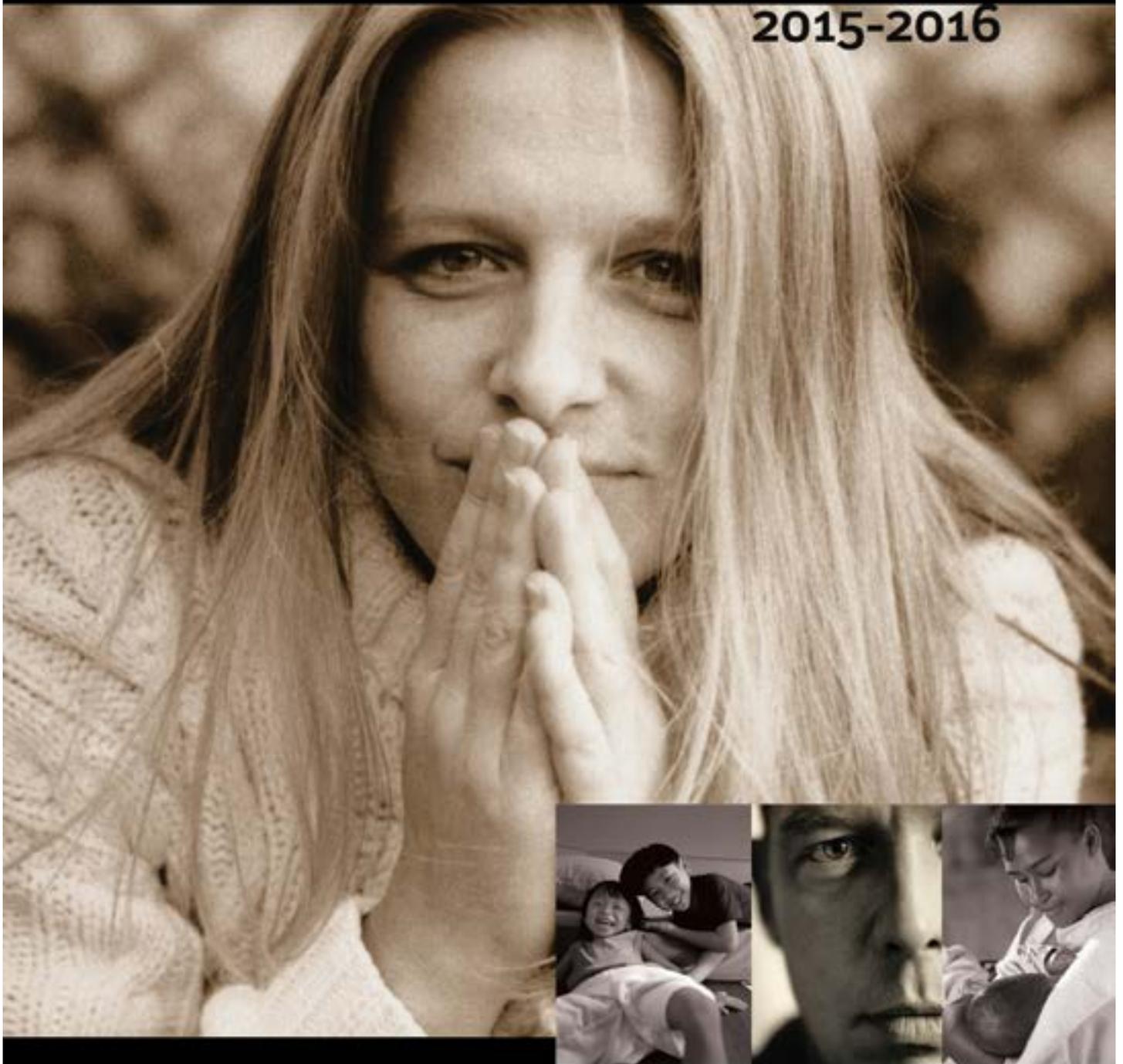


PENNSYLVANIA DRUG AND ALCOHOL ANNUAL PLAN AND REPORT

DRUG AND ALCOHOL ABUSE PREVENTION AND TREATMENT

2015-2016



pennsylvania
DEPARTMENT OF DRUG AND
ALCOHOL PROGRAMS

Table of Contents

Part 1: State Plan and Program Reports	3
<i>Chapter 1: Overview and State Plan 2015-16</i>	4
Acknowledgements.....	5
Letter from the Secretary.....	6
The Need For The Department	7
Department Accomplishments	10
Department History.....	11
Mission/Vision/Values	12
Core Values.....	13
Goals and Plan	14
Pennsylvania Advisory Council on Drug and Alcohol Abuse Recommendations.....	24
Interdepartmental Collaborative Projects.....	25
<i>Chapter 2: Annual Report 2012-13, Progress Report 2013-14</i>	31
Prevention	33
Intervention	43
Treatment	48
Program Licensure.....	66
Accountability & Program Improvement	68
Budgets & Grants Management	69
Administrative and Support Services.....	70
Training.....	71
County Program Oversight	71
Women and Children’s Annual Report	73
Part 2: Program Data and Financial Information.....	76
<i>Chapter 1: Overview of Program Data (SFY 13-14).....</i>	77
Prevention Data.....	78
Treatment Data.....	92
Financial Information	126
Appendix A: Resources and Contact Information.....	128
Appendix B: State Plan Acronyms.....	130

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 2015-2016.

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.

The Department gratefully acknowledges all of our stakeholders and partners statewide for their collaboration and innovative strategic approaches in accomplishing many new successes throughout this past year. 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 establishment and growth 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), the Department of Corrections (DOC) 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 (SAMHSA) 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 unwavering daily efforts to make our accomplishments and our far-reaching goals a reality.



Fellow Citizens of Pennsylvania,

Substance abuse and addiction continue to afflict at least one out of four families in Pennsylvania. Like diabetes or heart disease, addiction is a treatable disease, but far too often it is left untreated, resulting in unnecessary and tragic death. Substance abuse and addiction have crippling impacts on individuals, families and society. In addition, they create a heavy cost burden on taxpayers. Most importantly, we are in the midst of the worst overdose crisis in our history, with at least seven Pennsylvanians dying every day from heroin and other drug overdoses.

Drug and alcohol prevention, intervention and treatment programs are a priority for the Wolf Administration. Governor Tom Wolf's proposed fiscal year 2015-16 budget reverses the steady cuts to drug and alcohol programming that have occurred over the past decade, and move us toward our goal of reducing substance abuse and overdose in Pennsylvania. I am excited at the overwhelming county drug and alcohol agency response to our Governor's proposal to provide \$5 million in new funding allocated for heroin and opioid addiction programs.

We are moving forward to strengthen our intervention strategies for overdose survivors and others identified with drug and alcohol addiction in healthcare offices, to increase the funding and implementation of best practices, to increase utilization of Medicaid under Medicaid expansion and to engage private insurance entities to achieve more successful and cost-effective outcomes for Pennsylvanians. Our State Plan addresses the overdose crisis head-on, with a multi-faceted approach. Over the next four years, we intend to reduce overdose death, make our communities safer from addiction-driven crime and have healthier schools, workplaces and communities.

Governor Wolf's proposed budget is a powerful step toward achieving our plan for a safer, healthier and brighter future for all Pennsylvanians.

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 Programs

THE NEED FOR THE DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

On January 13, 2012, the Center for Disease Control (CDC) formally declared the current drug overdose situation an epidemic. Unfortunately, Pennsylvania, is likewise experiencing the worst public health crisis in nearly a century; a surge of fatal drug overdoses has reached epidemic proportions and are still increasing. In 2014, over 2,488 Pennsylvanians died of overdose; we have every reason to believe those numbers have increased substantially since that time^{1a}. Among a sample of misusers of prescription drugs who used heroin, 80% started with prescription drugs before transitioning to heroin^{1b}. Anecdotally, we are hearing reports 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. Nationwide in 2012, about 15.3 million people aged 12 or older used prescription drugs non-medically in 2012². According to SAMHSA, heroin use is higher in 2013 than it was a decade ago³.

The establishment of the Department comes at a time of an unprecedented opioid epidemic occurring in Pennsylvania and across the nation. 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 rose sharply from 2002 to 2012 with an increase in the rate of death from 7.5 to 16.3 per thousand Pennsylvanians, with over 2,000 men, women and children dying annually in Pennsylvania due to overdose⁴. 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 and current reporting methodologies.

Year	Number of Deaths	Population	Rate per 100,000
2012	2,026	12,763,536	16.3
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

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 2012³.

In response to this current epidemic, Pennsylvania has had a broad response including initiatives detailed in this report such as the Overdose Task Force, adoption of prescribing guidelines for opioids, and unused Prescription Drug Take

Back initiatives. In February 2015, based on this public health epidemic, Governor Wolf Administration increased the availability of treatment through Medicaid expansion. The Governor's Medicaid expansion will continue to support residential treatment and recovery for the uninsured and under insured. Furthermore, the Governor has taken an immediate supportive role in addressing the opioid use and overdose crisis currently being experienced in the state through his support of widening treatment access and preventative efforts such as the lifesaving overdose drug naloxone to be carried by state police officers statewide as of February 2016 there are approximately 600 reversals, as well as other efforts described throughout this document. In an unprecedented action, the Governor has proposed additional funds in his proposed 2015-16 budget expressly for this purpose.

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

From a broader perspective, substance abuse prevention, intervention, and treatment services have a profound beneficial impact on our commonwealth. 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).

The Department's success will result in an extraordinary cost savings to every citizen. For every dollar invested in addiction treatment, the taxpayer saves \$7.00 in costs to society⁵, primarily in reduced criminal justice costs and health care costs. Furthermore, research on the Pennsylvania system finds that effective treatment not only reduces criminal 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 .

In 2007, it was estimated that the national cost to society of drug abuse alone, not including alcohol abuse, was \$193 billion⁷, 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:

- \$61 billion in total criminal justice costs: 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.

- \$11 billion in total healthcare costs: 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.
- \$120 billion in total lost productivity costs: 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 \$120,304,004,000⁸.

The total cost of treating drug abuse on the other hand, (including all above costs, health costs, hospitalizations, and government specialty treatment) is estimated to be \$14.6 billion, a mere 7.56% of these overall societal costs⁷. If you add alcohol abuse to these figures all of these costs multiply.

For instance, 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 highly regarded landmark 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 services⁸.

Pennsylvania has a current population of nearly 13 million and according to the most recent (2012-2013) National Survey on Drug Use and Health (NSDUH) conducted by SAMHSA, within this population there is an estimated prevalence of 900,000 cases of substance use disorder.

This latest NSDUH survey indicates that 7% 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 23%. Alcohol use for adolescents age 12-20 for the past month was at 29%. 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 SFY 2012-2013 state budget was 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; but only \$15.13 of this \$429.59 is spent actually solving the problem through prevention, treatment, and/or research. As compared to cost being spent on the consequences of effects of the untreated illness as mentioned above. 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.⁹ We pay dearly – both in taxpayer cost and in human suffering – for our national failure to fully resource treatment and prevention.

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

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.¹⁰ 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: Nationally in 2013, an estimated 1.7 million adults ages 18 or older were on parole or other supervised release from prison at some time during the past year. About one quarter (27.4%) were current illicit drug users¹¹. In Pennsylvania, of the 50,756 total offenders in state corrections well over half of this population (65% were male and 68% were female respectively) required some type of alcohol and other drug (AOD) treatment in 2014. This does not include those in the county criminal justice system also in need.¹²
- Veterans: In 2014, there were 939,067 Pennsylvania

Veterans that had served our nation. A 2011 national Treatment Episode Data Set (TEDS) survey reported about 1 in 5 veterans (21.4%) were homeless when admitted to treatment programs^{13a}. In another study in 2008, an estimated 11% of all veterans reported misusing prescription drugs^{13b}. In 2010 according to the National Survey of Veterans, an estimated 1.3% of total veterans were hospitalized for a mental health or substance abuse treatment. While over half (53.1%) of all VA paid health care services were for mental health or substance abuse treatment outpatient visits^{13c}.

- Pregnant Women: Nationally among pregnant women aged 15 to 44, 5.4% were current illicit drug users and 19 percent drink alcohol during early pregnancy, based on data averaged across 2012 and 2013¹⁴.
- Adolescents: In 2013, an estimated 55,000 Pennsylvania children aged 12-17 had a dependency or abused illicit drugs or alcohol in the past year¹⁵.
- Employers: In 2009, the majority (67%) of current drug users aged 18 or older were employed, either full-time (48%) or part-time (19%), with the unemployed accounting for 13% and the remaining 21% not in the labor force at all. Among full-time workers aged 18 or older, nearly 1 in 12 (8%) reported use in the past-month of an illicit drug in 2009.³ Unemployed workers were twice as likely – one in six (17%) – to report current drug use in 2009.

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. We are driving toward greater accountability and measurement of effectiveness of services, through contract monitoring and licensing programs which is the standard business expectation.

The Department is working to establish a comprehensive needs assessment in the realm of prevention to determine the exact nature of the substance abuse problems across 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 developed.

The substance abuse service system in Pennsylvania 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 plan will be a continually evolving document that addresses the needs of the Department, 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.

1a) Pennsylvania State Coroners Association Report on Overdose Death Statistics 2014

1b) CBHSQ DATA REVIEW August 2013: Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States
<http://archive.samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.pdf>

2) 2013 National Survey on Drug Use and Health (NSDUH)
<http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHHTML2013/Web/NSDUHresults2013.pdf>

3) The CBHSQ Report: Short Report April 23, 2015
http://www.samhsa.gov/data/sites/default/files/report_1943/ShortReport-1943.pdf

4) Pennsylvania Department of Health, Bureau of Health Statistics Drug Poisoning Deaths 2012: These data were provided by the Pennsylvania Department of Health. The Department specifically disclaims responsibility for any analyses, interpretations or conclusion.

5) Rand Drug Policy Research Center, 2007

6) Villanova University, 1995

7) Office of National Drug Control Policy
<https://www.whitehouse.gov/ondcp/ondcp-fact-sheets/how-illicit-drug-use-affects-business-and-the-economy>
 National Drug Intelligence Center

8) California Alcohol and Drug Treatment Assessment (CALDATA), 2004

9) CASAColumbia. (2009). *Shoveling up II: The Impact of Substance Abuse on Federal, State and Local Budgets*. New York: Author. <http://www.centeronaddiction.org/addiction-research/reports/shoveling-ii-impact-substance-abuse-federal-state-and-local-budgets>

10) 2001–2015 Robert Wood Johnson Foundation, May 2007

11) Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014, p. 26. <http://archive.samhsa.gov/data/NSDUH/2013SummNatFindDetTables/NationalFindings/NSDUHresults2013.htm#2.6>

12) Pennsylvania Department of Corrections 2014-15 Budget Overview

13a) The TEDS Report: Data Spotlight Jan 2014, Twenty-one Percent of Veterans in Substance Abuse Treatment Were Homeless

13b) National Institute on Drug Abuse (NIH) DrugFacts: Substance Abuse in the Military Mar 2013

13c) National Survey of Veterans — Final Report: Table 4.2.6-C. Health Care and Payment Sources p.216

14) Source: Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014, p. 26. <http://archive.samhsa.gov/data/NSDUH/2013SummNatFindDetTables/NationalFindings/NSDUHresults2013.htm#2.6>

15) SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012 and 2013. Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. These estimates include data from original methamphetamine questions but do not include new methamphetamine items added in 2005 and 2006. <http://www.samhsa.gov/data/population-data-nsduh/reports?tab=38>

DEPARTMENTAL INITIATIVES & ACCOMPLISHMENTS

In its first three years, the Department has had several significant accomplishments since its creation, never before possible. Highlights include:

- *Supported the enactment and implementation of “David’s Law” (Act 139, 2014), which made naloxone available to police, firefighters, as well as family members and friends of those at risk of heroin or other opioid overdose. Naloxone has saved thousands of lives by rapidly reversing overdoses, and has limited side effects besides the extreme temporary discomfort of withdraw. Police in Pennsylvania have saved over 600 lives, as of February 2016. Additionally, through the Good Samaritan provision, the Act provides immunity from prosecution for those responding to and reporting overdoses.*
- *Initiated the Building Bridges to Recovery Event to encourage increasing collaboration of our recovery community with medical providers. Building Bridges to Recovery was an outreach effort which began in September 2014, during National Recovery Month, to raise awareness around substance use disorders. It conveys that individuals can and do recover from the disease, when given the appropriate level and duration of treatment. The Department used the initiative as a way to break down the stigma that far too often isolates individuals and their families who live with drug and alcohol addiction. Due to these continued efforts throughout 2014-2015, Secretary Gary Tennis received the national Ramstad/Kennedy Award for Outstanding Leadership for his leadership in recovery support across Pennsylvania.*
- *Partnered and implemented the Get Help Now Mobile Website with Harrisburg Area Community College students. A mobile friendly, statewide information resource for persons seeking drug, alcohol or gambling addiction treatment programs as well as other services. Providing individuals with a convenient way to locate treatment services anywhere, anytime in Pennsylvania.*
- *Partnered with Pennsylvania Commission on Crime and Delinquency, the Pennsylvania District Attorneys Association, the Pennsylvania National Guard and the Attorney General’s Office to expand the Prescription Drug Take Back process with over 400 permanent collection boxes across the*

commonwealth and over 40,000 pounds of drugs collected and destroyed in 2015.

- *Established the Overdose Task Force, to facilitate interagency coordination for communication and response to overdoses.*
- *Founded and co-chaired with the State Physician General on the Safe and Effective Prescribing Practices and Pain Management Task Force, together with a cross agency collaboration to adopt Pennsylvania Guidelines for Treatment of Chronic Non Cancer Pain, Emergency Department Pain Treatment Guidelines and Dental Guidelines.*
- *Established and continues to facilitate the Methadone Death and Incident Review team to create recommendations for best practices in the safe and effective use of Methadone pursuant to Act 148 of 2012 (See MDAIR Annual Report).*

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

- *Completed first round of updating program licensure regulations, which had not previously been updated for over 40 years.*
- *Expanded Medicaid Pilot project to 50 counties, coordinating both the Department and DHS staff to provide federally funded services to offenders returning from jail who are in need of SUD treatment through our Single County Authorities and Criminal Justice System.*
- *Partnered with Pennsylvania Department of Transportation and Pennsylvania Commission on Crime and Delinquency to seek enforcement of the statutory treatment requirements in Pennsylvania’s drunk driving law.*
- *Partnered with Lieutenant Governor and Board of Pardons to implement Pathway to Pardons.*
- *Partnered with Departments of Agriculture and Labor and Industry to build strong vocational rehabilitative supports.*

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.

Pursuant to 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 of drug and alcohol abuse and dependency, and the threat they pose to public health; and,
- Mitigating the economic and public safety 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, and 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 closing down prisons and jails.

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), Pennsylvania Commission on Crime and Delinquency (PCCD), Department of Health (DOH), Pennsylvania Insurance Department (PID), Department of Education (PDE), Board of Probation and Parole (PBPP), the Department of Corrections (DOC), Department of Agriculture, Department of State (DOS), Department of Transportation (PennDOT), Department of Labor and Industry (L&I), Board of Pardons, Department of Military and Veteran Affairs, and Attorney General's Office. 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.



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

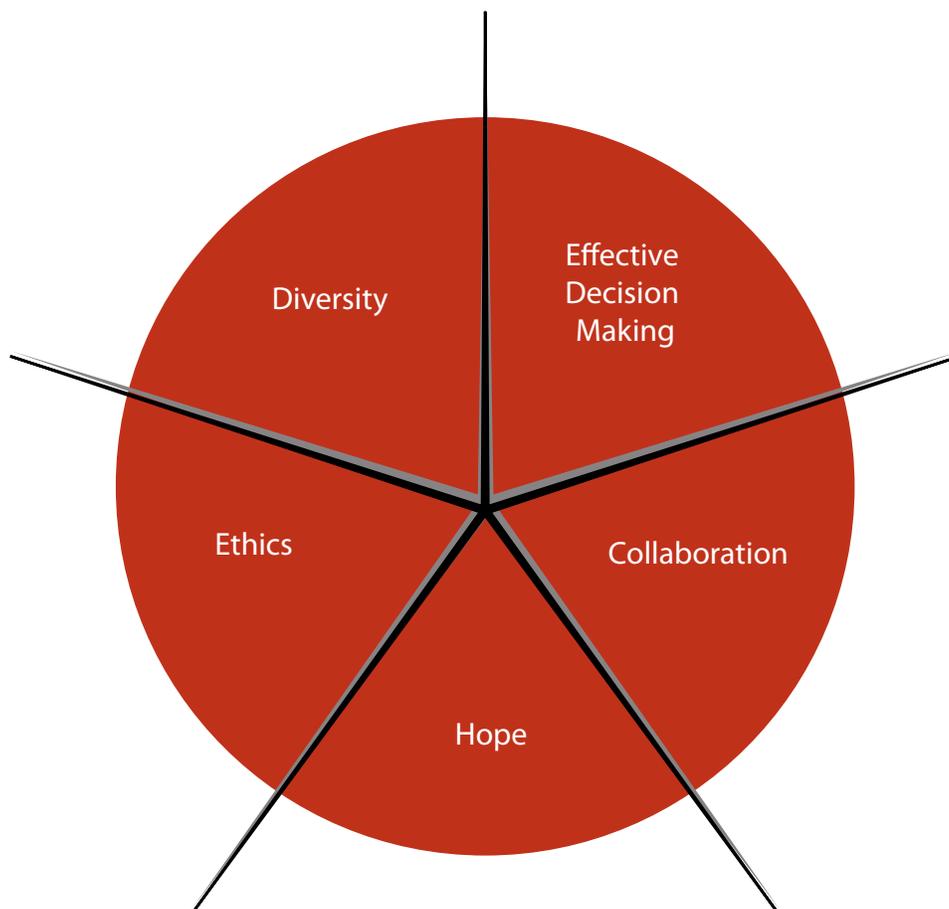
Effective Decision Making – We value decision making that is outcome-focused and quality-informed, that reflects an understanding of costs and benefits and that maximizes the impact of available resources.

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.

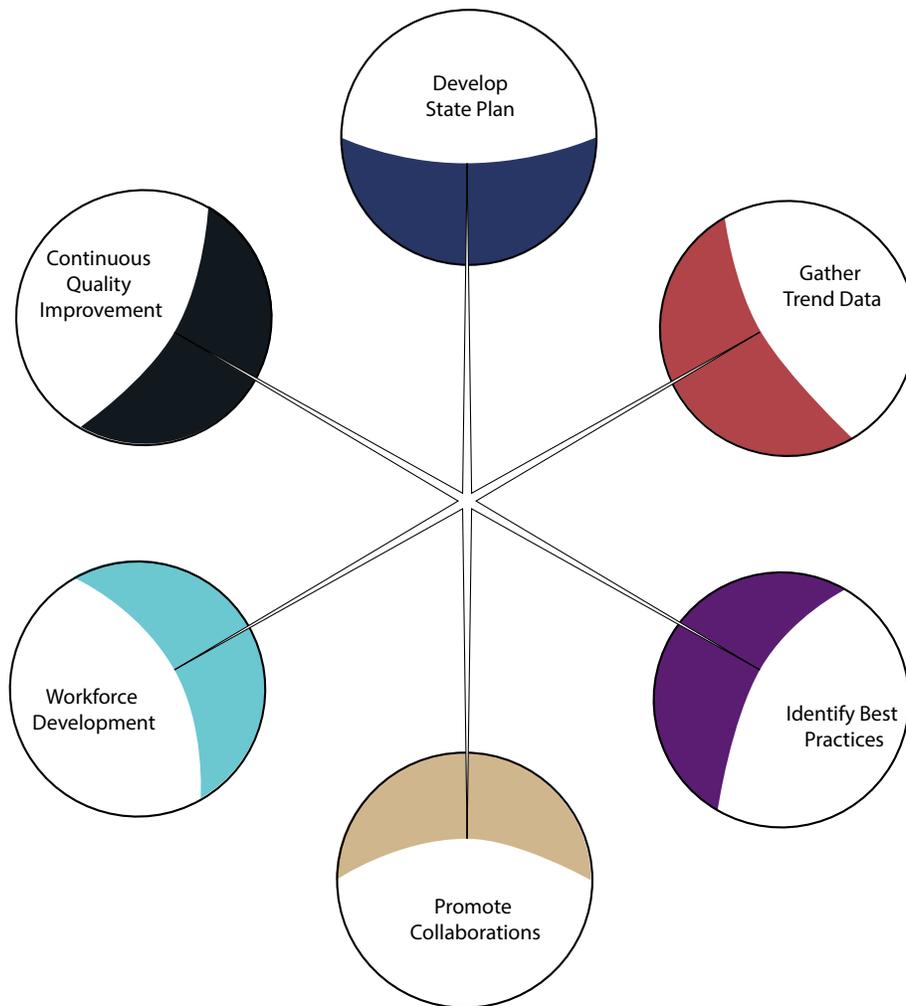
Hope – We know that change and recovery is attainable, yielding life changing benefits for individuals, family members and communities through their commitment to prevent, and achieve freedom from addiction through recovery.

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 Plan 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.

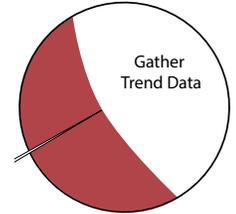
Goal // 4 - Increase effectiveness of Pennsylvania's drug, alcohol and gambling prevention and treatment efforts by promoting and establishing federal, state and local collaboration.

Goal // 5 - Develop, and expand, a highly competent, dedicated and efficient workforce and infrastructure to ensure the Department accomplishes its mission and achieves 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.

GOAL // 2 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 Act 50 of 2010 Section 2301-A, 1(vii)).

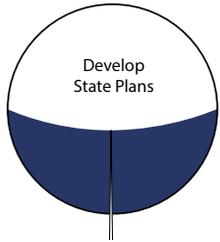
1. Establish needs assessment framework including baseline data sets.
2. Organize data for review and analysis by field experts, stakeholders and others.

B. Improve treatment, prevention, intervention and most importantly recovery outcomes through data-driven management (see p. 40, p. 62).

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 prevention data system and treatment services in the treatment 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 prevention and treatment 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.



GOAL // 1 Develop State Plan 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.

GOAL // 3 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. 39).

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.

(iii) Develop and deploy outreach materials (i.e. fact sheets, posters, email campaigns) on drug overdose/abuse/addiction and consequences.

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) Maintain data on the prevalence of prescription drug misuse/abuse/addiction as well as attitudes about use at the national, state and local level.

(iv) Expand prescription drug disposal availability and operability.

(v) Support state and national efforts on prescription drug monitoring programs and tamper resistant medications.

(vi) Physician training (see p. 26).

(vii) The Department will coordinate with Pennsylvania Department of Education

(PDE) to support to Student Assistance Programs.

(viii) The Department will offer PDE 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).

(ix) Implement and continue to evaluate effective programs through the prevention data system.

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.

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 the prevention data system 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. 38).

a. Identify effective programs for prevention

- 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 prevention data system 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.

2. Pregnant Women and Women with Children: Increase access to care, to reduce burden, and to foster care system (see p. 73).

- 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 Fetal Alcohol Spectrum Disorders (FASD) State Plan.
- d. Develop and implement programming during Fetal Alcohol Spectrum Disorders (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 older adults substance abuse and depression (see p. 29, 57).

- 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. 51).

- 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 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.

- 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 Department of Health (DOH) on the implementation of SYNAR tobacco compliance checks and other research such as Behavioral Risk Factor Surveillance System.

3. Fetal Alcohol Spectrum Disorders (FASD): Develop and implement a statewide plan to reduce the incidence of FASD(see p. 44).

4. Coordinate with DOH regarding development and implementation of training for physicians and other medical personnel regarding the Prescription Drug Monitoring Program (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. 51).

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 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. 54).

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

b. Train and monitor implementation of the Pennsylvania Client Placement Criteria (PCPC) Third Edition by following CSC guidance and recommendations.

2. Develop model curriculum that utilizes pertinent data and information that improves substance abuse prevention (see 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 Act 50 of 2010 Section 2301-A, 1(iv))(see p. 60, 68).

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.

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 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 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 email list serves and maintain repositories of information, Policy Bulletins, Informational Bulletins, and the Department's website to publicize best practices in detecting controlled substances and testing methods.

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

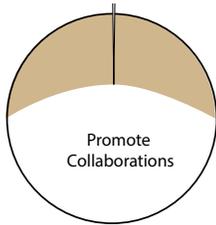
d. Training will continue to be offered on the synthetic drug use.

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.



GOAL // 4 Increase Effectiveness of Pennsylvania's 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 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.

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 offenders in need of drug and alcohol treatment prior to release.

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 Act 50 of 2010 Section 2301-A, 1(ii)).

a. Implement collaborative pilot project with the Department of Human Services (DHS), Department of Corrections (DOC), and Pennsylvania Board of Probation and Parole (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 Substance Use Disorders (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 the Pennsylvania Commission on Crime and Delinquency (PCCD), Office of Child, Youth and Families (OCYF), Office of Mental Health and Substance Abuse Services (OMHSAS), Pennsylvania Board of Probation and Parole (PBPP), Department of Corrections (DOC), Department of Education (PDE), Department of Transportation (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 Act 50 of 2010 Section 2301-A, 1(xvi)).

1. Continue to support multi-agency implementation of Substance Use Disorder (SUD) awareness and by providing technical assistance to state offices and other stakeholders who have the opportunity to engage in employee and public information sharing and initiatives.

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. 49, 50).

3. Pennsylvania Association of County Drug and Alcohol Administrators.

a. The Department senior management staff will continue to closely partner with Single County Authorities (SCA) and the Pennsylvania Association of County Drug and Alcohol Administrators (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, PRO-A, Message Carriers 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.



GOAL // 5 Develop, and Expand a Highly Competent, Dedicated and Efficient Workforce and Infrastructure to Ensure the Department Accomplishes Its Mission and Achieves Its Goals.

required credentials and work with stakeholders to promote pathway for recovery alumni to become credentialed clinical staff (see p. 30).

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. 26,28,30, and 71).

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.

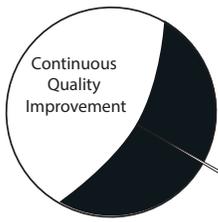
3. Stakeholder Training: To offer educational courses for law enforcement officials, including prosecuting attorneys, court personnel, the judiciary, probation and parole officers, correctional officers and other law enforcement personnel, welfare, vocational rehabilitation and other State and local officials who come in contact with drug abuse and dependence problems (see 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 Continuous Quality Improvement (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



GOAL // 6 Establish a System of Continuous Quality Improvement (CQI).

A. Bureau of Quality Assurance for Prevention and Treatment: Maintain licensing process that ensures quality standards of practice, protects health and safety, while avoiding unnecessary regulatory burdens.

1. Continue review and identify needed changes to licensing regulations.
2. Ensure consistency of application of regulations among all Licensing Specialists and Program Representatives.
3. Support the development of best practices for program, health and safety by providers.
4. Enhance the licensing business process to increase efficiencies.
5. Incentivize safe and effective SUD treatment provider practices by providing extended-period licenses.
6. Utilization of standardized forms to expedite requests from existing providers.
7. Enhance and streamline the application process for potential new SUD treatment providers.

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/outcome measures.

1. Work with relevant Bureaus and stakeholders, including PACDAA, providers, community partners, families and individuals in recovery in the development and continued improvement of state performance/outcome measures for Department and SCA contracts, including use of data systems and their continued enhancements.
2. Conduct annual SCA monitoring and reporting of state performance/outcome measures.
3. Conduct annual review, and SCA to propose actionable items for improving performance/outcome measures.

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

1. Coordinate with Pennsylvania Insurance Department (PID) 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 PID 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 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 for the Department 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.

- 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 Substance Use Disorder (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 one dollar tax on driver's license renewals with money to go towards drug and alcohol treatment, or related tax on alcohol sales.
- Consider a five 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.



INTERDEPARTMENTAL COLLABORATIVE PROJECTS PENNSYLVANIA STATE GOVERNMENT PLAN OVERVIEW

We are in the midst of a nationwide epidemic and our treatment system is only funded enough to treat one out of eight people in need. We need to create more treatment centers. Pennsylvania is uniquely positioned to model how state government responds to drug and alcohol problems and their consequences. Securing funding, building infrastructure and increasing access are essential to repairing our treatment system. Over the past few decades, our treatment providers have borne the consequences of overprescribing, scant funding and short-sighted managed care practices reducing length of stay/ level of care. The treatment programs do not bear it alone; so do our jails and emergency rooms and court systems, our highways, our employers, the child protective services system and each and every one of us as members of our communities. Just as giving half a dose of antibiotic, under treatment of Substance Use Disorder leads to a persistent effect including an intergenerational cycle affecting families and children. *Thus, this problem is an interdependent and intergenerational problem over time compounding upon itself. Not only does a person with a substance disorder continue to suffer within one family, this is passed down to the next generation. Children of substance abusers tend to follow their parents' examples and become the next generation of substance abusers. We need to take effective actions to end the cycle of substance abuse.*

Undertreatment is a consequence of chronic and severe underfunding. This underfunding has created a cost shift. Every dollar invested in treatment with the clinically appropriate level of care/length of stay (LOC/LOS) translates into a \$7 return to state coffers, primarily in reduced criminal justice costs. On the other hand, underfunding guarantees that we will spend more on DOC, children and youth services, domestic violence, and health expenses for hepatitis C, HIV, etc. While treatment is DDAP's primary focus, our interdepartmental collaboration includes four additional major areas of endeavor: Prevention, Intervention, Overdose Abatement and Recovery Supports.

Pennsylvanians deserve a comprehensive treatment system that works. Most of our state agencies, not just DDAP, DHS or DOH play a part in effective treatment. The following agencies will also play critical roles: the Departments of Agriculture, Community & Economic Development, Corrections, Education, Insurance, Labor, Military & Veterans Affairs, State, Transportation, as well as State Police, PCCD, Pardons Board, AOPC, Juvenile Court Judges Commission, and the Board of Probation & Parole.

The list of collaborative projects follows. Many projects require the work of multiple agencies; you will find them listed below. Projects in progress will include a status report from the program area implementing that project.

THE STATUTORY MANDATE OF ACT 50 OF 2010

Act 50 of 2010 requires the Department of Drug and Alcohol Programs to develop a comprehensive state plan that provides direction to all state government agencies to ensure the full continuum of coordinated, research-based, robust statewide efforts (prevention, intervention, treatment, recovery supports, and overdose abatement) to reduce the problem of drug and alcohol abuse in the Commonwealth. The pertinent provisions of Act 50 are attached. This plan reflects the interdepartmental coordination of the comprehensive state plan.

PREVENTION & INTERVENTION

1. Department of Education (PDE)

a. Reinvigorate and sustain Student Assistance Programs (SAPs)(PDE, PCCD, JCJC, DHS, DDAP).

SAPs are statutorily-mandated evidence-based programs in which students at risk are identified and provided critical resources to prevent their descent into mental illness, substance use disorders, violence and juvenile justice involvement. With the elimination of federal Safe & Drug-Free School funding, the state's SAP system has been significantly reduced over time. Curriculum requirements for alcohol, chemical, and tobacco abuse are required by Section 1547 of the School Code.

b. Develop Pilot Recovery Schools throughout the Commonwealth (PDE, PCCD, DHS, DDAP).

Students in recovery who return to their old schools after completing treatment have very high relapse of substance use rates due to overwhelming peer pressure to return to substance abusing behavior. Recovery schools, on the other hand, provide for a positive, pro-recovery peer pressure and overall environment. Recovery schools have the additional benefit of having a staff that understands substance abuse as well as fellow students who form bonds helping each other through as each student faces similar paths and challenges towards sobriety.

c. SAMHSA Prevention Videos for Parents (Talk. They Hear You.).

This acclaimed prevention campaign helps encourage parents to be able to talk with their children about drugs and alcohol abuse. Parental engagement is an evidence-based component of any comprehensive prevention program (it is a "protective factor" for children). These videos are well done, free and available to any parents, through Parent Teacher Organizations, and other avenues. PDE and DDAP should collaborate to disseminate these to all school districts and parent teacher organizations.

d. Preventing Drug/Alcohol Abuse on University & College Campuses (PDE, DOH, DDAP, PCCD).

Widespread alcohol abuse has been tolerated on campuses for decades, and has resulted in unacceptably high rates of accidents, sexual assaults and other violence. Today, this is exacerbated by increased use of prescription amphetamines "study drugs" and opioids, including heroin. Department of Health Secretary Karen Murphy has proposed a Governor's Conference of University Presidents to educate them about best prevention practices for campuses.

2. Department of Health (DOH)

a. Prescribing Guidelines (DOH, DDAP). (Primary leadership on this project has been transferred from the DDAP Secretary to DOH Physician General). Three sets of guidelines were promulgated in 2014: Opioid Prescribing for Chronic Noncancer Pain; Emergency Department Prescribing Guidelines; Prescribing Guidelines for Dental Pain. The Group is on the verge of publishing three additional sets of guidelines for Opioid Prescribing Guidelines in Geriatric Medicine; Opioid Prescribing Guidelines in Obstetrical Medicine (pregnant, and post-delivery) and Dispensing Guidelines. Next year the Group will work on prescribing guidelines for pediatric/adolescent pain, sports medicine/orthopedic, benzodiazepine prescribing, prescribing in the context of workers comp, and others.

b. Achieving Better Care By Monitoring All Prescriptions (ABC-MAP) (DOH). The prescription drug monitoring program will allow physicians to determine what medications were already prescribed to their patients by other areas of care to avoid adverse effects or medication interactions. Pennsylvania stands to be one of the first states in the nation to mitigate this impact with components integrated with its ABC-MAP program.

c. Continuing Education for Health Care Professionals (DOH, DOS, DDAP). These agencies are working with PA Med Society to create a free, online four hour CME for physicians, with one hour each for (i) Prescribing Guidelines, (ii) ABC-MAP, (iii) Naloxone co-prescribing and (iv) Warm Hand-Off (identification and referral to specialty care of patients with SUDs).

d. Medical School Curriculums in Addiction (DOH, DDAP). Very few medical schools in the nation have a required course in addiction. DDAP has been working with SAMHSA over the past 18 months to develop and implement a strategic plan to encourage PA's medical schools to include a responsible level of education about addiction, intervention and treatment in their curricula. The Physician General and Secretary of DOH have partnered with DDAP on this initiative. Physician General Levine and Secretary Tennis have met with, and is partnering with, all of Pennsylvania's medical school deans to develop a robust addiction and treatment curriculum.

3. Department of Human Services (DHS)

a. Medicaid-funded opioid prescribing. Using Medicaid payer system to ensure safer and more responsible prescribing of opioids and other addictive drugs. DHS-OMAP Medical Director has been part of the Prescribing Practices Workgroup since its inception, and continues to work on the

payer variable components.

4. Attorney General's Office (AG)

a. Pharmaceutical Industry. DDAP is following the response of other state Attorney Generals in ensuring that the industry fairly compensates the taxpayers for costs caused by over-marketing and misrepresentation of safety of other Rx drugs and has begun discussions with the Pennsylvania Attorney General.

b. Take-Back Rx Drug Disposal (AG, DMVA, DDAP, PCCD, PDAA, PSP). In 2014, DDAP has successfully collaborated with other agencies to install over 200 Rx drop boxes and over 8000 pounds of prescription drugs were collected; and more recently in 2015, over 400 Rx drop boxes installed and over 40,000 pounds of prescription drugs were collected across Pennsylvania. The DMVA agreed to take over the transportation these drugs to incineration sites already under contract with the Attorney General. Since beginning this initiative, DMVA has removed and destroyed over 80,000 pounds of prescription drugs. All agencies should work to continue to expand this successful program.

5. PA Commission on Crime & Delinquency (PCCD)

a. Executive Prevention Council (PCCD, D.Ed., DHS, DDAP, JCJC). PCCD Executive Director Linda Rosenberg has proposed establishment of an Executive Prevention Council of the above agencies' leading, prevention experts. This Council would ensure that state funding only goes to prevention programs that are either evidence-based or contain promising practices (innovative new practices containing the components identified with evidence-based practices). It should be established.

appropriate funding, developing collaborative working relationship with County Assistance Offices or CAOs, etc.) (DDAP, DHS, SCAs). Because of Affordable Care Act (ACA), funding drug and alcohol treatment is becoming more readily available through Medicaid and private health insurance. DDAP must continue to assist SCAs in assuming more of an overarching oversight role in their counties to facilitate funding and referral to appropriate treatment regardless of funding source.

b. Licensure Reform. The Department has completed the first of three major rounds of licensure reform, so that our regulations are streamlined, program-supportive, and up-to-date. Additionally, the Department is proposing a regulation change providing for extended (up to two year extension) licenses for programs that consistently have excellent inspection results. Once this regulation change is more "launched" with the IRRRC, DDAP will propose its second round of major licensure reform.

c. Co-occurring Treatment (PTSD/Addiction) for Veterans (DDAP, SCAs, Drug Court Judges, DMVA, VA). The Department is working with our SCAs to ensure that they carefully assist engagement and referral into clinically appropriate treatment, whether in the VA or in our community based system.

d. Prohibiting Onerous County Residency Requirements. Currently, county residency requirements vary widely, creating gaps in funding coverage (due to lack of meeting residency requirements at the new county) for a Pennsylvania citizen who moves from one county to another. DDAP should contractually prohibit the current widely varying residency requirements as applied to those moving from one Pennsylvania County to another, for DDAP-funded treatment. This will eliminate unnecessary delays in and impediments to access to care.

e. Dealing with co-pays and deductibles for treatment for those who are otherwise income-eligible. DDAP should clarify for all SCAs that if an individual in need of treatment is income eligible for DDAP funding, they should not be disqualified from DDAP/SCA funded treatment because they have purchased insurance. The fact that some of the treatment cost has the effect of paying down a policy deductible should not be an obstacle to treatment for an otherwise qualified individual.

f. Establishment of an 800 number for treatment access. Often, citizens in the general public do not know how to access care. The Department should work to implement a toll free telephone hotline that individuals can use to reach professional support to connect to care. This will help individuals to navigate

TREATMENT

According to the federal government, in Pennsylvania, treatment is funded at about 13-14% of need (better than the national rate of 10%), causing wait lists, clinically unsound levels of care/lengths of stay (LOC/LOS), and other scaling back in evidence-based treatment offerings, as well as the "catch22" of lack of resources to gather data. Our mission is to build a treatment system that offers the full continuum of clinically appropriate, individualized care for all Pennsylvanians with drug and alcohol addiction. There are three prongs that must be put into place contemporaneously in order to build a treatment system to serve Pennsylvanians: 1) Funding; 2) Infrastructure; and 3) Access. Each of the initiatives discussed below addresses at least one of these prongs.

1. Department of Drug & Alcohol Programs (DDAP)

a. Robust Case Management by SCAs (ensuring

their benefits and access a treatment program that is appropriate for their individual needs. DDAP should explore having this resource provide information on insurance and Medicaid drug and alcohol treatment coverage in coordination with DHS.

2. Department of Human Services (DHS)

a. Coordinate enrollment in the MA program and HealthChoices MCO networks. Treatment during this delay period is 100% state funded. Once enrolled with the Health Choices BHMCO funding is federally funded at the rate of either 55% (pre-ACA Medicaid population) or 90% (expanded population). If the delay is eliminated, we may achieve better client and financial outcomes. The Wolf Administration has made considerable strides in addressing this challenge, and should continue to reduce these delays to the greatest extent reasonably possible.

b. MA Health Choices-Funded Treatment for County Jail Releasees (DDAP, DHS, county criminal justice, and drug & alcohol stakeholders). Having offenders be released and signed up and taken to Health-Choices funded treatment at the time of release, is a subset of the preceding item. Counties are getting millions of dollars in additional federally-funded treatment with this project. This is being implemented so that more inmates will be released with continuing substance abuse care. This is a critical connection for this vulnerable population to access the treatment needed to prevent relapse of substance use and criminal recidivism. Fifty counties are now implementing this program; DDAP should work to facilitate implementation in the remaining seventeen counties.

c. MA Health Choices-Funded Treatment for State Prison Offenders (DDAP, DHS, DOC). The Department has been working for two years with DOC and DHS to begin pilot programs in several areas of the state. Under the Wolf Administration, this initiative is gaining momentum and expanding. More participant offenders are getting into the program, although still at a small fraction of what is possible. Our new Prevention & Treatment Bureau Director, is well-positioned to work through the bureaucratic challenges facing this project. Adjustments have been made to the program model to expand eligibility of the pilot and increase enrollment. This project should continue until all DOC releasees who are eligible for Medicaid and in need of treatment can begin Medicaid-funded treatment on the day of their release.

d. Ensuring MA Health Choices BHMCOs approve clinically sufficient levels of care and lengths of stay (LOC/LOS) in accordance with the PA Client Placement Criteria (PCPC) (DDAP, DHS). DDAP has completed trainings of all MA-HC BHMCO utilization

review staffers on the 3rd Edition of the PCPC. These trainings have resulted in some improvements in this area, but we still have far to go. A second round of these trainings will be planned to reinforce the material.

e. Increase use of D&A therapeutic communities for addicted mothers (DDAP, DHS, PA Supreme Court). Mothers gaining recovery while in this type of therapeutic community driven treatment may avoid losing their children to foster care. Research shows that family separation rather than focusing on breaking the cycle of addiction, is more likely to result in children ending up entering the child welfare system and ultimately, the criminal justice systems at far greater rates than the general population. Given the tremendous positive outcomes being realized by Pennsylvania's relatively strong network of women and children's drug & alcohol therapeutic communities, in which addicted women can bring their young children into treatment with them, we need to continue working with our court system, DHS Office of Children, Youth & Families, and other stakeholders, to encourage placement of addicted women and their children. These programs typically have lengths of stay from six to nine months followed by a combination of recovery housing, outpatient treatment, and other recovery supports. The Department has been working closely with Supreme Court Justice Baer's Children's Roundtable workgroup to implement more humane and functional handling of these cases, and progress is being made. Improvements have been implemented in cross agency collaboration, communication and identification of training needs.

3. Department of Transportation (DOT)

a. Compliance with DUI Treatment Requirements (DDAP, DOT, PA Supreme Court, AOPC, PCCD, Sentencing Commission, County & State Probation, Parole Boards, SCAs, and DUI Association) Most counties are not enforcing our Driving Under the Influence (DUI) statute, which requires completion of clinically correct treatment as a condition of parole for addicted/alcoholic offenders, and full reporting to DOT. Success rates in the Restrictive Intermediate Punishment treatment for DUI offenders are over 95%, and recovery for these individuals results in safer highways and less domestic violence (5,000+ inmates in DOC had a prior DUI). DOT and DDAP have provided funding to fund a project manager to bring all counties into compliance. Former National Drug Court President, Judge Michael Barrasse, is chairing the Oversight Committee for this project. Sixty percent of DUI offenders have private health insurance that covers treatment costs.

b. Posting Prevention Flyers (Rx Drug Abuse, Alcohol Abuse, etc.) at Highway Stops (DDAP, DOT, Turnpike Commission, SCAs, and Commonwealth Prevention

Alliance) Changing attitudes of the public at large about drug and alcohol abuse, stigma, and the need for seeking help, is an important component of an effective prevention infrastructure. Both DOT and the Turnpike Commission have agreed to let us place prevention flyers at these highway and Turnpike rest areas and service areas.

4. Department of Corrections (DOC)

a. Ensure clinical integrity and optimal use of prison behind-the-walls treatment for those who need it (DOC, DDAP)

DDAP and DOC need to collaborate to ensure that behind-the-walls treatment is clinically sound, both in treatment provided and length of stay. We also need to explore how to overcome the challenges that sometimes prevent inmates receiving behind-the-walls treatment are released immediately following completion of treatment (placing them in the general prison population after treatment undoes the benefits of treatment).

b. Explore the feasibility of reinstating the Pre-Release Program, or of developing some other mechanism, to provide both behind-the-wall and community based drug and alcohol treatment in a clinically sound and cost-neutral manner, for those in need of residential D & A rehab (DOC, DDAP, PCCD, PBPP)

The research shows positive outcomes reducing relapse for those who receive the clinically appropriate length of stay in behind-the-walls therapeutic communities, followed immediately by clinically appropriate levels of care and lengths of stay in community-based treatment. The current Justice Reinvestment Initiative is an appropriate forum to explore both this issue and 4. a.

5. State Board of Probation & Parole (PBPP)

a. Increase Cross-System Collaboration Between Probation & Parole Officers and D & A Treatment Counselors (DDAP, PBPP, County Probation/Parole Officers Association, Treatment Providers)

Close collaboration between Probation/Parole Officers and treatment counselors enhances outcomes by ensuring that probationers/ parolees are constructively engaging in the treatment process. Cross-training sessions with both officers and counselors together will lead to more effective collaboration and better outcomes in both systems.

6. Pennsylvania Insurance Department (PID)

a. Enforce Act 106 of 1989 and Mental Health Parity & Addiction Equity Act (MHPAEA) (PID, DDAP)

PID currently enforces Act 106 by ensuring insurance policy forms comply with the act and investigating any complaints brought to the Department. DDAP should educate treatment providers, insurers and the public at large about consumer rights under Act 106. For other health plans, DDAP will train and

require treatment programs to advocate for their clients to be funded for needed treatment. PID enforces the federal MHPAEA law as well as identical state law, which requires health insurers who cover benefits for mental health and substance abuse disorders to do so in parity with physical illnesses. PID also enforces Act 106, which requires treatment as determined by a physician or licensed psychologist, so long as it is provided by a Pennsylvania licensed facility. As such, PID is well-situated to ensure that privately insured Pennsylvanians needing addiction treatment get the care within the scope of their insurance coverage that they need.

7. Department of Military & Veterans Affairs (DMVA)/ Department of Aging

a. Full continuum of Drug and Alcohol Treatment for Seniors and Veterans (DDAP, Aging, DMVA)

Medicare covers a limited amount of hospital based rehabilitation and some outpatient treatment, but does not cover any nonhospital residential rehab at all. This is devastating to individuals, especially older adults and also for Veterans, since the Veterans "Choice" program (VA funding for community-based treatment) is modeled on the Medicare benefit. DDAP will work with DMVA, the Department of Aging, and the Governor's Legislative Office to seek federal changes ensuring the full continuum of treatment for those Americans covered by Medicare and the Veterans' Choice program.

8. Attorney General's Office (AG)

a. Enforcement of Act 106 of 1989 and Mental Health Parity & Addiction Equity Act (MHPAEA)

DDAP and the AG office can collaborate with PID to develop strategies for support the implementation of Act 106 and MHPAEA and other applicable laws related to SUD.

9. PA Commission on Crime & Delinquency (PCCD)

a. Pilots for Pre-Arrest Diversion by Police to Treatment (PCCD, DDAP, DHS, county & municipal stakeholders; PSP)

Seattle, Santa Fe, Knoxville and other cities are beginning to implement Law Enforcement Alternative Diversion (LEAD) projects (modeled after a British program) in which police are trained to screen for drug and alcohol problems (we could also include mental illness), and to take individuals who've been caught committing minor offenses to a center for assessment to treatment, rather than booking them for the minor offense. We could combine this with a program modeled after that in Gloucester, Massachusetts, in which anyone in the community needing treatment can go to any officer and ask for help; the officer will then transport them to the center for assessment to treatment, without risk of charges. We might also attempt an expedited sign-up on Medicaid Health Choices for these individuals. Department explorative discussions have taken place

with the PCCD Chair, who seems interested in moving forward. We should also explore implementation of this model with PA State Police.

10. Federal

a. IMD Exclusion (HHS-CMMS, Congress, NASADAD, DOH). The Department is engaging all levels (Patrick Kennedy, Bob Brady, National Drug Court Judges, etc.) to eliminate application of the IMD exclusion to drug and alcohol treatment. If successful, this will result in billions of dollars more Medicaid-funded treatment across the nation, and will preserve the Federal match Pennsylvania is apparently getting.

b. SAPT Block Grant Restoration (Congress, ONDCP, NASADAD) Adjusted for inflation, the Substance Abuse Prevention & Treatment federal block grant has been cut by 25% over the past decade; this coincides with the worst drug overdose crisis in the nation's history. (About \$60M of DDAP's roughly \$100M is from the SAPT block grant.) Once the IMD matter is resolved, restoration of these funds will be our next federal priority.

c. Medicare/VA Drug & Alcohol Benefit (Congress, HHS, Patrick Kennedy). See 7(a) above.

Rehabilitation OVR to assist those coming out of treatment to become trained and prepared for meaningful work. (L&I, DDAP, DHS) Over ten years ago, OVR offered very strong vocational rehab supports for those coming out of drug and alcohol treatment, but this has weakened over the past decade. We will work with OVR to restore this programming.

3. Department of Agriculture

a. Link treatment programs in rural areas of Pennsylvania to the Department of Agriculture initiatives to train new workforce in agricultural work A large portion of current agricultural workforce is retiring. The Department has been approached by the Rural Development Council at Commonwealth of Pennsylvania about connecting those clients coming out of treatment in our rural areas with training and careers in agriculture and linking them to resources.

4. Board of Pardons

a. Educating those in sustained recovery for drug & alcohol addiction on the pardons process In addition to proposing regulation change on a more streamlined pardons process for this population; the Department needs to inform all treatment programs and other possible stakeholders on the pardons process, so that they provide key information to those who complete treatment about when and how to seek a pardon. This is critical to enable recovering "ex-offenders" to clear their records and not be hampered in attaining meaningful employment, housing, etc.

b. Support expungement legislation that provides for automatic removal of certain offenses This legislation, SB 391 of 2013 was nearly enacted last session.

OVERDOSE ABATEMENT

1. Department of Health (DOH)

a. Epidemiology Data for Drug and Alcohol Overdose Drug and alcohol overdose (fatal and nonfatal) reporting is woefully inadequate throughout the nation. The DOH Secretary and Physician General are undertaking a robust review of current practices and how to revamp our system to gather more up-to-date and accurate data.

2. PA State Police (PSP)

a. Narcan Monitor and continuously increase quality of work in Narcan administration by PA State Police. Continued expansion of the Narcan availability increases our lifesaving opportunities throughout the state.

RECOVERY SUPPORTS

1. Department of Community & Economic Development (DCED)

a. Use of some portion of HUD and other Housing dollars for Recovery Housing (DDAP, DCED, Allegheny County Human Services Dept). Allegheny County pilot may involve the establishment of a revolving fund, such as that used in the Oxford House programs.

2. Department of Labor & Industry (L&I)

a. Engagement of Office of Vocational

CHAPTER 2

Annual Report 2013-14 and Progress Report 2014-15

THIS CHAPTER REVIEWS PROGRESS MADE ON GOALS/PRIORITIES ESTABLISHED BY THE DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS IN THE 2015-2016 STATE PLAN. THE CHAPTER INCLUDES THE ANNUAL REPORT FOR FY 2013-2014 AND THE PROGRESS REPORT FOR FY 2014-2015. IN ADDITION, THIS CHAPTER CONTAINS NEW AREAS OF INTEREST SINCE THE IMPLEMENTATION OF ACT 50 OF 2010.



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BUREAU OF TREATMENT, PREVENTION & INTERVENTION

The Department of Drug and Alcohol Programs, Bureau of Treatment, Prevention and Intervention, consists of two divisions responsible for the development, oversight and management of substance abuse services throughout Pennsylvania. The Division of Prevention and Intervention report as well as the Division of Treatment report is contained below.

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 and problem gambling prevention and intervention services throughout Pennsylvania. The Division strives to increase the implementation of quality prevention programs and use age-appropriate strategies, policies and practices that are based on research proving effectiveness and/or best practices within the substance abuse/gambling field. 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.

STRATEGIC PREVENTION FRAMEWORK (SPF)

The Department funds these efforts through grant agreements with Single County Authorities (SCAs) throughout the Commonwealth. SCAs are required to use SAMSHA's Strategic Prevention Framework (SPF) in the creation of their Comprehensive Strategic Plan and the information in this document describing that model has been taken from <http://captus.samhsa.gov/access-resources/about-strategic-prevention-framework-spf>. Distinctive Features of the SPF

- It is driven by the concept of outcome-based prevention. Increasingly, funders require evidence that communities have defined and achieved their prevention outcomes.
- It focuses on population-level change. Earlier prevention models usually measured success by looking at individual program outcomes or changes among small groups.
- It focuses on prevention across the lifespan. Traditionally, prevention has focused on adolescent consumption patterns. The SPF challenges prevention practitioners to look at substance abuse among other populations which are often overlooked, such as 18- to 25-year-olds and adults over 65.
- It emphasizes data-driven decision-making. The expectation is to collect data and to use data to describe their community, as well as their community's capacity to address identified problems. Finally, communities are required to choose programs and practices whose effectiveness is supported by data.

SCAs are required to utilize all six Federal Strategies and the Institute of Medicine (IOM) Prevention Classifications discussed below 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 the Department's prevention data system, regardless of the funding source.

SAMSHA's Strategic Prevention Framework (SPF) is a 5-step planning process to guide the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. The effectiveness of this process begins with a clear understanding of community needs and depends on the involvement of community members in all stages of the planning process.

The SPF model includes these five steps:

Step 1. Assess Needs

Step 2. Build Capacity

Step 3. Plan

Step 4. Implement

Step 5. Evaluation

These steps are guided by the principles of cultural competence and sustainability. The SPF is designed to help States, Jurisdictions, Tribes, and communities build the infrastructure necessary for effective and sustainable prevention. Each step contains key milestones and products that are essential to the validity of the process. Focused on systems development, the SPF reflects a public health, or community-based, approach to delivering effective prevention.

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.

Step 1: 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.

Step 2: 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.

Step 3: 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.

Step 4: 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.

Step 5: 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.

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.

PROGRAMS AND STRATEGIES

The Department encourages SCAs and prevention providers throughout the Commonwealth to utilize Evidence-Based and Evidence-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 Evidence-Informed programs.

Using a combination of Evidence-based and Evidence-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 and Supplemental Programs are defined as follows:

Evidence-Based Programs: Characteristics of evidenced-based prevention programs and strategies include:

- 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;
- Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals;
- Replicated and produced desired results in a variety of settings; and,
- Included in Federal registries of evidence-based programs (note: inclusion in a Federal registry is necessary, but not a sufficient characteristic to merit inclusion on DDAP's list of evidence-based programs). Examples of federal registries include:
 - ◆ The Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices (NREPP) <http://www.nrepp.samhsa.gov>
 - ◆ U.S Office of Juvenile Justice And Delinquency Prevention (OJJDP) Model Programs Guide <http://www.ojjdp.gov/mpg>
 - ◆ Exemplary and Promising State, Disciplined and Drug-Free Schools Programs sponsored by the U.S. Department of Education <http://www2.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf>
 - ◆ Center for the Study and Prevention of Violence Blueprints for Healthy Youth Development <http://www.blueprintsprograms.com>

Evidence-Informed Programs: Characteristics of Evidence-Informed prevention programs and strategies must include the following four characteristics:

- 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;
- Based on published principles of prevention, e.g., NIDA's Prevention Principles;

- 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; and,
- Must have an evaluation that includes, but is not limited to, a pre/post-test and/or survey.

Other characteristics of evidence-informed prevention programs and strategies may include:

- ◆ May be similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature;
- ◆ May have appeared in a non-refereed professional publication or journal; and,
- ◆ May have been identified or recognized publicly and may have received awards, honors or mentions.

Supplemental Programs: Characteristics of Supplemental programming must include:

- 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 evidence-informed programs

In order for a new program or strategy to be added to DDAP's program and strategy listing, it must be submitted to DDAP for review and approval. DDAP has a formal process for reviewing programs and strategies to determine the appropriate program classification.

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 prevention data system. 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 43 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;

Big Brothers Big Sisters – a mentoring program in which participating youth reach their potential through supported matches with adult volunteer mentors;

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;

Strengthening Families Program – For Parents & Youth 10 to 14 year-olds is a family skills training program designed to enhance school success and reduce youth substance use and aggression;

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 12th grade.
- Student Assistance Program Commonwealth Inter-agency 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 (SCAs) 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.

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 2013 PA Uniform Crime Report, the number of DUI offenses reported to police agencies decreased from 52,243 in 2012 to 49,714 in 2013. However, it is still a significant increase from the 41,613 arrests reported 10 years ago in 2003. The 2013 Pennsylvania Youth Survey State Report indicates that alcohol remains the substance most commonly reported to have ever been used by youth respondents. In 2013, 47% of students in grades 6, 8, 10, and 12 have used alcohol at least once in their lifetime. Among just 12th graders this percent increases to 74%. According to the Department of Transportation's 2013 Pennsylvania Crash Facts & Statistics report, alcohol-related crashes were 4.9 times more likely to result in death than those not related to alcohol.

ANNUAL REPORT FY 2013-2014

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 providing contact names and encouraging local participation in the National Town Hall Meetings Program, which provides public education and awareness on underage drinking in the Commonwealth and nationally. The Department coordinated and oversaw the county projects, provided technical assistance to county teams, and coordinated funding for various projects associated with underage drinking.

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."

The Department continued 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.



PROGRESS REPORT FY 2014-2015

In addition to the ongoing work of the FY 2013-14 projects the Department finalized a specific initiative to prevent underage drinking (UAD) with the finished production of a underage 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. The completed PSAs are posted on SAMSHA's website http://media.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 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.

During the 2014-2015 fiscal year the sub recipients were heavily focused on assessing needs and building capacity to lay a strong foundation for future programming. Through various activities of asset mapping, focus groups, and community surveys, as well as careful review of the Pennsylvania Youth Survey (PAYS) data, counties were able to identify community beliefs and overall neighborhood attitudes. They were also able to identify and prioritize target areas to focus their efforts.

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 monitoring and addressing the priority. In addition to drug misuse, there is an excessive increase in overdose death. The need to increase general awareness of increased risk factors for prescription and other opioid overdose and how to effectively respond to overdose has also been an identified priority of the department. is monitoring and addressing the priority.

According to the 2013 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 the 2013 Pennsylvania Youth Survey State Report 6.8% of students in grades 6, 8, 10, and 12 have used prescription narcotics without a doctor's orders in their lifetime. The 2013 PAYS also indicates that 14% of students surveyed perceived no or only a slight risk of harm from using prescription drugs not prescribed to them.

ANNUAL REPORT FY 2013-2014

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 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 PDAA sent the Prescription Drug Take Back Box Grant Program application to each District Attorney in PA's 67 counties in July 2013.

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 includes prescription drugs. In relation to overdose awareness, the Department included a specific page on its website dedicated to overdose information, covering specific signs and symptoms for various prescription medications, as well as illicitly used medications and the proper response for preventing or responding to each type of overdose.

PROGRESS REPORT FY 2014-2015

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. Through the grant, 203 permanent medication take back boxes were operational through December 31, 2013 and just over 8000 pounds of medications were collected. 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>

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 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 are used in building public awareness: including campaigns, educating youth, parents, prescribers, and other stakeholders, relationship-building with pharmacists and other

health care providers.

The Pennsylvania Strategic Prevention Framework Partnership for Success (SPF PFS) Project continues to attempt 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;
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- 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.

In the 2014-2015 fiscal year all sub recipients began implementing specific programming. All of the counties chose to implement evidenced based programming such as Strengthening Families Program: for Parents and Youth 10-14, Too Good for Drugs, and Guiding Good Choices. In addition to the evidenced based programming, many counties are implementing media campaigns targeting parents, college youth, and high school youth, all while continuing to build capacity and strengthen relationships with key community members such as school administration, local law enforcement and health care professionals. Additionally sub recipients are continuing their work with local and state evaluators to ensure the effectiveness of programming. With the passage of Act 139 in September of 2014, the department was instrumental in assisting stakeholders and the general public with implementation of this law. This statute includes a provision that allows for third party prescribing of the opioid overdose antidote medication, naloxone and that this medication can be administered by all first responders and bystanders at the scene of an overdose. Extensive information, including technical assistance to first responders and bystanders, on how to effectively respond to opioid overdose was included in a dedicated webpage on the agency's website. Information includes, but is not limited to: general information about opioid overdose, identification of high risk populations, approved training on naloxone administration, assistance in

how to discuss obtaining a naloxone prescription, a listing of pharmacies currently stocking naloxone, etc.

Because implementation of naloxone administration programs within local communities where overdose occurs is paramount to saving lives, the department has also worked closely with various law enforcement agencies to promote naloxone administration programs and has assisted in the establishment of public-private partnerships to raise awareness and funding to support such programs. In Delaware County alone, there were 31 overdose reversals within 4 months of local police departments carrying and administering naloxone throughout that county.

Substantial multi-disciplinary collaboration has occurred and will continue to occur, with federal, state, local, and community-based organizations to explore drug using trends and to develop effective and timely response protocols. Such efforts include workgroups and initiatives such as the Overdose Task Force (OTF), the Naloxone Law Enforcement Advisory Group (LEAG), participation in the SAMHSA organized Emerging Opioid Oversight Surveillance Group (EOOSG), etc.

PRIORITY: IMPROVE PREVENTION OUTCOMES THROUGH DATA-DRIVEN MANAGEMENT.

Background: As the Department has increased its capacity to collect and analyze data through the Prevention 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 2013-2014

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 data from the prevention data system. Also discussed with the workgroup was the plan for future needs assessments that will identify state and local priorities. Discussion took place about ways to provide each SCA with more statewide data to combine with local data.

PROGRESS REPORT FY 2014-2015

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 prevention data system 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 data from the prevention data system.

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.

On a broader note, the Department is working with a number of stakeholders and other State departments to redesign the prevention needs assessment process. The SEOW will be used to help identify data sets that be used by SCAs to inform what needs exist in their geographic area in order for them to make decisions about how best to provide services that will effectively address those identified needs.



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 across these five steps.

In 2000, transition toward the use of prevention programs that showed evidence of effectiveness resulting in a change in individual's 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.

ANNUAL REPORT FY 2013-2014

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.

PROGRESS REPORT FY 2013 -2014

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.

Background: In that underage drinking (29% 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 5151 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.

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. The Commonwealth of Pennsylvania's Student Assistance Program (SAP), which is administered by the PA Department of Education's Division of School Options and Safety in partnership with the PA Department of Drug and Alcohol Programs' Division of Prevention and Intervention, and the PA Department of Human Services' Office of Mental Health and Substance Abuse Services, is designed to assist school personnel in identifying issues including alcohol, tobacco, other drugs, and mental health issues which pose a barrier to a student's success. The mission of the Pennsylvania Network for Student Assistance Services is to provide leadership for developing a safe and drug-free environment and mental health wellness in schools and communities across the commonwealth. Barriers to learning will be removed and student academic achievement will be enhanced through collaborative prevention, intervention, and post-intervention services. Now in its 30th year, SAP helps schools identify students who are experiencing behavior and or academic

difficulties that are posing a barrier to their learning and success in school. SAP offers support to those students and their families.

ANNUAL REPORT FY 2013-2014

The Department support of PDE and PCCD's LST initiative contributed in 51 districts across PA being awarded a 3-year grant from the Center for the Study & Prevention of Violence (CSVP) to deliver LST to middle school students. Training workshops were conducted by National Health Promotion Associates (NHPA) certified trainers to provide teachers, administrators and classroom observers with the knowledge and skills to effectively deliver all three levels of LST. CSVP is providing technical assistance to school-districts on an as needed basis, including an annual site visit to discuss the implementation process. The Penn State University EPISCenter, with support from the PCCD, coordinated the collection and analysis of outcomes data to inform school districts if their efforts in delivering LST are having the desired impact on their student's attitudes, knowledge, and behaviors. The final outcomes report generated by the EPISCenter can be used by school-districts in conjunction with their Year-End Report provided by CSVP to increase the quality of the implementation.

In addition to the Department's partnership with PDE around the 3-year implementation LST grant, a close working relationship with PDE continued around the provision of Student Assistance Programs throughout the Commonwealth.

PROGRESS REPORT FY 2014-2015

The Department maintains a close working relationship with PDE around the provision of Student Assistance Programs throughout the Commonwealth.

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 known as 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: The Division of Treatment, Prevention and Intervention 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.

ANNUAL REPORT FY 2013-2014

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

PROGRESS REPORT FY 2014 -2015

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

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

Background: Fetal Alcohol Spectrum Disorders (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.

ANNUAL REPORT FY 2013-2014

In September 2013, FASD Awareness Month was observed by Governor's proclamation. 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.

PROGRESS REPORT FY 2014 -2015

FASD Awareness Month was annually observed in September. This coincided with national observances also held during the month. Various activities were directly supported by the Department and included the annual Kickoff Event, which was held on September 9, 2014 at the Days Hotel in Allentown, PA. The Kickoff event 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 Sara Wenger, Director of Education and Outreach Services for Family and Children's Services of Philadelphia. The Department worked with partners from the Center for Humanistic Change, Lehigh County Office of Drug & Alcohol Abuse and Northampton County Drug & Alcohol on the Kickoff event.

DDAP also implemented the Baby Bottle Distribution Project and distributed more than 5,000 baby bottles with FASD fact sheets about the dangers of drinking alcohol during pregnancy to OB/GYN offices and other providers serving pregnant women statewide.

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

The Department has held several meetings of the Executive Committee of the FASD Task Force. Department staff along with members of the Executive Committee met with several other potential partner organizations to identify opportunities for collaboration around the topic of FASD.

OTHER AREAS OF IMPORTANCE

PROBLEM GAMBLING

Legalized gambling is one of the fastest growing industries in the United States. For most of the industry's patrons, gambling is a form of harmless entertainment; however, it can create devastating consequences for those who become unable to control their addiction.

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 mission of this program is to increase public awareness of services available for problem and compulsive gamblers and their family members, ensure the widespread availability of treatment programs for problem and compulsive gamblers and their families, and implement problem gambling prevention programs throughout Pennsylvania.

The Department created a Problem Gambling Consortium in 2006 as a method to work in concert with other state agencies involved in gaming, including the Pennsylvania Lottery and the Pennsylvania Gaming Control Board (PGCB). Other agencies have been added to include the Pennsylvania Behavioral Health and Aging Coalition, Pennsylvania Commission on Crime and Delinquency (PCCD), Governor's Office on Asian-American Affairs and the Council on Compulsive Gambling of Pennsylvania (CCGP). The purpose of this consortium is to share information about member organizations as gambling develops across the Commonwealth, to collaborate on efforts and problems facing the gaming public, and to share resources.

The Department also provides problem gambling training through on-site training events, as well as through the Department's specialized training initiative (i.e., addressing a statewide need or new initiative). The Department provides trainings to all interested participants in order to increase the number of problem gambling treatment providers throughout the Commonwealth. By providing these trainings, the Department hopes to increase the number of qualified professionals who are eligible to provide problem gambling counseling services. During State Fiscal Year (SFY) 2013- 2014 there were 10 trainings held and 141 people completed problem gambling training courses.

Outpatient problem gambling counseling services have been made available within the Commonwealth since September 2008. Providers who have been approved under the

Department's Participating Provider Agreement (PPA) have been receiving reimbursement for these services since that date. As of July 31, 2014, the Department has PPAs with 96 providers. During SFY 2013-14, there were 166 unique DDAP-funded admissions to compulsive and problem gambling treatment. The total amount invoiced for services provided in SFY 2013-14 was \$262,670. Please visit <http://www.ddap.pa.gov/> for more information on the Compulsive and Problem Gambling Program. Click on the link for our 2014 Compulsive and Problem Gambling Annual Report.

ANNUAL REPORT FY 2013-2014

In 2013, 40 SCAs initially applied and received problem gambling prevention program funds through a two year funding initiative application process. Details about the problem gambling prevention programming that was implemented can be found in the Compulsive and Problem Gambling Annual Report: <http://www.ddap.pa.gov>

The 40 SCAs funded in FY 2013-2014 continue to implement a variety of problem gambling prevention programming. This programming includes information dissemination activities to raise awareness of problem gambling, educational presentations for older adults, and several educational programs for youth such as Stacked Deck and Kids Don't Gamble... Wanna Bet?

PROGRESS REPORT FY 2014 -2015

DDAP issued a two year Problem Gambling Prevention Program (PGPP) Funding Initiative Application (FIA) process in 2013-2014 and 2014-2015 for problem gambling needs assessments, prevention programs, outreach services, educational programs, and other DDAP approved services. Thirty-nine Single County Authorities (SCAs) applied and were awarded a total of \$ \$4,659,695 in SFY13-14. Forty SCAs applied and were awarded funds in amount of \$4,402,246 in SFY14-15. A new FIA process was developed and issued for the 2015-2017 time period for the comprehensive provision of problem gambling prevention evidence-based programs, evidence-informed programs, and state-approved strategies. The new FIA process will allow the department to ascertain the cost for each program to be rendered throughout the state and help improve SCA and provider accountability.

Also, a special initiatives budget and plan revision process was developed for the PGPP FIA SCAs in the SFY 2014-2015. This allowed program and fiscal staff to expedite department review of revisions and improve the approval time for the SCAs.

In April 2014, DDAP staff convened a workgroup of SCAs and providers to assist in the development of the "Problem Gambling Prevention Program Best Practice Guidelines for Youth-Focused Educational Programs." DDAP staff presented the draft version of the guidelines for feedback at the

Commonwealth Prevention Alliance conference in June 2015. Once finalized, the guidelines will be disseminated to the entire network of PGPP SCAs and providers. DDAP staff plans to reconvene the workgroup to develop guidelines for programs focused on the older adult population as well.

In addition, DDAP staff had the opportunity to collaborate with the Department of Education and the Pennsylvania Commission on Crime and Delinquency to provide input into the next Pennsylvania Youth Survey (PAYS). As a result, additional gambling questions will be included on the PAYS and this will allow more information to be collected relative to student gambling activities.



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SUBSTANCE ABUSE TREATMENT

The Division of Substance Abuse Treatment 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.

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.

During SFY 2013-2014, 250 offenders received various levels of residential treatment services. Sixty-five (65) went to long-term inpatient rehab, ninety-three (93) went to short-term inpatient rehab, seventy-seven (77) went to short-term inpatient Dual (Mental Health and Substance Use Disorder), thirteen (13) went to a halfway house, and two (2) went to long-term inpatient Dual (Mental Health and Substance Use Disorder). The average length of stay was 32.7 days.

ANNUAL REPORT FY 2013-2014

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 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 pilot programs included a drug and alcohol level of care assessment and expedited processing of Medical Assistance (MA) applications so that benefits can begin immediately upon release for eligible offenders. This process required close cooperation and frequent communication between all parties involved.

PROGRESS REPORT FY 2014-2015

During SFY 2014-2015, the expedited processing of Medical Assistance (MA) applications for inmates being released from county prisons and immediately being transferred to a Residential Drug and Alcohol Treatment Facility expanded throughout the Commonwealth.

Additionally, this project is being introduced at two (2) of Pennsylvania's state prisons (SCI Graterford and SCI Pine Grove). SCI Graterford is located in Montgomery County and houses adult male offenders and SCI Pine Grove is located in Indiana County and houses, in addition to regular adult male offenders, young adult male offenders.

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 (RCPA), 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), Pennsylvania DUI Association, 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.

PROGRESS REPORT FY 2014-2015

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, the expansion of Medicaid and Telehealth services to determine how these initiatives may impact substance abuse services throughout the commonwealth. The Department also monitors contract compliance (see p. 71) and licensure standards for these programs (see p. 66,68) as described to assist in the maintenance of service quality.

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.

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 has been revised through the work of the Clinical Standards Committee (CSC) and includes updated information on criminality as it relates to substance use treatment needs.

PROGRESS REPORT FY 2014-2015

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 provided training to the field on the ASAM.

The Department in collaboration with PCCD, PA Commission on Sentencing, the PA District Attorneys' Association, Penn DOT, PA DUI Association, and the Drug and Alcohol Service Providers Organization of Pennsylvania have developed a DUI Intervention Project that will perform compliance audits across the state to ensure that DUI offenders are receiving appropriate assessment and treatment services and that this information is being reported in a uniform manner.

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 trainings are designed to expand their knowledge of effectively working with individuals who use drugs and/or alcohol. The Department will continue to explore the development of new courses that will be beneficial to its sister agencies.

PROGRESS REPORT FY 2014-2015

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 course for Children and Youth caseworkers. The Department staff have offered training and educational presentations at 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.

ANNUAL REPORT FY 2013-2014

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.

PROGRESS REPORT FY 2014- 2015

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.

ANNUAL REPORT FY 2013-2014

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 provide leadership to the Persons In Recovery (PIR) Subcommittee of OMHSAS's Advisory Council. The PIR continues its efforts to develop standardization around Certified Recovery Specialists (CRS), similar to what has been accomplished with Peer Support Specialists in the mental health field. There has been considerable variation in roles of the CRS across Pennsylvania in training, supervision, interface with other agencies, service delivery process, etc. The PIR Subcommittee has been reviewing existing protocols and working to develop its own protocol specific to CRS, moving toward eligibility for Medicaid reimbursement.

The Department continued its partnership with the PA Recovery Organization Alliance which provided a variety of ROSC-related trainings throughout the state.

PROGRESS REPORT FY 2014-2015

The Department continues its partnership with the PA Recovery Organization Alliance which provides a variety of ROSC-related trainings throughout the state. Department key staff continues to provide continued leadership to the PIR Subcommittee of OMHSAS's PIR Advisory Council.

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 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.

ANNUAL REPORT FY 2013-2014

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 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 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 3,426 persons were contacted, reflecting a decrease of 324 clients when compared to the previous year.

Of 7,408 clients referred for counseling, 3,304 or 45% tested positive, significantly less than the 59% of individuals recorded as testing positive during the previous state fiscal year.

Case management data indicate that 2,916 individuals were referred for medical evaluation this year, significantly less than the 6,663 clients referred for medical evaluation during the previous year, principally due to significant reductions in Philadelphia (including staff turnover). 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, 164 clients accepted treatment during the year through the Allegheny, Clearfield/Jefferson and Northampton SCAs, a reduction of 31 clients compared to 195 in the previous year.

All four SCAs provided testing and case management services in 2013-2014. The Allegheny, Clearfield/Jefferson and Northampton SCAs conducted many outreach activities to promote their projects within their service areas. Allegheny SCA continued its viral hepatitis drop-in center ("Community C"), attended health fairs, developed educational tools and continued to offer rapid hepatitis C virus antibody tests at screening sites. Clearfield/Jefferson hired a new Rural Health Outreach Coordinator, conducted outreach activities at probation offices and tattoo parlors and maintained a Facebook page for its hepatitis C program. Northampton collaborated with partner organizations to provide HCV prevention, education, counseling and case management. They focused their efforts into educating hepatitis C positive patients and worked to link clients 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 materials 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.

PROGRESS REPORT FY 2014-2015

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 13, 2015 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 continued 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 through October 31, 2014 (Agency Funding Opportunity Number CDC-RFA-PS13-130302CONT14). The purpose of the one-year funding continuation award was to continue 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 through a variety of analytical, networking and educational activities. As a result of the effort, 2,180 HCV antibody tests were conducted, with 871 reactive (positive), of whom 809 were referred for polymerase chain reaction testing and 764 referred to health care.

As Pennsylvania's Viral Hepatitis Prevention Coordinator (VHPC), Dr. Boktor continues working to 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.

The Department will continue to review 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.

The major goal of the CABHI-States program is to ensure that the most vulnerable individuals who experience chronic homelessness receive access to sustainable permanent housing, treatment and recovery supports along with Medicaid and other mainstream benefits. To achieve this goal, Pennsylvania's CABHI-States funded "Homeless 2 Home Behavioral Health Project for Pennsylvania" supports the enhancement of Pennsylvania's statewide Agenda for Ending Homelessness to ensure sustained partnerships across public health and housing systems, delivers behavioral health, housing support, peer and other recovery-oriented services and provides navigation assistance to eligible participants in engagement and enrollment of Medicaid and other mainstream benefit programs through SSI/SSDI Outreach, Access and Recovery (SOAR).

ANNUAL REPORT FY 2013-2014

Supports for obtaining and maintaining permanent housing were 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 enabled 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, two Recovery Coaches were hired by MHASP

for the Project, and a Representative Payee was also hired by MHASP to provide further staff support. The Department submitted a Continuation Application for the Project to SAMHSA in January 2013 and coordinated monthly meetings of the Homeless 2 Home Project Team to receive input and provide guidance in support of the Project's outcomes.

Additionally, to prevent homelessness among individuals with substance use disorders and co-occurring substance use and mental health disorders in Pennsylvania, the Department also participated 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 served as a forum for information sharing, assessment and formulation of state homelessness policy and priorities, reviewed and developed procedures for the Regional Homeless Assistance Process' Continuum of Care application process, facilitated the collection of data on homelessness and directed and provided technical assistance to Regional Homeless Advisory Boards and individual project applicants. The Department 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 were included in the Agenda and recognized as populations of particular concern.

PROGRESS REPORT FY 2014-2015

The CABHI Main Grant continued into Year 2 of the 3-year project, FFY2015 beginning September 30, 2014. There have been 51 participant intakes to date, with a target number of 100 participants for the overall project.

The department also sought and was awarded a Supplemental Award to Benefit Veterans as part of the CABHI initiative. Operating during FFY2015 and FFY 2016, the Supplemental Team has hired a Veteran's Recovery Coach and is hiring another in support of the supplemental project.

There have been significant project activities under the CABHI Main Grant and Supplemental Award. A Recovery Coach started in November 2014, and a Veteran's Peer Specialist began work in January 2015. A part time nurse has begun work and a second Veteran's Peer Specialist will soon begin their assignment. The Peer Specialist Supervisor has been attending Veteran's Outreach meetings held at the Veteran's Multi-Service Center to share information and obtain referrals for the CABHI project. With regard to SOAR, 39 total referrals have been made, with 31 claims opened and 12 approved for benefits. The supplement will allow for five additional SOAR referrals per year for veterans. Ten participants moved into permanent supportive housing.

In addition to the CABHI Main Grant and CABHI Supplemental Grant to Benefit Veterans, the department is applying to SAMHSA for a one-year, \$1.8 million CABHI Enhancement Grant to assist more persons and further develop the infrastructure to end chronic homelessness among persons suffering from

substance use disorders or co-occurring substance use and mental health disorders in Pennsylvania.

The department continues to participate in the working body of the Interagency Council to End Homelessness, newly renamed the Homeless Program Coordination Committee (HPC) and repurposed in light of recent changes implemented by the HEARTH Act, including HUD's interim regulations. The functions and duties of the HPC Committee include serving as the Working Body of the Interagency Council (Pennsylvania Housing Advisory Committee), developing and revising the Plan to End Homelessness and interagency program coordination. It is hoped that the HPC Committee will be able to identify those statewide policies for assisting homeless persons, recommend the resources to eradicate homelessness conditions and propose action steps to the PHAC so the commonwealth may effectively assist the homeless population in gaining stability and limit its effect on the lives of homeless individuals and families.

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.

ANNUAL REPORT FY 2013-2014

The Clinical Standards Committee (CSC) was reconvened in February 2009 after a lengthy hiatus 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 continued to utilize a technical writer, the University of Pittsburgh's Program Evaluation and Research Unit (PERU), 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. Throughout fiscal year 2013-2014, PERU continued the task of revising the PCPC. The CSC did not convene during much of fiscal year 2013-2014, 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.

Most CSC subcommittees work has been completed; therefore, those subcommittees did not meet during the past year. The Intervention subcommittee did meet, and completed its work on the service description and level of care criteria for Early Intervention. The term "Early Intervention" has been chosen as the name for this service level and is defined by the subcommittee as: an organized screening and psychoeducational service designed to help individuals identify and reduce risky substance use behaviors. 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 was 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, and started meeting in September 2013. The committee began its work with the development of Principles of Training. Training principles include items such as minimum participant status, course objectives, skill targets, course prerequisites, administrative approval, and trainer requirements.

Once the training principles were established, the committee began to develop a course for current users of the PCPC who would only need to learn the revisions in the third edition, and

do not need of a full-content course. The course was designed to be 3 hours in duration, which allows the Department to offer two sessions per day. Course content includes: background of the third edition, Principles of Treatment, new Early Intervention level of care, special considerations, do/don't matrix, PCPC Summary Sheet revisions, language changes, change to Discharge/Referral Criteria, Act 106 and Act 152, and Training Principles. A pilot of the update course was conducted on May 7, the TOT was held on June 5, and DDAP plans to begin offering the update course in July 2014.

The timeline for completion and implementation of the PCPC Third Edition was extended into fiscal year 2014-2015 in order to accommodate operational demands of the Department.

PROGRESS REPORT FY 2014-2015

The primary role of the members of the CSC over the past year has been that of reviewing and providing feedback to the Department regarding PERU's edits to the PCPC. The PCPC Third Edition was released to the field in July, 2014, and the Department plans to offer the PCPC update course through June, 2015. The only active subcommittee of the CSC at this time is the Training Subcommittee. The Training Subcommittee is spending this year working diligently to revise the standard PCPC course and the Practical Applications of PCPC course. The standard course is being rolled out in January 2015, with Practical Applications to follow.

Department leadership plans to actively engage the Clinical Standards Committee with the following new subcommittees and charges over the course of the year. The Medication Assisted Treatment subcommittee is to be charged with recommending best practices in MAT, in response to a range of recent practice papers in MAT that have been published locally and nationally. These best practice recommendations are to reflect a consolidation of key issues so that providers may work with a single document rather than be faced with multiple and varied standards. The MAT Committee will be comprised of a cross-section of past, current MAT providers and related professionals. The responsibilities of this committee are to 1) Review established national standards for MAT; 2) Examine the recently promulgated documents for themes, to include testimony from the recent hearings on MAT and opiates; 3) Develop a white paper outlining its findings from local and national standards; 4) Develop summary paper suitable for inclusion as a special best practice paper in the PCPC.

The Assessment Committee is to be charged with recommending to DDAP a clinical assessment for use in collaboration with the PCPC. This mandate is developed in response to a request from the field for a unified assessment tool, as well as the need for a tool which assesses the information on the PCPC so that a proper placement can be made. The Assessment Committee will be comprised of a cross-section of past and current SUD treatment providers with expertise in assessment and the PCPC. Membership is to include a cross-section of users, as well as SCA membership. The

responsibilities of this committee are to 1) Review established national evidence based assessment tools 2) Define Screening, Level of Care Assessment and Biopsychosocial Assessments 3) Review screening and assessment tools currently in use 4) Review practice request from SCA Treatment Committee 5) Develop an level of care assessment tool outlining its findings from local and national standards. 6) Develop summary paper suitable for inclusion as an appendix in the PCPC.

The Recovery Specialists Committee is to be charged making recommendations to DDAP for utilization of recovery supports in the community. The Recovery Specialists Committee will be comprised of past and current recovery specialists and current substance use disorder treatment providers. The responsibilities of this committee are to 1) Review established national standards for Certified Recovery Specialists and its equivalent 2) Explore the relationship between Certified Recovery Specialists (CRS), Certified Peer Specialists, counselors, and the recovery community 3) Establish practice guidelines including common roles/duties, training issues, ethical issues, qualifications, ethical/confidentiality issues and other common issues related to best practice 4) Develop summary paper suitable for inclusion as a special provider paper in the PCPC.

The Evaluation Advisory Sub-Committee shall recommend to DDAP suggestions for implementation of an evaluation of the current practice with the PCPC. The Evaluation Advisory Sub-Committee will be comprised of representatives from SUD treatment experts, SCAs, payers, physicians, and the recovery community to ensure that the results are viewed as valid. The responsibilities of this committee are to 1) Review current practice of PCPC utilization 2) Make recommendations for the design of an effective evaluation to include goals, objectives and research design 3) Make recommendations on sources of funding for evaluation 4) Review results of evaluation and make recommendations on related changes in clinical practice.

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.

PROGRESS REPORT FY 2014-2015

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 and the Office of Children, Youth and Families; 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 PA Commission on Crime and Delinquency, Department of Human Services, Department of Corrections, Pennsylvania Board of Probation and Parole, Department of Health, Juvenile Court Judges Commission 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.

ANNUAL REPORT FY 2013-2014

The Department was closely involved with the Commonwealth Prevention Alliance's 24th Annual Prevention Conference to assist in the training and development of professionals in the prevention field.

The Division of Prevention and Intervention 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 recognized 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.

PROGRESS REPORT FY 2014-2015

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 plans to implement training to the field on the DSM 5 and the ASAM, 3rd edition. The Department has begun providing training to the field on the PCPC 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 maintains 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 continues to be a significant issue in PA. The Department has continued the Safe and Effective Prescribing Practices and Pain Management Taskforce consisting of medical stakeholders and co-chaired by the Department's Secretary and the Department of Health's Physician General, that will co-chair this taskforce moving forward. The focus of this group was (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. The Taskforce was able to create three sets of prescribing guidelines that included chronic, non-cancer; emergency room; and dental guidelines have been promulgated and this provides the most current information on prescribing practices for physicians.

PRIORITY: COORDINATE ALL HEALTH AND REHABILITATION EFFORTS TO DEAL WITH THE PROBLEM OF DRUG AND ALCOHOL ABUSE AND DEPENDENCE, INCLUDING, THOSE RELATED TO OLDER ADULTS 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 2014-2015

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 older adults 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 previously 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 criminal recidivism and increasing community safety.

PROGRESS REPORT FY 2014-2015

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 in collaboration with PCCD, PA Commission on Sentencing, the PA District Attorneys' Association, Penn DOT, PA DUI Association, and the Drug and Alcohol Service Providers Organization of Pennsylvania have developed a DUI Intervention Project that will perform compliance audits across the state to ensure that DUI offenders are receiving appropriate assessment and treatment services and that this information is being reported in a uniform manner.

The Department in collaboration with PCCD, PA Commission on Sentencing, the PA District Attorneys' Association, Penn DOT, PA DUI Association, and the Drug and Alcohol Service Providers Organization of Pennsylvania have developed a DUI Intervention Project that will perform compliance audits across the state to ensure that DUI offenders are receiving appropriate assessment and treatment services and that this information is being reported in a uniform manner.

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 the prevention data system 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.

practices. Guidelines have been promulgated and this provides the most current information on prescribing practices for physicians.

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

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

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 2012, there were 2,026 overdose deaths in Pennsylvania, which translates into a rate of 16.3 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.

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.

PROGRESS REPORT FY 2014-2015

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.

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 2014-2015

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.

To address the high number of overdose deaths in the commonwealth, the Department has formed an Overdose 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.

The Division of Prevention and Intervention contacted 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.

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 was (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

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 commonwealth employees. By working together, all entities in Pennsylvania can craft a benefit package that will improve the health and work performance of commonwealth employees.

PROGRESS REPORT FY 2014-2015

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 2014-2015

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. Department staff work collaboratively with SCA staff in numerous meetings and on

various initiatives and thus are in regular consultation with the SCAs.

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.

ANNUAL REPORT FY 2013-2014

To address the high number of overdose deaths in Pennsylvania, the Department has formed an Overdose 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 continued to work on a state needs assessment and plan which will provide guidance to SCAs for local planning. The Department anticipates implementing the state needs assessment and plan during FY 2015-2016.

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 2014-2015

The Department continues to chair the Overdose Task Force and Methadone Death and Incident Review Team to create recommendations for best practices for safe and effective coordination of services across agencies. Department continues in 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 and Physician General. 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 2014-2015

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 List serve 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 2014-2015

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 is 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 2014-2015

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, data collection and outcome systems, 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 2014-2015

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. As was previously noted, the Department also recognizes survivors of overdose as a priority population, and is to be treated as emergent with regard to referral for access to treatment from the hospital emergency department. Protocols have been developed requiring SCAs to partner with their local hospitals and urgent care centers to ensure that overdose survivors are being referred to treatment in an expedited 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 the treatment data system and the prevention 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 2014-2015

The Department mandates that certain information be collected by the SCAs and their providers in compliance with federal reporting requirements. Through the use of treatment data system, 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 the prevention data system. 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 the treatment data system and the prevention data system 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 2013-2014

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.

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. The most utilized services included care coordination, enhanced education/employment services, short term emergency housing, employment and vocational skills training, and anger management intervention.

The ATR project was scheduled to end September 2014; however, the department submitted a request to SAMHSA for a no-cost extension through March 31, 2015 in order to fully assist those individuals who had been enrolled in the program, but had not yet completed services. In addition to providing clinical treatment services, the majority of the ATR funds were used to make recovery support services available in the community. These services were designed to help individuals engage in the recovery process, adhere to clinical treatment, and provide coaching to maintain recovery within the context of the community. The project employed 22 Recovery Specialists to work exclusively with the 11,648 individuals enrolled in the program. The Recovery Specialists assisted with recovery planning, promoted self-advocacy, helped people identify their personal interests, goals, strengths and challenges in relationship to the recovery process. The ATR model was a shift away from acute care to a broader system that promotes recovery, resilience, and self-determination.

Over the course of ATR 3, the project exceeded intake coverage by 8% and surpassed the national average for this cohort's Government Performance and Results Acts (GPRA) rate by completing 8,376 follow-up surveys (72%). Based on National Outcome Measures (NOMS), the project led to the following positive outcomes among participants:

- An increase housing stability

- A decrease in criminal justice recidivism
- An increase in the number of individuals currently employed or attending school
- An increase in abstinence from alcohol and other drug use
- An marked improvement in health/behavior/social consequences

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

Background: According to the CDC, deaths from drug overdose have steadily been on the increase over the past two decades has become the leading cause of accidental death in the country. Not only have prescription opioid analgesics been a contributing factor to this increase in deaths, but deaths by heroin overdose have experienced a 39 percent increase between 2012 and 2013.¹⁶ Evidence shows that individuals at greatest risk for prescription opioid overdose include: white and American/Alaska Native people, men (although overdose among women is on the rise), people living in rural areas, adults aged 45-54 years, people who obtain multiple controlled substance prescriptions (especially the combination of opioids and benzodiazepines) from multiple providers, and people who take high daily dosages of opioid pain relievers. Rates of emergency department (ED) visits associated with misuse of prescription pain relievers have increased 114 percent between 2004 and 2001.¹⁷ Of additional grave concern is that nonmedical use of psychotherapeutic drugs in the past year among people 12 years and older has ranged from 5.7 to 6.7 percent during 2002-2013. According to the National Survey on Drug Use and Health (NSDUH) non-medical use of pain medications has raised sharply among young persons, with 53 percent reporting having received them from a friend or relative.¹⁸ However, the majority of non-medical users who, the highest-use, highest risk non-medical users were more likely to obtain the drugs directly from a doctor's prescription than any other source.¹⁹

Of those individuals who began abusing opioids in the 2000s, 75 percent of individuals indicated that they initiated their abuse with prescription opioids and later shifted to heroin use. Study results indicate that this transition to heroin occurs because heroin is more easily accessible and significantly cheaper, is easier to inhale and inject, and the potency is considerably greater than prescription opioids.²⁰

ANNUAL REPORT FY 2013-2014

An Overdose Task Force (OTF), now referred to as the Overdose Task Force (OTF), 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 OTF 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 was tasked with addressing particular objectives. Achievements in the first year include, but were 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 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 not the Department's alone, but was a collaborative effort for which the department was tasked to facilitate and provide oversight and assistance with implementation of the various strategies. Governor unveiled his recommendations as directed by this workgroup in September 2014. Throughout the year, the Department began to 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.

PROGRESS REPORT 2014 -2015

While significant progress was noted in the first year of this group's inception, various challenges were also identified: existing data systems within the commonwealth that were thought to have potential in the obtaining and sharing of drug trending and overdose incident reporting each have their limitations. Newly established methods of information sharing, such as the Coroner's Death Reports, have potential benefit, as well as challenges. While timeliness of information acquisition, limitations of information gathering and obstacles for information sharing have proven to create limitations for the OTF, the group continues to problem-solve to overcome these barriers.

Consultation with New Jersey's Drug Monitoring Initiative (NJ-DMI), a voluntary, statewide initiative in that state that uses real-time data sharing of overdose incidences to impact law enforcement strategies, drug treatment and prevention services, public awareness, and public health initiatives for prevention and response was sought out for insight and ideas. Lt. Juan Colon presented to the OTF and a group of OTF members attended a day-long presentation about the NJ-DMI at the NJ State Police Regional Operations Intelligence Center (ROIC, pronounced "Rock") to obtain lessons learned and to obtain information on best practice.

Evaluation of the Warm Hand-off Policy, created with the help of the OTF workgroup of the same name and issued by DDAP to the Single County Authorities was conducted. Improvements to this policy are currently under consideration and should be ready for review and approval by mid-year. Such a revision should improve the referral process post overdose to assist survivors in getting the treatment necessary to initiate recovery.

The Naloxone Workgroup has been instrumental in assisting DDAP in its technical advisory capacity to first responders wishing to establish naloxone administration programs.

Collaborative efforts continue to occur through the convening of the OTF, which not only serves to report trending of drug use and overdose incidents and to direct timely and effective response to overdose spikes, but also has begun to look at how this group might expand its mission. The members of the

OTF not only see information sharing efforts between group and stakeholder members as having significance, but that the expertise represented in this group, along with the information available to its members, should be used as a mechanism for increasing awareness among the general public.

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BUREAU OF QUALITY ASSURANCE FOR TREATMENT & PREVENTION

The Bureau of Quality Assurance For Treatment & Prevention is responsible for the licensure and/or approval of 700 licensed facilities located throughout the Commonwealth. Sixty four of those facilities must also be inspected as Narcotic Treatment Programs (NTPs). Current regulations require annual on-site inspections at each of those facilities. The purpose of the Division of Drug and Alcohol Program Licensing is to ensure that facilities are operating in compliance with state and federal regulations and that the facilities are providing a safe clinical and physical environment where quality care can happen. In addition to the on-site licensing inspections, Drug and Alcohol Licensing Specialists and Licensing Specialist supervisors conduct on-site complaint investigations, plan of correction follow-up inspections and physical plant inspections when there is a change of address or reconstruction. They are also called upon to conduct pre-survey reviews for new applicants to open drug and alcohol treatment facilities. The Accountability and Program Improvement Division oversees and implements MDAIR related activities and works very closely with the Division of Program Licensure (within the same bureau) regarding licensing applications and complex complaint investigations.

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.

ANNUAL REPORT FY 2013-2014

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 2014 -2015

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 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.

The Department is working in collaboration with the Department of Health; Office of Quality Assurance will be improving the quality of medical services provided to the public in the Commonwealth of Pennsylvania by the creation of a replacement for the current SAIS. The new system's ultimate goal is to obtain comprehensive and objective information while reducing burden on patients, medical personnel and executives, state surveyors and responsible State Officials, while substantially decreasing the cost of each and every inspection to the Government. This new system will allow conducting improved and enhanced surveys of medical treatment facilities and ensuring that provided services; equipment and facilities meet State and Federal norms and standards.

Bureau of Quality Assurance, Overview of Reviews Year To Date	
Requests for applications/standards processed	147
Initial and renewal licensing inspections conducted	591
Incident reports received and evaluated	559
Complaints investigated	73
Presurvey Manuals Reviewed	57
Narcotic Treatment Program monitoring inspections conducted	82

ACCOUNTABILITY AND PROGRAM IMPROVEMENT

The Accountability and Program Improvement Division in the Bureau of Quality Assurance for Prevention and Treatment is comprised of the Program Improvement Section and the Methadone Death and Incident Review (MDAIR) Section. This division oversees and implements MDAIR related activities and works very closely with the Division of Program Licensure (within the same bureau) regarding licensing applications and complex complaint investigations.

Program Improvement Section:

The sections emphasis is on continuous quality improvement by investigation and follow-up regarding complex complaints and complaints within licensed drug and alcohol (D&A) facilities, providing comprehensive technical assistance to both active and potential licensed D&A providers and analysis data for the use of enhancing the quality of care among licensed D&A providers. Additionally, this section serves as the lead for processing new D&A applications. Additionally, the division provides technical assistance to existing and potential licensed drug and alcohol providers within the commonwealth.

Methadone Death and Incident Review (MDAIR) Section:

This section was created to ensure the adherence to the METHADONE DEATH AND INCIDENT REVIEW ACT (Act of Oct. 24, 2012, P.L.1198, No. 148). The section investigates, reviews, and analysis data regarding all occurrences where methadone was a primary or secondary cause of death or may have been a contributing factor or a methadone serious incident whereas, methadone was a contributing factor to a serious injury or unreasonable risk of death or serious injury. The section is responsible for tracking trends, making recommendations to the official MDAIR committee regarding the improvement of methadone treatment practices thus, enhancing quality of care provided. Additionally, this section is responsible for the production of the MDAIR annual report. Furthermore, the section has developed and maintains excellent working relationships with other state agencies, local authorities, corners, health care providers, narcotic treatment providers (NTPs), corners, law enforcement and other MDAIR stakeholders.

PRIORITY: To ENSURE PROGRAM INTEGRITY, CONTINUOUS QUALITY IMPROVEMENT, EFFICIENCY AND FISCAL ACCOUNTABILITY WITHIN PENNSYLVANIA'S TREATMENT SYSTEM.

ANNUAL REPORT FY 2013-2014

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 2014 -2015

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 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.

BUREAU OF ADMINISTRATION & PROGRAM SUPPORT

The Department of Drug and Alcohol Programs has one deputy secretary, responsible for both administration and programmatic operations. As a result, there is heavy reliance on the Bureau of Administration and Program Support for all budgetary and administrative functions within the Department. The bureau director serves as Chief Financial Officer for the organization. The Bureau consists of the Division of Budget and Grants Management and the Division of Administrative and Support Services, as well as the County Program Oversight Section, which reports directly to the Bureau Director. While the Division of Administrative and Support Services maintains certain responsibilities related to human resource management and information technology, the Department also maintains agreements with the Office of Administration, Human Resources Office (OA-HR) and the Department of Health, Bureau of Information Technology (DOH-BIT) to assist in these support functions. The Director of DOH-BIT represents the Department as the Chief Information Officer on information technology matters.

BUDGETS & GRANTS MANAGEMENT

The Budget and Grants Management Division resides within the Bureau of Administration and Program Support. This Division is responsible for fiscal management, contract and procurement functions, and the application and management of grants received by 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 response and management of sub-recipient audits.

PRIORITY: EXECUTE NEW 2015-2020 FIVE-YEAR

GRANT AGREEMENTS TO FORTY-SEVEN SINGLE COUNTY AUTHORITIES FOR THE PREVENTION, INTERVENTION, CASE MANAGEMENT, TREATMENT AND RECOVERY ASPECTS OF SUBSTANCE USE AND GAMBLING DISORDERS.

PRIORITY: ELIMINATE BACKLOG OF OUTSTANDING

AUDITS APPLICABLE TO THE FUNDS RECEIVED FROM THE DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS OR ITS PREDECESSOR, THE BUREAU OF DRUG AND ALCOHOL PROGRAMS IN THE DEPARTMENT OF HEALTH, BY COUNTIES AND SINGE COUNTY AUTHORITIES ADMINISTERING SUBSTANCE ABUSE SERVICES.

PRIORITY: FINALIZE PROCEDURAL OPERATIONS

MANUAL FOR DIVISION OF BUDGET AND GRANTS MANAGEMENT ADDRESSING THE PROCEDURES APPLICABLE TO AGENCY FISCAL AND GRANTS MANAGEMENT.

DIVISION OF ADMINISTRATIVE AND SUPPORT SERVICES

The Administrative and Support Services Division is also a part of the Bureau of Administration and Program Support. The Division consists of three separate sections; the Administrative Section, the Business Workflow Section, and the Training Section. This Division is responsible for administrative management and functions related to human resource, information technology and business workflow of data collection systems, and management of the training needs for substance abuse and gambling service professionals. The Division provides support services to Department staff and stakeholders inside and outside the gambling and substance abuse fields. Specific roles of the staff in this Division include, but are not limited to human resource management, clerical support, office leasing and operational procurement, continuing education administration, information technology management and support, and procurement and support of software solutions utilized by the Department.

ADMINISTRATIVE SECTION

The Administrative Section coordinates all personnel actions related to staffing of the Department. A number of administrative functions related to maintaining operations for the Department are included within the functions of this section, along with the provision of clerical support to the Bureau of Administration and Program Support and the Bureau of Treatment, Prevention and Intervention. Some of the administrative functions performed include coordination of real estate and automobile lease management, office purchasing, and travel management.

The vendor provided system used by the Division of Program Licensure is a database utilized by the Departments of Health, Aging and Drug and Alcohol Programs to manage the licensing and certification systems. The data system used by the Division of Prevention serves both as a tool to assess processes in service determination and to measure and evaluate the actual services being delivered. The treatment data system is intended as a tool to assist the SCAs in the management of service delivery while also serving the providers in recording and administering the services being delivered. Ultimately, all of these systems provide the Department the ability to report on activities, both for the purpose of overall management of operations, as well as to meet federal and state reporting obligations. The Business Workflow Section also manages the Department website and is responsible for maintenance and processing of internet-based communications.

PRIORITY: ESTABLISH A SERIES OF DEPARTMENT LEVEL POLICIES AND PROCEDURES ADDRESSING THE CONDUCT AND PROCESSES TO BE ADHERED TO IN DEPARTMENTAL OPERATIONS. THE DEPARTMENT WAS FORMALLY ESTABLISHED ON JULY 1, 2012. WITH THE AMOUNT OF WORK DEDICATED TO THE TRANSITION FROM A BUREAU IN ANOTHER DEPARTMENT TO A CABINET-LEVEL AGENCY, TIME HAS NOT BEEN AFFORDED TO ADEQUATELY FORMALIZE A SYSTEM OF POLICIES AND PROCEDURES.

PRIORITY: FACILITATE TRANSITION OF THREE RETIRED OR RETIRING VENDOR PROVIDED DATA SYSTEMS TO REPLACEMENT SYSTEMS CAPABLE OF MEETING THE OPERATIONAL AND REPORTING NEEDS OF THE DEPARTMENT.

BUSINESS WORKFLOW SECTION

The primary responsibility of the Business Workflow Section is assistance in development, maintenance and technical assistance of the various data systems utilized by the Department. This section is also responsible for the inventory and maintenance of information technology equipment utilized by the Department. Data systems operated by the Department include two internally developed systems used to support the continuing education program administered by the Training Section and the SCA Data Site (SDS) utilized by the County Program Oversight Section for managing oversight and analyzing operations of the Single County Authorities (SCAs).

PRIORITY: FACILITATE TRANSITION OF DEPARTMENT WEBSITE FROM RETIRING PLATFORM TO NEW SHARE-POINT BASED PLATFORM, ESTABLISHING VARIOUS PROGRAM AREAS AS CONTENT MANAGERS IN NEW ENVIRONMENT.

PRIORITY: ASSIST IN CONTINUED DEVELOPMENT AND MODIFICATION OF INTERNALLY DEVELOPED SYSTEMS TO MEET OPERATIONAL NEEDS OF THE TRAINING SECTION AND THE COUNTY PROGRAM OVERSIGHT SECTION.

TRAINING SECTION

The Training Section coordinates 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 utilization 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.

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>.

COUNTY PROGRAM OVERSIGHT SECTION

A portion of the personnel contained in what was formerly identified as the Division of Evaluation and Contract Compliance in the Bureau of Quality Assurance for Prevention and Treatment was transferred to the Bureau of Administration and Program Support in May of 2014 as a direct report to the bureau director. All functions related to the former division were transitioned with this section, with new responsibilities related to fiscal oversight previously completed by the Division of Budget and Grants Management (formerly the Fiscal Section under the Bureau of Drug and Alcohol Programs) added to their job duties. The reason for this was twofold. First, the capacity of the Division of Budget and Grants Management to continue Single County Authority (SCA) fiscal oversight was challenged by new duties inherent to performing agency level budget office obligations. Secondly, in order to more effectively oversee the SCAs, it seemed prudent that the County Program Oversight Section review and approve SCA submitted budgets and expenditure reports, assuming a more comprehensive project management role. Inclusion of these new responsibilities was facilitated by the enhancement of the SCA Data Site (SDS), incorporating fiscal reporting within the larger functionality of the system. SDS is the data system used by the County Program Oversight Section to assist in management and oversight of the SCAs. Consideration to expand and elevate the County Program Oversight Section is underway due to the challenge in meeting these expanded duties, along with plans to enhance the monitoring process to incorporate additional case management evaluation and quality improvement measures.

Under the new five-year grant agreement effective July 1, 2015, staff of the County Program Oversight Section are serving as the project officers to the forty-seven grant agreements with the SCAs and have the primary responsibility to oversee SCA adherence to agreement requirements and to evaluate the SCAs' efficacy in carrying out their administrative and programmatic functions, while efficiently managing all available resources at the local level. The Section conducts annual monitoring of the SCAs. This process is designed to assess the SCAs administratively, fiscally and programmatically.

The County Program Oversight Section utilizes a 12-month monitoring process, incorporating an annual onsite review with in-depth interoffice reviews to verify adherence to Department grant agreement requirements. The monitoring 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. In order to make effective use of the amount of time spent on-site, the Section incorporates the use of pre-submitted materials, conference calls, technical assistance, and in-house review and evaluation. The on-site portion of the monitoring process allows the Project Officer to review the SCA's case management service delivery, which includes ensuring that individuals are placed into and retained in proper level of care. The on-site visit is also used to speak with staff from the SCA, as well as to review contract documents, invoices, payments to providers, the SCA's process

PRIORITY: BOTH THE TRAINING COURSE CATALOG AND THE INFORMATION CLEARING-HOUSE ARE TO BE COMPLETELY REVIEWED FOR RELEVANCE AND APPLICABILITY TO MISSION. COURSE CURRICULUM AND PUBLICATIONS WILL BE EVALUATED FOR CURRENCY AND OUTDATED COURSES AND PUBLICATIONS WILL BE DISCONTINUED. A SYSTEMATIC UPDATE OF COURSE CURRICULUM WILL BEGIN DURING THE REPORTING PERIOD. ANALYSIS WILL BEGIN TO INTRODUCE NEW COURSES AS DEEMED APPROPRIATE.

COUNTY PROGRAM OVERSIGHT SECTION cont'd.

for tracking funding sources, and other information that is not conducive to pre-submission of documents.

Programmatically, the monitoring process is intended to gauge quality in the local drug and alcohol service delivery system; ensure that emergent care needs are being addressed; evaluate if 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 is occurring; verify availability of adequate case management services; and ensure 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.

Administratively, the reviews completed by the County Program Oversight Section consist of several major elements. These include treatment service authorization methodologies, representation on the local advisory councils, effectiveness in facilitating access to public and private insurance coverage, efficiencies in administrative structure, appropriateness of fiscal processes, timeliness of required reports, subcontractor work statements, and the performance monitoring of the providers of service. Internal fiscal reviews by Section staff occur throughout the fiscal year and provide a close inspection of fiscal reports and budget information associated with Department issued dollars.

Beginning with the fiscal reporting for State Fiscal Year ending June 30, 2014, SCAs were required to enter more detailed information into the SDS related to the expenditure of Department funds, as well as other funding sources. This allows 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 remainder of the former fiscal reporting package is to be incorporated into SDS for the five-year grant agreement beginning July 1, 2015.

PRIORITY: MAKE APPROPRIATE MODIFICATIONS TO THE SINGLE COUNTY AUTHORITY AND PROVIDER MONITORING TOOLS TO ADDRESS THE NEW FIVE-YEAR GRANT AGREEMENT AND THE APPROPRIATE APPLICATION OF THE PENNSYLVANIA CLIENT PLACEMENT CRITERIA, THIRD EDITION.

PRIORITY: COMPLETE CONVERSION OF SINGLE COUNTY AUTHORITY (SCA) FISCAL REPORTING FROM EXCEL FILE FORMAT TO SCA DATA SITE (SDS) DATABASE REPORTING.

PRIORITY: COORDINATE WITH THE DIVISION OF TREATMENT TO MODIFY THE CURRENT TREATMENT MANUAL IN REGARD TO THE FUNCTIONS OF CASE MANAGEMENT AND THE APPROPRIATE RECORDING AND REPORTING OF TREATMENT RELATED DATA.



WOMEN AND CHILDREN'S ANNUAL REPORT | STATE FISCAL YEAR 2013-2014

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 2013-2014, 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 = 275
- Total Capacity for Children = 442
- Residential Programs for Women = 10
- Total Capacity = 171+
- Halfway House Programs, two of which allow women to bring their children
- Total Capacity for Women = 410
- 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 2013-2014, 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, Inc. in Philadelphia County
- Libertae Family House 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
- In addition, there were 19 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
- Good Works Life Recovery House in Fayette County
- Libertae, Inc. in Bucks County
- Myah's House of Hope
- 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
- Treatment Trends, Inc. Halfway Home of the Lehigh Valley in Lehigh 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
- 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
 - 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

The Department continued to offer support to 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, attend meetings, provide administrative support and facilitate 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. Though WATCH has been inactive over the past year, the Department will continue to offer technical assistance to WATCH and utilize this resource to ascertain feedback relative to women's treatment services, best practices, provider education and other needs facing this population.

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 presentation was "Where You End and I Begin: Perspectives on Co-Dependence and Boundary Setting". Participants learned about the concepts of co-dependence and boundary setting as they manifest in the lives of the client populations they serve. They explore the history and origin of the terms in conjunction with the 12-step model of addiction recovery as well as trauma treatment. In addition, students have the opportunity to examine the ways in which these dynamics impact their personal lives and the ways in which they practice. Participants develop a 'tool kit' of exercises, modalities and interventions that assist consumers in moving through their particular challenges with greater rapidity and deeper insight. Presenter Rev. Edie Weinstein is an opti-mystic who views life through the eyes of possibility. Her creative, career and spiritual paths have led her to become a writer, speaker, interfaith minister, reiki master, clown, greeting card text writer.

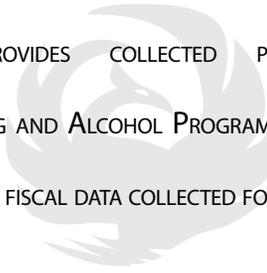
PART 2: PROGRAM DATA AND FINANCIAL INFORMATION



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 2013-2014.



Prevention Data Analysis

State Fiscal Year 2013-2014

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. The following tables and graphs are an analysis of the data entered into the Department's Performance Based Prevention System (PBPS).

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 2013-2014's increase of 6,629 services overall is mainly attributed to an increase in both single and 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 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 participant numbers have increased.

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 2009-2010 through 2013-2014

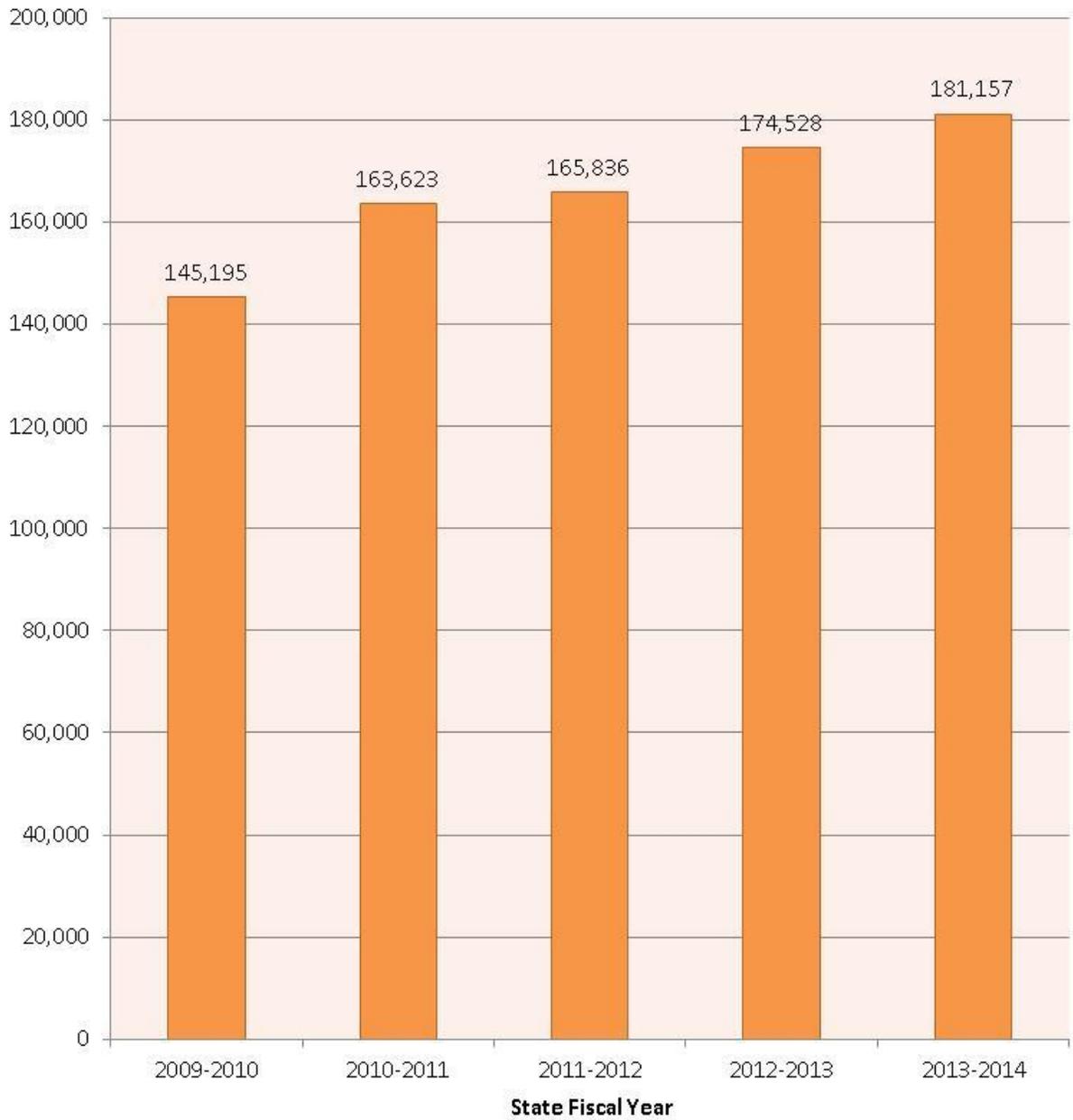


Figure 2

Single and Recurring Prevention Services as Reported to PBPS State Fiscal Years 2009-2010 through 2013-2014

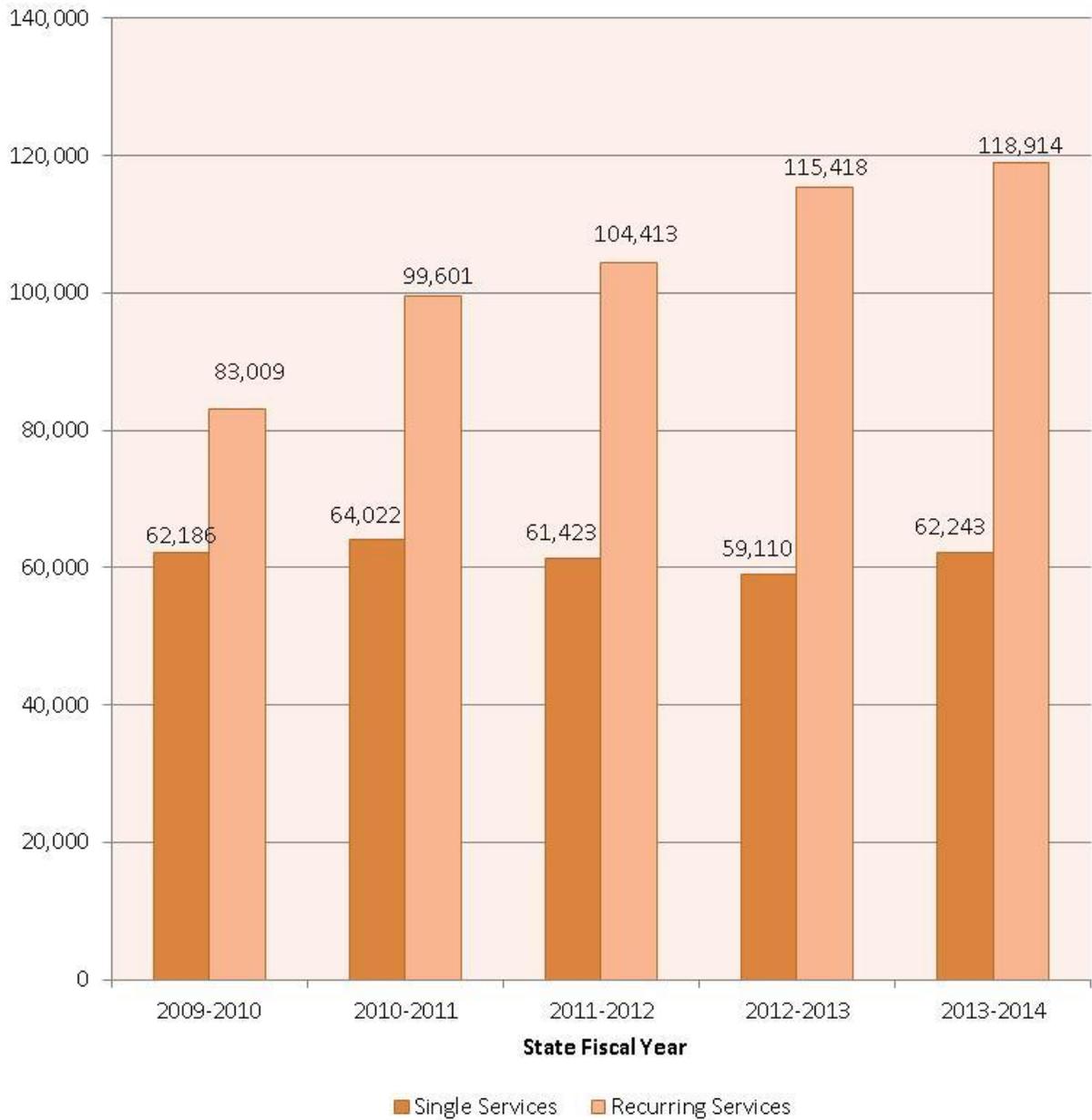
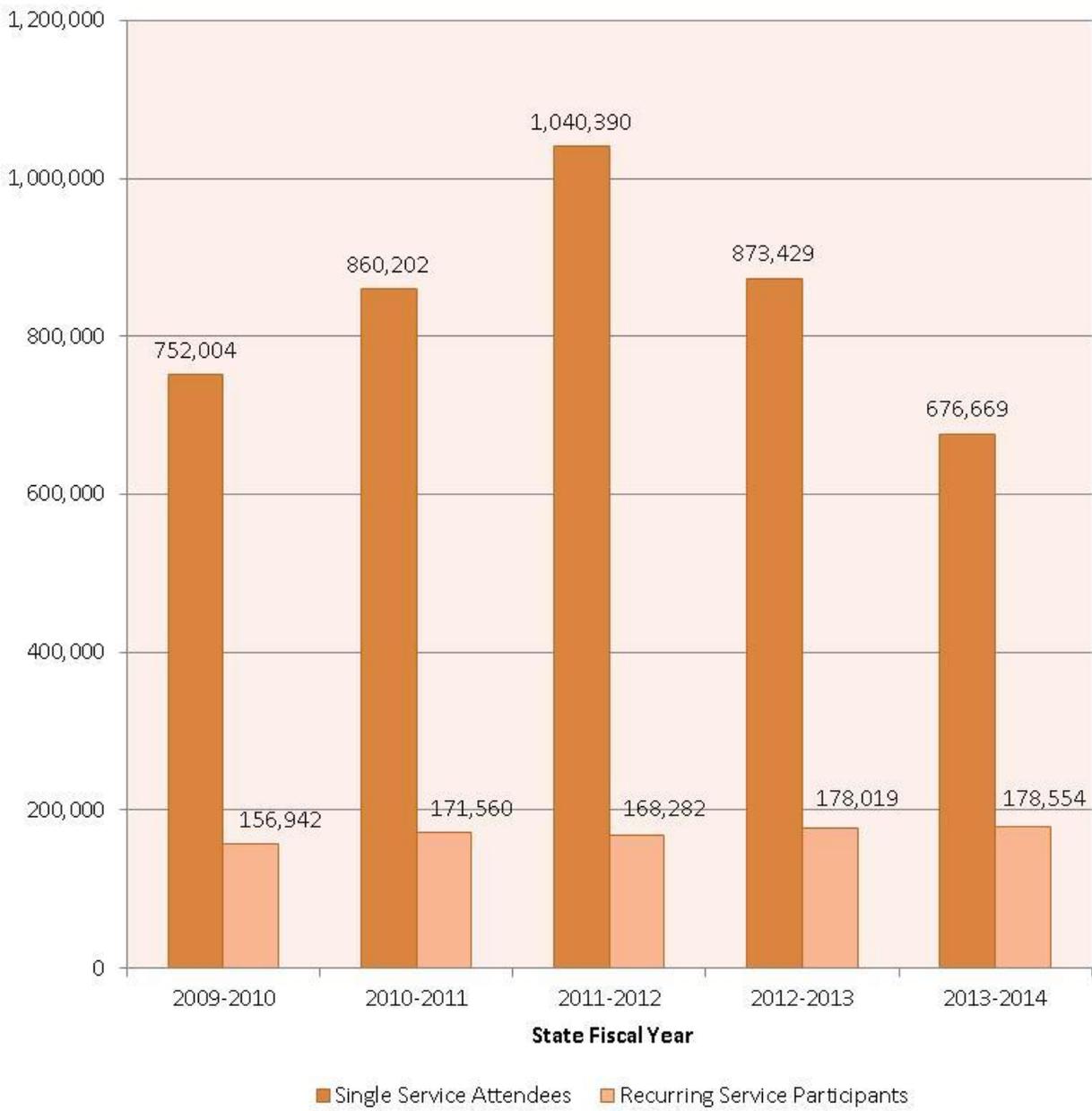


Figure 3

Prevention Service Attendees and Participants State Fiscal Years 2009-2010 through 2013-2014



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

Figure 4 demonstrates a five-year trend of the three prevention service categories: Evidence-Based Programs, Evidence-Informed 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 and Evidence-Informed Programs. There has been an increase in Evidence-Based and Evidence-Informed Program services. Evidence-Based and Evidence-Informed programs provide more rigor and effectiveness than State Approved Strategies.

The programs are defined as follows:

Evidence-Based Programs include programs and strategies 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;
- Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals;
- Replicated and produced desired results in a variety of settings; and,
- Included in Federal registries of evidence-based programs (note: inclusion in a Federal registry is necessary, but not a sufficient characteristic to merit inclusion on DDAP's list of evidence-based programs).

Evidence-Informed include programs and strategies which are:

- 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;
- Based on published principles of prevention, e.g., NIDA's Prevention Principles;
- 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; and,
- Must have an evaluation that includes, but is not limited to, a pre/post-test and/or survey.
- May be similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature;
- May have appeared in a non-refereed professional publication or journal; and,
- May have been identified or recognized publicly and may have received awards, honors or mentions.

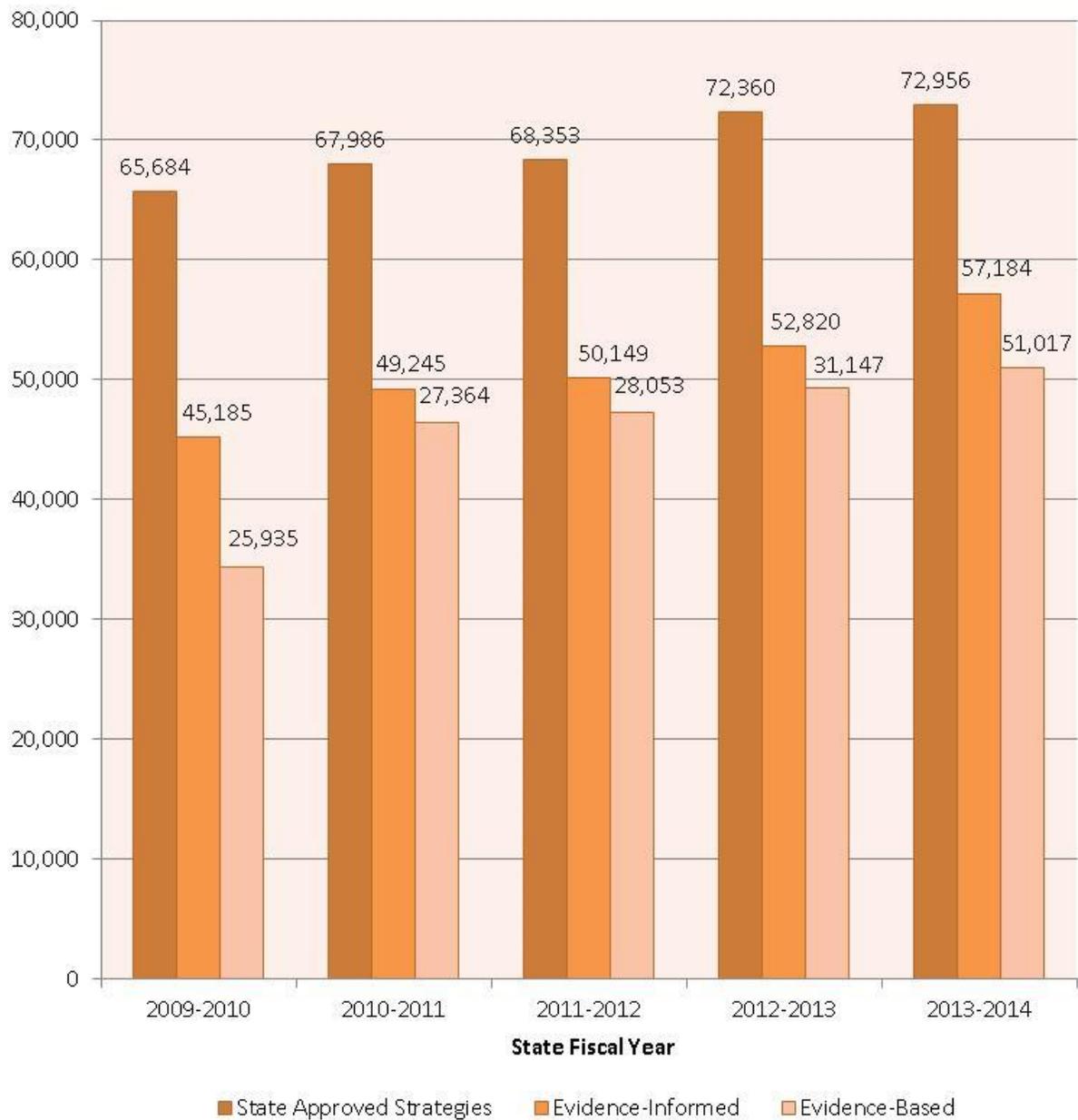
State Approved Strategies are defined as programs which:

- 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 evidence-informed programs

Figure 4

Prevention Services by Program Category as Reported to PBPS State Fiscal Years 2009-2010 through 2013-2014



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:

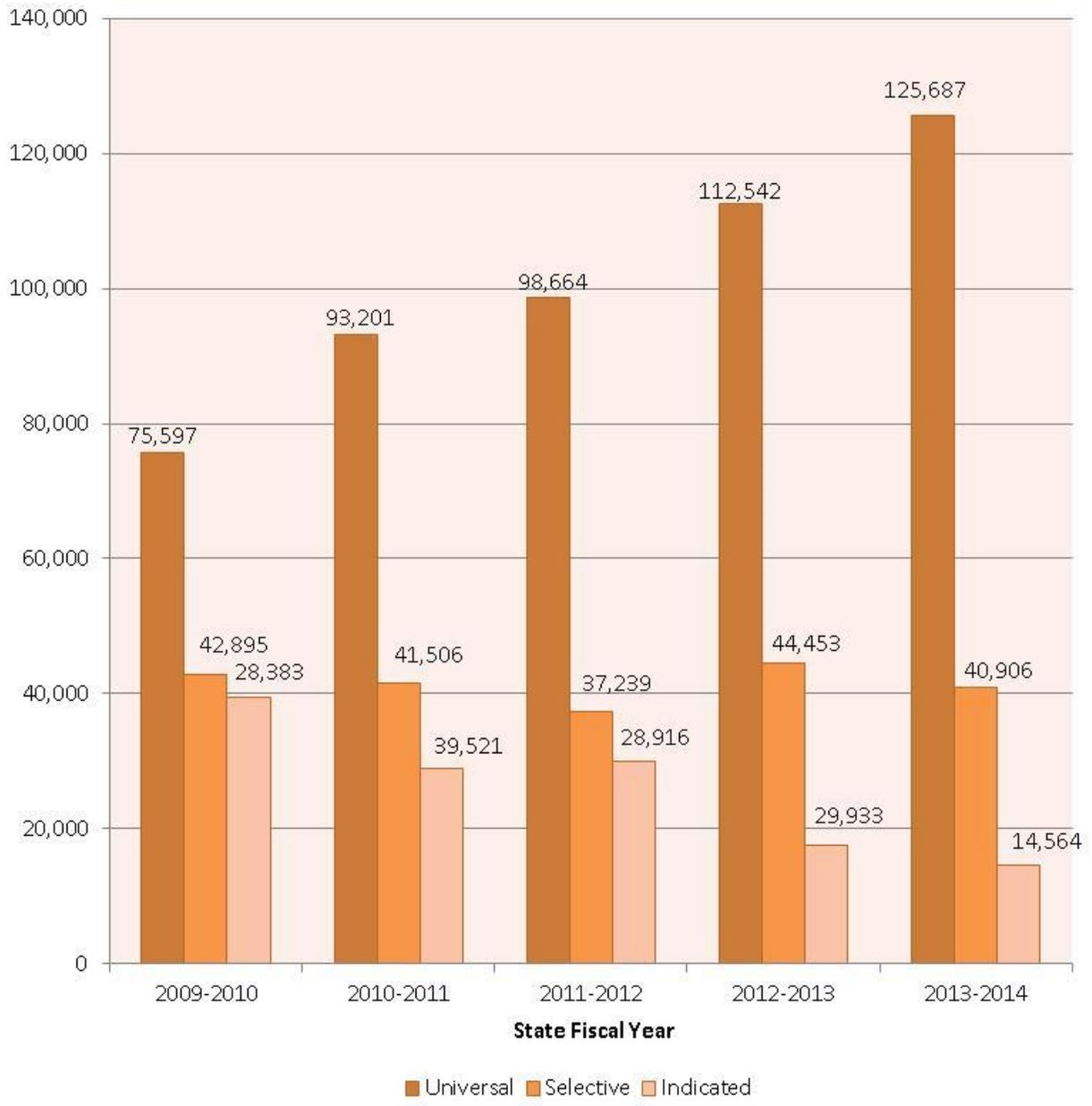
- Universal strategies address the entire population.
- Selective strategies focus on subsets or subgroups of the population exposed to greater levels of risk.
- Indicated strategies are designed to prevent the onset of substance abuse in individuals who have initiated the use of alcohol or other drugs.

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 13,145 services from SFY 2012/2013. Services to Selective and Indicated populations decreased slightly from 2012/2013 to 2013/2014.

Figure 5

Prevention Services by Institute of Medicine Population Categories as Reported to PBPS State Fiscal Years 2009-2010 through 2013-2014



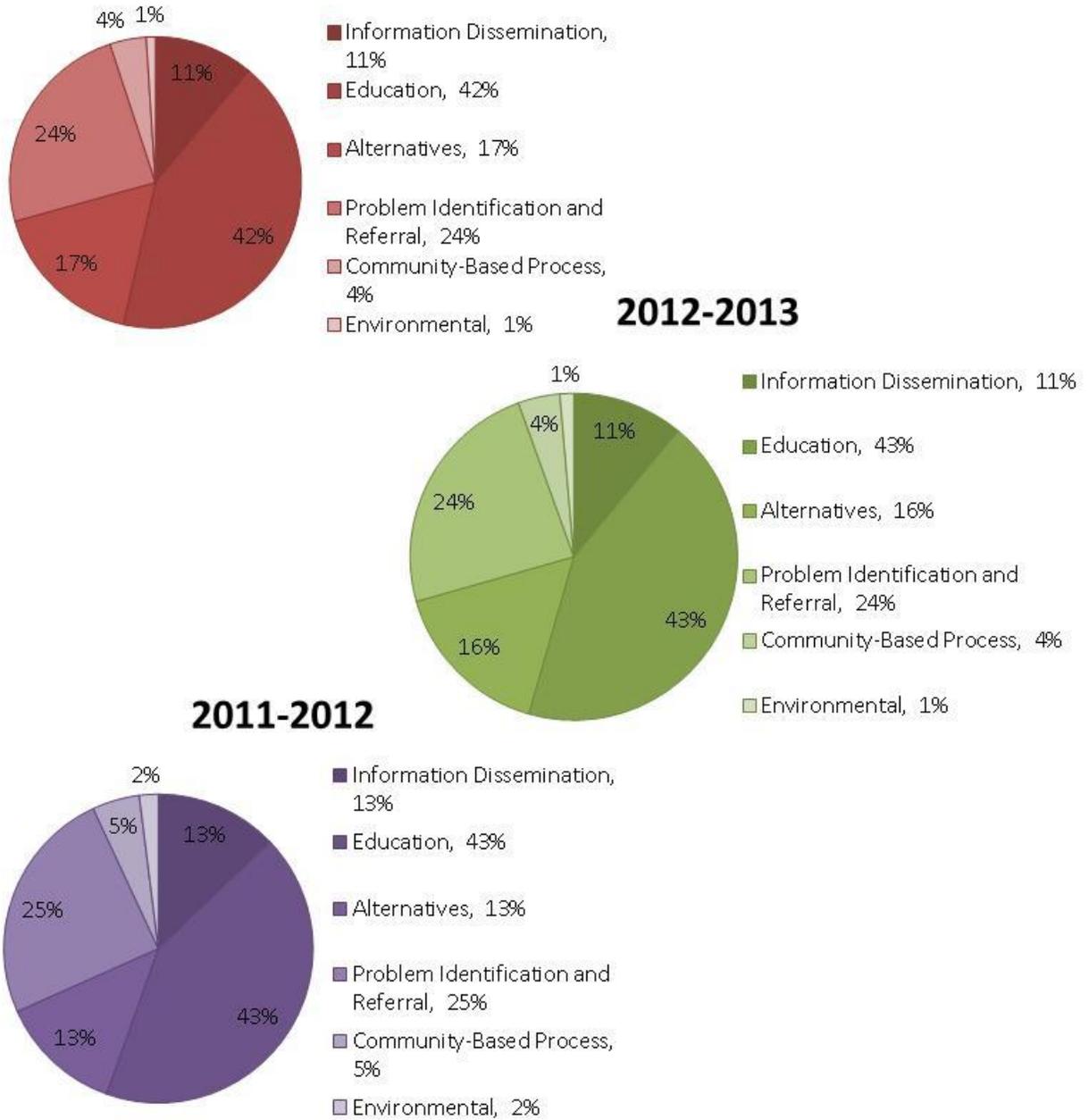
Federal Strategies in Prevention

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. Just under 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 fairly balanced approach to prevention services, but improvements could be made by increasing the number of services provided under the Community-Based Process and Environmental strategies. 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.
- **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 2011-2012 through 2013-2014



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 2013-2014. 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 nearly 75% 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.

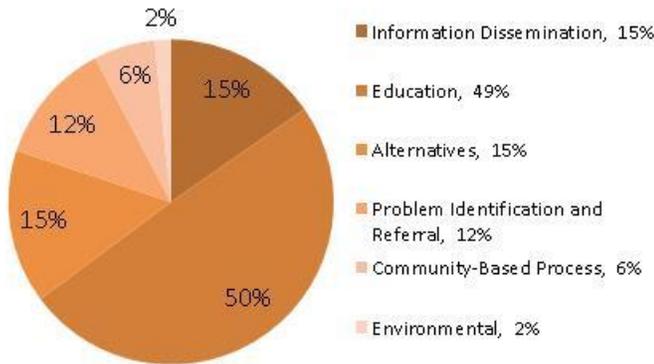
Selective Prevention Interventions are activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than the universal population. Education and Problem Identification/Referral are a large part of successfully providing service to this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

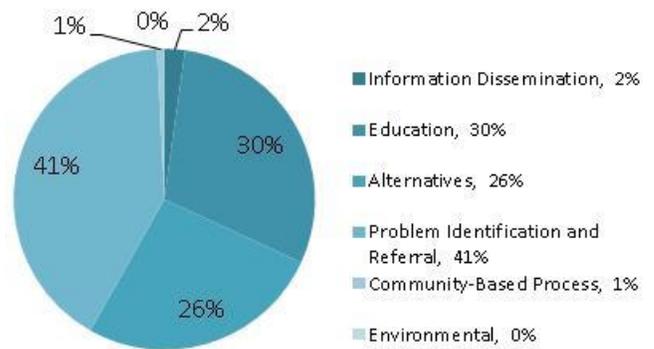
Figure 7

Institute of Medicine Population Categories by Federal Strategy Prevention Services as Reported to PBPS in 2013-2014

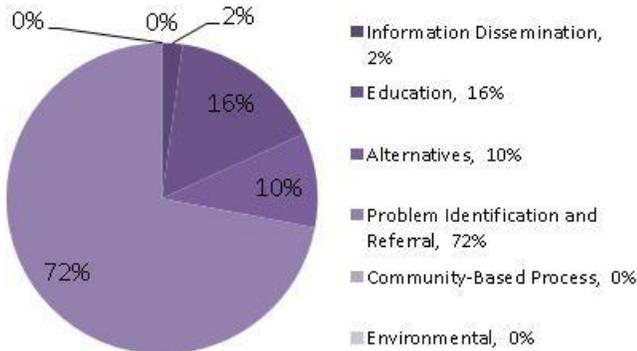
Universal



Selective

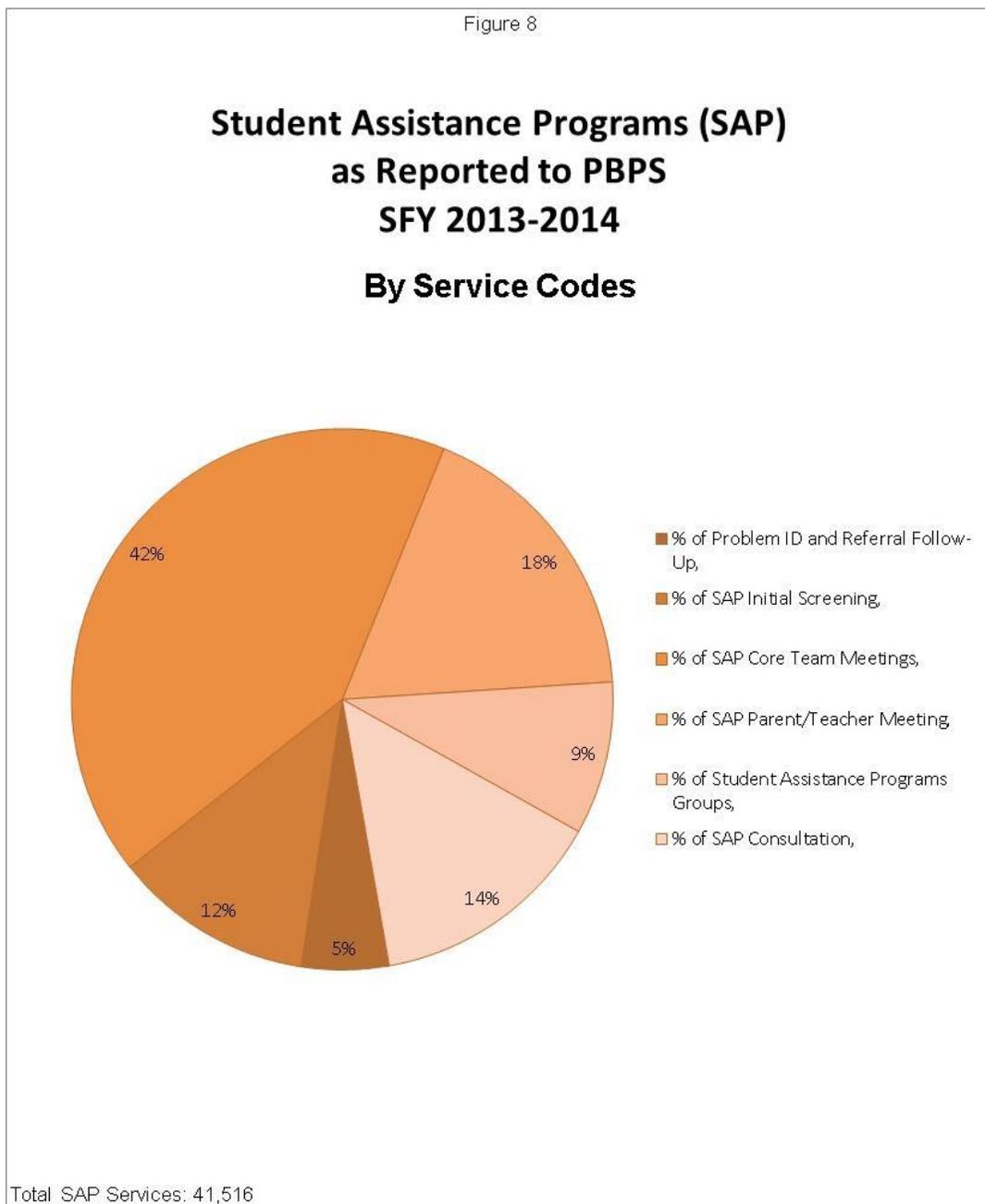


Indicated



Student Assistance Data

The Student Assistance Program (SAP) is an important intervention for the youth in Pennsylvania. Figure 8 shows a total of 41,516 SAP services provided to SAP-identified students for Fiscal Year 2013-2014 broken down into their specific approach (service code). 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 provided to SPA-identified students include screening, consultation, referral and follow-up and/or small group education for SAP-identified youth. SAP is mandated to all SCAs to complement their prevention initiatives.



Treatment Data Analysis

State Fiscal Year 2013-2014

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

Treatment Data System

The Department is in the process of procuring a treatment data system is a web-based application that will manage client data on three levels: provider, SCA and state. The treatment data system will establish a mechanism to receive data from providers that already have existing technology solutions. Use of this standardized application will allow federal and state reporting requirements to be fulfilled. The data system will also allow the state, SCAs and providers to report care provided to individuals throughout their Episodes of Care. An Episode of Care is defined as the entirety of services in which an individual engages from the date of initial contact through the final date of any service, including treatment and non-treatment services. In a complete Episode of Care, no more than one month can elapse between different levels of care or between encounters in a given level of care/type of service in which an individual was not discharged. Within an Episode of Care, an individual is admitted into a specific program. Each time he/she changes a level of care, a discharge must be entered from that program. At such time that the individual is no longer receiving *any* services funded from the SCA, he/she is discharged. That discharge marks the end of the Episode of Care.

Client Confidentiality & Data Reporting

The SCA and its contracted providers agree that all persons currently or formerly screened, assessed, diagnosed, counseled, treated and rehabilitated for drug and alcohol abuse and dependence, shall be protected from disclosure of their names, identities, patient records and the information contained therein except as disclosure is permitted by state and federal statute and regulations. To assure confidentiality of client information, the SCA shall make adequate provision for system security and protection of individual privacy. The SCA, treatment providers, and others are subject to the confidentiality requirements of the Pennsylvania Drug and Alcohol Abuse Control Act (71 P.S. §§ 1690.101, et seq.), the Public Health Service Act (42 U.S.C §§ 290ee-3, 290dd-2), Federal Confidentiality Regulations (42 CFR Part 2). Drug and alcohol information is protected in a number of ways that include the following:

71 P.S. § 1690.101, et seq. - established the Pennsylvania Advisory Council on Drug and Alcohol Abuse in 1972 to advise the Department of Health, and now, pursuant to Act 50 of 2010 advises DDAP. Also, addresses confidentiality requirements at 71 P.S. §§ 1690.108.

28 Pa. Code § 709.28 – state regulation for freestanding treatment facilities mandating adherence to confidentiality requirements at 4 PA Code §255.5.

42 CFR Part 2, Subparts A-E - federal regulation governing confidentiality of drug and alcohol records and information.

45 CFR Part 96 - federal regulation governing the privacy of health care information.

4 Pa. Code § 255.5 and § 257.4 - state regulations governing confidentiality of drug and alcohol records.

42 Pa. C.S.A. § 6352.1 - state statute clarifying what information may be released by SCAs and treatment providers to children and youth agencies and the juvenile justice system.

Admissions and Unique Clients

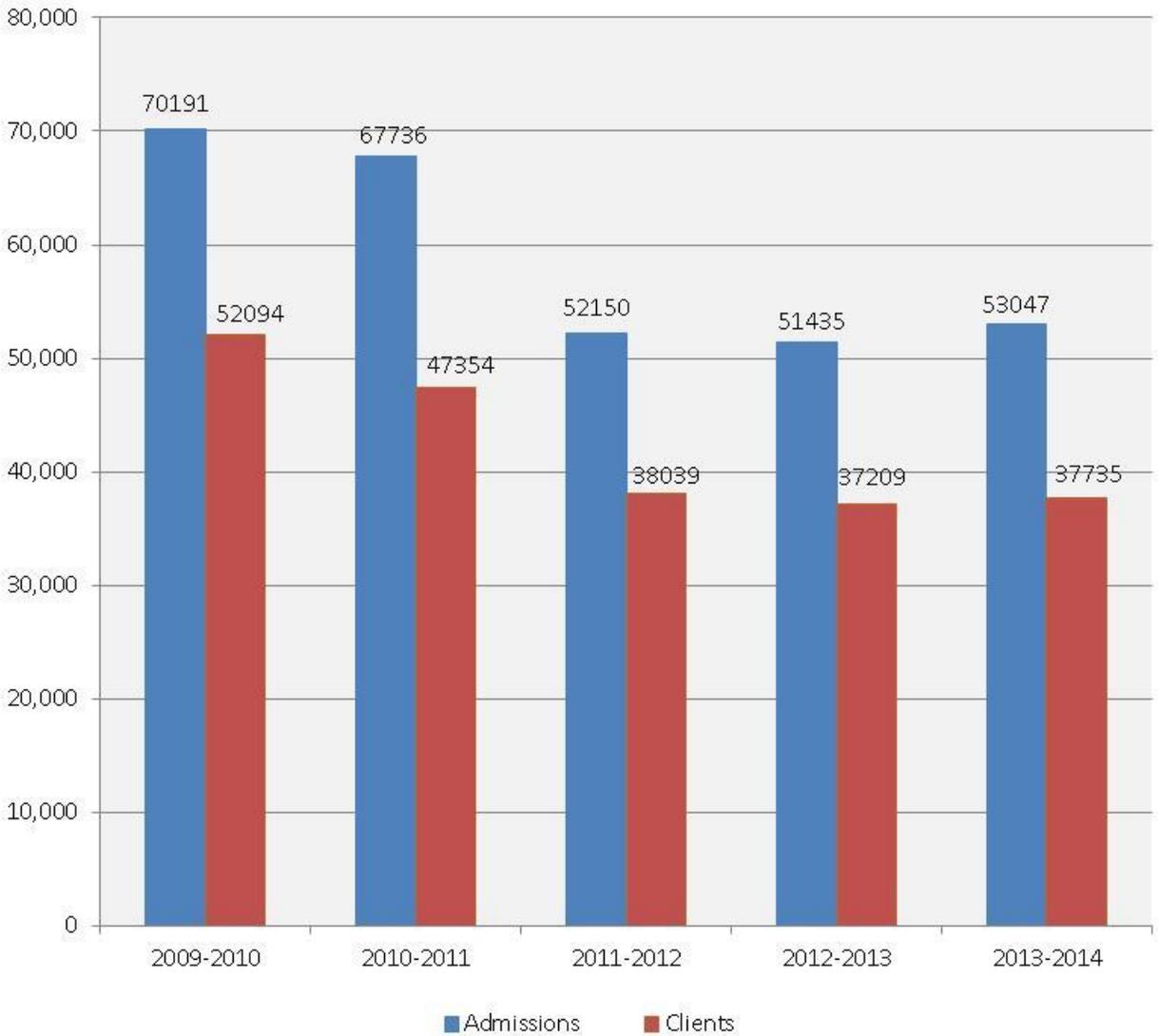
(Figure 1) shows total admissions and total unique clients served for the past five state fiscal years. A unique client is a single person who has been admitted and has received any substance abuse treatment at a licensed provider during the given state fiscal year. An admission occurs when a client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

The graph shows that admission totals and unique client totals are closely related. Both totals change in a similar pattern. In the past five state fiscal years (2009-2010 through 2013-2014), reported admissions and clients have been on the decline with the exception of this last fiscal year. The 2013-2014 fiscal year reported a slight increase in admissions, while unique client counts remain in a stabilized range over the last three years.

The large admission decreases seen previously are not necessarily a direct reflection of a decrease in need for treatment or a decrease in the amount of services provided. The Single County Authorities (SCAs) and providers have reported treating fewer clients as a direct result of less funding to provide services. Also, the Department is in its second year of reporting with the new data system and as with every new computer system there is often a new learning curve for system operators and challenges regarding import data definitions. Many providers are utilizing the new data reporting system, but are still working on integrating it into their day to day operations. The Department is in the process of remedying these issues.

Figure 1

Admissions and Unique Clients* Trending from 2009-2010 through 2013-2014



*Clients are unique admissions counted once in the time period.

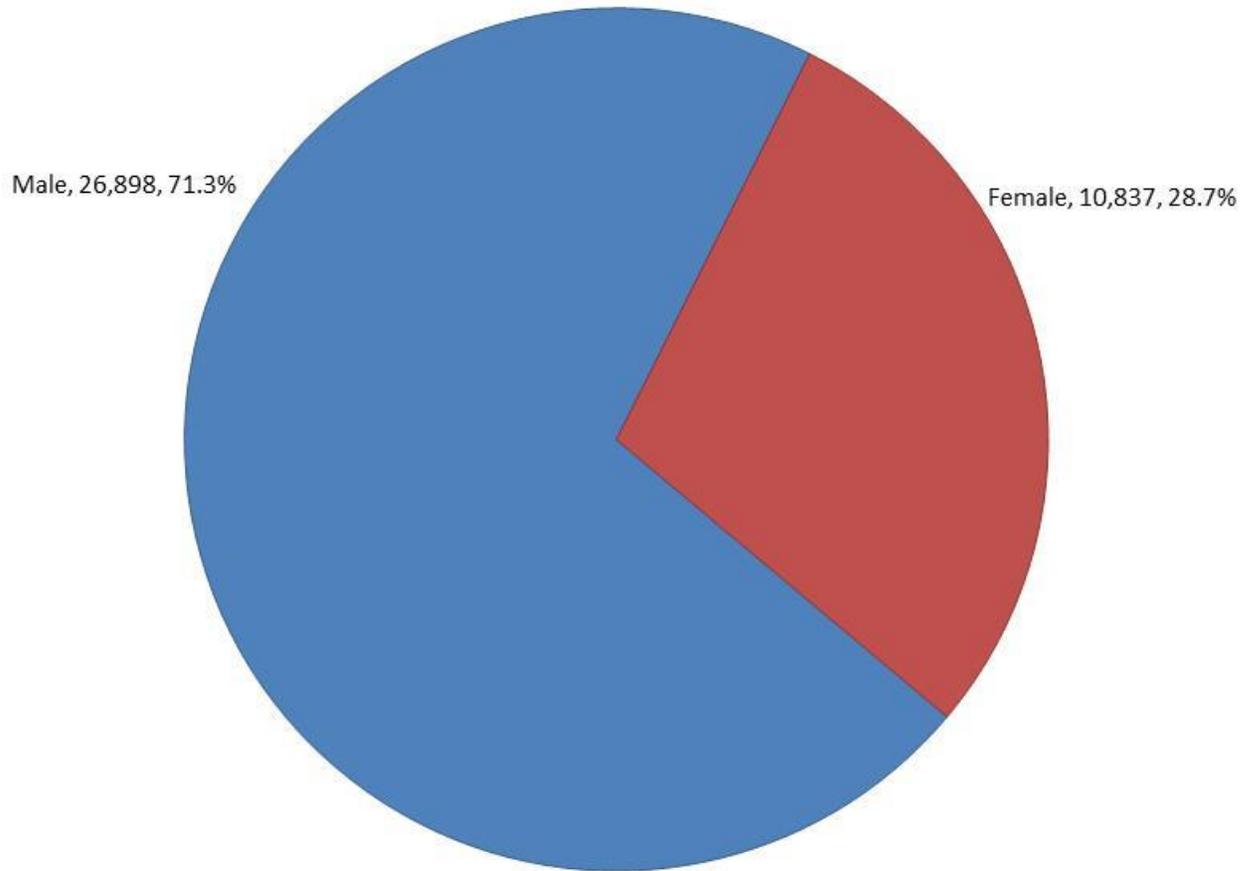
Client Demographics

Clients that are treated by programs funded by the Department are quite different from the general population in many ways. The following charts and narrative describe these differences. The majority (71 percent) of clients are male (Figure 2), while the general population is 49 percent male. Well over half (62 percent) of all clients are in the 15-34 year old age group (Figure 3). There is a slightly higher percentage of African-American clients in treatment compared to the total Pennsylvania population of African-Americans (13 percent and 11.5 percent, respectively) (Figure 4). There is a higher percentage of Hispanics in treatment compared to the general population (7 percent and 6 percent, respectively) (Figure 5). This higher percentage of Hispanic clients in treatment was determined to be higher based on more accurate reporting from the statewide data system. Nearly one in ten (9.4 percent) clients in treatment is still of unknown ethnicity (Figure 5). All Pennsylvania population percentages are from the 2013 Pennsylvania State Data Center Estimates.

Figure 2

Unique Client Admissions to Treatment SFY 2013-2014

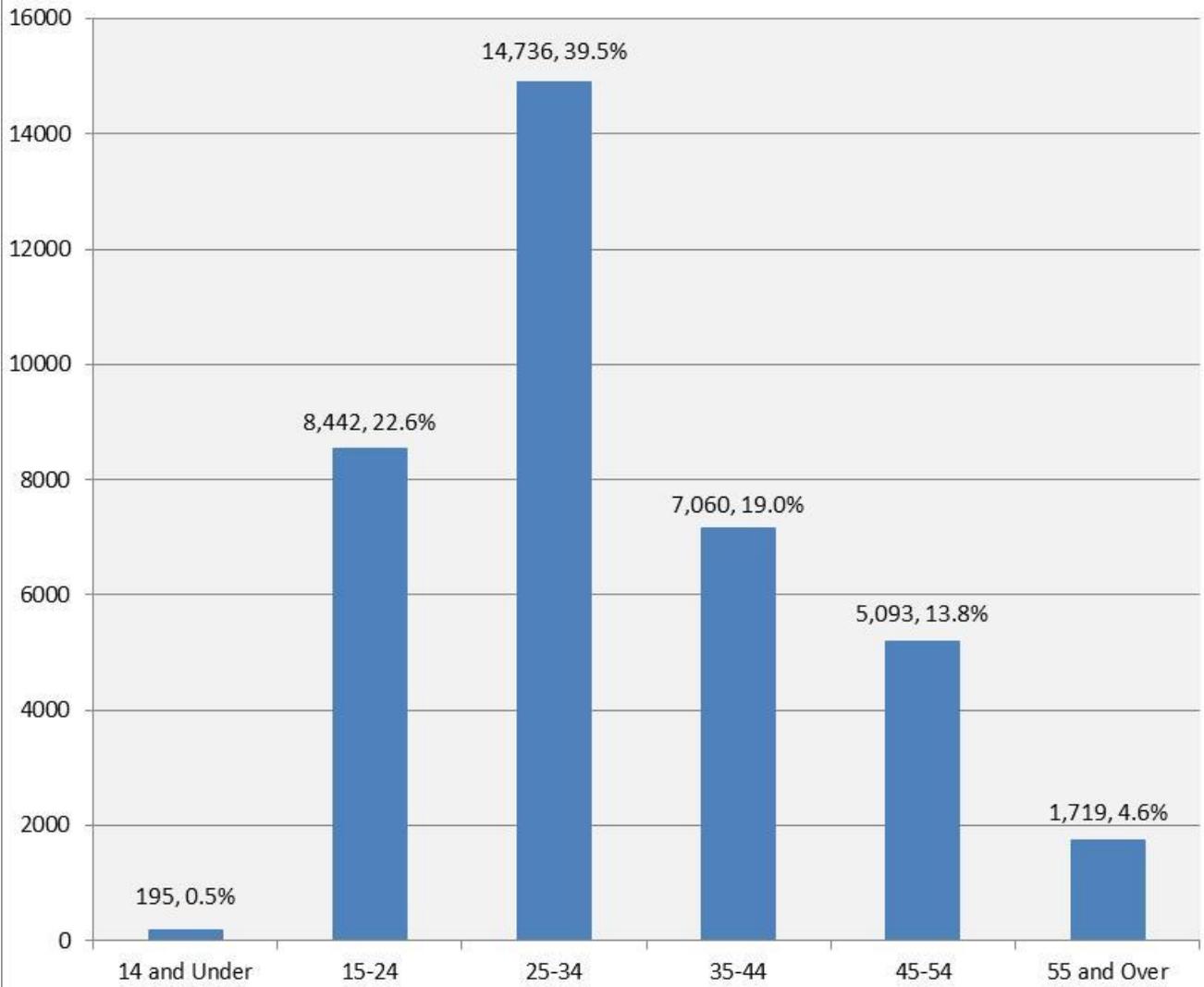
By Gender



Clients are unique admissions counted once in the time period.
Total Clients=37,735

Figure 3

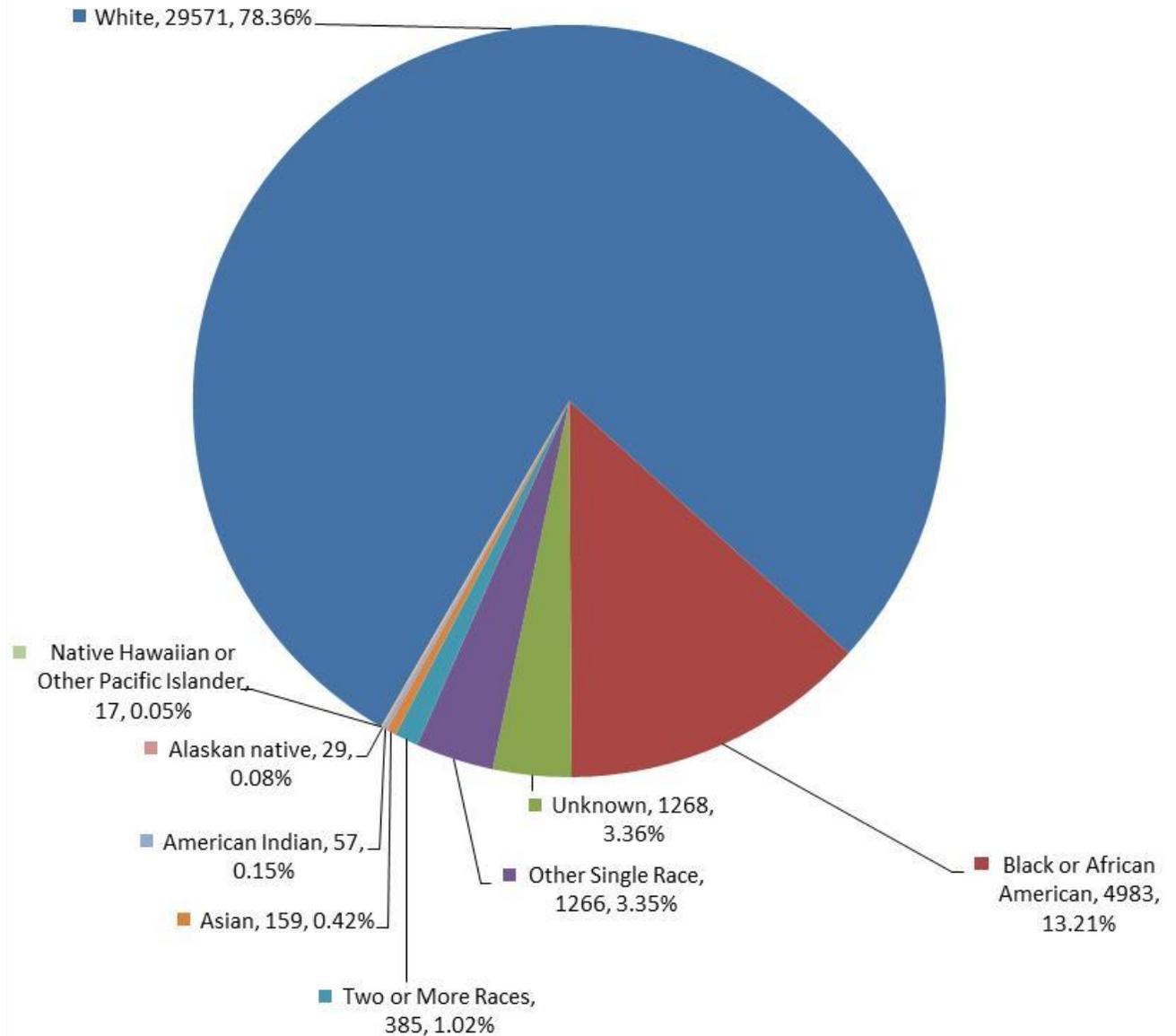
Unique Client Admissions to Treatment SFY 2013-2014 By Age Groups



Clients are unique admissions counted once in the time period.
Total Clients=37,735

Figure 4

Unique Client Admissions to Treatment SFY 2013-2014 By Race

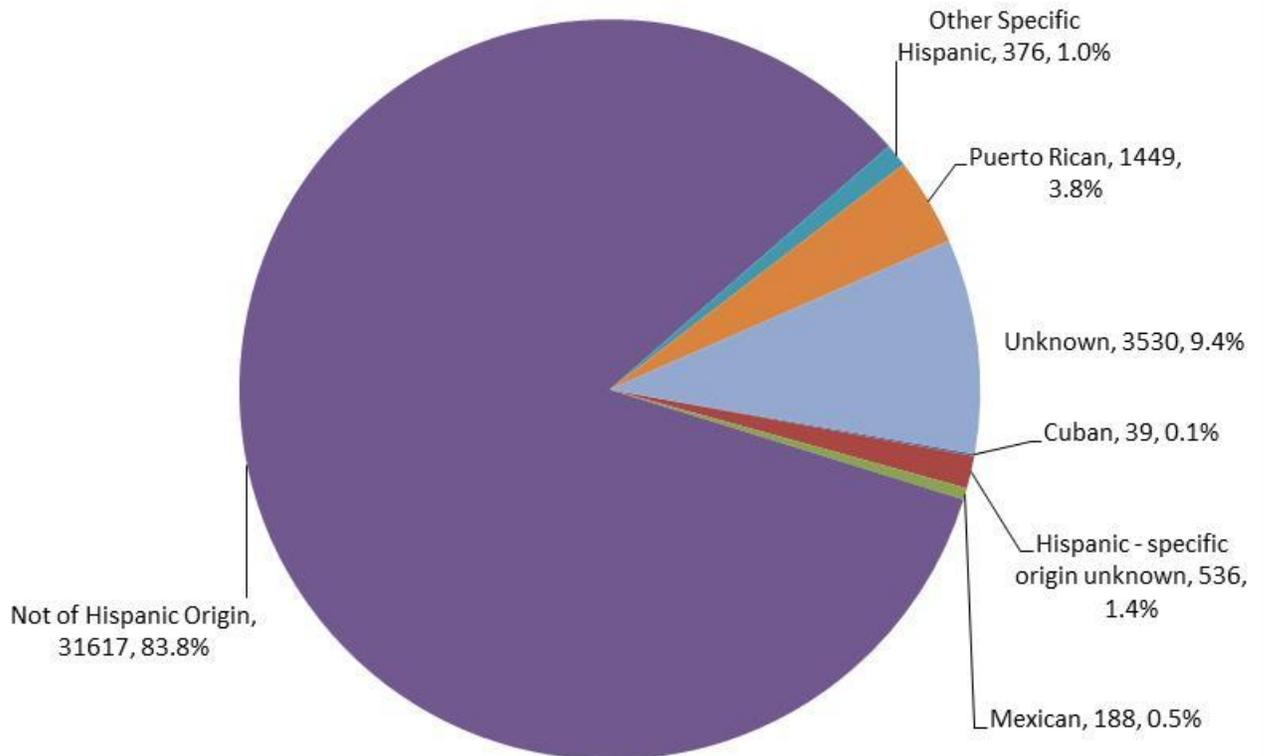


Clients are unique admissions counted once in the time period.
Total Clients=37,735

Figure 5

Unique Client Admissions to Treatment SFY 2013-2014

By Ethnicity



Clients are unique admissions counted once in the time period.
Total Clients = 37,735

Admissions Characteristics

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

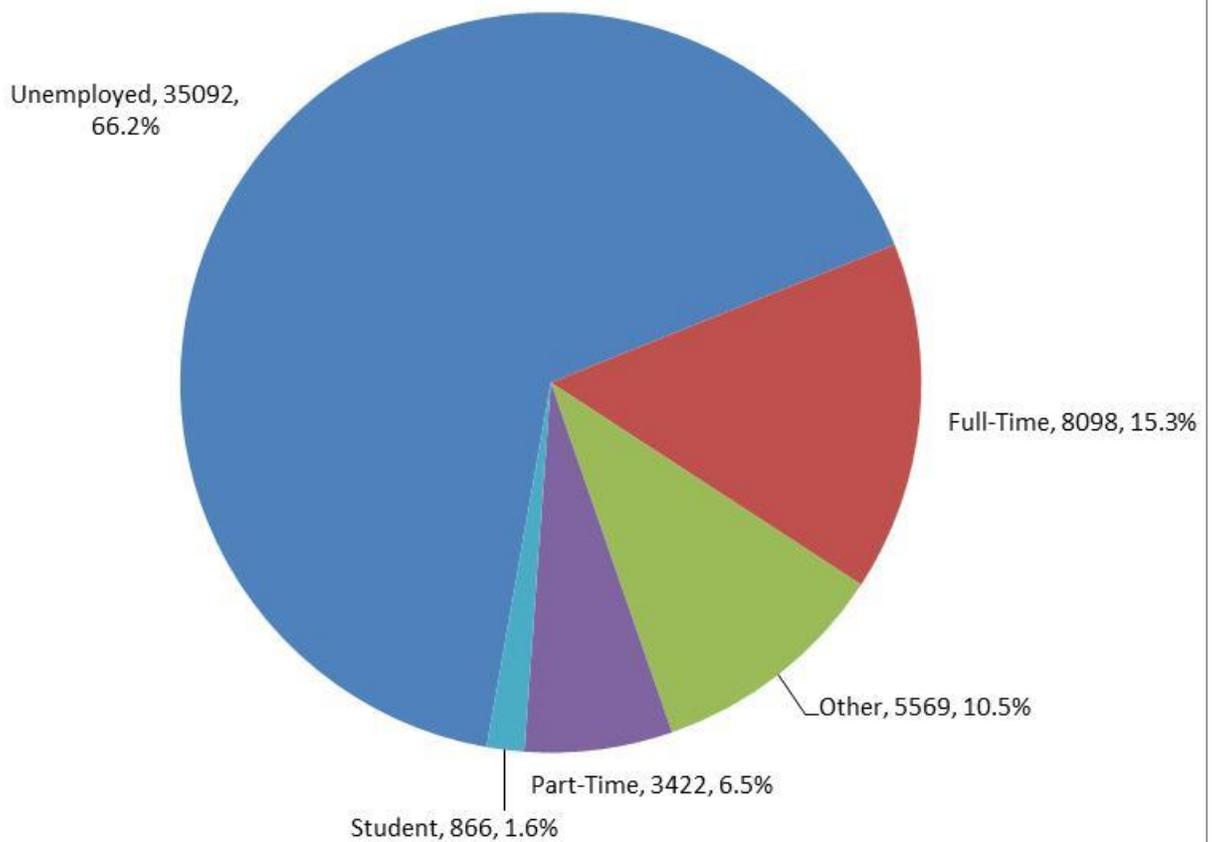
The majority (66 percent) of clients reported being unemployed. In addition, only 1 in 7 admissions reported clients being employed on a full-time (15 percent) or even fewer on a part-time (7 percent) basis. The remaining admissions were of other employment statuses (Figure 6). Nearly three-fourths (74 percent) have never been married. Only 9 percent of clients were married when they were admitted. The remaining clients reported their status as divorced (11 percent), separated (5 percent) or widowed (1 percent) (Figure 7). Very few (1 percent) clients were admitted under other non-voluntary circumstances (Figure 8). Almost one third (31 percent) of clients were involved in the criminal justice system, and/or substance abuse treatment was mandated. Trending this data over the last three fiscal years, there have been no significant changes concerning state client admission characteristics.

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

Figure 6

Client Admissions to Treatment SFY 2013-2014

By Employment Status

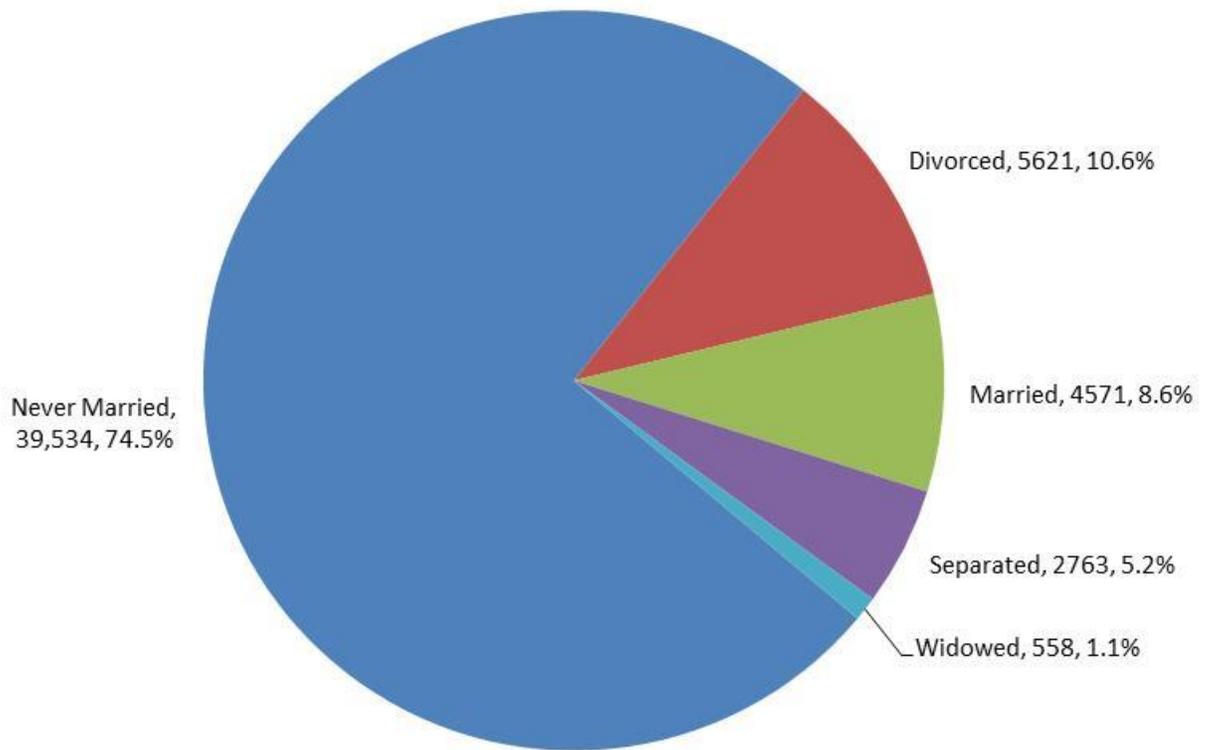


*Other includes: Disabled, Retired, Homemaker, Unknown, Inmate, and Other Employment Status.
Total Admissions=53,047

Figure 7

Client Admissions to Treatment SFY 2013-2014

By Marital Status

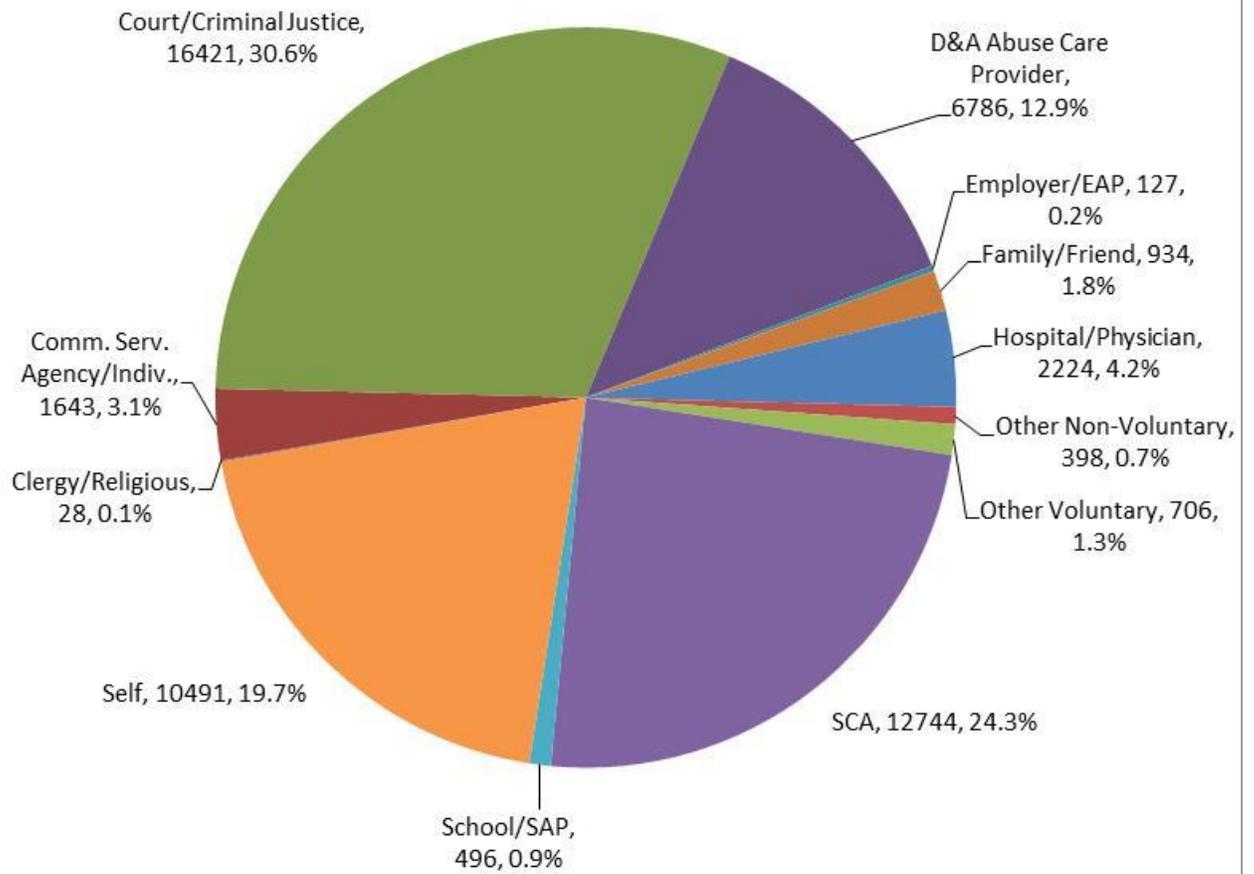


Total Admissions=53,047

Figure 8

Client Admissions to Treatment SFY 2013-2014

By Referral Sources



Total Admissions=53,047

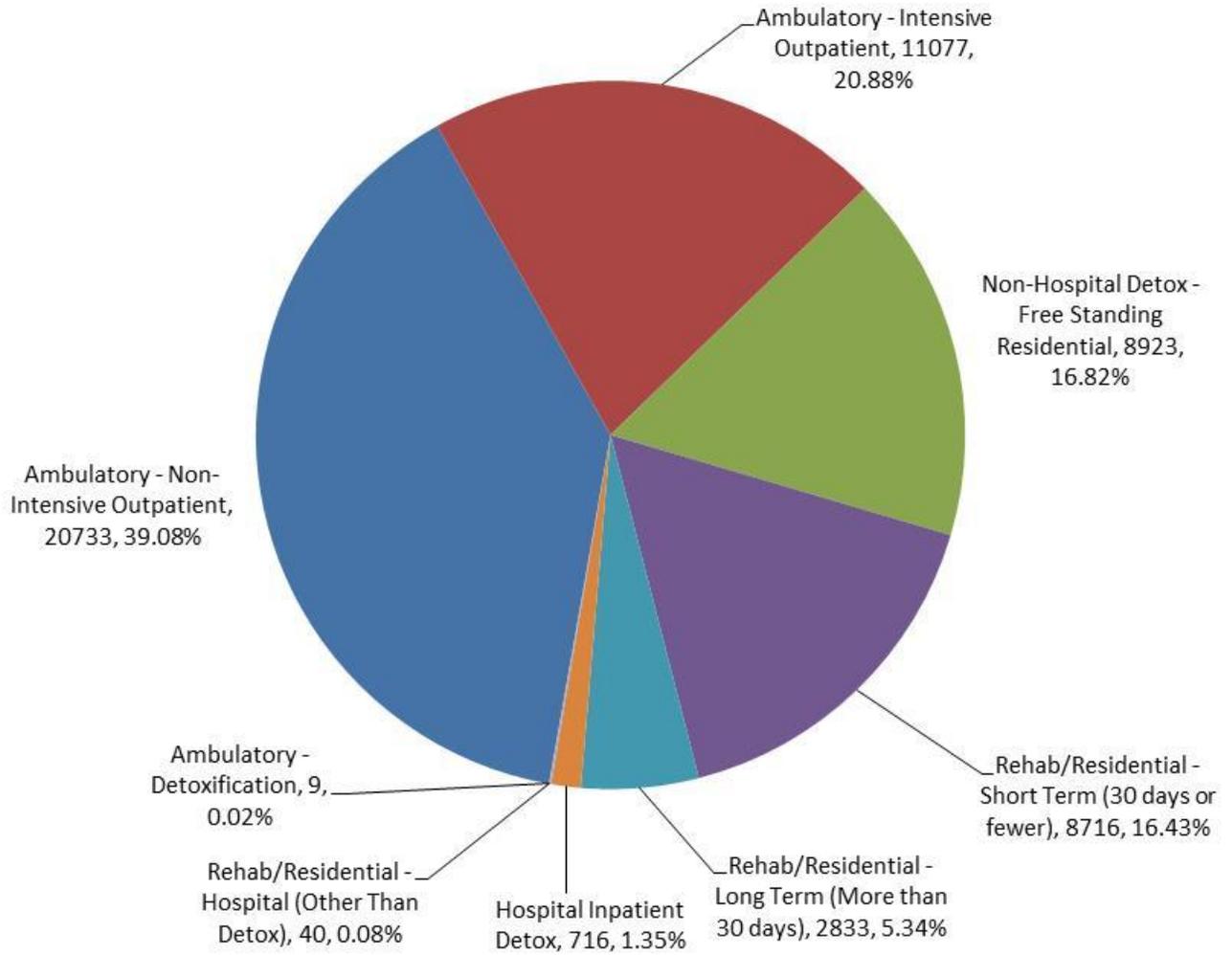
Types of Treatment

There are several different types of treatment available to clients in Pennsylvania. Treatment modality or Levels of Care usage varies widely by SCA, so these statewide figures may not give an accurate representation of local area modality utilization. The most prevalent type of treatment received is Ambulatory – Non-Intensive Outpatient, with 39 percent of clients receiving this modality (Figure 9). This type of treatment is also the least intensive and least expensive modality. One in five admissions (21 percent) was for Ambulatory– Intensive Outpatient. While Non-Hospital Detox – Free Standing Residential treatment followed in prevalence at 17 percent. Such treatment is more intensive, with the client living and receiving treatment services at the facility. There have been no significant changes concerning treatment modalities trend data over the last five fiscal years.

Figure 9

Client Admissions to Treatment SFY 2013-2014

By Treatment Modalities



Total Admissions=53,047

Patterns of Drug Use

Clients are admitted to treatment for a wide range of primary substances of abuse. Different groups of clients also use very different types of substances. The following charts and narrative illustrate these points. The common primary substance of abuse is heroin (38 percent), alcohol (30 percent), marijuana/hashish (12 percent), other opiates/synthetics (11 percent) and cocaine/crack (5 percent), these top five primary substance categories account for 96 percent of total admissions (Figure 10).

Over the last five years, heroin has increased nearly 20 percent overtaking alcohol as the primary substance abused (Figure 12). Another primary drug of interest over the last five years, marijuana/hashish trended downward in reporting from 16 percent to 12 percent. Opiates/synthetics increased from 5 percent in SFY 2004-2005 to 13 percent in SFY 2011-2012 (Figure 11).

Admissions for particular primary drugs of abuse vary by gender, race, ethnicity and age group. While both genders admitted for heroin use are increasing, females are admitted more frequently than males (42 percent and 36 percent, respectively) (Figure 13). Males are admitted for alcohol use more frequently (32 percent) than females (24 percent), as well as more frequently for marijuana/hashish (14 percent and 8 percent, respectively). Females are admitted for cocaine/crack use more frequently (6 percent) than males (5 percent). Females are also admitted more frequently for other opiates/synthetics (14 percent) than males (10 percent).

African-Americans were admitted for alcohol use more frequently than Whites (33 percent and 29 percent, respectively); Whites were admitted over three times as frequently for heroin (42 percent and 12 percent, respectively) and more frequently for other opiates/synthetics (13 percent and 5 percent, respectively). African-Americans were admitted over five times as often for cocaine/crack than whites (16 percent and 3 percent, respectively) and over 3 times more frequently for marijuana/hashish (31 percent and 9 percent, respectively) (Figure 14).

Hispanics were admitted for marijuana/hashish more frequently than Non-Hispanics (20 percent and 11 percent, respectively) and more frequently for cocaine/crack (8 percent and 5 percent, respectively). Non-Hispanics were admitted more frequently for heroin than Hispanics (38 percent and 35 percent, respectively) and were admitted three times as frequently for other opiates/synthetics (12 percent and 4 percent, respectively) (Figure 15).

Primary drugs of use also vary quite significantly among age groups (Figure 16). Heroin use is becoming prevalent in all age groups; however the largest increase was within the 15-24 age group and 25-34 age group (42 percent and 48 percent, respectively). This accounts for an increase in heroin use at admission of 17 percent since 2009-2010 (Figure 12). Use of alcohol increases with age: the older the client is at admission, the higher the percentage of individuals who reported alcohol as their primary drug of use. Marijuana/hashish is similar, but the relationship is the "inverse"; the older the client is at admission, the lower the percentage who reported marijuana/hashish as their primary drug of use.

The age group 14 and under is admitted for marijuana/hashish use most frequently (73 percent), although this age group accounts for less than a half percent of admissions. Many in this age category receive services through programs not reported in the data system. Clients in this age group are of particular interest, because they require more specialized services oriented towards youth.

The age group 55 and over is admitted for alcohol use most frequently (64 percent), and accounts for 4 percent of admissions and is of special interest in regards to the growing number of older Pennsylvanians.

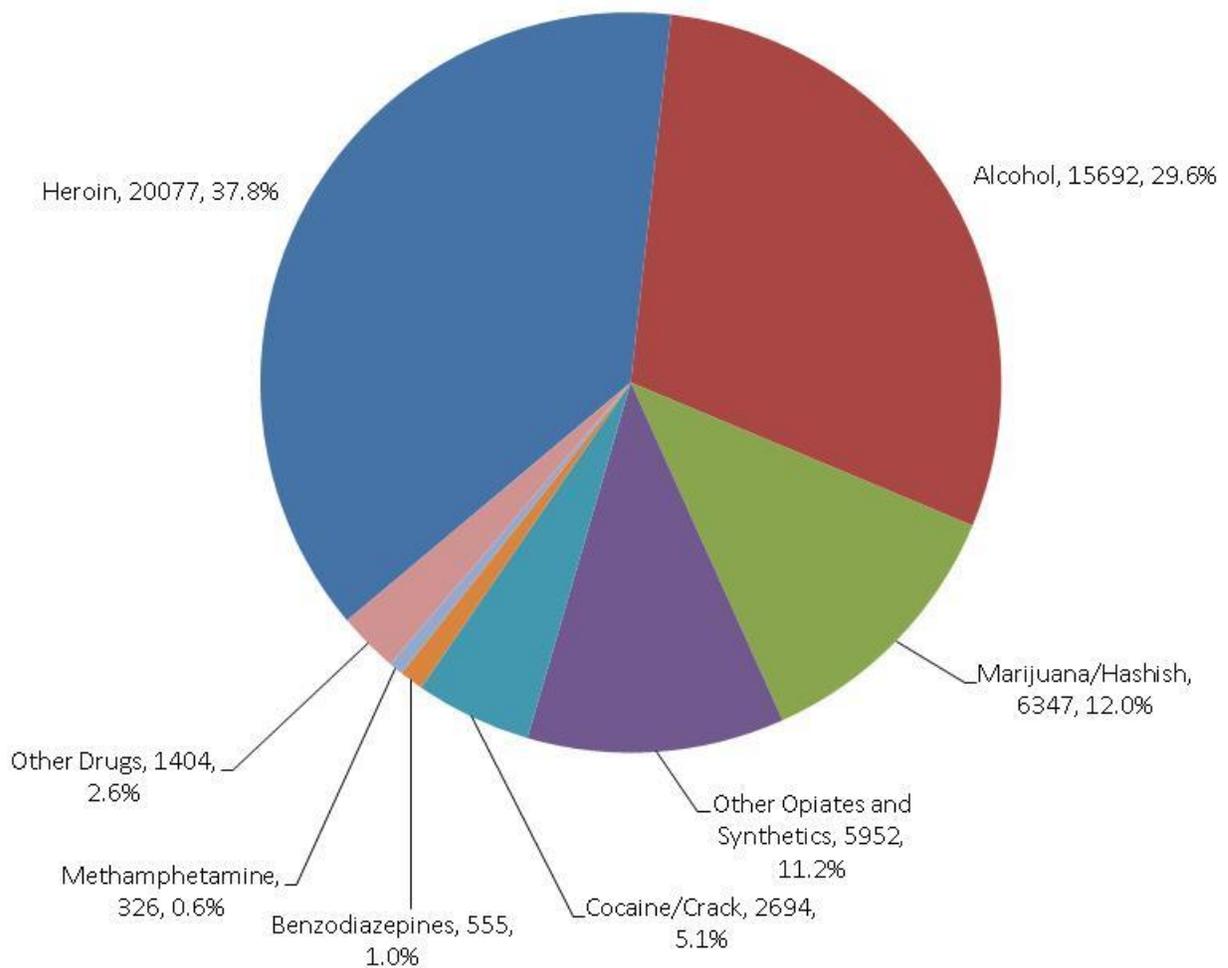
The age group 15-24 is also of particular interest due to its transitional nature (Figure 17). The total admissions for this age group has been further broken down into ages 15-17 (1,077 admissions), 18-20 (2,252 admissions) and 21-24 (8,437 admissions).

Marijuana/hashish is the most prevalent drug of use for the age groups 15-17 and 18-20 (74 percent and 33 percent, respectively), but marijuana/hashish usage by almost half (41 percent) between these two age groups as a person becomes progressively older. Also, marijuana/hashish admissions decline further in all subsequent age groups. Heroin begins to be seen much more in the 18-20 age group at 36 percent of admissions, then climbs higher in age group 21-24 to 47 percent of admissions.

Figure 10

Client Admissions To Treatment SFY 2013-2014

By Primary Drug of Use

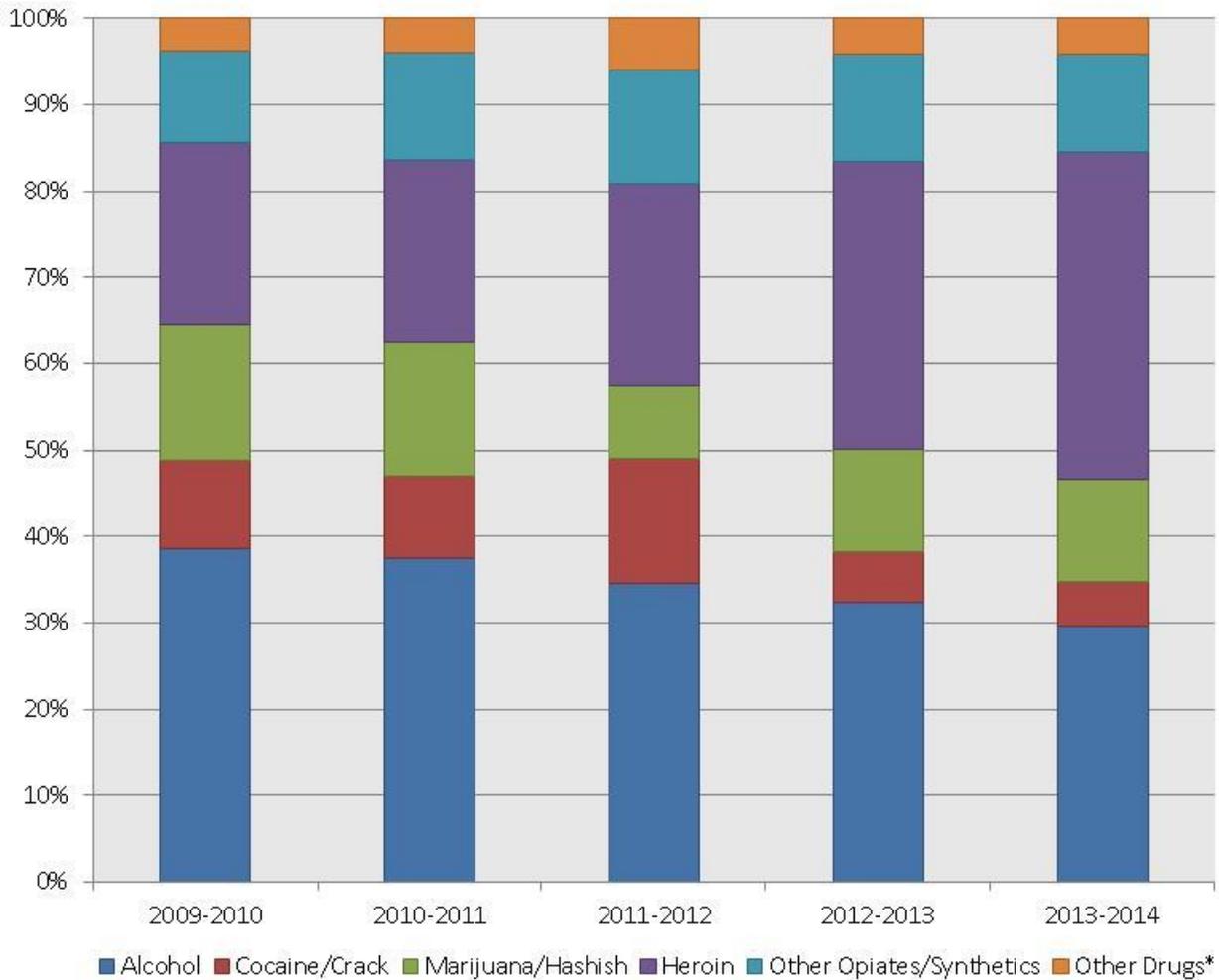


*Other Drugs includes: PCP, Other Amphetamines, Non-Prescription Methadone, Other Hallucinogens, Not Applicable (None), Other Stimulants, Over the Counter, Unknown, Inhalants, Barbiturates, Other Non-Barbiturate Sedatives or Hypnotics, Other Non-Benzodiazepine Tranquilizers, None, Buprenorphine and Other Drugs. Total Admissions=53,047

Figure 11

Client Admissions To Treatment SFY 2009-2010 through 2013-2014

Primary Drug of Use



*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs
Total Admissions=53,047

Figure 12

Treatment Admissions for Heroin and Alcohol SFY 2009-2010 through 2013-2014

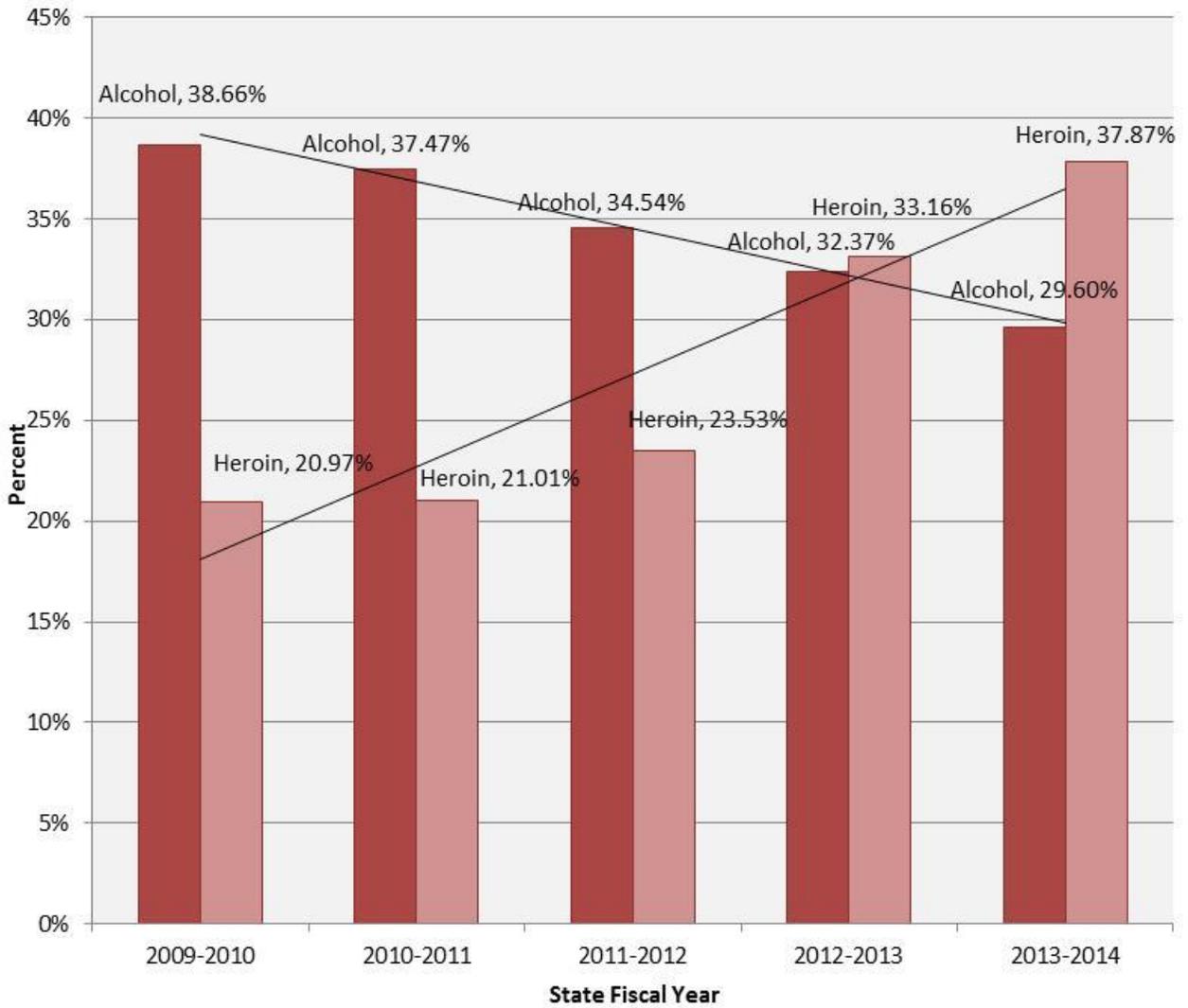
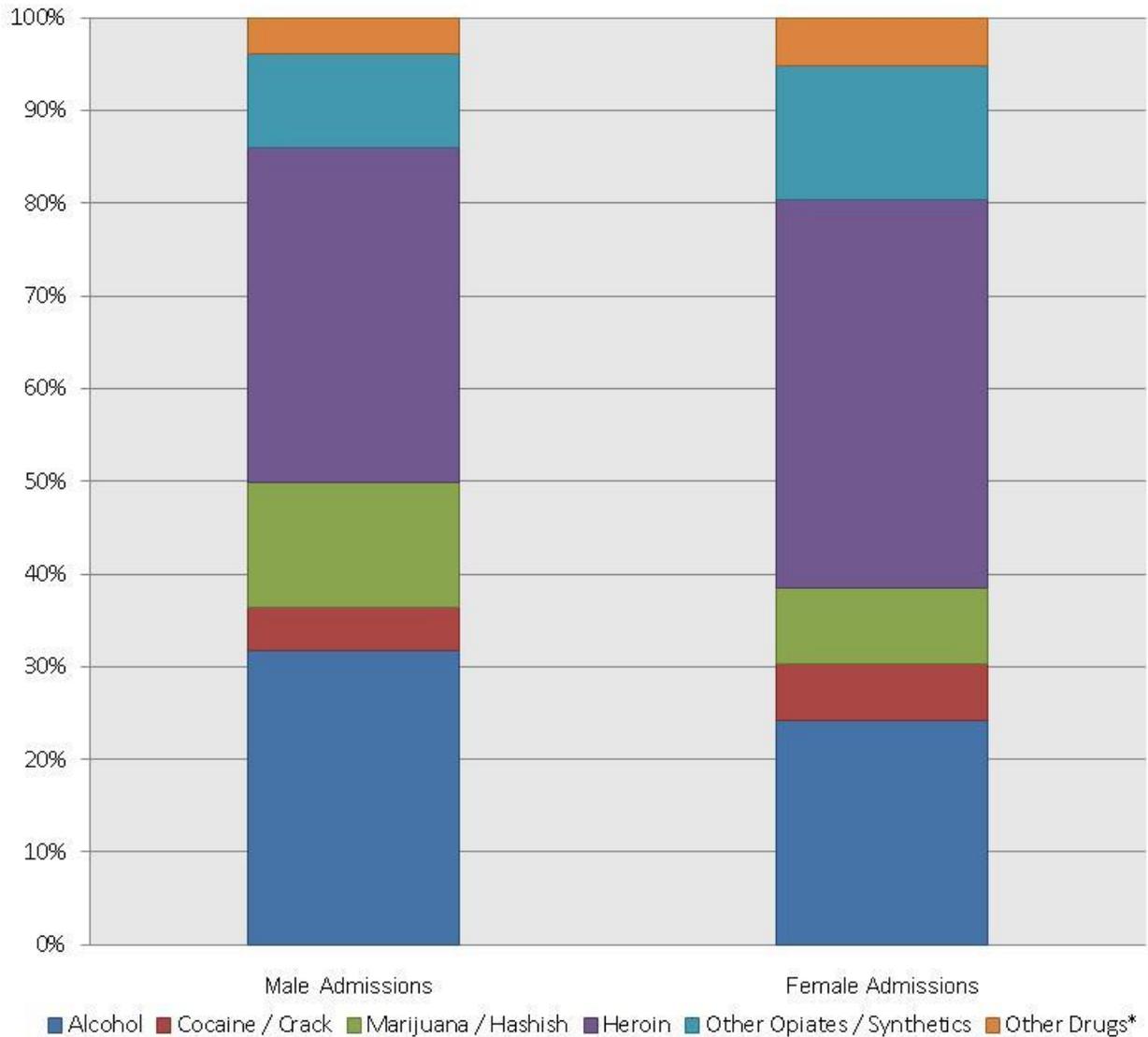


Figure 13

Client Admissions To Treatment SFY 2013-2014

Primary Drug of Use by Gender



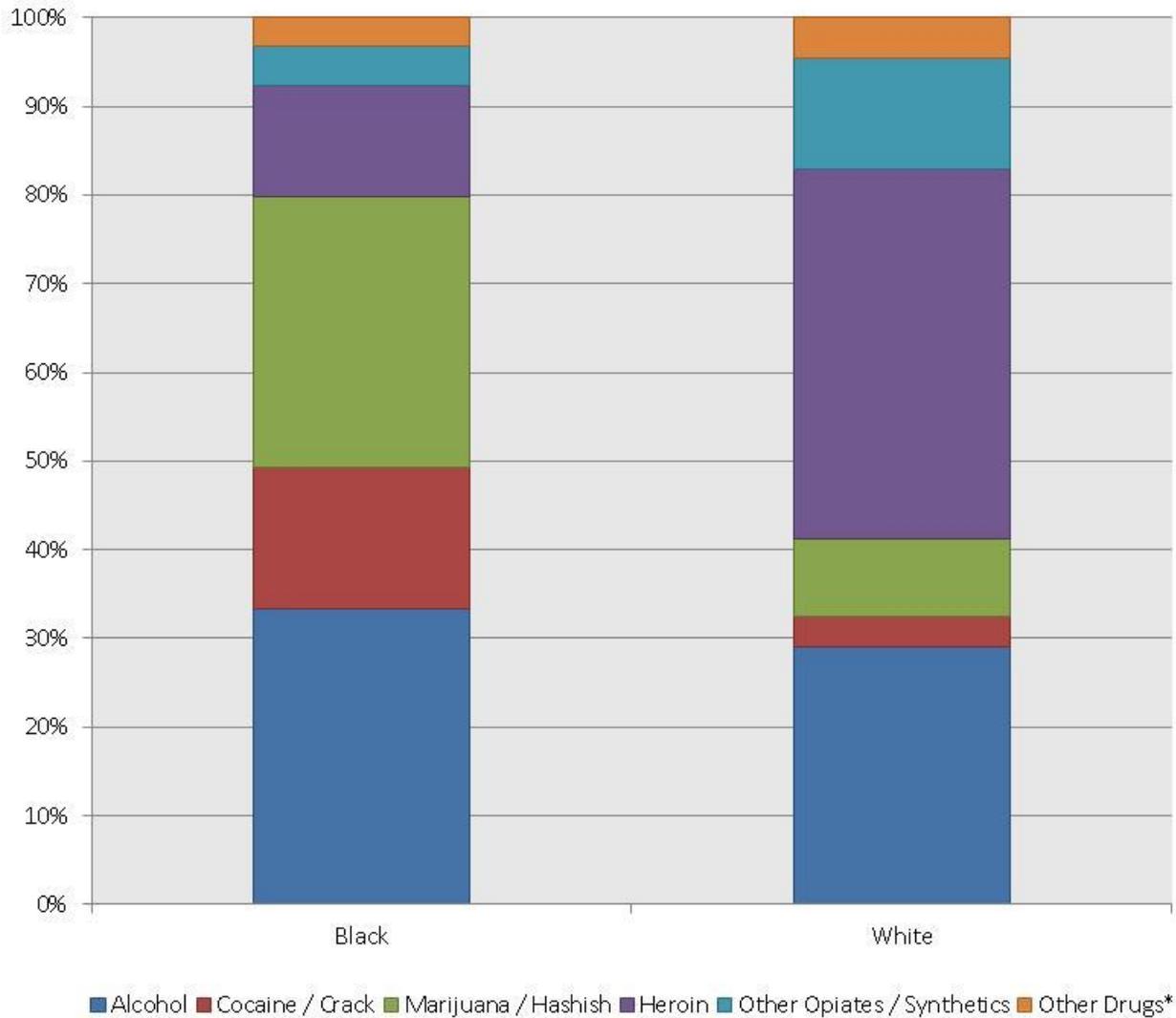
*Other Drugs includes: Other Opiates/Synthetics, Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.

Total Admissions=53,047

Figure 14

Client Admissions to Treatment SFY 2013-2014

Primary Drug of Use by Race



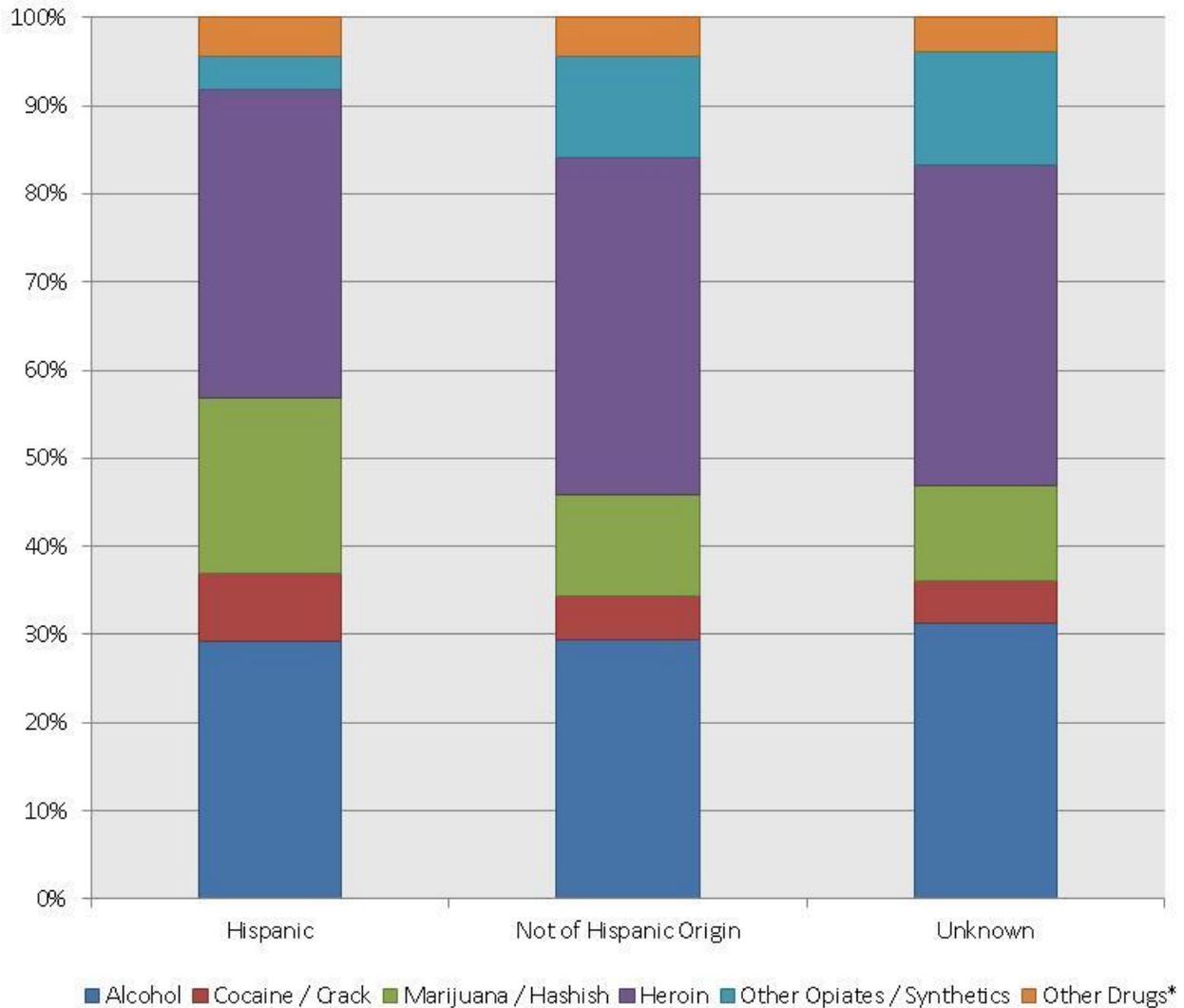
*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.

Total Admissions for Black and White=48,706 (91.8% of Total Admissions)

Figure 15

Client Admissions to Treatment SFY 2013-2014

Primary Drug of Use by Ethnicity



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

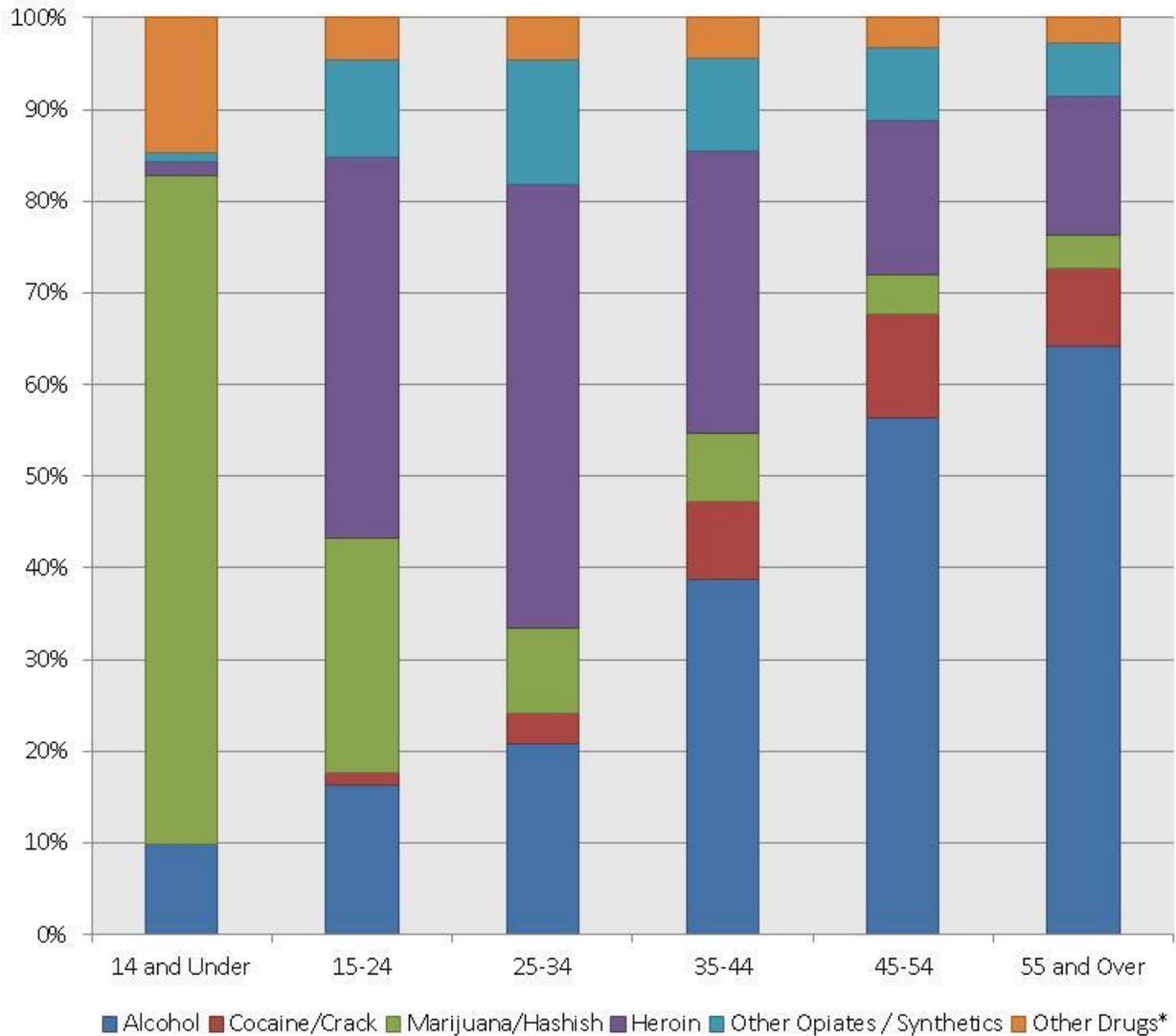
Total Admissions for Hispanic and Not of Hispanic Origin=47,941 (90.3% of Total Admissions)

The remaining 5,106 admissions are of unknown ethnicity.

Figure 16

Client Admissions to Treatment SFY 2013-2014

Primary Drug of Use by Age Group



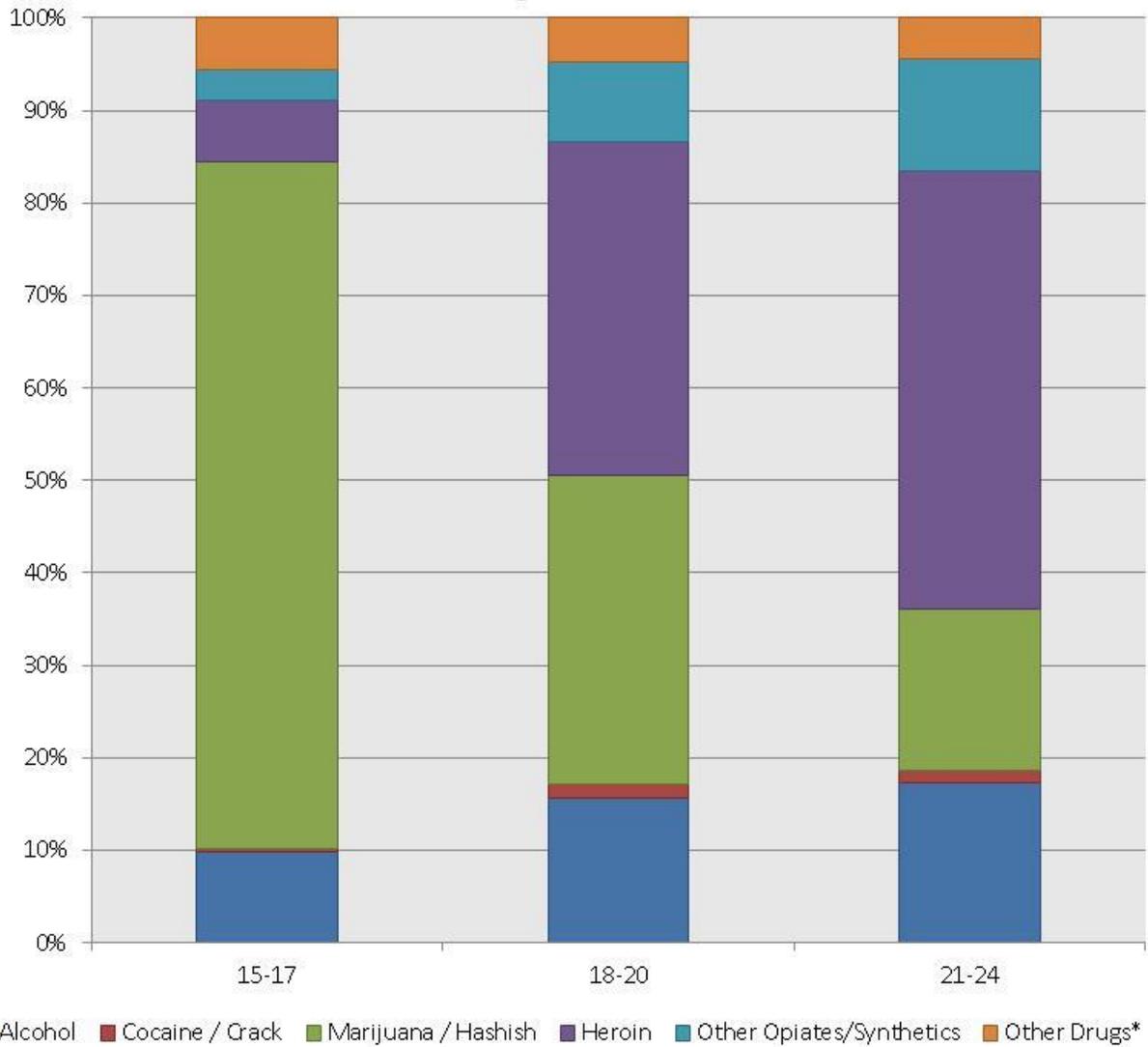
*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.

Total Admissions=53,047

Figure 17

Admissions to Treatment SFY 2013-2014

Primary Drug of Use by Age Group Ages 15-24



*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.
Total Admissions For Ages 15-24 =11,766

Discharges

When a client has completed a particular type of treatment or changes treatment providers, a discharge record is submitted to the data system with an associated reason for discharge. A discharge marks the end of the Episode of Care or a level of care. There are varying types of treatment discharges: detoxification and non-detoxification. The kind of services rendered in detox and non-detox treatments is very different, so there are different reasons for being discharged from detoxification or non-detoxification. The following discharge data is associated with admissions that occurred in state fiscal year 2013-2014. The data system reported a new categorical breakdown of non-detox treatment discharge categories (Figure 18, 19 and 20) then the previous data system. Due to the change in our data systems there is no equivalent trend data present. Once trend data is established we will be able to further analyze these new results.

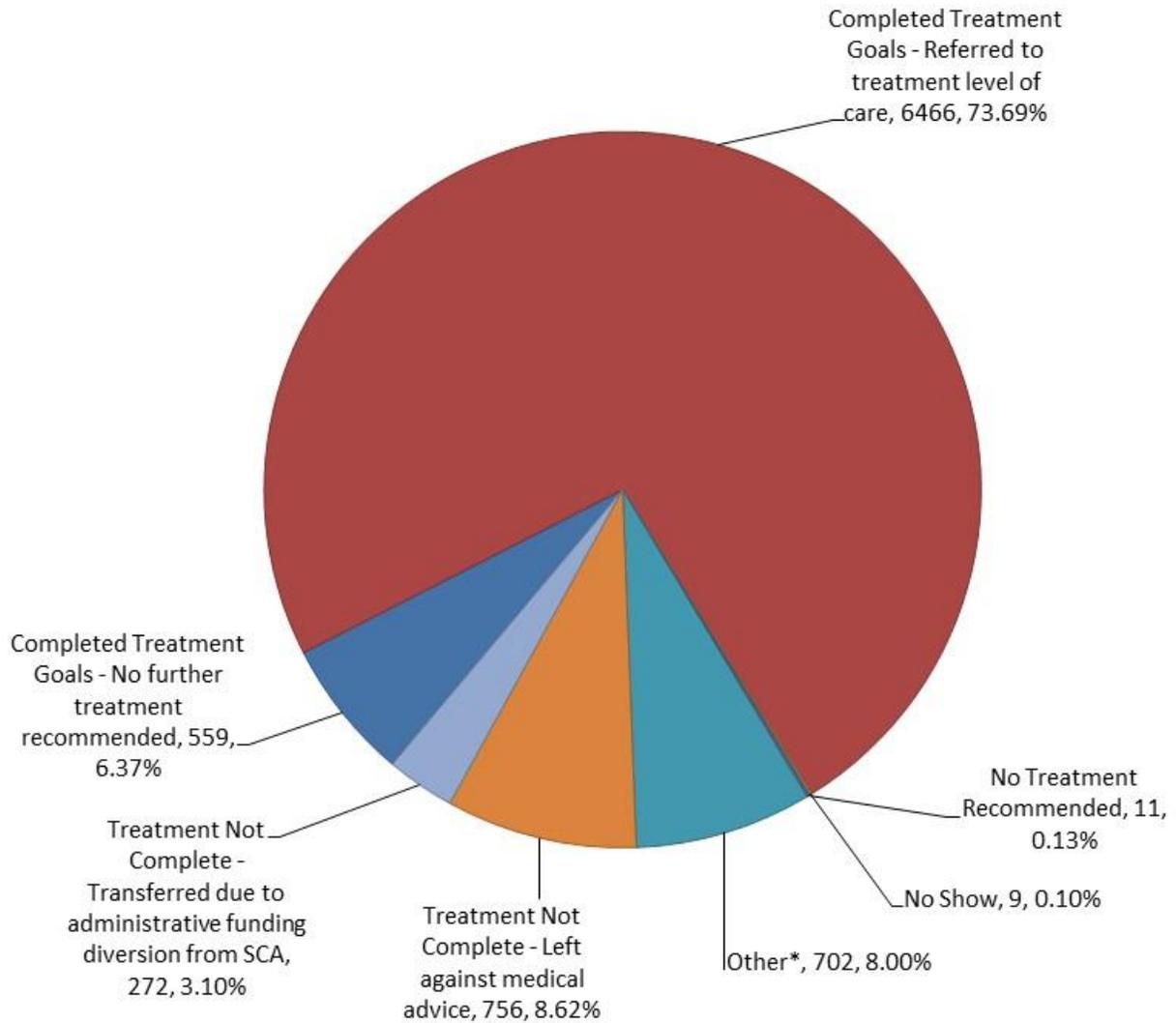
After detox treatment was completed, 74 percent of patients were either transferred within the facility or were referred to another facility for drug and alcohol treatment. However, 9 percent completed their detox and were not transferred and left against medical advice (Figure 18).

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

Currently 47 percent of those discharged from non-detox treatment completed their treatment goals and had not used substances or reduced their dependency. For those who completed treatment 37 percent did so with no drug use, while 63 percent completed their treatment goals and were referred to a lower level of care (Figure 20).

Figure 18

Client Discharges from Treatment SFY 2013-2014 Detox Reasons for Discharge

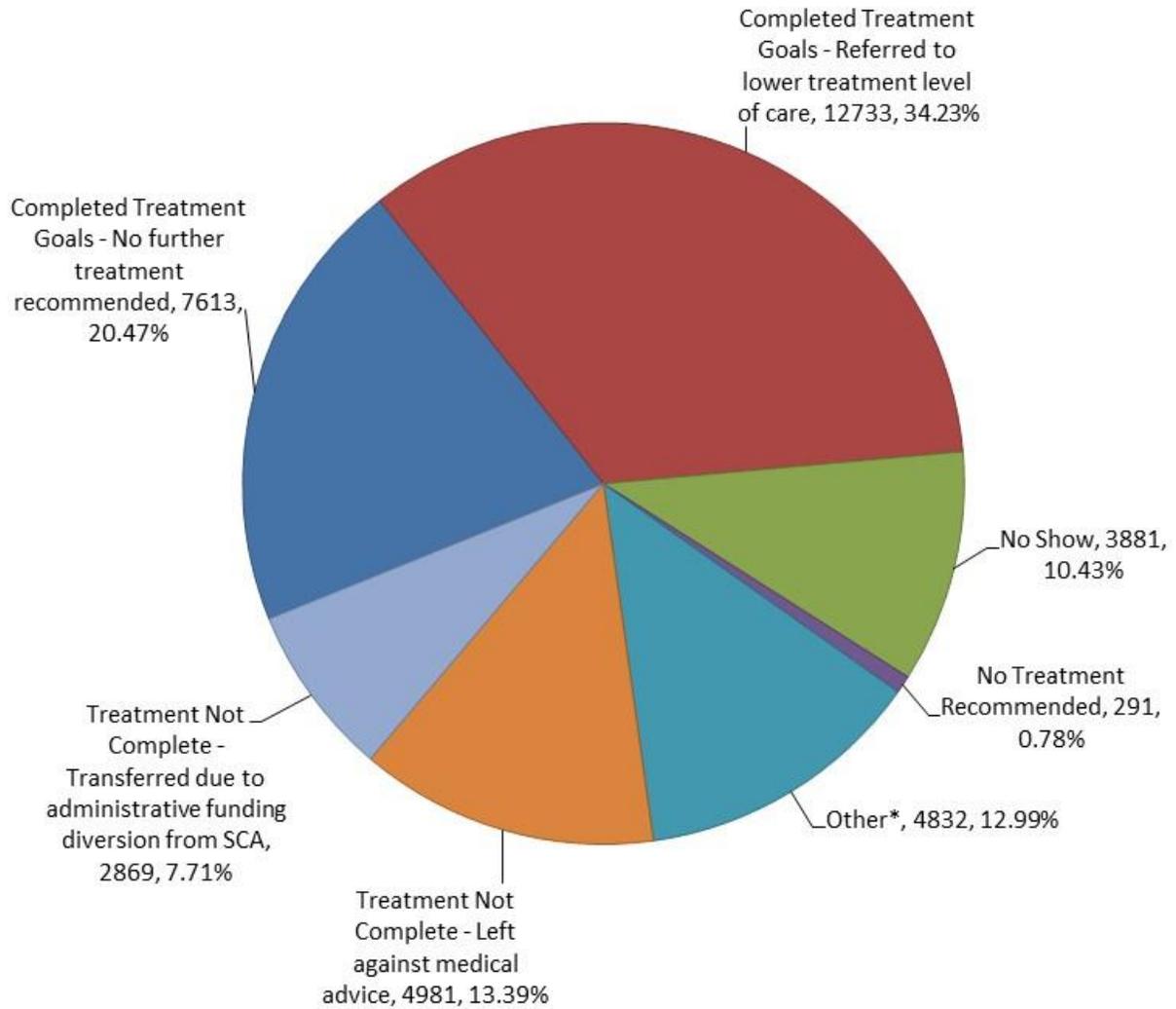


*Other Reasons includes: Incarcerated, Treatment Not Complete - Transferred to other non-D&A Facility, Treatment Not Complete - Transferred to other D&A Facility, Terminated by facility, SCA, Deceased and Other.

Total Detox Discharges=8,775

Figure 19

Client Discharges from Treatment SFY 2013-2014 Non Detox Reasons for Discharge



*Other Reasons includes: Incarcerated, Treatment Not Complete - Transferred to other non-D&A Facility, Treatment Not Complete - Transferred to other D&A Facility, Terminated by facility, SCA, Deceased and Other.

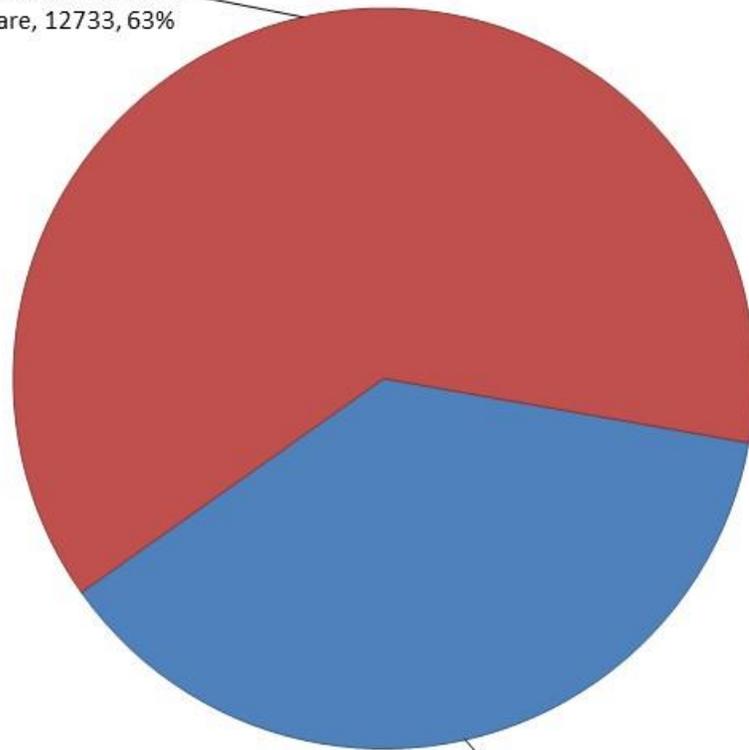
Total Non Detox Discharges=43,426

Figure 20

Client Discharges from Treatment SFY 2013-2014

Non Detox Reasons for Discharge for those who completed treatment goals

Completed Treatment
Goals - Referred to
lower treatment level
of care, 12733, 63%



Completed Treatment
Goals - No further
treatment
recommended, 7613,
37%

Total Discharges Completing Treatment=20,346

Pennsylvania Substance Abuse Outcome Measures

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

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

Employment and Education

The employment outcome measure records if the client is employed (full-time, part-time or student) at admission and discharge. Overall, clients improved in most levels of care from unemployed at admission to employed at discharge with the exception of short-term care (Figure 21).

Figure 21		
Employment/Education Status*		
July 1 2013 - June 30 2014		
Level of Care	Admission	Discharge
Outpatient (Non-Intensive)		
Employed/Student	5835	5767
Total Non-Missing/Unknown	14856	13836
Percent	39.3%	41.7%
Intensive Outpatient		
Employed/Student	1951	1990
Total Non-Missing/Unknown	8167	7729
Percent	23.9%	25.7%
Short-Term (Up to 30 Days)		
Employed/Student	774	634
Total Non-Missing/Unknown	7010	7073
Percent	11.0%	9.0%
Long Term (Over 30 Days)		
Employed/Student	54	413
Total Non-Missing/Unknown	2292	2293
Percent	2.4%	18.0%
* Employment and Education Status includes: A client's fulltime, part-time and student status at the admission and discharge to treatment.		

Without Arrests

The arrests outcome measure records the client's arrest status. At admission, the client is asked if he/she has been arrested in the thirty days preceding their admission date to treatment services. At discharge, the client is asked if he/she has been arrested thirty days preceding their discharge to treatment.

Overall, 31 percent of referred admissions (Figure 8) involve some client interaction with the criminal justice system, so this special population's engagement and wellbeing is of great interest and importance to the Department. Meanwhile, only 3 percent of clients were discharged due to incarceration, while they were engaged in treatment programs (Figure 19). Overall, clients improved in all levels of care (Figure 22).

Figure 22		
Without Arrests Status*		
July 1 2013 - June 30 2014		
Level of Care	Admission	Discharge
Outpatient (Non-Intensive)		
No Arrests	14121	14512
Total Non-Missing/Unknown	15219	15219
Percent	92.8%	95.4%
Intensive Outpatient		
No Arrests	7859	8020
Total Non-Missing/Unknown	8377	8377
Percent	93.8%	95.7%
Short-Term (Up to 30 Days)		
No Arrests	7082	7418
Total Non-Missing/Unknown	7570	7570
Percent	93.6%	98.0%
Long Term (Over 30 Days)		
No Arrests	2215	2295
Total Non-Missing/Unknown	2335	2335
Percent	94.9%	98.3%
* Criminal Justice Without Arrests Status includes: Clients without any arrests 30 days preceding the date of admission to treatment services or date of discharge.		

Increased Stability in Housing

The increased stability in housing outcome measure records whether the client's living situation is improving or not. Only those clients indicating independent living are considered for the calculation. Clients improved in the long term level of care (Over 30 Days) at the time of discharge (Figure 23).

Figure 23		
Stable Housing*		
<i>July 1 2013 - June 30 2014</i>		
Level of Care	Admission	Discharge
Outpatient (Non-Intensive)		
Stable Living Situation	14640	14260
Total Non-Missing/Unknown	14974	14488
Percent	97.8%	98.4%
Intensive Outpatient		
Stable Living Situation	7702	7522
Total Non-Missing/Unknown	7911	7692
Percent	97.4%	97.8%
Short-Term (Up to 30 Days)		
Stable Living Situation	5239	5176
Total Non-Missing/Unknown	5842	5739
Percent	89.7%	90.2%
Long Term (Over 30 Days)		
Stable Living Situation	1471	1473
Total Non-Missing/Unknown	2177	1978
Percent	67.6%	74.5%
* Stability in Housing includes: Clients in a stable living situation independently at the time of admission to treatment services or date of discharge.		

Social Connectedness

The social connectedness outcome measure records a client's attendance at a self-help program thirty days preceding the date of admission to treatment services or date of discharge. Self-help attendance includes AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence. Overall, clients improved attendance in each level of care; however long term (Over 30 Days) increased to 47 percent attendance at their discharge (Figure 24).

Figure 24		
Social Connectedness/Support Attendance*		
<i>July 1 2013 - June 30 2014</i>		
Level of Care	Admission	Discharge
Outpatient (Non-Intensive)		
Attended	3007	3722
Total Non-Missing/Unknown	11604	9692
Percent	25.9%	38.4%
Intensive Outpatient		
Attended	2509	2573
Total Non-Missing/Unknown	6816	5463
Percent	36.8%	47.1%
Short-Term (Up to 30 Days)		
Attended	1007	2181
Total Non-Missing/Unknown	4228	4290
Percent	23.8%	50.8%
Long Term (Over 30 Days)		
Attended	387	1701
Total Non-Missing/Unknown	972	1964
Percent	39.8%	86.6%
<p>* Social Connectedness/Support includes: Client's attendance at self-help program in the 30 days preceding the date of admission to treatment services or date of discharge. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence.</p>		

Single County Authority Expenditures State Fiscal Year 2013-14

by Fund Source Values

SINGLE COUNTY AUTHORITY	TOTAL DDAP FUNDS	TOTAL COUNTY FUNDS	TOTAL OTHER FUNDS	TOTAL FUNDS
Allegheny	\$ 11,360,257	\$ 142,604	\$ 5,836,087	\$ 17,338,948
Armstrong/Indiana/Clarion	\$ 1,396,197	\$ -	\$ 2,165,268	\$ 3,561,465
Beaver	\$ 1,220,946	\$ 80,000	\$ 765,695	\$ 2,066,641
Bedford	\$ 394,587	\$ -	\$ 320,589	\$ 715,176
Berks	\$ 3,076,758	\$ 1,845,841	\$ 3,475,659	\$ 8,398,258
Blair	\$ 1,146,799	\$ -	\$ 307,572	\$ 1,454,371
Bradford/Sullivan	\$ 497,925	\$ 22,847	\$ 59,585	\$ 580,357
Bucks	\$ 3,475,387	\$ 380,942	\$ 1,626,603	\$ 5,482,932
Butler	\$ 1,116,896	\$ 25,316	\$ 977,437	\$ 2,119,649
Cambria	\$ 1,030,090	\$ 24,790	\$ 483,137	\$ 1,538,017
Cameron/Elk/McKean	\$ 830,488	\$ 81,393	\$ 1,046,182	\$ 1,958,063
Carbon/Monroe/Pike	\$ 1,026,595	\$ 55,147	\$ 1,490,808	\$ 2,572,550
Centre	\$ 766,871	\$ 30,085	\$ 602,083	\$ 1,399,039
Chester	\$ 2,414,610	\$ 597,062	\$ 3,920,866	\$ 6,932,538
Clearfield/Jefferson	\$ 1,019,684	\$ -	\$ 807,436	\$ 1,827,120
Col/Montour/Snyder/Union	\$ 821,530	\$ 14,785	\$ 730,672	\$ 1,566,987
Crawford	\$ 731,367	\$ 16,620	\$ 1,045,438	\$ 1,793,425
Cumberland/Perry	\$ 1,644,491	\$ 212,300	\$ 1,037,883	\$ 2,894,674
Dauphin	\$ 2,402,752	\$ 207,870	\$ 1,279,158	\$ 3,889,780
Delaware	\$ 3,526,398	\$ 122,471	\$ 2,786,126	\$ 6,434,995
Erie	\$ 3,535,022	\$ 281,864	\$ 2,016,787	\$ 5,833,673
Fayette	\$ 1,053,255	\$ -	\$ 1,588,813	\$ 2,642,068
Forest/Warren	\$ 302,454	\$ 7,228	\$ 230,582	\$ 540,264
Franklin/Fulton	\$ 601,927	\$ 51,661	\$ 567,870	\$ 1,221,458
Greene	\$ 290,477	\$ 10,281	\$ 143,787	\$ 444,545
Huntingdon/Mifflin/Juniata	\$ 652,722	\$ -	\$ 346,386	\$ 999,108
Lackawanna/Susquehanna	\$ 1,687,775	\$ 82,500	\$ 1,018,196	\$ 2,788,471
Lancaster	\$ 2,472,225	\$ 63,579	\$ 2,278,211	\$ 4,814,015
Lawrence	\$ 779,145	\$ -	\$ 690,009	\$ 1,469,154
Lebanon	\$ 641,120	\$ 195,347	\$ 426,868	\$ 1,263,335
Lehigh	\$ 2,214,651	\$ 94,184	\$ 1,648,007	\$ 3,956,842
Luzerne/Wyoming	\$ 2,180,588	\$ 184,096	\$ 1,423,089	\$ 3,787,773
Lycoming/Clinton	\$ 953,358	\$ 79,545	\$ 1,355,149	\$ 2,388,052
Mercer	\$ 990,336	\$ 45,000	\$ 832,215	\$ 1,867,551
Montgomery	\$ 3,849,412	\$ 172,463	\$ 2,324,419	\$ 6,346,294
Northampton	\$ 1,664,716	\$ 63,278	\$ 1,652,234	\$ 3,380,228
Northumberland	\$ 527,196	\$ 21,472	\$ 353,011	\$ 901,679
Philadelphia	\$ 25,830,722	\$ 1,558,218	\$ 15,956,618	\$ 43,345,558
Potter	\$ 171,105	\$ 18,717	\$ 86,735	\$ 276,557
Schuylkill	\$ 1,110,539	\$ 58,800	\$ 755,169	\$ 1,924,508
Somerset	\$ 538,869	\$ 17,415	\$ 166,389	\$ 722,673
Wayne	\$ 302,242	\$ 226,453	\$ 216,380	\$ 745,075
Tioga	\$ 330,337	\$ 41,748	\$ 157,953	\$ 530,038
Venango	\$ 455,278	\$ 16,665	\$ 516,642	\$ 988,585
Washington	\$ 1,398,301	\$ -	\$ 1,308,571	\$ 2,706,872
Westmoreland	\$ 2,525,945	\$ 38,302	\$ 836,547	\$ 3,400,794
York/Adams	\$ 1,775,245	\$ 100,000	\$ 932,882	\$ 2,808,127
TOTAL	\$ 98,735,590	\$ 7,288,889	\$ 70,593,803	\$ 176,618,282

Single County Authority Expenditures by Major Activity

for State Fiscal Year 2013-14 (All Sources)

SINGLE COUNTY AUTHORITY	TOTAL ADMINISTRATION	TOTAL PREVENTION	TOTAL INTERVENTION	TOTAL TREATMENT	TOTAL AMOUNT
Allegheny	\$ 1,836,969	\$ 2,626,164	\$ 2,621,094	\$ 10,254,721	\$ 17,338,948
Armstrong/Indiana/Clarion	\$ 480,709	\$ 736,946	\$ 208,600	\$ 2,135,210	\$ 3,561,465
Beaver	\$ 421,471	\$ 319,290	\$ 5,058	\$ 1,320,822	\$ 2,066,641
Bedford	\$ 118,809	\$ 358,171	\$ 29,615	\$ 208,581	\$ 715,176
Berks	\$ 824,733	\$ 1,200,392	\$ 292,473	\$ 6,080,660	\$ 8,398,258
Blair	\$ 928	\$ 75,304	\$ 584,272	\$ 793,867	\$ 1,454,371
Bradford/Sullivan	\$ 100,978	\$ 145,496	\$ 55,940	\$ 277,943	\$ 580,357
Bucks	\$ 1,052,795	\$ 771,508	\$ 780,718	\$ 2,877,911	\$ 5,482,932
Butler	\$ 225,680	\$ 328,901	\$ 163,398	\$ 1,401,670	\$ 2,119,649
Cambria	\$ 201,884	\$ 200,941	\$ 48,330	\$ 1,086,862	\$ 1,538,017
Cameron/Elk/McKean	\$ 193,389	\$ 237,806	\$ 2,116	\$ 1,524,752	\$ 1,958,063
Carbon/Monroe/Pike	\$ 337,855	\$ 338,780	\$ 120,042	\$ 1,775,873	\$ 2,572,550
Centre	\$ 180,131	\$ 300,091	\$ 41,993	\$ 876,824	\$ 1,399,039
Chester	\$ 1,045,460	\$ 536,199	\$ 10,948	\$ 5,339,931	\$ 6,932,538
Clearfield/Jefferson	\$ 119,024	\$ 558,472	\$ 112,409	\$ 1,037,215	\$ 1,827,120
Col/Montour/Snyder/Union	\$ 212,369	\$ 155,401	\$ 139,452	\$ 1,059,765	\$ 1,566,987
Crawford	\$ 115,372	\$ 257,618	\$ 70,481	\$ 1,349,954	\$ 1,793,425
Cumberland/Perry	\$ 299,057	\$ 794,501	\$ 41,968	\$ 1,759,148	\$ 2,894,674
Dauphin	\$ 711,837	\$ 804,746	\$ 148,152	\$ 2,225,045	\$ 3,889,780
Delaware	\$ 719,129	\$ 697,262	\$ -	\$ 5,018,604	\$ 6,434,995
Erie	\$ 317,377	\$ 1,310,905	\$ 548,876	\$ 3,656,515	\$ 5,833,673
Fayette	\$ 224,819	\$ 351,043	\$ 244,265	\$ 1,821,941	\$ 2,642,068
Forest/Warren	\$ 132,530	\$ 68,618	\$ 1,926	\$ 337,190	\$ 540,264
Franklin/Fulton	\$ 211,380	\$ 137,361	\$ 22,070	\$ 850,647	\$ 1,221,458
Greene	\$ 83,217	\$ 104,288	\$ -	\$ 257,040	\$ 444,545
Huntingdon/Mifflin/Juniata	\$ 220,504	\$ 147,384	\$ 34,989	\$ 596,231	\$ 999,108
Lackawanna/Susquehanna	\$ 153,848	\$ 516,821	\$ 193,407	\$ 1,924,395	\$ 2,788,471
Lancaster	\$ 500,102	\$ 1,553,825	\$ 49,304	\$ 2,710,784	\$ 4,814,015
Lawrence	\$ 231,310	\$ 269,380	\$ 6,045	\$ 962,419	\$ 1,469,154
Lebanon	\$ 212,046	\$ 180,243	\$ 100,808	\$ 770,238	\$ 1,263,335
Lehigh	\$ 388,929	\$ 715,099	\$ 271,842	\$ 2,580,972	\$ 3,956,842
Luzerne/Wyoming	\$ 271,465	\$ 593,744	\$ 95,308	\$ 2,827,256	\$ 3,787,773
Lycoming/Clinton	\$ 320,371	\$ 269,155	\$ 11,376	\$ 1,787,150	\$ 2,388,052
Mercer	\$ 262,905	\$ 437,412	\$ 15,459	\$ 1,151,775	\$ 1,867,551
Montgomery	\$ 848,420	\$ 444,192	\$ 260,343	\$ 4,793,339	\$ 6,346,294
Northampton	\$ 449,494	\$ 436,642	\$ 138,254	\$ 2,355,838	\$ 3,380,228
Northumberland	\$ 169,072	\$ 83,890	\$ 90,977	\$ 557,740	\$ 901,679
Philadelphia	\$ 8,371,542	\$ 4,203,069	\$ 2,008,448	\$ 28,762,499	\$ 43,345,558
Potter	\$ 70,563	\$ 60,671	\$ -	\$ 145,323	\$ 276,557
Schuylkill	\$ 245,440	\$ 434,318	\$ 43,649	\$ 1,201,101	\$ 1,924,508
Somerset	\$ 93,148	\$ 140,022	\$ 27,307	\$ 462,196	\$ 722,673
Wayne	\$ 144,719	\$ 113,043	\$ 70,518	\$ 416,795	\$ 745,075
Tioga	\$ 124,124	\$ 67,249	\$ -	\$ 338,665	\$ 530,038
Venango	\$ 184,740	\$ 147,256	\$ 7,453	\$ 649,136	\$ 988,585
Washington	\$ 387,397	\$ 478,121	\$ 6,771	\$ 1,834,583	\$ 2,706,872
Westmoreland	\$ 536,317	\$ 950,495	\$ -	\$ 1,913,982	\$ 3,400,794
York/Adams	\$ 343,887	\$ 432,783	\$ 14,877	\$ 2,016,580	\$ 2,808,127
TOTAL	\$ 24,698,245	\$ 26,091,018	\$ 9,741,331	\$ 116,087,688	\$ 176,618,282

Appendix A: Resources and Contact Information

FOR IMMEDIATE HELP, CALL 911. IN AN EMERGENCY, IF YOU CALL FOR SOMEONE ELSE, STAY WITH THE PERSON UNTIL HELP ARRIVES. THESE APPENDIXES CONTAIN VARIOUS INFORMATION RESOURCES ON "SUICIDE," "CRISIS" OR "MENTAL HEALTH."

Prevention Web Sites

The Center for Communities That Care:
www.communitiesthatcare.net/getting-started/

Social Development Research Group:
www.sdrp.org

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/population-data-nsduh

Monitoring the Future:
www.monitoringthefuture.org

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

MADD:
www.madd.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

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

DOH – PA Department of Health:
www.health.pa.gov

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

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

PDE – PA Department of Education, Office of Safe Schools (Elementary and Secondary):
www.education.pa.gov/K-12/Safe%20Schools

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

Pennsylvania Student Assistance Programs (SAP):
www.PNSAS.org

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:
ncsacw.samhsa.gov

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

National Institute on Drug Abuse (NIDA):
www.nida.nih.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 in need of addiction services- Get Help Now:
www.ddap.pa.gov

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

Council on Compulsive Gambling of Pennsylvania, Inc.
www.pacouncil.com
1-800-GAMBLER or 1-800-848-1880

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

ABC-MAP	Achieving Better Care By Monitoring All Prescriptions	PACDAA	PA Association of County Drug and Alcohol Administrators
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	PDMP	Prescription Drug Monitoring Program
CSAT	Center for Substance Abuse Treatment	PIR	Persons In Recovery
CSC	Clinical Standards Committee	RCPA	Rehabilitation & Community Providers Association
DAAC	Drug and Alcohol Advisory Council	PATOD	Pennsylvania Association for Treatment of Opioid Dependence
DDAP	Department of Drug and Alcohol Programs	PCPC	PA Client Placement Criteria
DOC	Department of Corrections	PDE	PA Department of Education
DOH	Department of Health	PERU	Program Evaluation and Research Unit (University of Pittsburgh)
DHS	Department of Human Services	PPAC	Parent Panel Advisory Council
FASD	Fetal Alcohol Spectrum Disorder	PRO-A	PA Recovery Organizations Alliance
FDA	US Food and Drug Administration	ROSC	Recovery Oriented Systems of Care
HCV	Hepatitis C Virus	SAMHSA	Substance Abuse and Mental Health Services Administration
H-OO	Heroin and Other Opioid Workgroup	SAPT	Substance Abuse Prevention and Treatment
IRETA	Institute for Research, Education, and Training in Addictions	SBIRT	Screening, Brief Intervention and Referral to Treatment
MAT	Medication Assisted Treatment	SCA	Single County Authority
OCYF	Office of Children, Youth and Families	SCI	State Correctional Institution
OMAP	Office of Medical Assistance Programs	STAR	Strengthening Treatment and Recovery Data System
OMHSAS	Office of Mental Health and Substance Abuse Services	VMS	Voucher Management System
OTF	Overdose Task Force		
OTP	Opioid Treatment Program		

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