Commonwealth of Pennsylvania
Department of Health

BUREAU OF DRUG AND ALCOHOL PROGRAMS

DRUG AND ALCOHOL PROGRAM REPORTS

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CHAPTER ONE:
OVERVIEW

BUREAU OF DRUG AND ALCOHOL PROGRAMS
DEPARTMENT OF HEALTH

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

- Mr. Kenneth S. Ramsey, PhD
- Mr. Carmen F. Ambrosino
- Mr. Carlos E. Graupera
- Mr. Dickie Noles
- Ms. Marlene E. Burks
- Ms. Bonnie S. Summers
- Mr. George W. Dowdall, PhD
- Vacant

It is important to note that Act 50 of 2010 was enacted on July 3, 2010 and amends Section 201 of the Administrative Code of 1929 by adding the Department of Drug and Alcohol Programs to other 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, under the article, Section 2301-A, Powers and Duties, which repeals Act 63, section 1690.104. Lastly, the Act transfers all personnel, allocations, appropriations, equipment, files, records, contracts, agreements and obligations concerning drug and alcohol abuse housed within the Department to the Department of Drug and Alcohol Programs, effective July 1, 2011.

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

- Coordination of the efforts of all state agencies in the control, prevention, intervention, treatment, rehabilitation, research, education and training aspects of drug and alcohol abuse and dependence problems so as to avoid duplications and inconsistencies in the efforts of the agencies;

- Coordination of all health and habilitation efforts to deal with the problem of drug and alcohol abuse and dependence, including, but not limited to, those relating to vocational rehabilitation, manpower development and training, senior citizens, law enforcement assistance, parole and probation systems, jails and prisons, health research facilities, mental retardation facilities and community mental health centers, juvenile delinquency, health professions, educational assistance, hospital and medical facilities, social security, community health services, education professions development, higher education, commonwealth employees health benefits, economic opportunity, elementary and secondary education, highway safety and the civil service laws;

- Encouragement of the formation of local agencies (now called Single County Authorities [SCAs]) and local coordinating councils, as well as the promotion of cooperation and coordination among such groups and the encouragement of communication of ideas and recommendations from such groups to the Advisory Council on Drug and Alcohol Abuse;

- Development of model drug and alcohol abuse and dependence control plans for local government, utilizing the concepts incorporated in the State Plan. The plans shall be reviewed on a periodic basis, but not less than once per year, and reviewed to keep them current. The model plans shall specify how all types of community resources and existing federal and commonwealth legislation may be utilized;

- Assistance and consultation to local governments, public and private agencies, institutions and organizations and individuals with respect to the prevention and treatment of drug and alcohol abuse and dependence, including coordination of programs among them;

- Cooperation with organized medicine to disseminate medical guidelines for the use of drug and controlled substances in medical practice;

- Coordination of research, scientific investigations, experiments and studies relating to the cause, epidemiology, sociological aspects, toxicology, pharmacology, chemistry, effects on health, dangers to public health, prevention, diagnosis and treatment of drug and alcohol abuse and dependence;

- Investigation of methods for the more precise detection and determination of alcohol and controlled substances in urine and blood samples, and by other means, and publication on a current basis of uniform methodology for such detections and determinations;

- Any information obtained through scientific investigation or research conducted pursuant to this act shall be used in ways that no name or identifying characteristics of any person shall be divulged without the approval of the Department and the consent of the person concerned. Persons engaged in research pursuant to this section shall protect the privacy of individuals who are the subject of such research by withholding from all persons not connected with the conduct of such research the names or other identifying characteristics of such individuals. Persons engaged in research shall protect the privacy of such individuals and may not be compelled in any state, civil, criminal, administrative, legislative or other proceeding to identify the individuals;

- Establishment of training programs for professional and non-professional personnel with

respect to drug and alcohol substance abuse and dependence, including the encouragement of such programs by local governments;

- Development of a model curriculum, including the provision of relevant data and other information, for utilization by elementary and secondary schools for instructing children and for parent-teacher associations, adult education centers, private citizen groups or other state and local sources for instruction of parents and other adults about drug and alcohol abuse and dependency;

- Preparation of a broad variety of educational, prevention and intervention material (for use in all media), which is available to all segments of the population for use by public and private agencies, institutions and organizations in educational programs with respect to alcohol and drug abuse and dependence;

- Establishment of educational courses, including the provision of relevant data and other information on the causes and effects of, and treatment for, drug and alcohol abuse and dependence 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 into contact with drug and alcohol abuse and dependence problems;

- Recruitment, training, organization and employment of professional and other persons, including former drug and alcohol abusers and dependent persons, to organize and participate in programs of public education;

- Treatment and rehabilitation services for male and female juveniles and adults who are charged with, convicted of or serving a criminal sentence for any criminal offense under the laws of this commonwealth. Provision of similar services shall be made for juveniles adjudged to be delinquent, dependent or neglected. These services shall include, but are not limited to, emergency medical services, inpatient services and intermediate care, rehabilitative and outpatient services;

- Giving priority to developing community-based drug or alcohol abuse treatment services and encouraging cooperation among state and local governmental agencies and departments and public and private agencies, institutions and organizations. Consideration shall be given to supportive medical care, services or residential facilities for drug and alcohol dependent persons for whom treatment has repeatedly failed or for whom recovery is unlikely;

- Establishment of a system of emergency medical services for persons voluntarily seeking treatment, for persons admitted and committed to treatment facilities according to the procedural admission and commitment provisions of the Act of July 9, 1976 (P.L.817, No.143), known as the Mental Health Procedures Act, and for persons charged with a crime under Pennsylvania law. Upon the establishment of such emergency services, the Department of Drug and Alcohol Programs, by regulation, shall require that appropriate emergency medical services be made available to all drug and alcohol abusers who are arrested for a crime under Pennsylvania law;

- Providing standards for the approval by the relevant state agency for all private and public treatment and rehabilitative facilities. Such facilities may include, but are not limited to, state hospitals and institutions, public and private general hospitals, community mental health centers or their contracting agencies, as well as public and private drug or alcohol dependence and drug and alcohol abuse and dependence treatment and rehabilitation centers;

- Grants and contracts from the appropriate state department or agency for the prevention, intervention and treatment of drug and alcohol dependence. The grants and contracts may include assistance to local governments and public and private agencies, institutions and organizations for prevention, intervention, treatment, rehabilitation, research, education and training aspects of the drug and alcohol abuse and dependence problems within the commonwealth. Any grant made or contract entered into by a department or agency shall be pursuant to the functions allocated to that department or agency by the State Plan;

- Preparation of general regulations for and operation of programs supported with assistance;

- Establishment of priorities for deciding allocation of the funds;

- Review of the administration and operation of programs under this Act (including the effectiveness of such programs in meeting the purposes for which they are established and operated) and submission of annual reports of the findings;

- Evaluation of the programs and projects carried out and the dissemination of the results of such evaluations; and,

- Establishment of such advisory committees as deemed necessary to assist the Department in fulfilling its responsibilities.

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

- Facilitate the recovery of drug and alcohol dependent persons;

- Decrease the probability of drug and alcohol experimenters from becoming dependent;

- Assist this and future generations in avoiding drug and alcohol abuse or dependence;

- Assist society in becoming fully informed about drug and alcohol abuse and dependence; and,

- Develop open lines of communication between the Department, community agencies and its service providers.

The Department shall provide the following services:

- Be responsible for providing requirements defined in Act 63, as well as those prescribed in

Act 50 of 2010;

- Function as the Single State Agency (SSA) for the acquisition and disposition of federal and state drug and alcohol funds;

- Assure the development, coordination and adoption of a State Plan for the control, prevention, intervention, treatment, rehabilitation, research, education and training aspects of drug and alcohol abuse and dependence problems;

- Serve as the policy making body that directs operations pertaining to the implementation of the State Plan;

- Review and adopt regulations for the operation of community agencies and coordinating councils under Act 63 of 1972 and Act 50 of 2010;

- Encourage the formation of community agencies and coordinating councils in an effort to promote local cooperation and communication;

- Determine policy and coordinate and evaluate the efforts of community agencies in the commonwealth;

- Establish funding priorities for SCAs; and,

- Approve grants and contracts.

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

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

In addition to enabling legislation and operating regulations, a provision of the federal Public Health Service Act, 42 U.S.C. §300x et seq., places additional requirements on how drug treatment abuse and prevention funds are used. This statute authorizes use of the Substance Abuse Prevention and Treatment Block Grant. Since the Council's inception, the provision of publicly funded drug and alcohol treatment and prevention services has had a strong community orientation through a system of SCAs. The Department is designated as the SSA to plan and allocate the Block Grant in combination with the state appropriation to SCAs and other community-based programs, based upon population, competitive awards and other factors. SCAs serve as local

administrative entities for a catchment area that includes one or more counties. Currently, there are 47 SCAs serving the 67 counties in the commonwealth. It is the SCAs' responsibility to determine the needs of their catchment area and engage providers to deliver the appropriate services. In some cases, the Department may directly engage a provider for specific services or services with a statewide impact.

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

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

Statement of Policy

Pursuant to Section 2301-A of Act 50 of 2010, Powers and Duties, the Department of Drug and Alcohol Programs is responsible for the development of a State Plan. Per §§2301-A(1) (iii), (1)(v), (1)(xix) and (1)(xxi), the Department reserves the right to coordinate the agencies or organizations for the planning and administration of community-based services. The Department is the entity designated to fulfill these responsibilities and functions as the SSA for federal funds and planning.

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

CHAPTER TWO

ANNUAL REPORT
FOR THE PERIOD
STATE FISCAL YEAR 2009-10

PROGRESS REPORT
STATE FISCAL YEAR 2010-11

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

STATE FISCAL YEAR 2011-12

BUREAU OF DRUG AND ALCOHOL PROGRAMS

BACKGROUND

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

A second responsibility is to maintain oversight of its drug and alcohol system through the monitoring of SCAs and to develop new prevention, intervention and/or treatment programs or adapt existing ones to enhance the current service delivery system. This often requires sensitivity to the needs of a particular geographic region or particular subpopulations. This section describes BDAP's major goals and objectives, as a Bureau, and, more specifically, within each Division/Section within the Bureau. Each section describes the responsibilities of the Bureau/Division/Section and outlines the goals and objectives in a past, present and future format. The past is represented by the Annual Report for FY 2009-10; the present consists of the progress occurring for FY 2010-11, and the future is represented by the State Plan for FY 2011-12.

PREVENTION

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

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

SIX FEDERAL STRATEGIES

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

- Information Dissemination - provides awareness and knowledge on the nature and extent of alcohol, tobacco and drug use, abuse and addiction and the effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.

- Education - involves two-way communication, which is distinguished from the Information Dissemination category by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this category are to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages) and systematic judgment abilities.

- Alternative Activities - operates under the premise that healthy activities will deter participants from the use of alcohol, tobacco and other drugs (ATOD). The premise is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by ATOD, and would, therefore, minimize or eliminate use of ATOD. These activities must be directly linked to an educational or skill-building activity.

- Problem Identification and Referral - targets those persons who have experienced first use of illicit/age-inappropriate use of tobacco and those individuals who have indulged in the first use of illicit drugs and alcohol. This helps to assess if the behavior of such individuals can be reversed through education.

- Community-Based Process - aims directly at building community capacity to enhance the ability of communities to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities include organizing, planning, enhancing efficiency and effectiveness of services, inter-agency collaboration, coalition building and networking.

- Environmental - establishes or changes written and unwritten community standards, codes, ordinances and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the population. This category is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those that relate to action-oriented initiatives.

Institute of Medicine (IOM) Prevention Classifications

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

- Universal Preventive Interventions – activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

- Selective Preventive Interventions – activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

- Indicated Preventive Interventions – activities targeted to individuals in high-risk environments identified as having minimal but detectable signs or symptoms foreshadowing a disorder or having biological markers indicating predisposition for a disorder which does not yet meet diagnostic levels.

Strategic Prevention Framework Model

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

- Needs Assessment - The needs assessment is designed to profile population needs, resources and readiness to address needs and gaps. The process involves the collection and analysis of data to define problems within a geographic area. Assessing resources includes identifying service gaps, assessing cultural competence and identifying the existing prevention infrastructure in the county and/or community. It also involves assessing readiness and leadership to implement programs, strategies, policies and practices.

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

- Capacity – The SCA and those funding or delivering drug and alcohol prevention services must increase efforts to mobilize and/or build capacity to address needs. Building capacity involves the mobilization of resources within a community. A key aspect of capacity building is convening key stakeholders, coalitions and service providers to plan and implement sustainable prevention efforts during the planning and implementation phase. The mobilization of resources includes financial and organizational resources, as well as the creation of partnerships. Readiness, cultural competence and leadership capacity are addressed and strengthened through education and systems thinking. Additionally, capacity building should include a focus on sustainability, as well as an evaluation of capacity.

- Planning – Planning involves the creation and development of a plan that includes implementing programs, strategies, policies and practices that create a logical, data-driven plan that reduces the risk factors and enhances the protective factors that contribute to substance abuse in a specific county/community. The planning process produces strategic county-wide and community targeted goals, as well as logic models and preliminary action plans. In addition, it also involves the identification and selection of evidence-based strategies that include changes in programs, strategies, policies and practices that will reduce substance abuse. Even though one community may show similar alcohol-related issues, the underlying factors that contribute most to them will vary between communities. If the programs, strategies, policies and practices do not address the underlying risk and protective factors that contribute to the problem, then the intervention is unlikely to be effective in changing the substance abuse problem or behavior.

- Implementation – SCAs and those funding or delivering drug and alcohol prevention services are required to implement and provide ongoing monitoring of their Comprehensive Strategic Plan. This includes, but is not limited to, the collection of process measure data, performance targets and the fidelity of implementation. Any modifications and changes that are made to the original programs must be documented throughout the implementation of the program, utilizing the developer's program fidelity/adaptation instrument and reported in the SCA's Annual Outcome Evaluation Report. This is to understand whether or not expected outcomes have been attained as a result of adaptations made to programs.

- Evaluation – The SCAs must evaluate their Comprehensive Strategic Plan. The SCAs must measure the impact of the implemented programs, strategies, policies, practices and identify areas for improvement.

Current Initiatives

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

Programs and Strategies

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

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

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

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

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

State Approved Effective Programs meet the following criteria:

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

State Approved Effective Strategies are defined as programs which:

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

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

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

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

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

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

- Student Assistance Program (SAP) – a mandatory intervention program provided within the school setting intended to identify and address problems negatively impacting student academic and social growth.
- 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) who implement action plans to reduce and prevent underage drinking tobacco and other drugs.

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

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

ANNUAL REPORT FY 2009-10, PROGRESS REPORT FY 2010-11 AND STATE PLAN FY 2011-12

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

ANNUAL REPORT FY 2009-10

BDAP continued to assist the Substance Abuse and Mental Health Services Administration (SAMHSA), in collaboration with the Federal Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), in supporting national initiatives on underage drinking.

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

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

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

The SPF SIG underage drinking priorities gave the 17 grantees the opportunity to address underage drinking through a variety of evidence-based programs and environmental programs and strategies. The grantees implemented community plans which outlined:

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

The 17 SPF-SIG grantees provided 3,227 services in FY 2009-10. Through these activities they served a total of 205,234 individuals (48,292 single service attendees and 156,942 recurring service participants). Programs and strategies implemented by SPF-SIG grantees included Communities Mobilizing for Change on Alcohol, Too Good for Drugs, Class Action, Brief Alcohol Screening

and Intervention for College Students and Social Norms Campaigns.

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

BDAP staff were members of the committee which planned the Annual Community Forum Against Underage Drinking, sponsored by the Center for Traffic Safety in York, PA. The annual event is a community-based program aimed at increasing student awareness of the risks and consequences of underage drinking and other destructive decisions. The forum aims to empower all participants in the three counties served by the Lincoln Intermediate Unit #12 (York, Adams, Franklin) to take an active role in underage drinking education and prevention. Approximately 400 identified students participated in the event in March 2010.

PROGRESS REPORT FY 2010-11

The 17 SPF SIG grantees continue to address their targeted underage drinking priorities through the implementation of a variety of evidence-based programs and environmental programs and strategies. Grantees are required to meet quarterly with their Community Level Planning Council to be inclusive of all key stakeholders in the targeted community. Each site is responsible for collecting outcomes data to be entered into the Performance-Based Prevention System and the federal reporting system. Sites are participating in local and statewide evaluation.

The SPF SIG Advisory Council is meeting quarterly to guide the efforts of the SPF SIG. Through these efforts, the Advisory Council continues to be responsible for providing direct feedback to BDAP regarding the development of specific program deliverables/products from the perspective of state policy development, community/county interests, cultural competency and individual/organizational experience and expertise.

BDAP collaborated with the Northeast Center for the Application of Prevention Technologies (CAPT) for technical assistance on the SPF SIG project to the grantees. In November 2010, CAPT provided training on sustainability to the SPF SIG grantees.

BDAP continues to participate in the statewide Multi Agency Safety Team (MAST), which is tasked with the development and implementation of the Comprehensive Strategic Highway Safety Improvement Plan. In addition to other highway safety issues, this group focuses on underage drinking and driving. BDAP will be reporting on the following data elements for MAST: persons receiving prevention education on alcohol programs and percentage of persons who report they have driven under the influence. BDAP is participating in the MAST Safety Advisory Committee, which assists in deciding how to spend federal highway safety funds.

BDAP staff are members of a committee which is looking for ways to continue provision of the Annual Community Forum Against Underage Drinking, sponsored by the Center for Traffic Safety in York, PA. Funding previously used to support this event (Safe and Drug Free Schools grant funding) is no longer available, so new avenues are being explored to support the continuation of this activity.

National Guard services are being provided statewide as a result of a Memorandum of Understanding between the Department of Health and the Pennsylvania National Guard Drug Demand Reduction Division. Services have been expanded to reach more communities. Services are provided as need arises or as they are requested.

BDAP is working with SAMHSA, in collaboration with the Federal Interagency Coordinating Committee on the Prevention of Underage Drinking, to support national initiatives on underage drinking.

STATE PLAN FY 2011-2012

The 17 SPF SIG grantees will continue implementing evidence-based programs and environmental programs and strategies which focus on reducing alcohol use and related problems among persons 11 through 21 years of age. In the final year of this grant, grantees will focus on ways to sustain their efforts after the grant is completed.

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

BDAP will continue to collaborate with various agencies and organizations, such as the DUI Association, to address underage drinking and underage drinking and driving-related issues.

BDAP will continue to participate in the statewide Multi Agency Safety Team which is tasked with the development and implementation of the Comprehensive Strategic Highway Safety Improvement Plan. BDAP will continue to report on persons receiving prevention education on alcohol programs and percentage of persons who report they have driven under the influence for MAST. BDAP will continue to participate in the MAST Safety Advisory Committee.

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

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

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

PRIORITY: Improve prevention outcomes through data-driven management.

Although SAMHSA/CSAP does not require States to collect the National Outcomes Measures (NOMs) survey as part of the Substance Abuse Prevention and Treatment (SAPT) Block Grant, BDAP felt it was important for those receiving services funded by the SAPT Block Grant to respond to the survey questions. BDAP requires SCAs and prevention providers to administer the Adult and Youth (ages 12-18) NOMs once to all single services that count attendees and all recurring service participants from October 1 through November 30 of each year. This survey was to be administered once per attendee/participant. After administering the NOMs, SCAs were required to record the survey results into the Performance Based Prevention System by January 31, 2010. During SFY 09/10, 11,226 youth 12-18 years of age took the NOMs survey during their participation in BDAP-funded prevention services. During the same time period, 4,765 adults 18 and older completed the NOMs survey while participating in BDAP-funded prevention services.

SFY 2009/2010 Youth NOMs Survey Findings

- 84.38 percent of youth reported no alcohol use in the past 30 days, an increase of .45 percent, compared to SFY 08/09 (n=11176.)
- 66.42 percent of youth report they have never used alcohol, an increase of .580 percent, compared to SFY 08/09 (n=11133.)
- 96.06 percent of youth reported that during the past 12 months they have not driven a vehicle while under the influence, an increase of 1.04 percent, compared to SFY 08/09 (n=10751.)
- 40.76 percent of youth reported they would be more likely to work for an employer who randomly drug and alcohol tests his employees, a decrease of .65 percent, compared to SFY 08/09 (n=6965.)
- 84.46 percent of youth reported they have never used marijuana, a decrease of .08 percent, compared to SFY 08/09 (n=11148.)
- 92.37 percent of youth reported they have never used other illegal drugs, an increase of .82 percent, compared to SFY 08/09 (n=11145.)
- 17.19 percent of youth reported they first used alcohol between the ages of 12-14, a decrease of .15 percent, compared to SFY 08/09 (n=11133.)
- 40.28 percent of youth reported that people are at great risk of harming themselves physically and in other ways when they have five or more alcoholic beverages once or twice a week, a decrease of 3.27 percent, compared to SFY 08/09 (n=11097.)
- 61.94 percent of youth strongly disapprove of someone their age trying marijuana or hashish once or twice, a decrease of .45 percent, compared to SFY 08/09 (n=10805.)

SFY 2009/2010 Adult NOMs Survey Findings

- 34.28 percent of the adults reported they took their first drink between the ages 15 and 17, an increase of 1.84 percent, compared to SFY 08/09 (n=4714.)
- 44.18 percent of the adults reported they have never used marijuana, a decrease of 6.32 percent, compared to SFY 08/09 (n=4697.)
- 32.34 percent of adults reported they would be more likely to work for an employer who conducted random drug and alcohol tests on their employees, a decrease of 1.29 percent, compared to SFY 08/09 (n=4672.)

- 79.54 percent of adults reported that, during the past 12 months, they have not driven a vehicle while under the influence, a decrease of 1.14 percent, compared to SFY 08/09 (n=4678.)
- 26.65 percent of adults reported that, during the past 12 months, they have spoken to their children many times about the dangers or problems associated with the use of tobacco, alcohol or other drugs an increase of 3.53 percent, compared to SFY 08/09 (n=3317.)
- 45.21 percent of adults reported that people are at great risk of harming themselves physically and in other ways when they smoke marijuana once or twice a week, a decrease of 7.95 percent, compared to SFY 08/09 (n=4678.)

SCAs completed Needs Assessments in Spring 2010. The purpose of this needs assessment was to gather data that would guide the planning and development of drug and alcohol prevention services. However, needs that SCAs planned to address had to be supported by data. SCAs utilized the "Key Representative Survey" and "Convenience Survey" as data collection tools during the needs assessment process.

BDAP and the Pennsylvania Department of Health Bureau of Statistics worked together to develop the "Key Representative Survey." The goal of this survey was to get information from key representatives in a given community. For the purposes of this survey, a key representative is a professional or volunteer person who has special knowledge and experience in a particular role in the community that is somehow affected by substance abuse. The "Convenience Survey" was developed to survey the general population. People attending certain events or meetings and/or participating in existing groups, health fairs, various meetings, school events, etc., are targeted to complete the "Convenience Survey."

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.

In January 2010, a contract was signed to move BDAP's Performance-Based Prevention System to KIT Solutions. The KIT service model embraces the concept that software is not a commodity that is built, but a service that constantly evolves. A primary benefit of using KIT to host, maintain and support the PBPS is being a member of the Learning Community. The Learning Community is made up of states that are using a tailored version of PBPS. The Learning Community meets face-to-face once a year prior to the National Prevention Network (NPN) annual conference and a few times a year in a virtual online meeting. The intent of the Learning Community is to share ideas and ways of applying and using the PBPS and data. Any new functionality developed by one member of the Learning Community can be integrated into all others at no additional development charges. Some of the benefits that KIT offers:

- SCAs and providers can capitalize on new technical advances, as KIT currently holds several Federal contracts with SAMHSA, CSAP and the Office of National Drug Control Policy.
- BDAP, SCAs and Providers need less staff time devoted to technical matters.
- SCAs and providers benefit from reduced down-time associated with system outages.
- SCAs and providers benefit from reduced travel costs regarding training.
- SCAs and providers find their data to be more accessible.

- BDAP Prevention staff have more time to focus on prevention programming related to duties, rather than technical support and testing issues that were plaguing PBPS.

PROGRESS REPORT FY 2010-11

BDAP required SCAs and prevention providers to administer the Adult and Youth (ages 12-18) NOMs once to all single services that count attendees and recurring service participants from October 1 through November 30, 2010. BDAP continues to encourage SCAs to analyze the NOMs surveys. BDAP also encourages SCAs to administer pre/post tests for recurring prevention activities and evidence-based programs as a method of collecting outcomes for these programs/activities. The results of these pre/post tests are entered into PBPS. The results of this data will not be available until the fourth quarter of SFY 10/11.

PBPS is currently being used by BDAP and SCAs to ensure that:

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

PBPS was moved to KIT Solutions at the beginning of SFY 10/11. PBPS is currently moving from the roll-out phase with KIT Solutions to a maintenance phase. The move to KIT Solutions resulted in benefits such as:

- Capitalizing on new technical advances;
- Reduced down-time associated with system outages;
- Online training;
- More accessible data through new reports and the continued development of a query builder to create customized reports;
- Less BDAP staff time spent on technical support to SCAs and providers, since this function has been taken over by KIT Support.

BDAP is continually enhancing the PBPS data system by, for example, developing additional reports within the system. The enhancements allow for improved data-driven management. BDAP is working with the established Prevention Data Workgroup to make improvements to the PBPS data system and decide on additional reports to develop or data elements to collect. Reports are being created for pre/post tests and collected survey data, which can be used to evaluate the success of programs and services. Demographics are being collected on service attendees and participants, and reports have been created that summarize this demographic data. This data will be used to gather more information about who is receiving what programs and services. The latter can then be used to guide planning and ensure that high-risk demographic groups are receiving adequate and appropriate prevention services.

SPF SIG is requiring the use of NOMs, and SCAs which are awarded SPF SIG funding are expected to turn in all NOMs-related data, including pre/post tests and six-month follow-up. Data will continue to play an important role in the SPF process. By reviewing data from various

programs, SCAs will be able to conduct both the process and outcome evaluation and make appropriate revisions to their programming, where needed.

The SPF process (assessment, capacity building, planning, implementation, evaluation) is being integrated into the all prevention programming. Data-driven assessment and planning are completed by all SCAs. The collection of measurable outcomes is required from SCAs for program evaluation that guides future capacity building, planning and implementation.

BDAP decided to combine the Prevention and Treatment Needs Assessment process. A Needs Assessment is conducted every two years to serve as a basis for SCA planning efforts. The new combined Needs Assessment process and document are currently being created. Input will be sought from the SCAs and providers on this newly combined document. The Needs Assessment will guide SCAs in the collection and analysis of data regarding: 1) use of alcohol, tobacco and other drugs, 2) prevalence of substance use disorder, 3) risk and protective factors that affect substance use, 4) trends impacting prevention, intervention, treatment and recovery efforts, 5) emerging substance use problems, 6) demand for prevention, intervention, treatment and recovery services, 7) resources available and needed for prevention, intervention, treatment and recovery and 8) barriers to addressing needs that have been identified.

The Prevention Committee, a committee under the Pennsylvania Drug and Alcohol Coalition, has created a data subcommittee. This subcommittee has established three priority issues that will be the focus of the subcommittee: data-driven decision making, review and assessment of the long-term impact of prevention efforts and enabling communities to conduct evaluations to determine effectiveness of their prevention efforts.

STATE PLAN FY 2011-12

SPF-SIG will continue to require the use of NOMS, and SCAs which are awarded SPF SIG funding will be expected to turn in all NOMs-related data, including pre/post tests and six-month follow-up. As the SPF SIG grant comes to a close, this data will be important for illustrating the successes and failures of the grantees efforts.

The SPF process of identifying priority communities where the magnitude of the problem is greatest and the capacity to address the need is present will be further integrated into all prevention programming in the state. SCAs will be required to target programs and services to specific communities that have been identified through data. Communities can be defined in many ways. Communities can be a town, township, borough, certain number of blocks within a city or even a specific demographic group.

The combined Prevention and Treatment Needs Assessment will be released to SCAs to be completed. The data collected for this Needs Assessment will guide planning efforts.

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

BDAP will continue to require SCAs to enter prevention service data into PBPS within two weeks

of service delivery and will encourage SCAs to analyze services delivered at the local level to ensure that:

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

PBPS will continue in the maintenance phase with KIT Solutions. BDAP will continue to develop the functionality of PBPS in regard to data collection and analysis. The Prevention Data Workgroup will meet quarterly to discuss improvements and enhancements to PBPS. Work will continue on the development of new reports and the query builder in order to improve data analysis. Current collection of addresses and service locations in PBPS will be utilized for mapping of data and services delivered.

The Data Subcommittee of the Prevention Committee will continue to meet to establish and work toward accomplishing action steps under each of the three identified priority issues which relate to the use and collection of data.

PRIORITY: Enhance the Pennsylvania prevention system capacity.

ANNUAL REPORT FY 2009-10

BDAP participated in the Service to Science (STS) national initiative supported by SAMHSA/CSAP to enhance the evaluation capacity of innovative programs and practices that address critical substance abuse prevention or mental health needs within the commonwealth. STS consists of a combination of training events and customized technical assistance aimed at providing participants with technical assistance that will help programs evaluate their efforts with increasing levels of methodological rigor. Those recommended by BDAP for participation in the Service to Science were Media Straight Up, the Just One Campaign and Getting Back Alive.

The Lead & Seed program was selected for the Service to Science program, and the program was researched and studied intensely for an entire year from June 2009 to June 2010. In 2009 Lead & Seed also received a SAMHSA Capacity Building Award. Due to the success of the program, Lead & Seed has been replicated in urban, rural and suburban communities all over the U.S.

The Division participated in the PA Drug and Alcohol (D&A) Coalition, whose purpose is to identify and build a coordinated system of care in Pennsylvania capable of collaboratively offering quality health care that addresses the needs and priorities of Pennsylvanians regarding substance use and co-occurring prevention, intervention, treatment and recovery. A Prevention Committee was created under the D&A Coalition and met to discuss priority areas of focus for the committee.

The 17 SPF SIG grantees attended a two-day Grantee training and technical assistance meeting in order to increase the capacity. The following topics were addressed at the training: 1) assessing the

consequence and consumption patterns, 2) assessing risk and protective factors, 3) assessing resources and readiness, 4) building and mobilizing capacity, and 5) developing a plan of action plus hands-on exercises.

PROGRESS REPORT FY 2010-11

BDAP is participating in the Service to Science (STS) national initiative supported and spearheaded by SAMHSA/CSAP. The Division is working with SCAs and their providers to identify innovative programs that they are currently implementing and encouraging them to create a structured evaluation of these programs. These programs are currently being implemented as State Approved Effective Strategies, but more formalized evaluation will allow for consideration to become a State Approved Effective Program and potential recommendation for participation in STS. Previously selected for STS, Lead & Seed is being expanded throughout the state.

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

The Division has partnered with the training section at BDAP to incorporate information regarding training into the new combined Prevention and Treatment Needs Assessment. Information about trainings SCAs and their providers have had and the trainings that they still need will be collected in the Needs Assessment. This will provide an opportunity to note gaps in training specifically related to significant issues/problems/trends that SCAs have identified.

The 17 SPF SIG grantees attended a one-day grantee training and technical assistance meeting in order to increase capacity. Grantees were given the opportunity to share what they have been doing. They also shared challenges they are facing and ways they can address these challenges/barriers. Training was also provided on sustainability. Grantees were provided with information and strategies to plan for sustainability. Prior to this training, a meeting was held with the SPF SIG Advisory Council to gather new ideas and insights to help improve the work being done under SPF SIG.

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

- Enhance the existing State System Special Projects Committee on Alcohol to become a system-wide coalition inclusive of representatives of all 14 State System institutions, key internal and agency constituents.

- Implement identified evidence-based programs at the participating PASSHE universities for the purpose of reducing underage alcohol use and binge drinking among first year students residing in campus residence halls.
    - Implementation of Brief Alcohol Screening and Intervention of College Students (BASICS) on all of the participating campuses.
    - Implementation of a system-wide social norms marketing campaign that is linked to specific student learning outcomes.
- Identify what the Coalition considers additional priorities and activities to be undertaken based on the outcomes of strategic planning process.

The Division is participating in the PA Drug and Alcohol (D&A) Coalition. The Prevention Committee that was created under the D&A Coalition decided on five subcommittees that would work on the priority areas defined by the Prevention Committee. The five subcommittees are Development of the Field, Coordination of Effort, Community Education, Institutional Education and Data. The Prevention Committee met in September 2010 to determine three priority issues for each subcommittee. Initial action steps were created for each of these priority issues. Co-chairs and members for the subcommittees are being solicited to continue work on creating action steps for each subcommittee. Division staff will serve as a co-chair on each subcommittee to help facilitate the work of these subcommittees.

A coalition module is being developed in PBPS. The purpose of the module is to help SCAs facilitate their coalitions. Multiple coalitions can be created in the module, and the module can also be used for planning and advisory councils. Within the module SCAs will be able to organize meetings, create subcommittees, create plans for coalitions, upload agendas and minutes, type minutes directly into the module and list meeting attendance. This module will help to improve the effectiveness of coalitions through better organization and management.

STATE PLAN FY 2011-12

BDAP will continue to partner with various other state, federal and local agencies in all of its efforts to continue to build Prevention Capacity. As SPF SIG comes to a close, BDAP will complete a statewide evaluation of the grant, as well as review evaluations completed by each of the grantees. This evaluation will be used to identify successes, failures and program elements that can be replicated in other SCAs to improve programming and enhance capacity. Focus will also be put on coalitions and partnerships created under SPF SIG as a vital avenue for sustainability. Support will be provided in the form of one-on- one discussions, trainings, meetings/conferences or other means required to better strengthen the SCA's capacity to sustain SPF SIG prevention efforts.

The Prevention Committee under the PA Drug & Alcohol Coalition will continue to meet. Co-chairs and members for each subcommittee will have been established. Subcommittees will begin work on action steps that have been defined for each subcommittee.

BDAP will continue to support the SCAs in the development and evaluation of innovative programs they have developed. 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 the program move toward becoming an evidence-based program.

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

BDAP will continue to enhance cross-agency prevention efforts through SPF SIG and the Pennsylvania Interagency Coordinating Committee on the Prevention of Underage Drinking, as well as by continuing to attend committee meetings such as the Commonwealth Student Assistance Programs Interagency Committee, Pennsylvania State System of Higher Education (PASSHE) Alcohol Grant Consortium, the Multi Agency Safety Team (which is coordinated by the Pennsylvania Department of Transportation [Penn DOT]), Center for Safe Schools Conference Planning Committee, New Options Steering Committee, State Juvenile Firesetters Prevention and Intervention Advisory Group, Suicide Prevention Monitoring Committee, Disproportionate Minority Contact Committee, Statewide Positive Behavior Support State Leadership Team, PA-State Fetal Alcohol Spectrum Disorder Task Force, the Commonwealth Prevention Alliance, Pennsylvania Prevention Directors Association and Pennsylvania National Guard, among others.

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

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

- The Compensation Subcommittee recommended cost of living allocations for the field (that are tied to the inflation index) and plans to work with the Single County Authorities (SCAs) to help them design incentive packages for preferred providers as a way for providers to earn more based on standardized benchmarks. Additionally, Loan Forgiveness legislation will be supported for persons working in the drug and alcohol field.

- The Marketing Subcommittee is defining recruitment strategies for high schools and community colleges, in addition to developing partnerships with recovery organizations, in order to identify how to effectively engage volunteer and paid recovering community individuals into our field. All levels of recruitment efforts will require marketing materials for distribution.

- The Administrative Relief Subcommittee chose to look at ways to reduce the paperwork burden required through regulation and grant agreement requirements. This reduction in paperwork will allow more time to clinically treat addicts and make those that work in the field feel that they are having a positive impact, rather than just doing administrative paperwork.

- The Credentialing/Licensing Subcommittee decided to identify ways to expand opportunities to access our field for non-degreed and/or recovering individuals.

Pennsylvania's certification process, as well as licensing/staffing regulations, must be reviewed to determine how best to proceed.

ANNUAL REPORT FY 2009-10

Due to staff shortages and the lack of attendance by provider representatives, the subcommittees did not meet in 2010. BDAP staff continued to meet to discuss ongoing initiatives and workforce activities outside of the Taskforce and its subcommittees.

With the assistance of PACDAA, a survey was distributed to the field to ascertain the extent of the drug and alcohol workforce problem in Pennsylvania. BDAP received 102 responses by the May 1, 2009 deadline. The following information was gathered from the survey results:

- When asked why a position was vacant for a period of time, 57 responses indicated that the salary was too low and 72 responses that the applicant degree did not meet licensing requirements.

- The average tenure was 3.54 years.

- Of the 195 counselors that voluntarily left during the past year, 47 left for better salary or benefits, and 31 left for promotion opportunity available elsewhere.

The Administrative Relief Subcommittee convened a one-day Focus Group to brainstorm on ways to reduce the administrative burden related to requirements and paperwork generated at the initial client contact. The meeting took place on June 25, 2009, with representatives from PACDAA, service providers, the Institute for Research, Education and training in Addictions (IRETA) and the Divisions of Treatment and Drug and Alcohol Program Licensure. The Focus Group made suggestions related to monitoring/licensing duplication, SCA forms, monitoring frequency and assessment requirements. The assessment requirements have been reduced in the Treatment Manual.

Work was accomplished outside of the Taskforce through meetings with legal counsel, the Division of Drug and Alcohol Program Licensure (DAPL) and the Pennsylvania Certification Board (PCB). The Pennsylvania Drug and Alcohol Coalition also has a Workforce Committee, which includes representation from BDAP, DAPL and PCB. This committee has had more success with participation and moved ahead with a number of initiatives, such as working with DAPL to accept online training and conduct shorter licensing visits. Additionally, the committee has worked with both DAPL and the Certification Board to develop a non-degreed credential.

PROGRESS REPORT FY 2010-11

The Workforce Development Committee of the Pennsylvania Drug and Alcohol Coalition has had success in reducing the regulatory burden on providers by assisting the Division of Drug and Alcohol Program Licensure in reducing the number of days required to complete a licensure survey. This committee has also worked with the Pennsylvania Certification Board to encourage the expanded use of Certified Recovery Specialists to help individuals gain access to needed resources in the community by assisting them in overcoming barriers and helping them bridge gaps

between their needs and available resources. Working with Committee members, the Certification Board has developed a credential for non-degreed workers. The Certified Associate Addiction Counselor has basically the same requirements as a Certified Addiction Counselor but does not require a bachelor's degree.

STATE PLAN FY 2011-12

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

TREATMENT

BACKGROUND

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

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

- Facilitates program development, based on state and federal research data, which targets the need for programming and treatment placement tools that maximize the accessibility and effectiveness of treatment services;

- Evaluates data and research, via a comprehensive approach, as it relates to the development, promotion and implementation of treatment services;

- Assesses training needs for treatment professionals within the counties and the state and responds with targeted technical assistance and regional training initiatives to meet those needs; and,

- Collaborates with state agencies, such as the Governor's Policy Office; the Department of Public Welfare's (DPW) Offices of Mental Health and Substance Abuse Services (OMHSAS), Children, Youth and Families (OCYF) and Medical Assistance Programs (OMAP); the Department of Corrections (DOC); the Pennsylvania Commission on Crime and Delinquency (PCCD); the Pennsylvania Board of Probation and Parole (PBPP); the Departments of Education and Revenue; and the Pennsylvania Gaming Control Board (PGCB), as well as local agencies, to develop programming and coordinate systems which serve the multiple needs of substance abusers and/or problem gamblers throughout the Commonwealth of Pennsylvania.

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

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

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

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

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

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

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

ANNUAL REPORT FY 2009-10, PROGRESS REPORT FY 2010-11 AND STATE PLAN FY 2011-12

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

ANNUAL REPORT FY 2009-10

The Division and its contracted provider, Gaudenzia ACCESS, worked together to implement an Emergency Preparedness Training that would guide the SCAs and treatment providers in the development of an All Hazards Preparedness Plan. However, due to a limited SCA and treatment provider response this training was cancelled. Plans were then begun to develop a Disaster and Emergency Preparedness Plan Toolkit that would be disseminated to SCAs and providers throughout the commonwealth.

PROGRESS REPORT FY 2010-11

Through Gaudenzia ACCESS, the Division provided Disaster and Emergency Preparedness Plan Toolkits to the SCAs and providers during winter 2011 to help in the development and implementation of Emergency Preparedness Plans. These toolkits provided information on preparing for various emergency situations, as well as the continuity of operations should a disaster occur.

STATE PLAN FY 2011-12

The Division will continue working with preparedness groups including the Department of Public Welfare and OMHSAS to be able to provide information to SCAs and providers about preparedness and disaster-related issues; however, this goal will no longer be included in future State Plans.

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

ANNUAL REPORT FY 2009-10

The statewide FASD Action Plan, which was officially unveiled on September 8, 2008, has been implemented with various action steps being achieved toward meeting the goals of increasing awareness and education about FASD and promoting systems change for those impacted by one of these disorders. BDAP continued to work with the Executive Committee of the State FASD Task Force to provide additional leadership and oversight for mobilization of the Action Plan.

Bureau staff conducted various initiatives across the commonwealth in observance of FASD Awareness Week, September 8-14, 2009, beginning with a Kickoff Event on Tuesday, September 8 at Gaudenzia's Vantage House for Women, Lancaster, PA. The Kickoff was attended by approximately 100 individuals from various organizations and the general public.

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

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

In addition to the above-noted activities, BDAP made a concerted effort to increase FASD training, not only during Awareness Week, but at various locations throughout the year.

PROGRESS REPORT FY 2010-11

The Bureau conducted various initiatives during FASD Awareness Week, held September 7-12, 2010, and supported many others through the work of its community partners, reaching upwards of 290,000 individuals. An FASD Kickoff Event was held at The Southern Bucks Recovery Community Center in Bristol, PA, in collaboration with The Council of Southeast Pennsylvania, Inc., Libertae, Inc., and the Bucks County Drug and Alcohol Commission, Inc. There was a direct correlation with Drug and Alcohol Recovery Month activities, as the theme of the kickoff was "Generational Recovery – Now More than Ever." Keynote speakers were Dr. Mary DeJoseph and her son, Stephen DeJoseph, who told of their personal experiences of substance use and the impact of FASD on their family.

Week-long initiatives were held across the commonwealth through community partners. The Baby Bottle Distribution Project was conducted for the fourth consecutive year, with 45 OB-GYN/ Pregnancy Centers distributing 4,140 baby bottles with prevention message inserts to expectant mothers in 33 counties. Forty-two SCAs conducted prevention activities during Awareness Week. BDAP supported their initiatives by making resources available to each SCA by request. In addition to its OB-GYN and SCA partners, BDAP also provided resources to 24 WIC Agencies in 113 clinics throughout the 67 counties of the commonwealth, seven Municipal Health Offices, the Office of Mental Health and Substance Abuse (OMHSAS) Advisory Council and 19 other organizations and individuals.

In April 2010, the Department of Health, BDAP entered into a Memorandum of Understanding with The Arc of Riverside County, California, for licensing use of the NineZero Project, allowing the Department to puts its logo and contact information on NineZero posters and materials, thus providing a more unified awareness campaign across the commonwealth. These materials were distributed for the first time during Awareness Week. The total number of resources disseminated through the bureau to all of the Awareness Week partners was over 41,000 pieces.

BDAP continued to provide FASD training with nine training events at various locations throughout the year.

STATE PLAN FY 2011-12

BDAP will continue to move forward with the implementation of the FASD State Plan. The Executive Committee is expected to play an integral part in the continued execution of the plan, as will the Task Force. Members have agreed to actively participate in workgroups, which will be essential to assure adequate manpower and expertise for the plan's success.

FASD Awareness Day activities will continue to be expanded and will run the week of September 6-11, 2011, at locations throughout the commonwealth. The Awareness Week subcommittee will continue to assist in the formation and implementation of activities and will make widespread involvement across the commonwealth possible. It is expected that the baby bottle distribution project will be expanded and that awareness campaigns will continue to be targeted to communities that have colleges and universities. It is also anticipated that cooperative efforts will resume between BDAP and the Pennsylvania State Liquor Control Board. Training efforts will continue through the BDAP training system.

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

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The General Assembly of Pennsylvania passed House Resolution 585 in 2006 directing the Department of Health to establish a parent panel to study and address family and community access to alcohol and drug abuse information, intervention and treatment services. Initially convened in 2008, the Parent Panel Advisory Council (PPAC) continued to meet throughout State Fiscal Year 2009-2010, with the culminating efforts of PPAC occurring on November 16, 2009, when they presented their recommendations to the Health and Human Services Committee.

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

report was also sent to all members of the General Assembly. An electronic copy of the PPAC document is located on the BDAP Publications page under "Treatment Publications:" http://www.portal.state.pa.us/portal/server.pt?open=514&objID=557524&mode=2.

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

PROGRESS REPORT FY 2010-11

House Resolution 585 tasked the PPAC to study and address family and community access to alcohol and drug abuse information, intervention and treatment services and to make recommendations to the Health and Human Services Committee and the Bureau. PPAC participated in National Recovery Month 2010 by presenting at the Luzerne County Community College on September 16, 2010, and at the Pittsburgh Pirates baseball game on September 26, 2010. While in Pittsburgh, they were recognized during the pre-game events and assisted in singing the National Anthem. Recruitment for additional panel members will be ongoing. Although their formal recommendations were presented on November 16, 2009, the group opted to remain intact in an effort to put forth their recommendations on an ongoing basis and to encourage their implementation. As a result, PPAC presented at the Pennsylvania Community Providers' Association (PCPA) Conference held at Seven Springs, PA on October 6, 2010 and at the Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA) meeting in State College, PA, on October 20, 2010, as well as various other venues.

STATE PLAN FY 2011-12

The members of PPAC plan to recruit additional members on an ongoing basis and will continue to meet periodically throughout the year. They also intend to make their availability known to speak at additional conferences and meetings and have already been invited to speak at the Luzerne County Community College Recovery Month Symposium in September, 2011.

GOAL: Establish Recovery-Oriented Systems of Care (ROSC) within the commonwealth that will support the shift of the substance abuse care system from an acute care model to a recovery management model through coordinated networks of community-based services and supports that are person-centered and strength-based.

ANNUAL REPORT FY 2009-10

The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) has been in support of ROSC and has been encouraging states to adopt the recovery management model of care. BDAP has been moving in this direction since attending CSAT's National Summit on Recovery in 2005. To further support this transition, Bureau staff, along with invited state department colleagues, participated in its first of several Technical Assistance Trainings with CSAT on May 17, 2010. The Bureau also encouraged the local implementation of ROSC by requiring the inclusion of ROSC planning in the Treatment Needs Assessments and Treatment Plans submitted in 2009 by the Single County Authorities.

In conjunction with the Department of Public Welfare's (DPW) Office of Mental Health and Substance Abuse Services (OMHSAS), the Bureau supported two committees to facilitate the implementation of ROSC. The Recovery Based Issues Committee of the Pennsylvania Drug and Alcohol Coalition studied nationally published information about a ROSC and made recommendations regarding the transition to ROSC in Pennsylvania from the perspective of the recovery community. The Persons in Recovery Committee, a subcommittee of the OMHSAS Advisory Council, was established to provide OMHSAS and the Bureau with feedback, dialogue, input and recommendations on systemic issues pertaining to drug and alcohol program development and implementation and recovery-oriented systems of care.

PROGRESS REPORT FY 2010-11

The Bureau is continuing its efforts to support the establishment of ROSC within the commonwealth. Beginning in its 2010 -2015 Grant Agreements with the SCAs, the Bureau has established the requirement that each county provide a plan for the development and incorporation of a ROSC, including the use of recovery-based support services at the local level. In August 2010, bureau staff along with Ms. Charlene Givens and Ms. Cheryl Floyd made up a team representing Pennsylvania at the Addiction Technology Transfer Center (ATTC) ROSC Training of Facilitators. This three-day training was sponsored by SAMHSA in an effort to educate additional individuals to assist the "national experts" in providing technical assistance and training at the state level. This team will be utilized, in addition to the technical assistance being obtained directly through CSAT, to further educate stakeholders at the state and county level about ROSC and to provide transition assistance as necessary.

The Recovery Based Issues Committee and the Persons in Recovery Subcommittee continue to meet and establish ongoing goals for the implementation of ROSC.

STATE PLAN FY 2011-12

The Bureau will continue its statewide implementation of ROSC by supporting SCAs in developing their local networks of care by providing education and technical assistance as needed. A formalized training plan will be developed in order to make this assistance available regionally and to best meet the needs of local stakeholders.

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

ANNUAL REPORT FY 2009-10

The Buprenorphine Access Workgroup met to discuss the status of the previous Workgroup recommendations in the areas of Physician Education/Training, Regulatory Barriers and Reimbursement; Outpatient Treatment Implementation Issues; Diversion and Abuse concerns; Expansion of Access to Treatment Services; and steps to be taken to accomplish identified goals.
The Workgroup re-convened for a meeting that included a presentation by representatives of the Department of Public Welfare (DPW), Office of Medical Assistance Programs (OMAP) on the Buprenorphine Prior Authorization Bulletin update of the Pharmaceutical Services Handbook

section on Oral Buprenorphine Agents; a general discussion of the three proposed Buprenorphine subcommittees (Reimbursement, Chapter 715 Regulations and Physician Education/Training); a discussion and update on Prescription Monitoring; further comments on the patent expiration of Suboxone and Subutex; and recommendations for the Workgroup to consider for future discussion.

In July, 2009 the Bureau published a peer review report of residential treatment facilities using Buprenorphine for detoxification in coordination with the Mercyhurst College Civic Institute. Six sites were selected for written surveys and site visits to gather further information about each program. Results of the peer review process indicated staff appear to be highly dedicated, well-educated and having a high drive for delivering this type of service. Funding for clients was a common concern, but programs indicated that they do what they have to do so clients receive the treatment they need.

PROGRESS REPORT FY 2010-11

The Reimbursement and Chapter 715 Regulations Workgroups met to discuss issues related to their specific area and to answer any related questions that were previously submitted to the Treatment Division. The information gathered at these two meetings will be disseminated to the Physician Education/Training Workgroup to review and consider for possible resolution via education/training events. Their recommendations, along with the information from the other two workgroups, will be discussed by the entire Buprenorphine Workgroup when it meets in 2011.

Six hundred and eighty-four physicians have been approved for administration of Buprenorphine and 85 narcotic treatment programs have been approved to use Buprenorphine as of December 31, 2010.

STATE PLAN FY 2011-12

The Division plans to continue holding meetings of the Buprenorphine Access Workgroup, which will collaborate with the Department's Division of Drug and Alcohol Program Licensure to: 1) further explore the feasibility of expanding the scope of the exception to 28 Pa. Code Chapter 715 §715.1 for residential levels of care; 2) monitor progress on recommendations made regarding prescription monitoring as it relates to diversion; and 3) monitor progress on any recommendations made by the specific workgroups in regards to physician education/training, reimbursement and expansion of access to treatment services.

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

ANNUAL REPORT FY 2009-10

In Fiscal Year (FY) 2009-2010, a total of $564,000 was allocated to four Single County Authorities (SCAs) through the drug and alcohol appropriation for the Hepatitis C Project. This includes $212,935 to Philadelphia, $122,280 to Allegheny, $106,165 to Clearfield/Jefferson and $122,620 to Northampton. Coordinated through Mercy Behavioral Health, Allegheny's Hepatitis C Project consists of 27 sites, six of which are methadone providers. Clearfield/Jefferson's project

consists of 10 sites, including one methadone provider. Northampton's project is operated through New Directions Treatment Services and consists of 10 sites, one of which is a methadone provider site. Philadelphia's project consists of 13 project sites, six of which are methadone providers.

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

In FY 2009-10, the Hepatitis C Project encompassed three service areas: Outreach, Testing and Case Management. The following State Fiscal Year 2009-2010 data are inclusive of all four projects with the exception of the Outreach component, which only includes performance measure data from Allegheny, Clearfield/Jefferson and Northampton SCAs. Outreach data indicates that 4,445 persons were contacted in the three SCAs that collected the data. In addition, 1,346 persons were referred for testing. Pre-test counseling was provided to 5,607 clients in the four SCAs this year. One hundred percent of the persons tested this year received pre-test counseling. Overall, 2,384 individuals or 42.5 percent tested positive. Also, 4,411 persons or 79 percent received post-test counseling. Case management data indicate that 2,360 individuals were referred for medical evaluation this year. 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. In addition, 162 persons received Hepatitis A and B vaccines, representing a decrease of 103 clients as compared to last year.

All four SCAs provided testing and case management services this year. In addition, the Allegheny, Clearfield/Jefferson and Northampton SCAs conducted many outreach activities to promote their projects within their service areas. The Allegheny SCA conducted staff in-services at local methadone maintenance clinics, administered free vaccinations, collaborated with Genentech/Roche Pharmaceuticals to promote Hepatitis C virus awareness and offered a community support group for persons living with HCV. Clearfield/Jefferson distributed Hepatitis C educational materials at local county jails, shelters, churches, universities and community-based organizations. They conducted in-service training for local medical facility staff and utilized local newspaper and radio stations to promote their Hepatitis C screenings and educate the public about risk factors. Additionally, they formed a "Pregnant Opiate Addicted Women Multi-Disciplinary Team" to address the issue of narcotic use among pregnant women and newborn withdrawal. This newly created team has begun to develop plans to educate doctors and allied health care workers about this issue in order to increase referrals, promote early intervention and reduce Neonatal Abstinence Syndrome. Northampton provided community presentations and assisted clients with service linkages, transportation, interpretation services and advocacy.

PROGRESS REPORT FY 2010-11

BDAP continues to provide funding to the 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 annual meetings with all the Hepatitis C Project sites, the Bureau of Communicable Diseases, the Bureau of Epidemiology, Genentech/Roche Pharmaceuticals 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.

STATE PLAN FY 2011-12

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

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

ANNUAL REPORT FY 2009-10

The CSC was reconvened in February 2009 and consists of representatives from 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 has a corresponding work statement and timeline for task completion.

The Co-Occurring Disorders Subcommittee completed a revision of the Co-Occurring Disorders special needs and considerations paper that is part of the current PCPC. To ensure that persons with co-occurring disorders gain access to appropriate and quality treatment that is specific to the individual's needs, the Co-Occurring Disorders Subcommittee membership recommended the inclusion of co-occurring enhanced placement criteria as a subset to the existing PCPC. It was the Subcommittee's assertion that the assessor can place a client in the appropriate level of care utilizing the PCPC, but if a co-occurring issue or issues were assessed and an enhanced co-occurring placement potentially warranted, additional criteria is needed to accomplish the placement goal.

The Criminal Justice Subcommittee completed a revision of the *"Research to Practice Brief: Understanding, Assessing, and Treating Substance Use Disorders among the Criminal Justice Population."* The Subcommittee's conclusion was that effective assessment, placement and treatment of criminal justice clients pose a number of important challenges for practitioners and providers. The uniquely complex characteristics of this population, in addition to the need for

appropriate levels of substance use disorder treatment and criminal justice supervision across all phases of the continuum of care, require close collaboration between both the treatment system and the criminal justice system. When appropriately integrated with criminal justice goals, substance use disorder treatment for this population can be an effective method for improving individual client outcome, reducing recidivism and enhancing overall public safety.

The Cultural Competence and Sexual Orientation Subcommittee completed revisions to the Cultural Competency and Sexual Orientation special needs and considerations papers that are part of the current PCPC. Cultural consideration is a crucial component in gaining understanding and trust within the ethnic population. Healing practices, languages, values and beliefs will vary with each ethnic grouping. It is important to comprehend these diversities and be able to provide effective treatment in order to facilitate the level of care an individual requires. Regarding sexual orientation, in conducting the assessment it is important to create an atmosphere wherein it feels safe for the person being assessed to respond honestly, without fear of judgment or recrimination. The Subcommittee developed a number of questions related to sexual orientation and cultural background that should be considered during the assessment and placement process.

The Medication Assisted Treatment (MAT) Subcommittee (formerly Pharmacotherapy) completed revisions to the Pharmacotherapy special needs and considerations paper that is part of the current PCPC. Guidelines currently outlined in the PCPC indicative of appropriateness for MAT may not be recognized or may be bypassed in favor of other types of services. The development of medical necessity criteria for MAT is recommended to prevent overlooking MAT when determining an appropriate treatment modality for an individual.

The Women and Women with Children Subcommittee completed revisions to the Women's Issues and Women with Children special needs and considerations papers that are part of the current PCPC. It is recommended that the PCPC be modified to reflect non-sexist, non-judgmental, inclusive language, family counseling and reunification issues. Also recommended is implementation of assessment measures that take into consideration treatment barriers and readiness. Areas in need of consideration were identified in each dimension of the PCPC that are specific to this population.

The Intervention Subcommittee (formerly SBIRT) developed a position paper and proposed that criteria for a new level of care, called Intensive Intervention, be created for inclusion in the revised PCPC. The position paper includes the definition and application of intervention services within Pennsylvania; how placement for intervention services can be incorporated into the PCPC; the most current evidence-based practices for applying intervention activities; barriers (i.e., policy, financial, etc.) to the application of recommended evidence-based practices; and training considerations that may be needed to effectively implement these recommended evidence-based practices.

The PCPC-ASAM Crosswalk Subcommittee completed a crosswalk and written analysis of the PCPC and ASAM criteria. The nearly 20 recommendations included: continued use of the PCPC in Pennsylvania; review of scoring and dimensional criteria, specifically hospital-level care, as many conditions currently listed that can be safely managed in a non-hospital setting; consideration of the development of guidelines to assist in decision making regarding detoxification or maintenance when using narcotic treatment medications; clarification of diagnosis requirements; and consideration of adding a subset of criteria to determine the need for co-

occurring treatment.

The PCPC Utilization Subcommittee conducted a survey of PCPC users across the commonwealth and began the process of analyzing the results of the survey to determine the strengths, weaknesses and major problem areas of the PCPC.

PROGRESS REPORT FY 2010-11

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

- The Co-Occurring Disorders Subcommittee is moving forward with its recommendation of including additional criteria within the PCPC to determine the need for placement in a program that is able to address an individual's co-occurring issues. To begin this process, the Subcommittee is summarizing its paper through the completion of a template provided by BDAP that will outline placement considerations and coordination of care considerations.
- The Intervention Subcommittee is working to develop criteria for the newly defined Intensive Intervention Level of Care.
- The PCPC-ASAM Crosswalk Subcommittee has completed its assigned task. A new task has been created for this Subcommittee, to write an introduction to the revised PCPC that includes guiding principles.
- The PCPC Utilization Subcommittee continues to review and analyze the results of the PCPC survey, so that a summary can be presented to the full Clinical Standards Committee.
- The Criminal Justice, Cultural Competence and Sexual Orientation, Medication Assisted Treatment, and Women and Women with Children Subcommittees are working to summarize their respective papers through the completion of templates provided by BDAP that will outline placement considerations and coordination of care considerations.

STATE PLAN FY 2011-12

The CSC and the subcommittees will meet throughout the fiscal year to continue their efforts related to the review and revision of the PCPC. It is the intent of the CSC to have a draft of the revised PCPC completed by June, 2012.

GOAL: Increase access to substance abuse treatment services 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.

ANNUAL REPORT FY 2009-10

On March 10, 2010, the Bureau applied for Access to Recovery (ATR) discretionary program funding from the Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Treatment (CSAT). The Bureau partnered with the Philadelphia Single County Authority (SCA), which is the Department of Behavioral Health and Mental Retardation

Services/Office of Addition Services (DBH/MRS/OAS), to pilot the four-year project, which would provide individuals with vouchers to purchase treatment services for substance use conditions and recovery support services (RSS) at the provider of their choice. The project would enable DNB/MRS/OAS to expand its current provider network, including additional faith-based and community-based treatment providers aimed at reaching individuals that might not otherwise receive treatment or support services. Uninsured and underinsured individuals are the primary target population, with particular focus on those involved with the criminal justice system, pregnant and parenting women, homeless persons and veterans.

PROGRESS REPORT FY 2010-11

On September 30, 2010, the Bureau was awarded $11,889,262 in grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Treatment (CSAT) for the period of 9/30/2010 to 9/29/2014 to implement an Access to Recovery III (ATR) project. Funding by year for the four-year project includes $2,617,201 for the first year (9/30/2010 to 9/29/2011), $3,249,418 for the second year (9/30/2011 to 9/29/2012), $3,221,322 for the third year (9/30/2012 to 9/29/2013), and $2,801,321 for the fourth year (9/30/2013 to 9/29/2014). Project partners include the Department of Behavioral Health and Mental Retardation Services/Office of Addiction Services (DBH/MRS/OAS), which is the Philadelphia Single County Authority (SCA), and KIT Solutions, LLC as the voucher management system contractor.

The four-year ATR project provides individuals with vouchers to purchase treatment services for substance use conditions and recovery support services (RSS) at the provider of their choice. The project enables DBH/MRS/OAS to expand its current provider network, including additional faith-based and community-based treatment providers aimed at reaching individuals that might not otherwise receive treatment or support services. Uninsured and underinsured individuals are the primary target population, with particular focus on those involved with the criminal justice system, pregnant and parenting women, homeless persons and veterans. The notice of award was received September 30, 2010, and the project is to be fully implemented by January 31, 2011. Overall, 10,705 clients are to be served during the four years of the project. This project expands consumer choice, increases service capacity and improves outcomes within the Philadelphia service area. The Bureau is continuing to work closely with project partners to implement ATR.

STATE PLAN FY 2011-12

The Bureau will continue to work with project partners to implement the Access to Recovery (ATR) project within the Philadelphia service area. Between 1,314 and 3,642 uninsured or underinsured individuals with substance abuse problems will be provided with a choice of clinical and recovery support services annually through this voucher program.

PROGRAM MONITORING

BACKGROUND

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

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

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

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

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

ANNUAL REPORT FY 2009-10, PROGRESS REPORT FY 2010-11 AND STATE PLAN FY 2011-12

GOAL: On-site Quality Assurance Assessment Review Monitoring of Single County Authorities and Gambling Provider Reviews.

ANNUAL REPORT FY 2009-10

The Division began the fiscal year with the intention to provide on-site QAAs to the remaining SCAs that were not able to be monitored during FY 2008-09. With the budget impasse lasting several months, the Division was only able to monitor federal block grant requirements, which could be completed without on-site visits to the SCAs. The Division continued to finalize language for the new five-year Grant Agreement with SCAs to cover the period July 1, 2010, through June 30, 2015. Staff also continued to work internally with the Fiscal section to develop the Bureau's Request for Application (RFA) with a submission date to the Department's Division of Contracts for June 30, 2010.

Although no gambling treatment providers were monitored during the fiscal year, the Division continued its planning process related to the development of the Preferred Provider Agreement Problem Gambling Review monitoring tool visits. Staff time was also spent developing the initial protocols for implementing the overall monitoring process to include preparation, on-site, report and follow-up expectations.

Division staff provided one technical assistance (TA) visit outside of the QAA process to assist SCAs in enhancing the management of their service delivery system. Based on that TA experience, Bureau staff refined their review of fiscal, program, data and personnel information, as well as how these component areas interrelate. As a result, meetings were held with other Divisions and Sections that focused on fiscal and administrative efficiencies and identified ways to work with the SCAs, not only to address questions generated by the Bureau's internal review, but to help them to evaluate how their own fiscal, program, data and personnel information interrelate at the local level.

PROGRESS REPORT FY 2010-11

Staff continues to work internally with the Fiscal section to make revisions to the Bureau's Request for Application (RFA) as it goes through the Department's contracting process. The RFA is needed to identify a private, non-profit entity to assume the duties of the SCA for both Clarion and Blair Counties. It is anticipated that the RFA will be approved and posted on the Department's General Services website by the end of February 2011. All bids will be reviewed as per Department protocols and the selected bidders identified to begin implementation on or after July 1, 2011.

Since the new five-year Grant Agreement began July 1, 2010, the Division will monitor SCAs on the new requirements beginning January 1, 2011, and continue through the next fiscal year to June 30, 2012. The rationale for going beyond an annual Quality Assurance Assessment monitoring visit timeline is based on the Bureau's decision to focus the review on a management perspective and not only on the basis of compliance to Grant Agreement requirements. This focus on how the

SCAs manage the delivery of D&A services in their geographic area involves many more SCA staff when on-site; hence, more time on-site, in preparation, and with report development once the QAA process is complete. The Division was able to maintain an annual review of federal block grant requirements in the second quarter of this fiscal year, which were completed without on-site visits to the SCAs.

The Division finalized the Preferred Provider Agreement (PPA) Problem Gambling Review monitoring tool mid-year and will monitor all current Problem Gambling Providers by March 31, 2011. Since these monitoring visits are the first on-site visits to occur, the Division is also using the on-site review to gather feedback relative to the Provider's perspective about requirements and processes associated with the provision of problem gambling services. The Provider's feedback section of the tool (accessibility; provider qualifications; screening; assessment through discharge; reporting and authorization; confidentiality; and grievance & appeal) will be included in a summary report, without identifying any specific Provider's name, and presented to the Bureau Director, the Division of Treatment Director and the Gambling Coordinator for their review. The summary report should be completed and disseminated to all Providers by June 30, 2011.

STATE PLAN FY 2011-12

The Division will continue monitoring SCAs and approved problem gambling providers. Additional monitoring responsibilities will be added as a result of Act 1 as they are identified by the Divisions of Treatment and Prevention.

TRAINING

BACKGROUND

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

Mini-Regional Trainings

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

On-Site Trainings

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

Specialized Trainings

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

Regional Training Institutes

The Regional Training Institute is a five-day event designed to offer higher level courses to the substance abuse field. This event is held once each year. As with all our trainings, courses offered in the Regional Training Institutes offer Certified Addiction Counselor and NASW credits so that employees can maintain their PCB and/or NASW certifications. There is no charge for participation in the Regional Training Institutes.

Public Health Information Clearinghouse

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

ANNUAL REPORT FY 2009-10, PROGRESS REPORT FY 2010-11 AND STATE PLAN FY 2011-12

GOAL: Better Utilization of Training Resources.

ANNUAL REPORT FY 2009-10

Through restructuring of the training system, BDAP was able to increase attendance and reduce the no-show rate at Mini-Regional Trainings and on-site trainings. Regional Training Institutes were not presented during this reporting period, due to issues of contracting for sites. A TOT was held in February 2010 for Clinical Supervision trainers. The following table lists the course types and attendance for the past two fiscal years:

Course Type	Number of Courses		Participants	
	08-09	09-10	08-09	09-10
On-site	267		5,845	7,797
Mini-Regional Trainings	132		2,568	2,738
Specialized	39		1,197	604
PACNET	15		186	0
Training of Trainers	3		34	10
Regional Training Institute	0		0	0
Total	**456**	**523**	**9,830**	**11,149**

PROGRESS REPORT FY 2010-11

The Training Advisory Workgroup has met several times and has identified some problem areas and made recommendations to address them. One major recommendation was to implement online training. The Department of Health is currently working to contract for an online training package, which will be used to present some of our didactic courses. It is anticipated that the system will be available by July 2011.

BDAP is in a constant process of reviewing training needs and determining the need for scheduling various Trainings of Trainers (TOT) to expand the trainer base. TOTs are currently being scheduled for a variety of courses, including, but not limited to: FASD, 12 Step Program and Advanced Pharmacology.

STATE PLAN FY 2011-12

BDAP is continually exploring a variety of ideas to improve utilization of training resources. Issues surrounding a distance learning system should be addressed and an online system should be fully implemented by July 2011.

DATA

BACKGROUND

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

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

- ***Identify*** a sub-group of AOD clients with positive outcomes in their appropriate utilization of substance abuse services and review consistencies in service;
- ***Estimate*** substance abuse care-related cost-savings that might result from applying appropriate AOD services to this target group;
- ***Decide*** to expand treatment capacity and utilization of appropriate treatment services among this target group;
- ***Evaluate*** the impact of that programmatic decision on applying this appropriate service utilization and evaluate new client outcomes; and
- ***Share*** results with stakeholders as best practices.

The Bureau maintains drug and alcohol data as a routine part of our operations. Treatment data is collected through the Client Information System (CIS), and prevention data is collected through Performance Based Prevention System (PBPS). Along with the Substance Abuse Mental Health Services Administration (SAMHSA), our Federal funder, we continue to report national outcome measures (NOMs) for prevention and treatment related to substance abuse disorders. NOMs measures include abstinence from drug and alcohol use, increased school attendance and employment and cost effectiveness. Much of the data currently collected has provided agencies with basic information on the number of services, number of people served and the types of services provided.

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

Research, Education and Training in Addictions (IRETA), has defined state performance-based measures. These measures, as well as new treatment NOMs, will soon become a reality through the early 2012 launch of our new treatment data system, dubbed the Pennsylvania STAR System (Strengthening Treatment and Recovery System). The Data Section also provides Government Performance and Results Act (GPRA) oversight to the Access to Recovery treatment project, which will be launching in January 2011. Other important areas being developed are new Prevention NOMs and an expansion of our prevention accountability through data reporting, fulfilling the SAPT Federal Block Grant data reporting, updating information to the Federal Drug and Alcohol Services Information System (DASIS) Treatment Episode Data Set reporting and maintaining BDAP's website and list serve communications.

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

ANNUAL REPORT FY 2009-10, PROGRESS REPORT FY 2010-11 AND STATE PLAN FY 2011-12

GOAL: To improve communication with the substance abuse and gambling fields, as well as the general public.

ANNUAL REPORT FY 2009-10

For FY 2009-2010, the BDAP List Serve reached 2,244 registered members. This accounted for 136,731 emails sent, with 97 percent delivered successfully with a 26 percent open rate and a 22 percent read rate.

BDAP continued to use the BDAP Communicator as its main communication with SCAs and key stakeholders. For 2009-2010, the BDAP Communicator introduced 103 posts and delivered 4198 messages to SCA Administrators. The Bureau also expanded the use of the BDAP Communicator so that providers could directly access current BDAP Manuals.

PROGRESS FY 2010-11

In January 2011, as part of our ongoing effort to increase membership to the BDAP List Serve, we began to segment our list into topically specific sends. During that same month, there were 2,432 registered email addresses in the List Serve. In 2010-2011, the Bureau surpassed our targeted 5 percent annual email subscription increase by 3 percent for a total of 8 percent in subscription growth. At approximately halfway through the fiscal year, 66,664 emails have been delivered, with a 98 percent delivery rate. Of that number, 22 percent were opened and 18 percent of those e-mails were read. By segmenting the list, the Bureau has increased the email open rate to 37 percent and the email read rate to 34 percent, with an average click-through rate of 10 percent.

STATE PLAN FY 2011-12

BDAP will continue to use the List Serve and the BDAP Communicator to provide information to the field and the community. In 2011-2012, BDAP hopes to increase our outreach in subscriptions by 5 percent. One approach that the Bureau will be taking is to rebrand and make a more cohesive communications strategy with our emails. The intent is to make emails more aesthetically pleasing, organize them better and make them easier to read and navigate by introducing website navigation at the top and bottom for users to go directly to key areas of the BDAP website.

GOAL: To bring effective substance abuse prevention to every community through effective drug and alcohol prevention data collection and to maintain a national leader position in prevention outcomes.

ANNUAL REPORT FY 2009-10

BDAP worked to move the Performance-Based Prevention System (PBPS) back to KIT Solutions. KIT originally created the Pennsylvania PBPS, and the system has since been enhanced and improved. The Division of Prevention and the Data Section worked with BIT to ensure data integrity and quality were maintained through this process. BDAP believed this move would benefit the field in the long term, while showing accountability by providing the "right data" in reporting in the short term. The new PBPS is leading the transition to outcome-based planning and accountability to ensure appropriate use of funds for prevention programs.

PROGRESS FY 2010-11

BDAP will continue to advance the PBPS. This will be accomplished as a result of the successful move to KIT Solutions and, most importantly, through the PBPS users group. The PBPS users group is working on identifying other areas of improvement. In addition, the users group is assisting BDAP with evaluating and revising the Prevention Outcome Measures.

Based on the successful move to KIT Solutions, the benefits that BDAP is already realizing is access to new technical advances. KIT currently holds several Federal contracts with SAMHSA, the Center for Substance Abuse Prevention (CSAP), and the Office of National Drug Control Policy (ONDCP). This allows the 17 states with which they also contract "to have an edge up" on NOMS and other reporting requirements.

Less staff time devoted to technical matters means more time to analyze the data. Since KIT manages data base system contracts with the Federal Government and multiple states, they can offer Pennsylvania the latest cutting edge prevention system, up-to-date technology, user friendly navigation and a system with minimum to no downtime. System updates do not require the Department Information Technology (IT) personnel.

The Bureau has experienced reduced down-time associated with PBPS outages due to KIT's increased IT staff coverage, including over 70 Information Technology support staff who work in specialized areas of the system. Therefore, issues that arise in the database system are fixed at time of discovery. KIT offers technical assistance for troubleshooting and provides solutions until 8

p.m. during the work week. Reduced travel costs when it comes to training PBPS users has also been a benefit as KIT provides PBPS, Prevention 101 and MDS training online. This means a saving in travel costs, as well as staff time, for both the SCAs and prevention providers.

Another benefit to note is that the data will be more accessible. KIT offers a number of standard reports, as well as the ability to create unique reports specifically designed to meet the Bureau's needs.

STATE PLAN FY 2011-12

BDAP will continue to advance PBPS by utilizing all resources. Features to add would be Geospatial Information Systems (GIS) and a query tool for the end users to generate reports by selecting custom data elements, as well as online system training. Also, the Data Section will assist the Division of Prevention in designing an advanced training on interpretation of reports and how to use the PBPS data.

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

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

ANNUAL REPORT FY 2009-10

In October 2009, the PA Department of General Services awarded Core Solutions the contract to begin implementation of a new statewide Treatment Data System. BDAP worked with all its interagency partners and stakeholders involved in the customization of a new data system. A Treatment Data System Committee was formed to address the development of the new Treatment Data System. Members include SCAs, providers and related associations. All were in attendance for the November 2009 project kick-off meeting to launch development of the system. During State Fiscal Year 2009/10, the Treatment Data System Committee completed a discovery process and gap analysis relative to the system components and data elements in relation to our business processes and practices.

PROGRESS FY 2010-11

BDAP continues to work collaboratively with the SCAs, providers, related associations and internal commonwealth stakeholders regarding the discovery, development and testing phases of the new system. BDAP anticipates offering a statewide full service Treatment Data System that provides detailed real-time treatment data to the SCA and provider community and will be implementing the new system via a phased rollout. Application development is scheduled for completion in February 2011, and user acceptance testing (UAT) is scheduled to be underway by April 2011. The system rollout of a pilot region and regional trainings will take place post UAT. Data collection will commence for each region when that region has successfully signed onto the system and training is complete. Data in the system will include, but will not be limited to, the

Referral & Screening Process, the Assessment & Treatment Process, the Intervention & Continued Stay Process, as well as Recovery Process, and the Discharge and Reporting Process for all paid clients within the Continuum of Care. BDAP has recently submitted the latest version of the PA TEDs Crosswalk for data submission to SAMHSA's vendor Synectics for Management Decisions, Inc. (SMDI).

STATE PLAN FY 2011-12

Currently, BDAP is targeting full deployment for Phase 1 of the project by February 2012. Phase I of the project is strictly applicable to the commencement of TEDS and NOMs data reporting and establishing a complete substance abuse treatment data system. Phases II and III involve the engagement of the Department of Public Welfare, Office of Mental Health and Substance Abuse Services relative to Mental Health outcomes data and the establishment of a data clearinghouse. As the commonwealth continues to develop a system capable of adequately capturing the National Outcome Measures, as well as other state defined performance measures, the monitoring and review process will be modified to accommodate a more comprehensive and detailed evaluation of programs.

GOAL: To develop and maintain a new Bureau of Drug & Alcohol Programs website.

ANNUAL REPORT FY 2009-10

The new Gambling website launched by BDAP, in December 2009, one month ahead of schedule. The new site was redesigned within the state's new portal and was constructed using WebCentric. The site has a new look and feel, while organizing information better for its various audiences and stakeholders. After moving to WebCentric, a web analytics package was never procured or installed by the commonwealth; consequently, there is no information as to whether any web analytics will be available in the near future.

PROGRESS FY 2010-11

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

In July 2010, The Pennsylvania Department of Health Public Health Information Clearinghouse (PADOHPHIC) was revamped to contain new features, including online shopping cart ordering, a better search engine and, an easier-to-use interface. The PADOHPHIC operates as the information clearinghouse for the Pennsylvania Department of Health. In a statewide effort to promote healthy lifestyles for all Pennsylvanians, PADOHPHIC's mission is to serve as a resource center and provide a wide range of health-related information.

STATE PLAN FY 2011-12

In January 2011, BDAP is planning to integrate training courses and training course descriptions, as well as course registration from the Bureau Training Management System (BTMS) into the

BDAP website. This will allow for a more seamless user experience, in which users will not need to commit to logging into the BTMS to view course offerings and will be able to view the latest course offerings at a click from the BDAP homepage.

GOAL: Utilize technology to improve operations.

ANNUAL REPORT FY 2009-10

A discovery process was initiated to evaluate all BDAP technology currently in use and to assess whether separate applications can be integrated, including the SCA Data System (SDS) and the BDAP Communicator. This integration is in relation to provider monitoring reports. SCA discussions about the integration and incorporation of contract and contact information from the SDS to the new Treatment Data System have taken place and will continue.

PROGRESS FY 2010-11

The Data Section is always looking for a way to make it easier for our SCAs and stakeholders to work with the Bureau. For the new SCA Grant Agreement 2010-2015, we recently deployed a change to the SCA Data System (SDS) that makes it easier for the SCAs to update their contractual information with their business partners. In simple terms, this new update acts as an easier way for the SCAs to do a "Save As Copy" to current or outdated contracts and allows them to edit and update them, thus saving time for the SCA and reducing administrative burden. Meanwhile, the benefit to the Bureau allows a seamless monitoring of their contract process.

The BDAP Training Management System (BTMS) usability was enhanced from its current state with several more reports added and new features to assist in administration validation.

STATE PLAN FY 2011-12

The plan is to continue to enhance and stabilize all recent changes made to BDAP applications in general. The BDAP Data Section is continuously assessing the benefits and impact to integration of all applications. All applications will be streamlined & enhanced to assist operations and keep "consistency and ease of use" in mind for the SCAs, stakeholders and BDAP.

CHAPTER THREE

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

STATE FISCAL YEAR 2009/2010

WOMEN AND CHILDREN'S ANNUAL REPORT

Act 65 of 1993 authorizes the Department of Health (Department) to establish and fund residential drug and alcohol treatment programs for pregnant women and women with dependent children. The Department contract with Single County Authorities (SCAs) authorizes expenditure of the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant allocations for Women with Children and Pregnant Women to include all levels of care that 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/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 2009-2010, service capacity for women/women with children was as follows:

- Programs providing residential treatment services exclusively for pregnant women and/or women with dependent children = 15
    - Total Capacity for Women = 249
    - Total Capacity for Children = 419
- Residential Programs for Women = 6
    - Total Capacity = 126
- Halfway House Programs = 13 (one of which also houses children)
    - Total Capacity for Women = 274
    - 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 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/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 2009-2010, the following residential women with children programs were in operation:

- Familylinks (Allegheny)
- Familylinks – Family Treatment Center (Fayette)
- RHD Family House (Montgomery)
- RHD Family House NOW- (Philadelphia)
- Gaudenzia, Inc. - Fountain Springs (Schuylkill)
- Gaudenzia, Inc. - Kindred House (Chester)
- Gaudenzia, Inc. - New Image (Philadelphia)
- Gaudenzia, Inc. - Vantage (Lancaster)
- Gaudenzia, Inc. - WINNER (Philadelphia)
- Genesis II - Caton Village (Philadelphia)
- Interim House - West (Philadelphia)
- Libertae, Inc. - Family House (Bucks)
- My Sister's Place (Philadelphia)
- Samara House (Chester)
- Sojourner House, Inc. (Allegheny)

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

- Abstinent Living at the Turning Point (Washington)
- Another Way (Fayette)
- Clem-Mar House, Inc. (Luzerne)
- Catholic Charities – Evergreen House (Dauphin)
- Community House, Inc. (Erie)
- Cove Forge Renewal Center (Cambria)
- Gate House for Women (Lancaster)
- Gaudenzia-New Destiny (Schuylkill)
- Highland House (Lawrence)
- Lighthouse for Women (Washington)
- Libertae, Inc. (Bucks)
- PA Organization for Women in Early Recovery (Allegheny)
- Pyramid Healthcare - Tradition House (Blair)

There were six facilities across the commonwealth that provided residential treatment programs exclusively for women:

- Gaudenzia DRC (Philadelphia)
- Eagleville Hospital (Montgomery)
- Familylinks (Allegheny)
- Interim House, Inc. (Philadelphia)
- Womanspace (Montgomery)
- Womanspace (Philadelphia)

BDAP continued to support the provider organization, Women and Their Children Heal (WATCH). WATCH consists of residential and outpatient treatment providers statewide who provide drug and alcohol treatment services to women, pregnant women and women with children, particularly serving women within a gender-specific model of care. Their mission is the enhancement of gender-specific drug and alcohol programs and the protection of mandated services for women, pregnant and parenting women and their children. BDAP staff served as a liaison to WATCH, attended meetings, provided administrative support and facilitated collaboration between this group and other state agencies. BDAP utilized 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. In March 2010, WATCH revised their "Gender-Responsive Treatment for Women with Substance Abuse Disorders" white paper, which included recommendations to BDAP relative to women's treatment needs. In cooperation with BDAP's Treatment Division and Training Section, WATCH has developed a training curriculum which encompasses best practices for the provision of treatment services to women. BDAP will continue to provide technical assistance to WATCH as they finalize the gender-responsive training curriculum entitled "Gender-Responsive: Treatment that Matters for Women with Substance Use Disorders" for inclusion into BDAP's training venue. BDAP will continue to support WATCH and utilize this resource to ascertain feedback relative to women's treatment services, best practices, provider education and other needs facing this population.

BDAP 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 impacting women. 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, WATCH member and BDAP contracted trainer Celeste H. Wansley-Carpenter, MA, LPC, NCP, CCDP-D, facilitated the treatment forum training, "Gender Responsiveness – Any Woman's Journey." The next treatment forum is slated for May 2011 and will include the topic of female-specific recovery support services.

PART 2

PREVENTION / TREATMENT DATA

AND

FINANCIAL INFORMATION

Data Analysis Compiled from the Performance Based Prevention System (PBPS)
State Fiscal Year 2009-2010

The Division of Prevention strives to increase the implementation of substance abuse prevention policies and practices that are based on the latest research within the substance abuse field. To help Pennsylvanians lead healthier and longer lives, BDAP promotes a structured, community-based approach to substance abuse prevention through the Strategic Prevention Framework. The framework aims to promote youth development, reduce risk-taking behaviors, build assets and resilience and prevent problem behaviors across the individual's life span. This report approach provides information that can be used by communities to build an effective and sustainable prevention infrastructure. The following tables and graphs are an analysis of that information.

Prevention Services in Pennsylvania

In Figure 1, Total Prevention Services are shown for all BDAP-funded services reported through the PBPS. This State Fiscal Year 2009-2010's slight nudge down of total services reinforces stabilization and a correction trend in total services across Pennsylvania. Providers of these prevention services are becoming more efficient with delivery of both recurring and single services.

Prevention Services by Single and Recurring Type

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

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

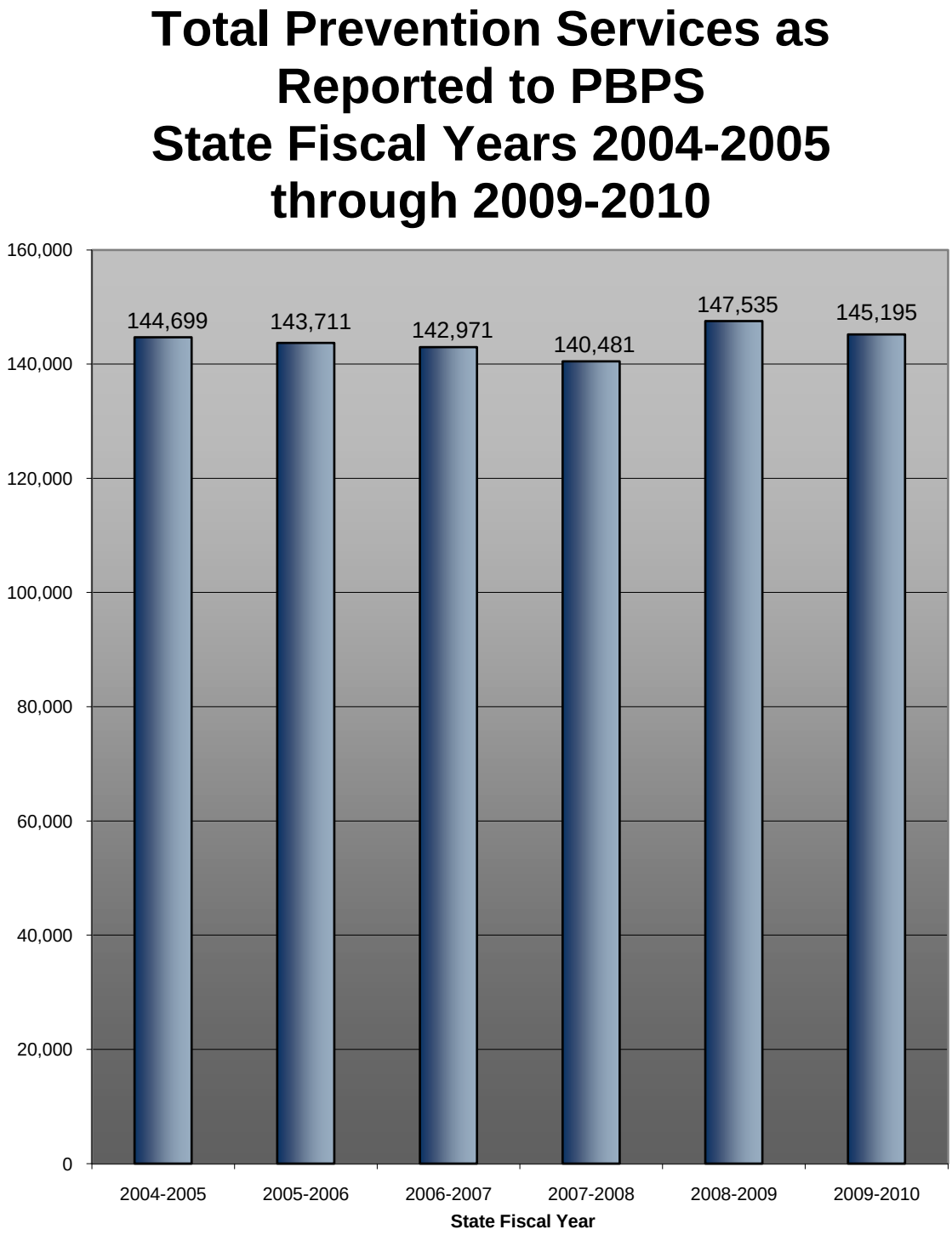


Figure 2

Single and Recurring Prevention Services as Reported to PBPS State Fiscal Years 2004-2005 through 2009-2010

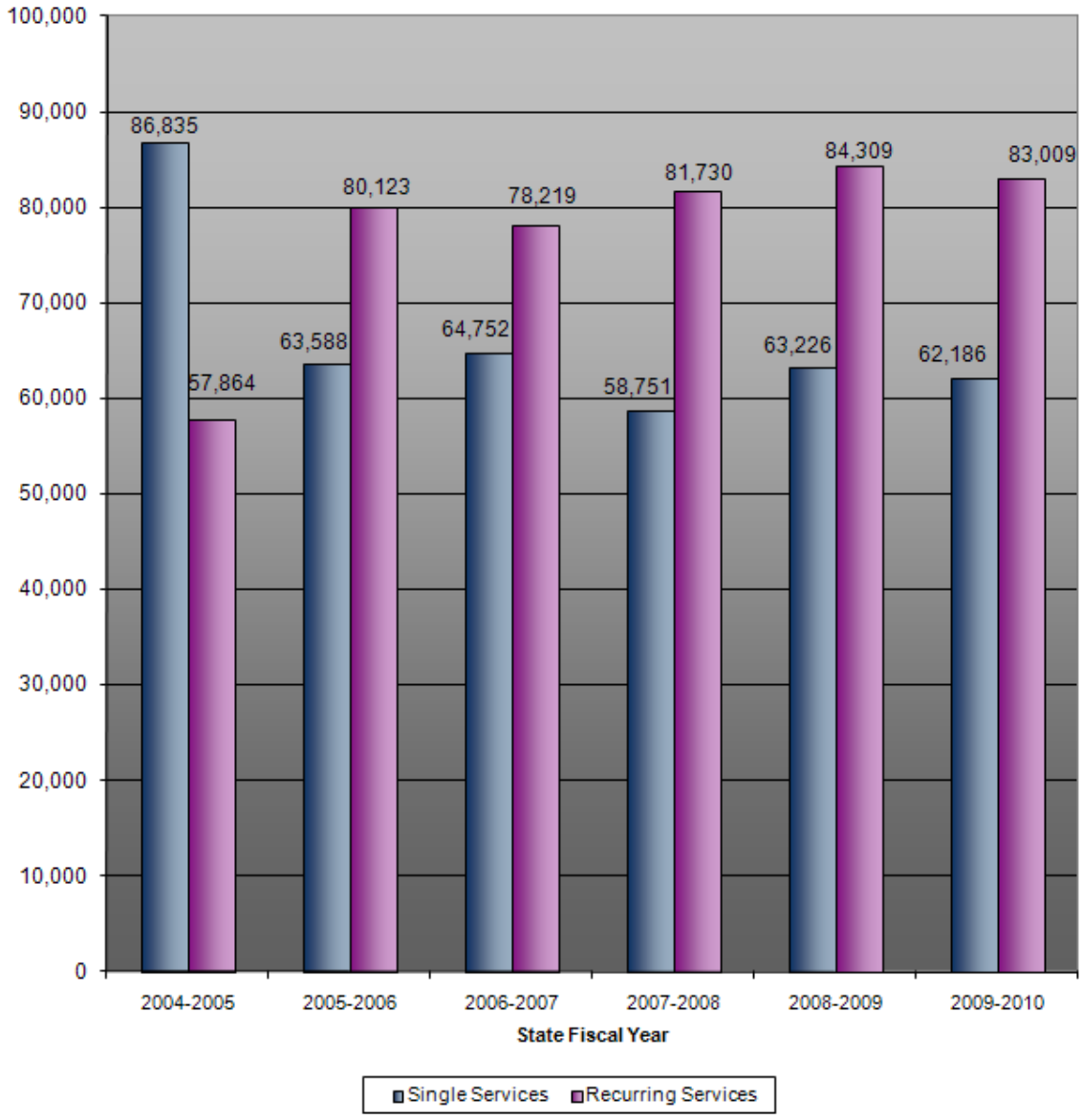
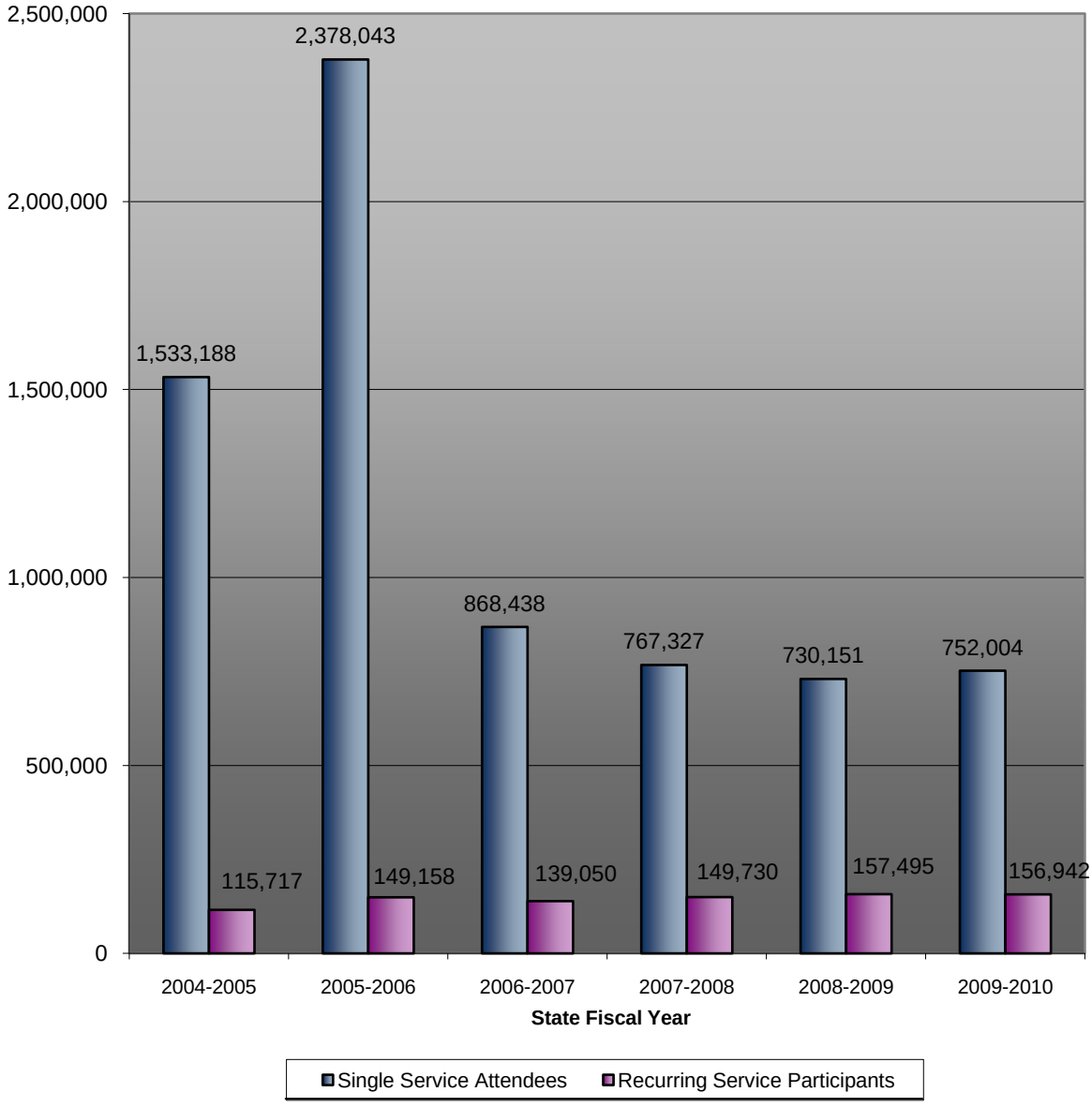


Figure 3

Prevention Service Attendees and Participants State Fiscal Years 2004-2005 through 2009-20010



Evidence-based, Innovative and Generic Programs

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

The programs are defined as follows:

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

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

Innovative Programs meet the following criteria:

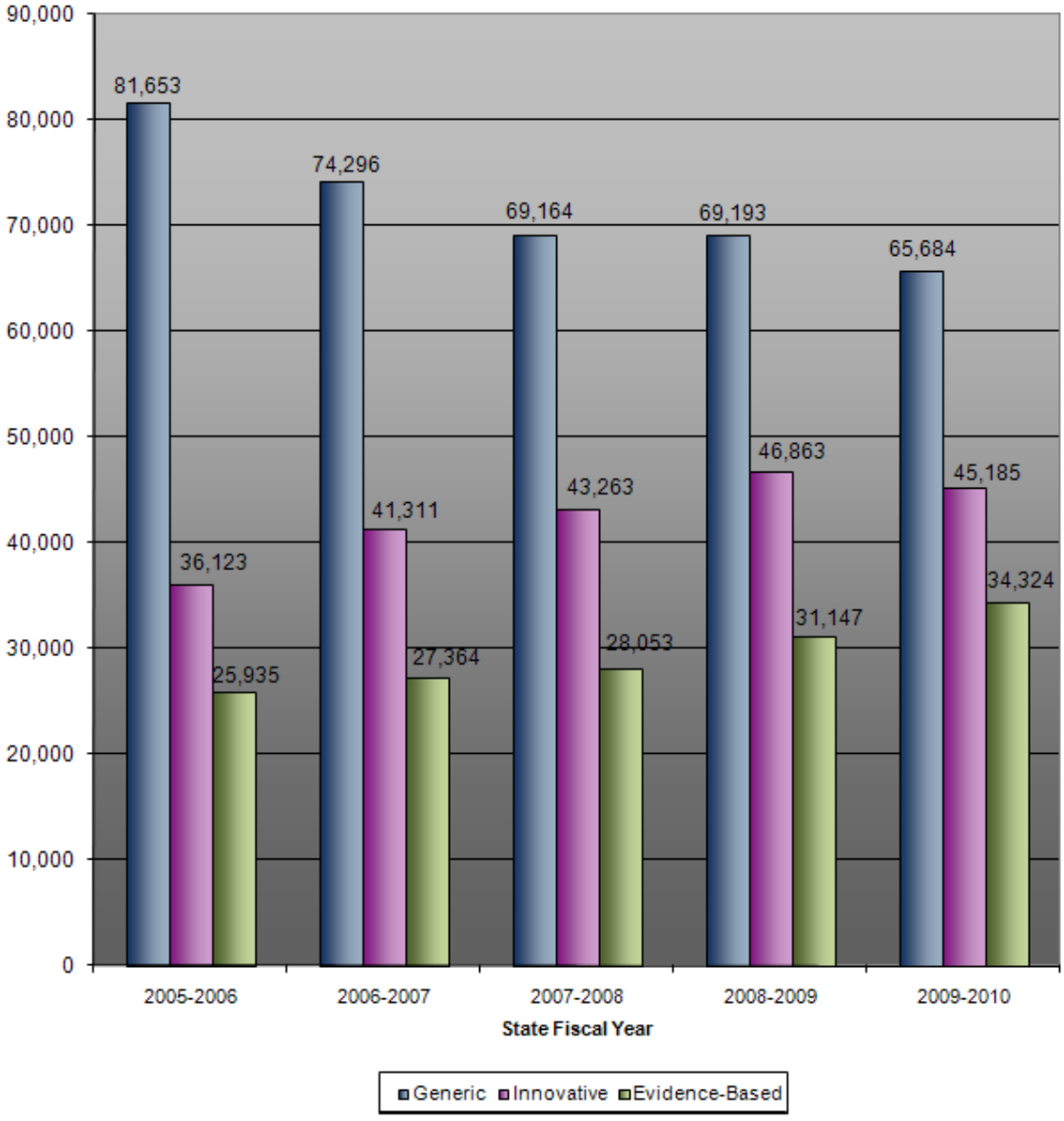
- Program/principle has been identified or recognized publicly and has received awards, honors or mentions.
- Program/principle has appeared in a non-referred professional publication or journal.
- Programs that were purchased from a developer to be Innovative Programs may be considered by BDAP. Examples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

Generic Programs are defined as programs which:

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

Figure 4

Prevention Services by Program Category as Reported to PBPS State Fiscal Years 2005-2006 through 2009-2010



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:

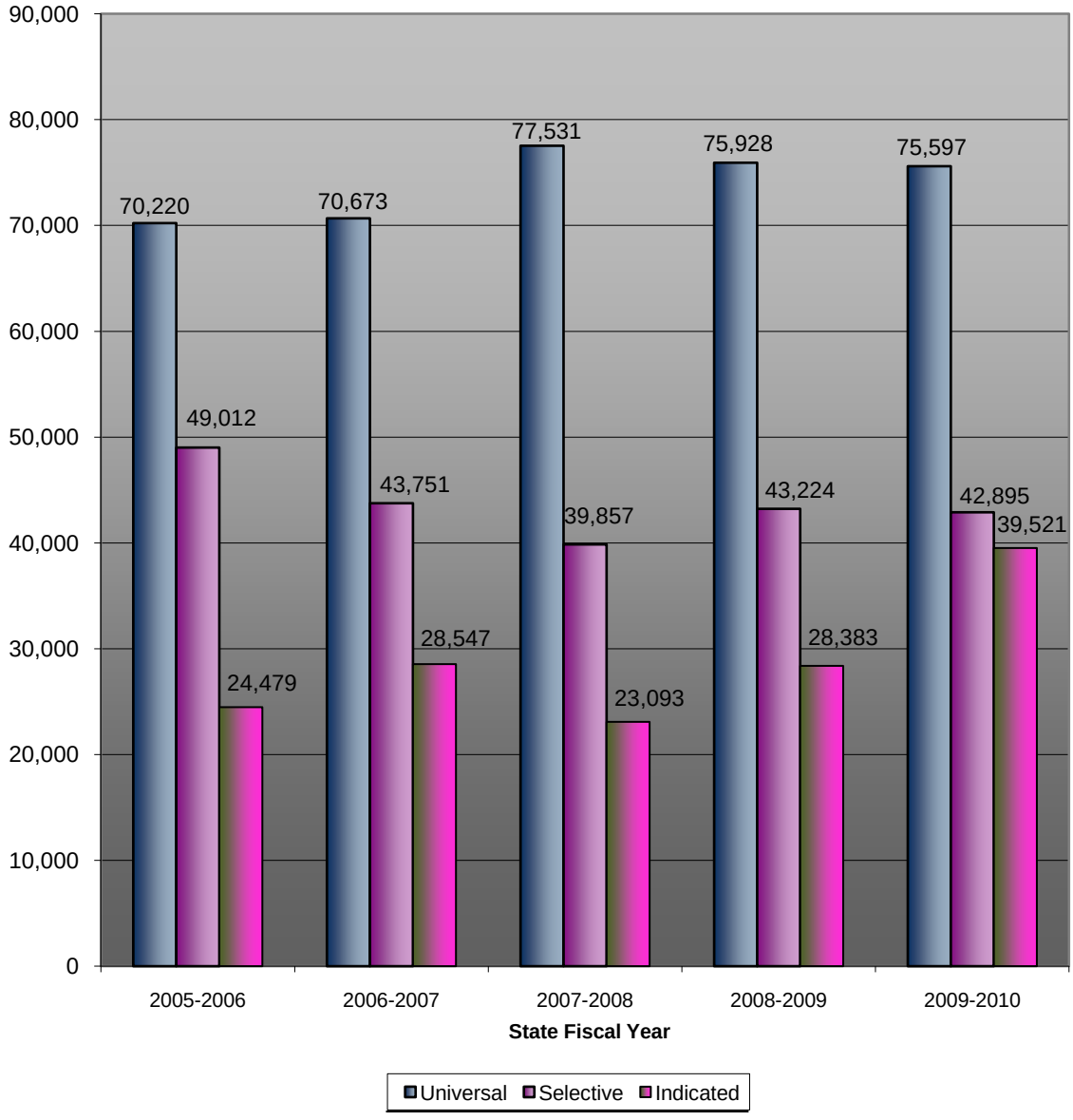
- Universal strategies address the entire population.
- Selective strategies focus on subsets or subgroups of the population exposed to greater levels of risk.
- Indicated strategies are designed to prevent the onset of substance abuse in individuals who have initiated the use of alcohol or other drugs.

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 four-year trend of reporting data under the IOM classifications. These results are due to the CSAP strategic prevention framework that encouraged targeting specific populations and communities. The trend data shows all population category counts stabilizing, while those individuals at greater risk received more effective services. Through FY 2009-2010, the service data regarding Selective and Indicated strategies appear to be converging, which may indicate that data definitions for the two strategies are not clear or are misunderstood by the organizations reporting or that perhaps both target populations reference the same community needs. Nevertheless, we will need to establish more trend data to better understand this anomaly.

Figure 5

Prevention Services by Institute of Medicine Population Categories as Reported to PBPS State Fiscal Years 2005-2006 through 2009-2010



Federal Strategies in Prevention

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

The six Federal Strategies are defined as:

- **Information Dissemination** – provides awareness and knowledge on the nature and extent of alcohol, tobacco and drug use, abuse and addiction and the effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.

- **Education** – involves two-way communication, which is distinguished from the Information Dissemination category by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this category are to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages) and systematic judgment abilities.

- **Alternative Activities** – operates under the premise that healthy activities will deter participants from the use of alcohol, tobacco and other drugs. The premise is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by, alcohol, tobacco and other drugs (ATOD) and therefore minimize or eliminate use of ATOD. These activities must be directly linked to an educational or skill-building activity.

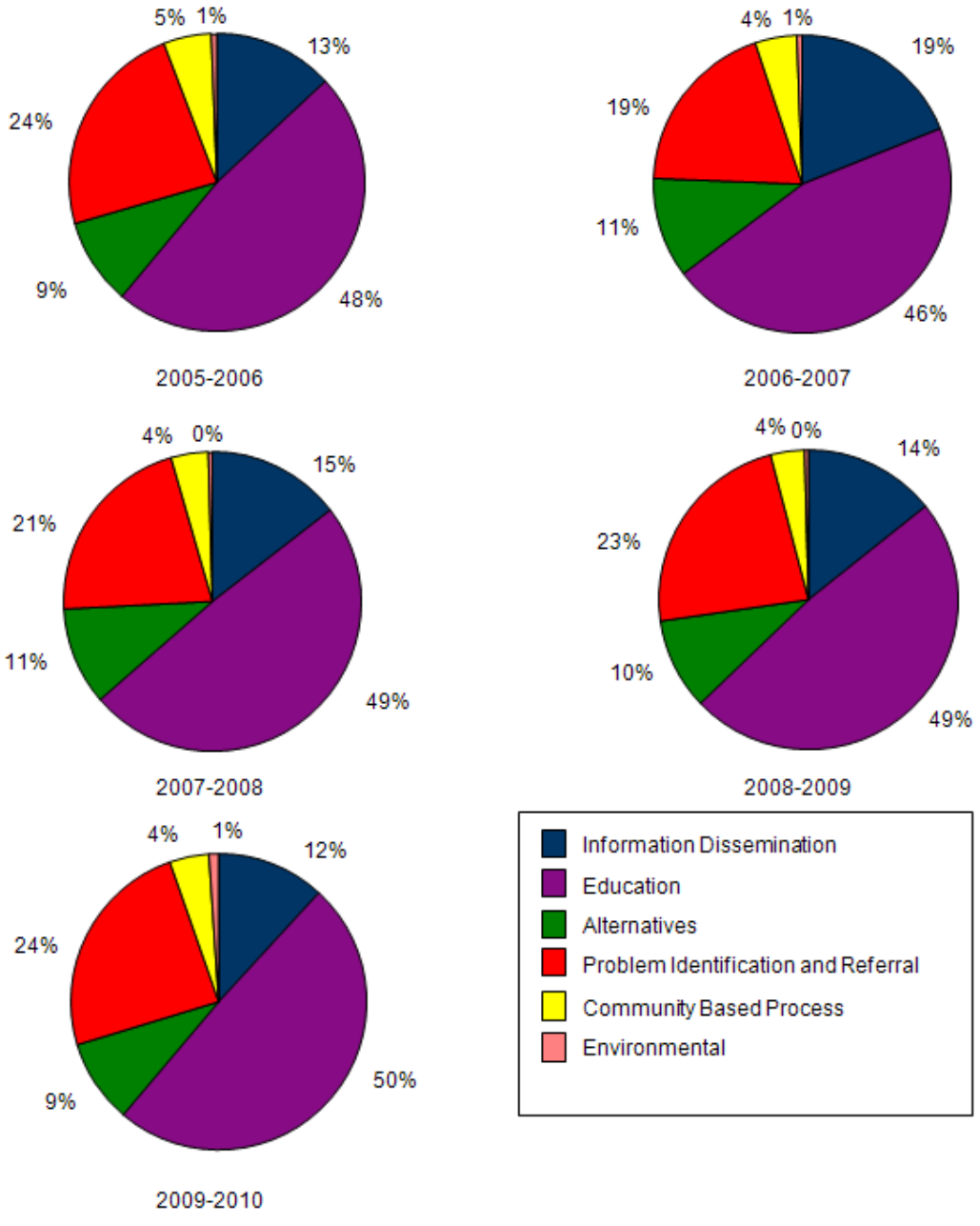
- **Problem Identification and Referral** – targets those persons who have experienced illicit/age-inappropriate use of alcohol, tobacco or other drugs in order to assess if their behavior can be reversed through education.

- **Community-Based Process** – aims directly at building community capacity to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities include organizing, planning, enhancing efficiency and effectiveness of services, inter-agency collaboration, coalition building and networking.

- **Environmental** – establishes or changes written and unwritten community standards, codes, ordinances and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the population. This category is divided into two subcategories: activities which center on legal or regulatory initiatives and those that relate to action-oriented initiatives.

Figure 6

Prevention Services by Federal Strategy as Reported to PBPS State Fiscal Years 2005-2006 through 2009-2010



Defined below are the three IOM Population Categories. The six Federal Strategies can be done in each population category. Figure 7 shows these population categories broken out by Federal Strategy for state fiscal year 2009-2010. 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 well over 50 percent Problem Identification and Referral services. Based on Federal guidelines this makes for more effective prevention programs statewide.

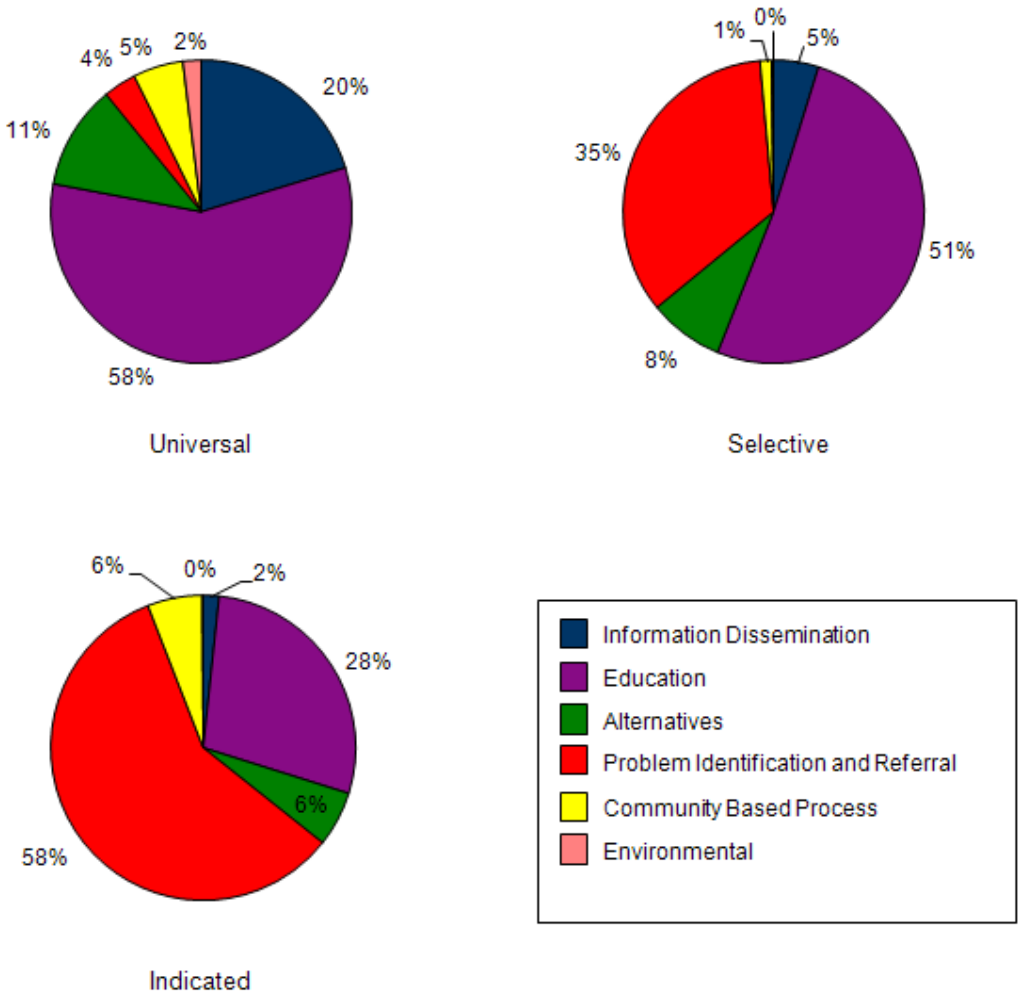
Universal Preventive Interventions are activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk. Information Dissemination is a large part of informing large general audiences successfully. Education to the universal population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

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

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

Figure 7

Institute of Medicine Population Categories by Federal Strategy Prevention Services as Reported to PBPS in 2009-2010

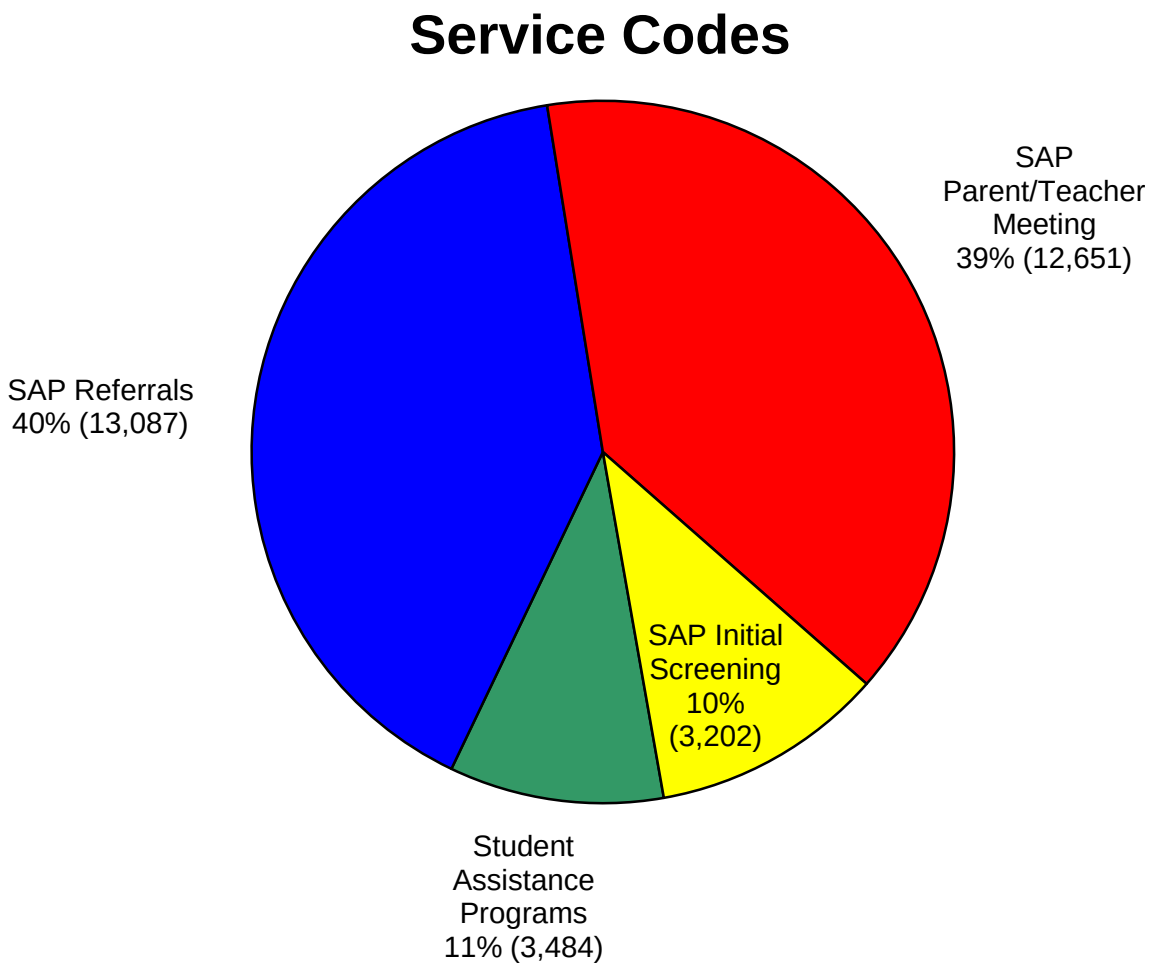


Student Assistance Data

The Student Assistance Program (SAP) is an important intervention for the youth in Pennsylvania. Figure 8 shows the total 32,424 for SAP services for Fiscal Year 2009-2010 broken down into their specific approach (service code), three (3) percent overall increase in services from Fiscal Year 2008-2009. The SAP referrals were initiated by teachers, parents or counselors. These are recurring educational services that are provided to SAP-identified students only. SAP assists school personnel in identifying issues like alcohol, tobacco and other drugs, as well as mental health issues which can impede students' success. Services include assessment, consultation, referral and/or small group education for SAP-identified youth. SAP is mandated to all SCAs to complement their prevention initiatives.

Figure 8

Student Assistance Programs (SAP) as Reported to PBPS SFY 2009-2010

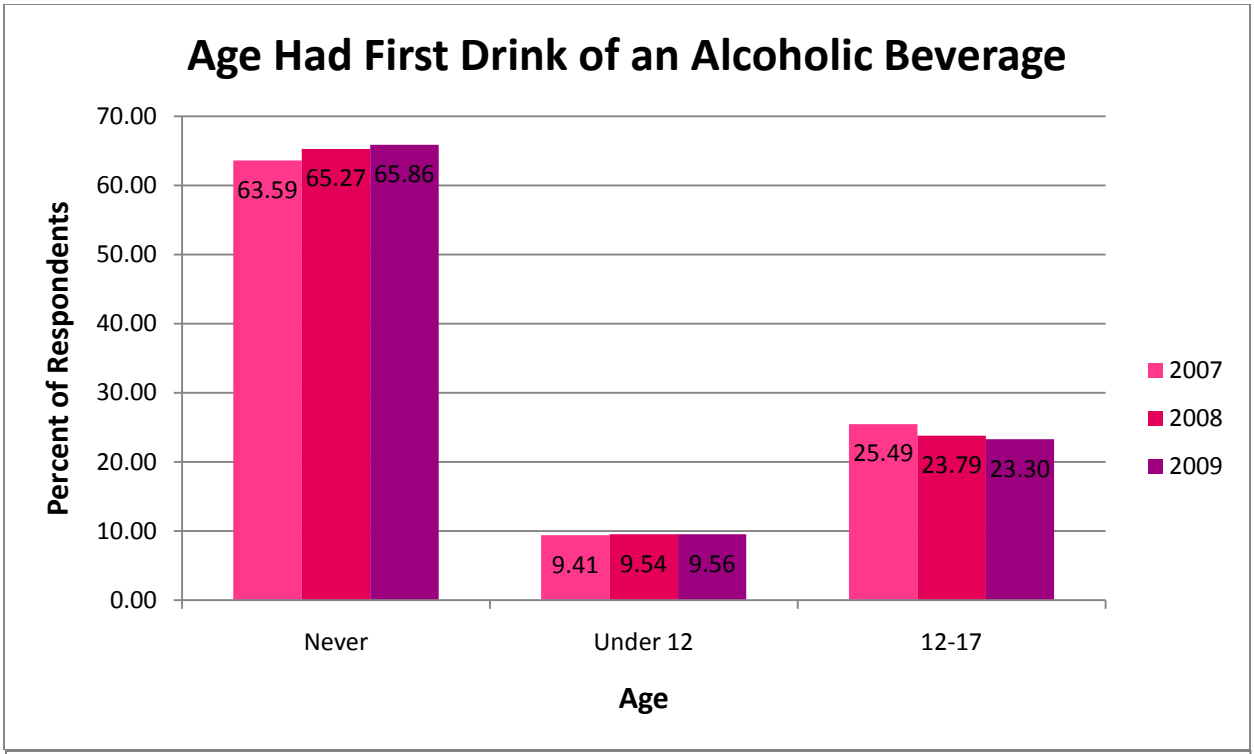


Total SAP Services: 32,424

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

The following surveys were gathered from Pennsylvania youth who attended selected single prevention services and recurring prevention service participants from October 1 to November 30 of 2007, 2008 and 2009. The October to November timeframe helps provide some consistency to these survey results from year to year. Because service participants or attendees are not necessarily representative of the general population, please consider this a convenience sample.

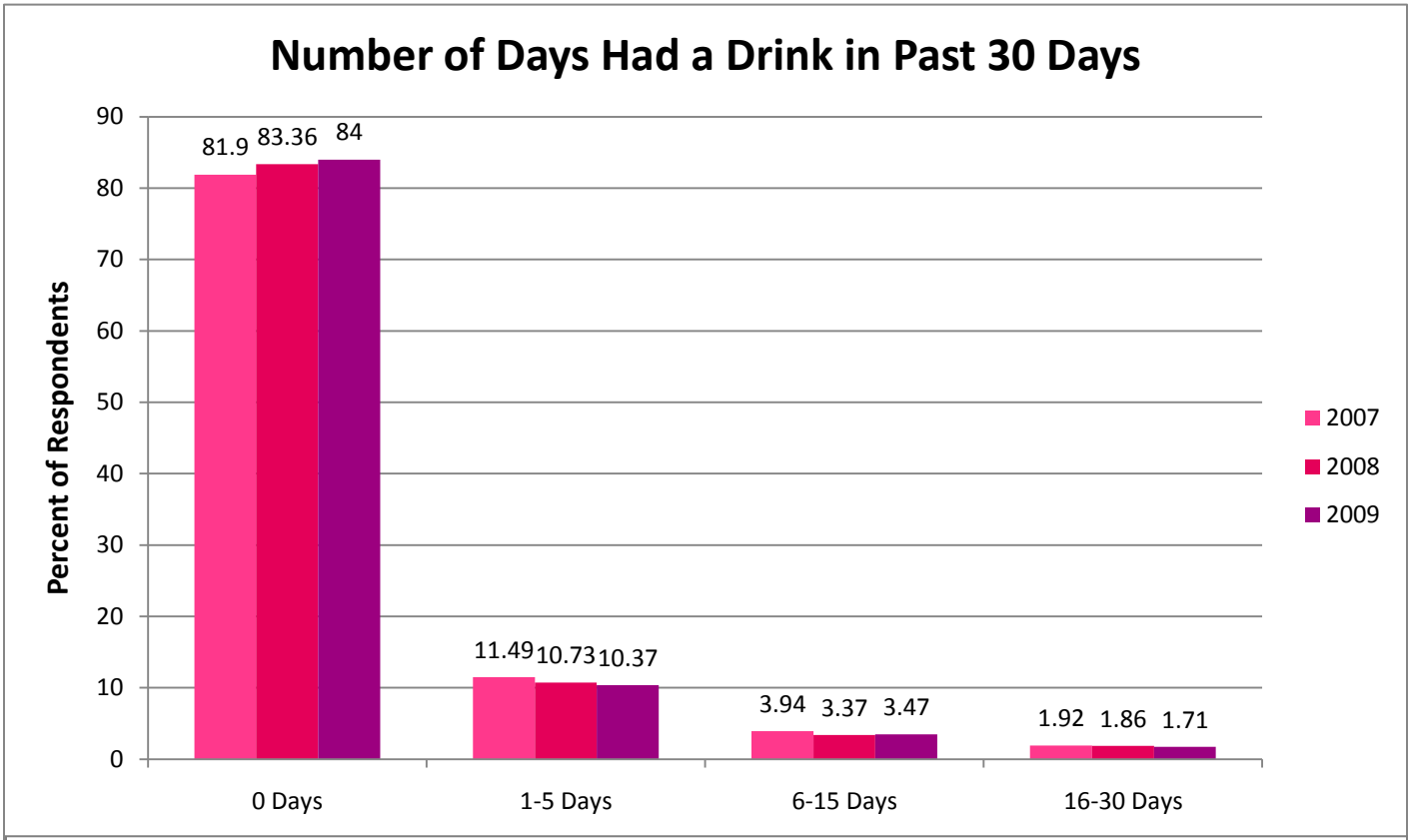
Question: How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink.



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

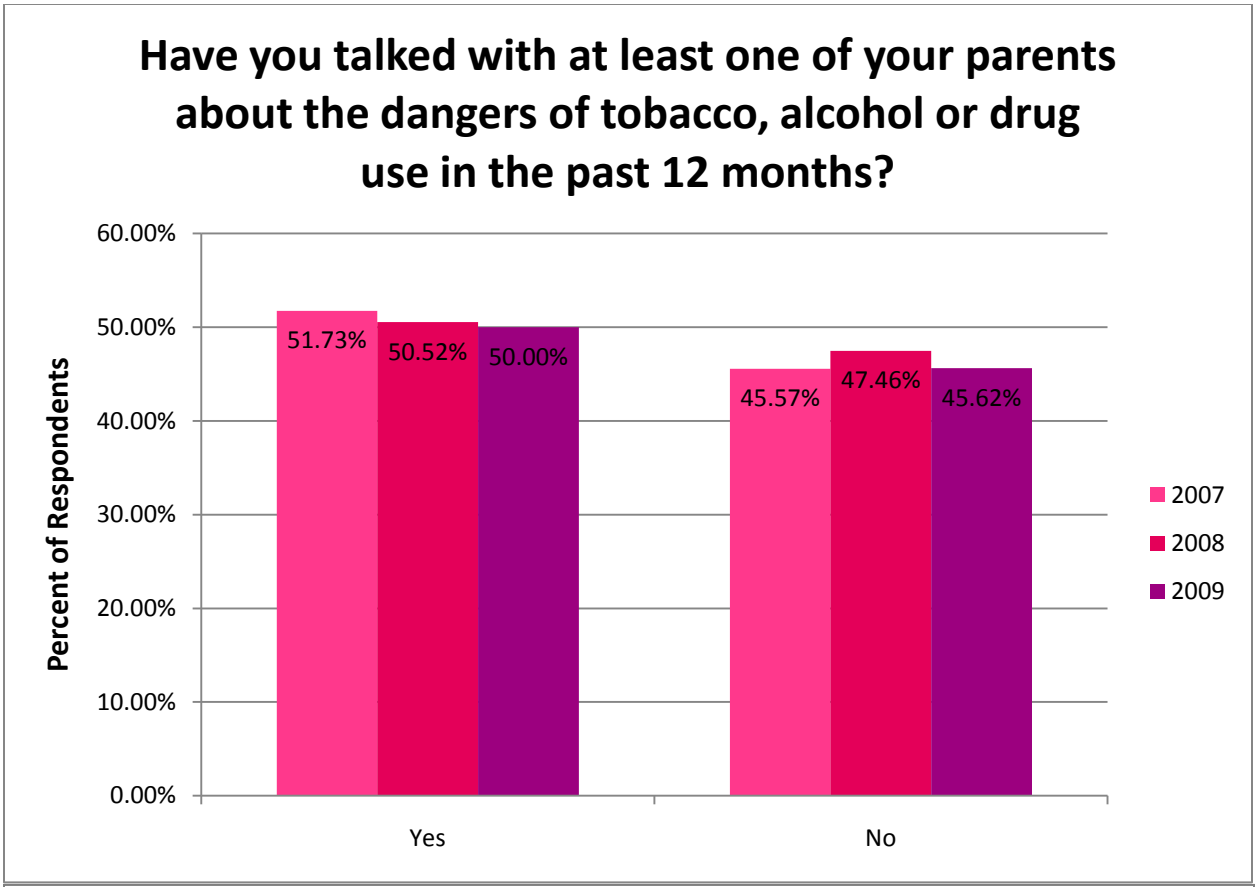
	2007	2008	2009
18-21	0.36%	0.55%	0.45%
No Response	1.16%	0.86%	0.82%

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



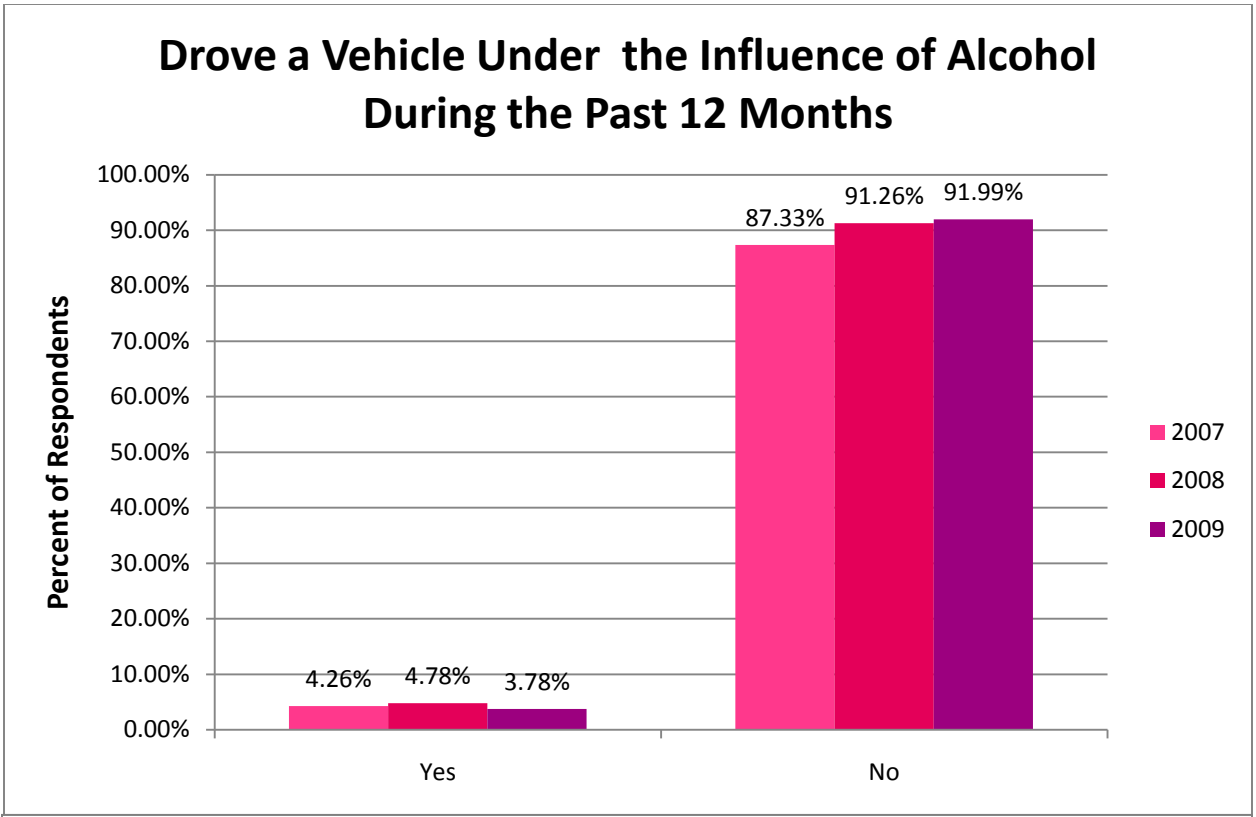
* .74% (2007), .69% (2008) and .45% (2009) of survey respondents did not respond to this question.

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



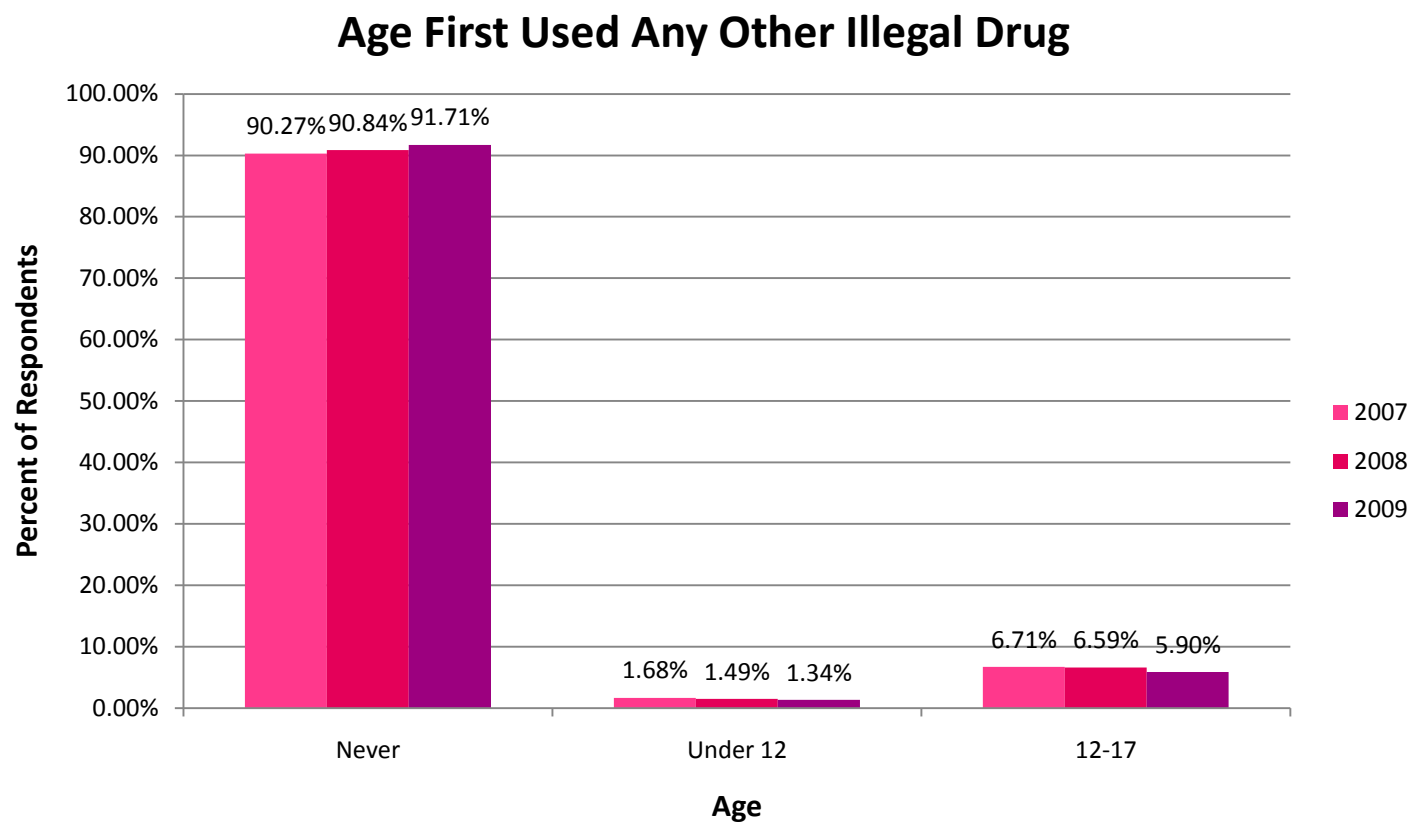
* 2.70% (2007), 2.02% (2008) and 4.37% (2009) of survey respondents did not respond to this question.

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



* 8.37% (2007), 3.95% (2008) and 4.21% (2009) of survey respondents did not respond to this question.

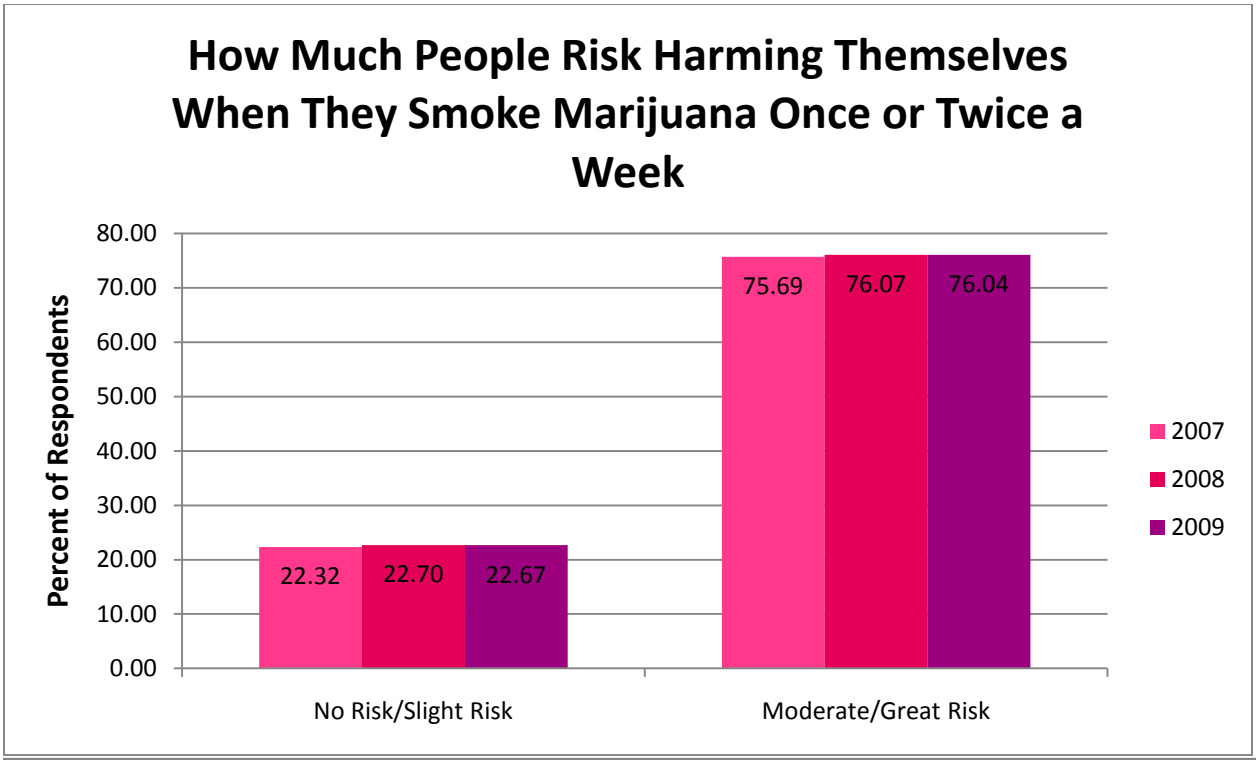
Question: How old were you the first time you used any other illegal drug?



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

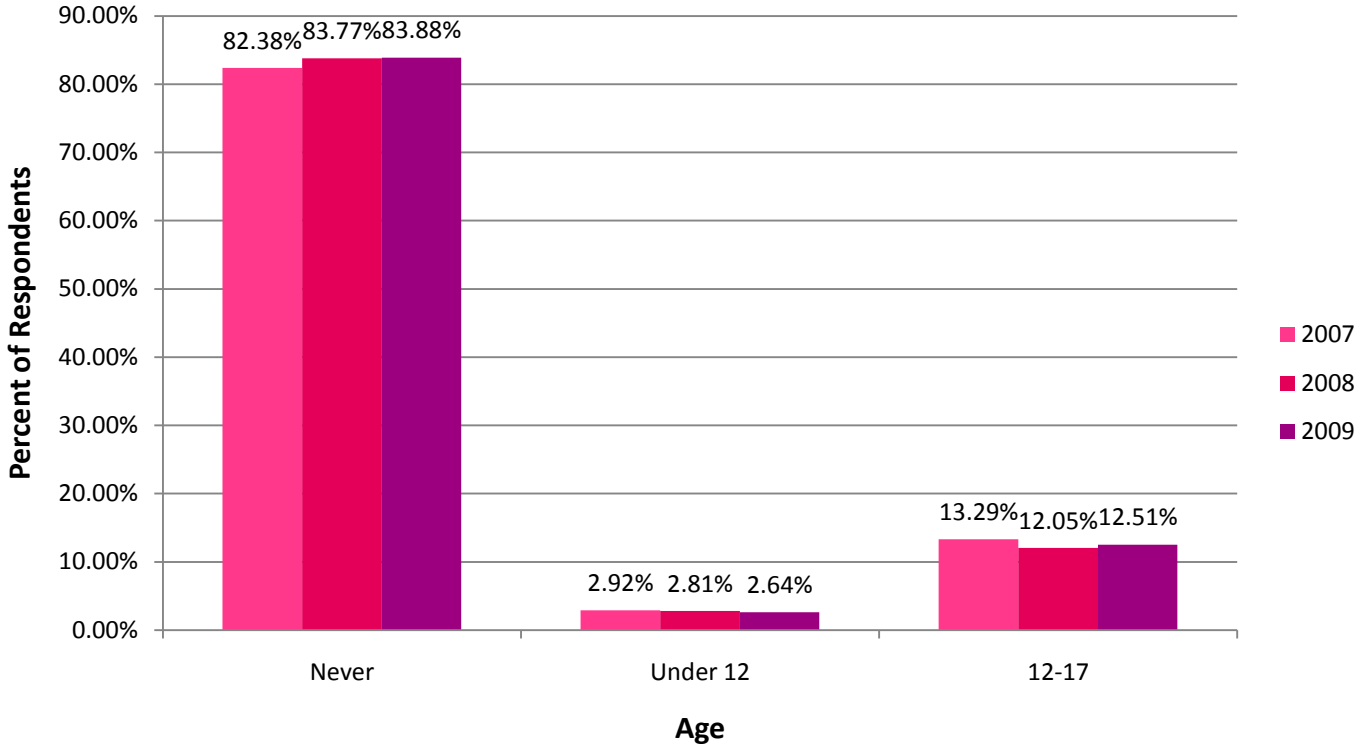
	2007	2008	2009
18-21	0.17%	0.30%	0.34%
No Response	1.17%	0.80%	0.70%

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



* 1.98% (2007), 1.24% (2008) and 1.25% (2009) of survey respondents did not respond to this question.

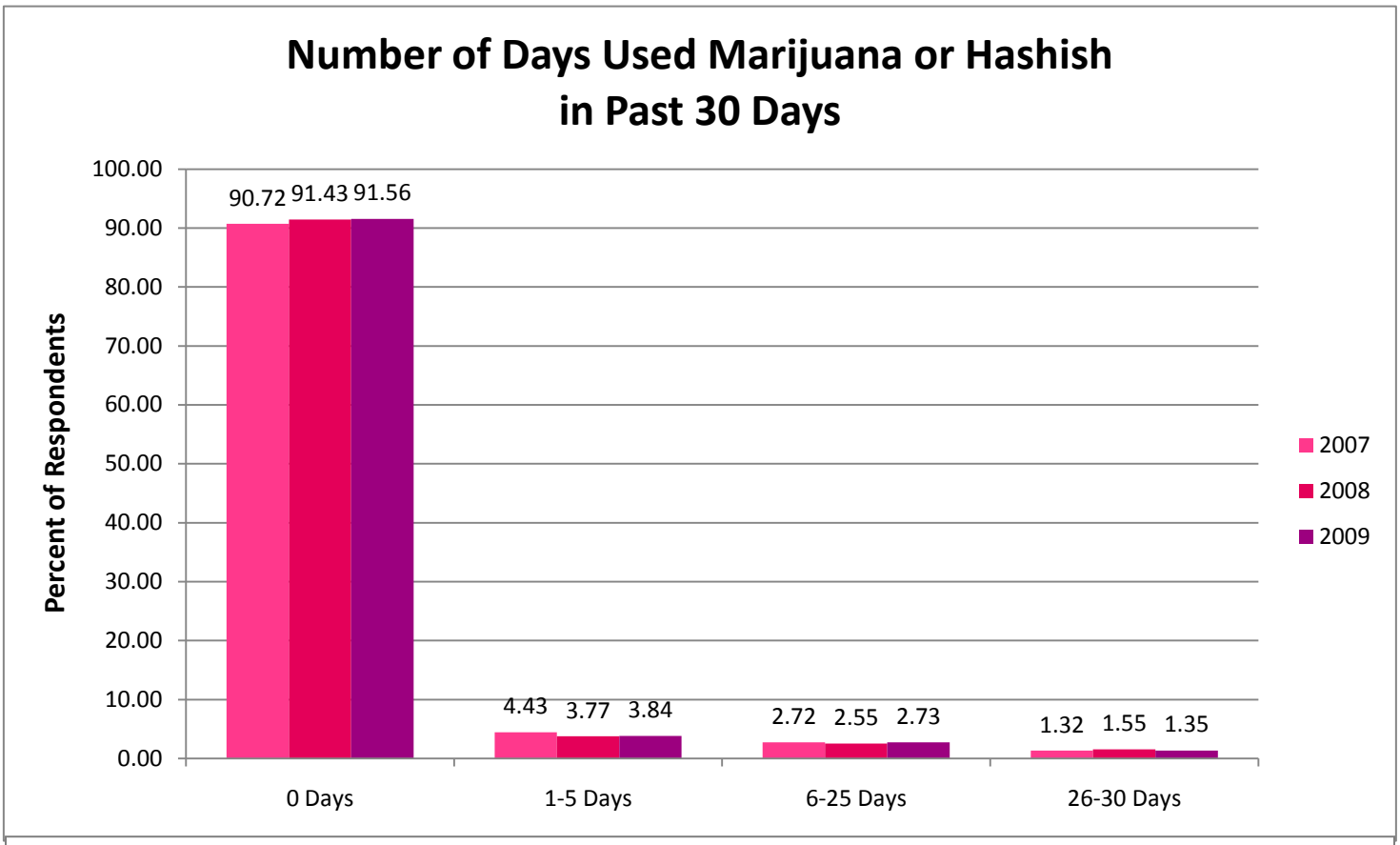
Question: How old were you the first time you used marijuana or hashish?



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

	2007	2008	2009
18-21	0.22%	0.45%	0.29%
No Response	1.17%	0.93%	0.67%

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



* .81% (2007), .73% (2008) and .52% (2009) of survey respondents did not respond to this question.

Data Analysis Compiled from the Client Information System (CIS)
State Fiscal Year 2009-2010

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

Admissions and Unique Clients

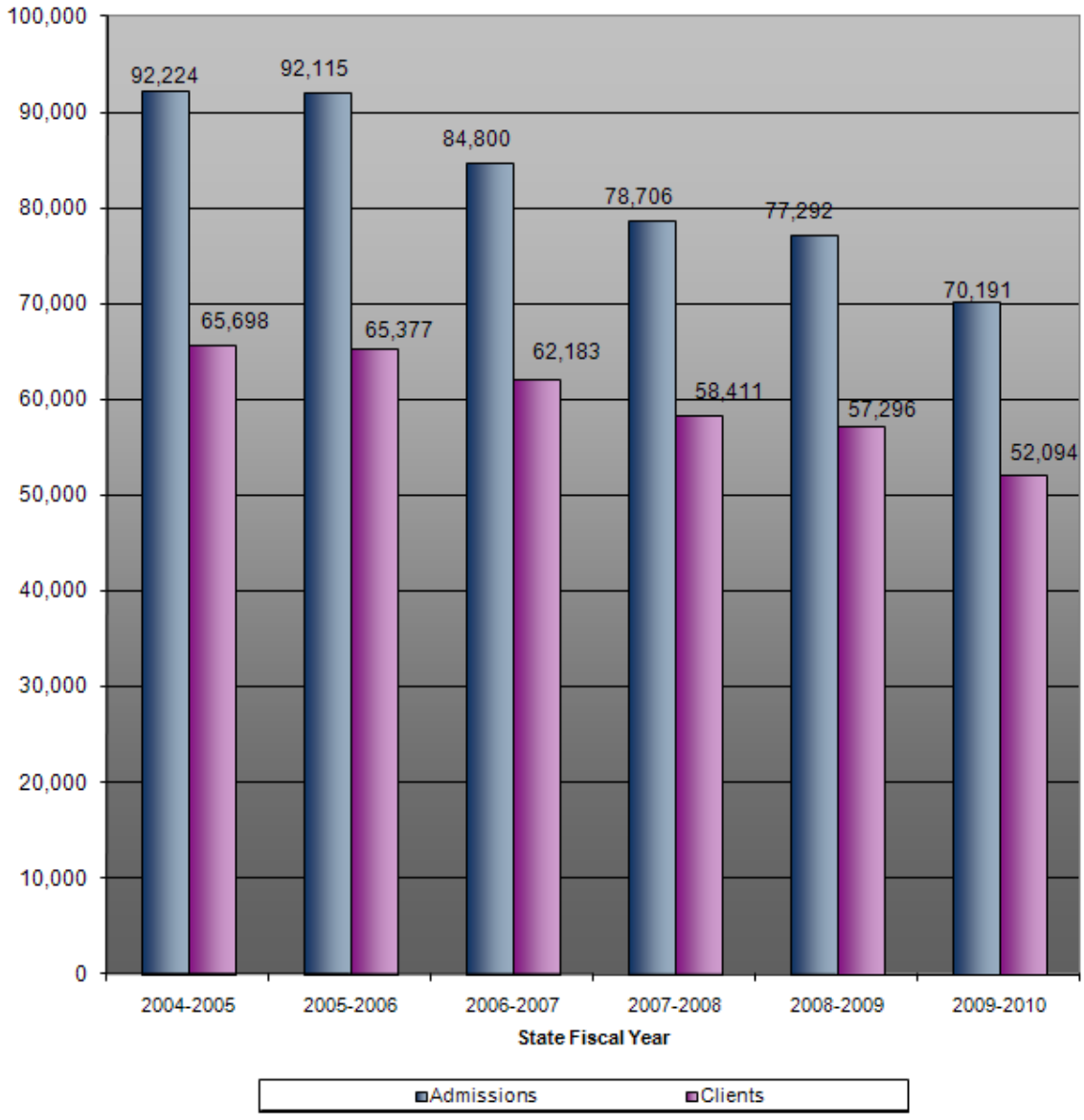
Figure 1 shows total admissions and total unique clients served for the past six state fiscal years. A unique client is a single person who has been admitted and has received any substance abuse treatment at a licensed provider during the given state fiscal year. An admission occurs when a client is 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 (2005-2006 through 2009-2010), reported admissions and clients have been on the decline.

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

Figure 1

CIS Admissions and Unique Clients for State Fiscal Years 2004-2005 through 2009-2010



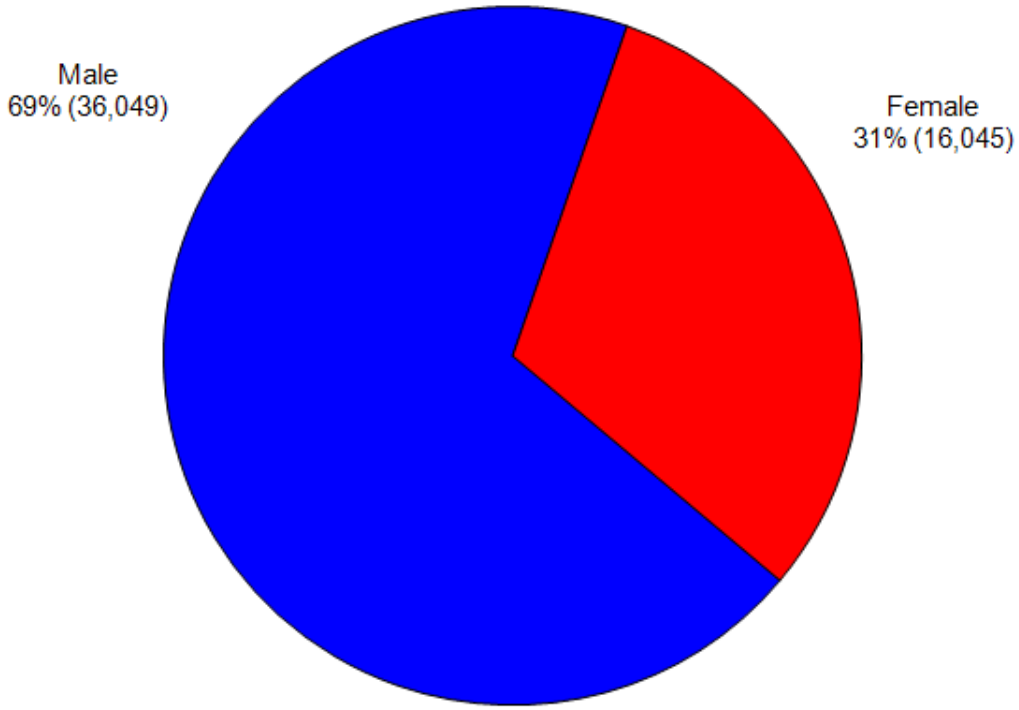
Client Demographics

Clients that are treated by programs funded by the DOH are quite different from the general population in many ways. The following charts and narrative describe these differences. The majority (69 percent) of clients is male (Figure 2), while the general population is 49 percent male. Over half (61 percent) are in the 15-34 year old age group (Figure 3). There is a much higher percentage of African-American clients in treatment compared to the total Pennsylvania population of African-Americans (16 percent and 10.8 percent, respectively). There is a much lower percentage of Asian/Pacific Islander clients in treatment compared to the total Pennsylvania population (0.2 percent and 2.4 percent, respectively) [Figure 4]. There is a lesser percentage of Hispanics in treatment compared to the general population (4 percent and 5.1 percent, respectively) [Figure 5]. Nearly one in five (19 percent) clients in treatment is of unknown ethnicity (Figure 5), so the percentage of Hispanic clients in treatment may actually be higher. All Pennsylvania population percentages are from the 2009 Pennsylvania State Data Center Estimates. There have been no significant changes concerning state client demographics over the last three fiscal years.

Figure 2

CIS Unique Client Admissions SFY 2009-2010

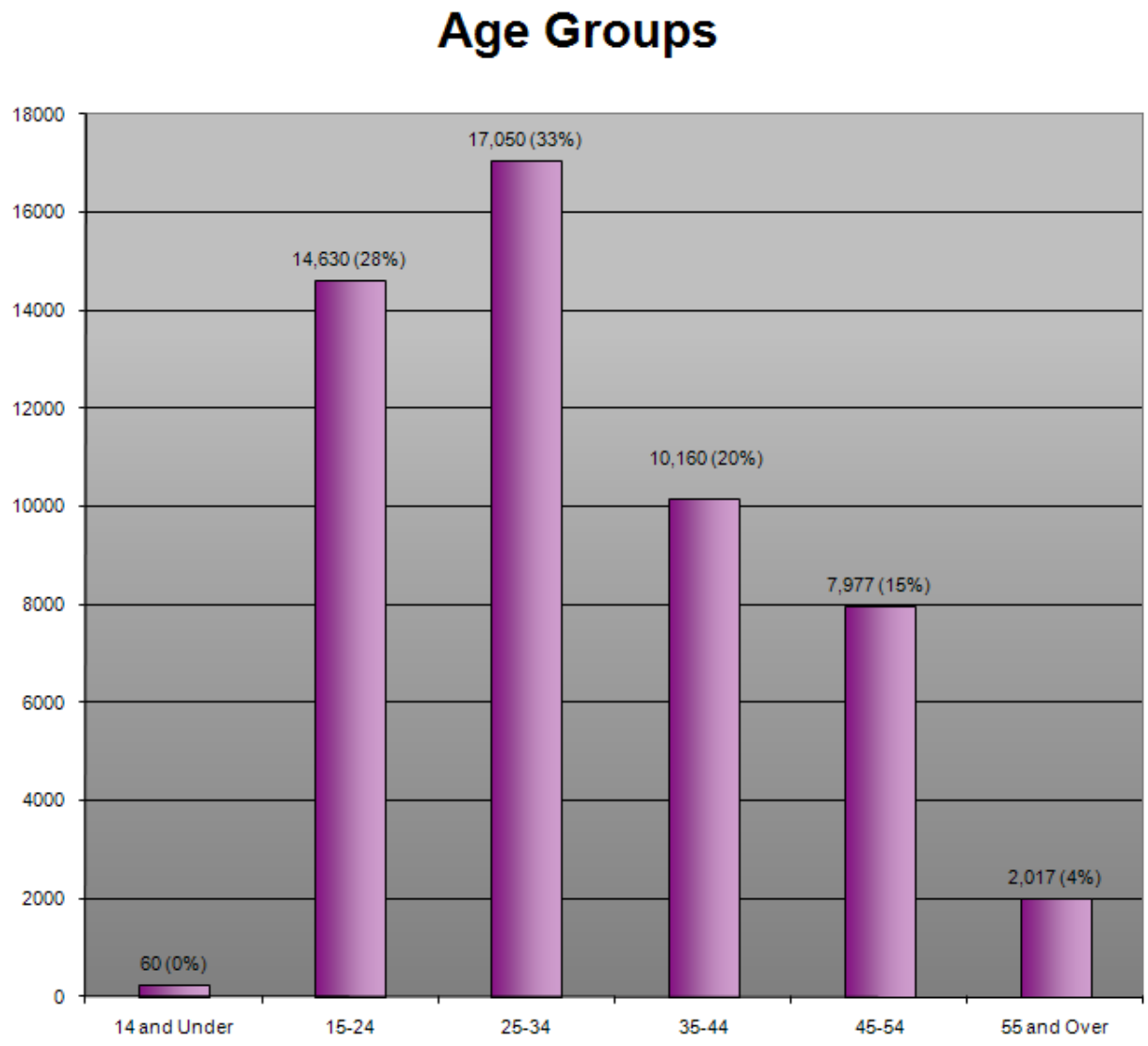
Gender



Clients are unique admissions counted once in the time period
Total Clients=52,094

Figure 3

CIS Unique Client Admissions SFY 2009-2010

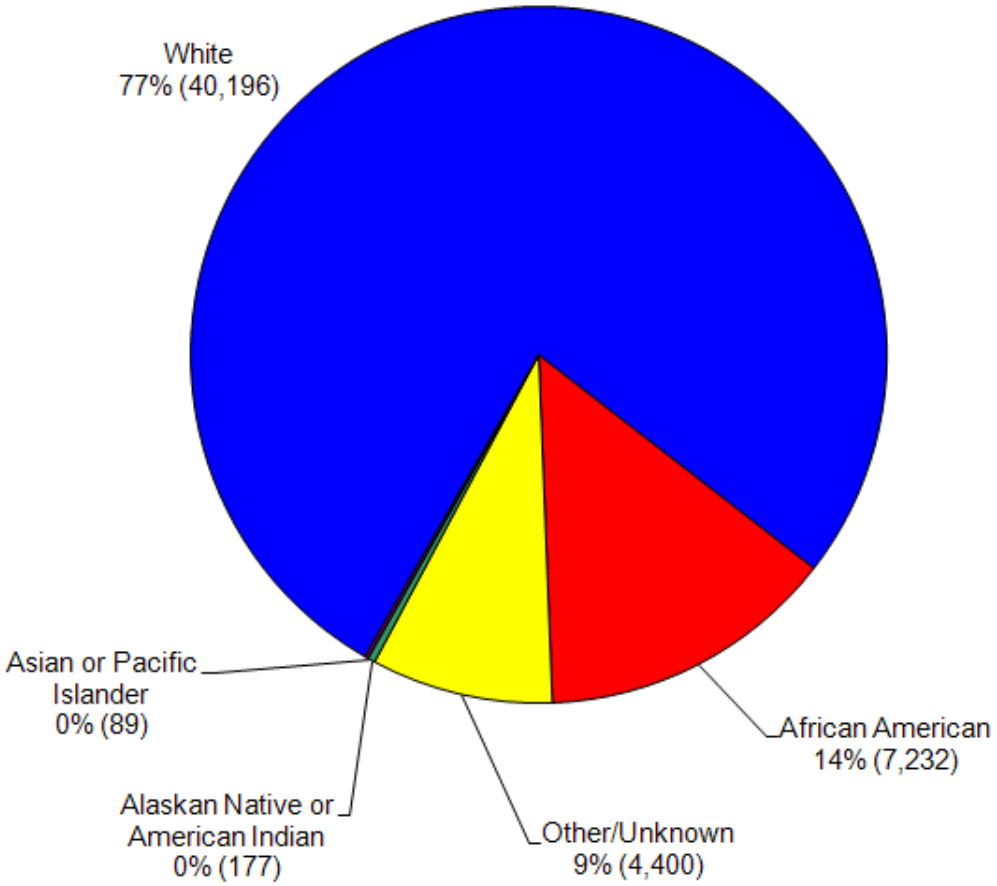


Clients are unique admissions counted once in the time period
Total Clients=52,094

Figure 4

CIS Unique Client Admissions SFY 2009-2010

Race

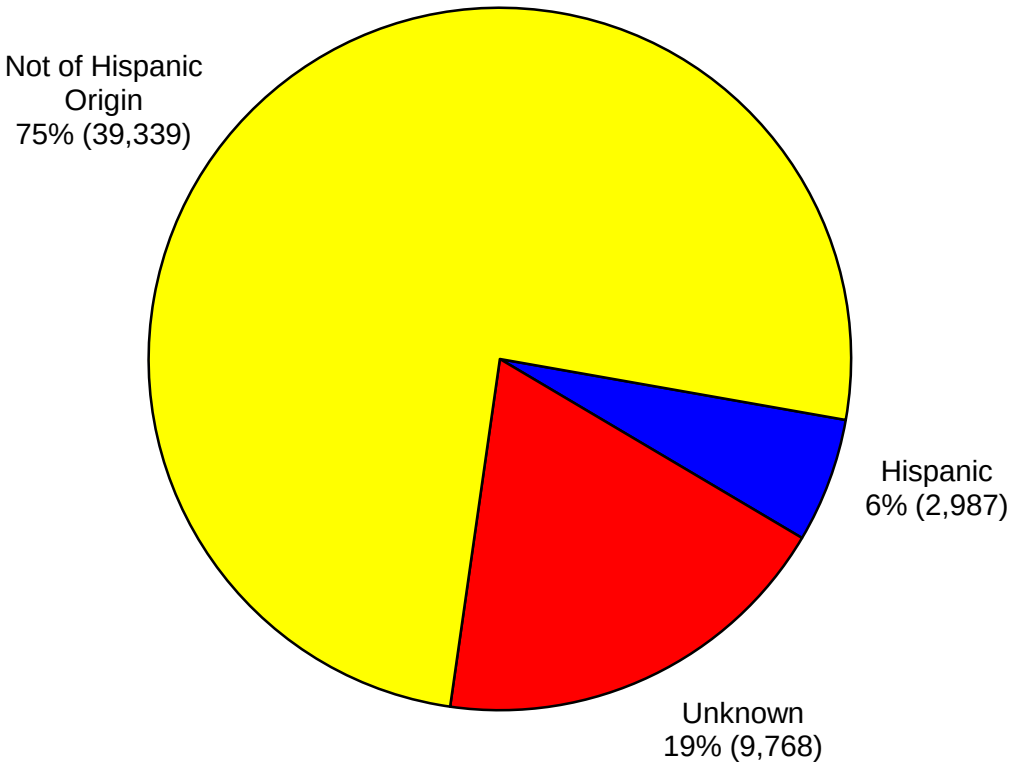


Clients are unique admissions counted once in the time period
Total Clients=52,094

Figure 5

CIS Unique Client Admissions SFY 2009-2010

Ethnicity



Clients are unique admissions counted once in the time period
Total Clients=52,094

Admissions Characteristics

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

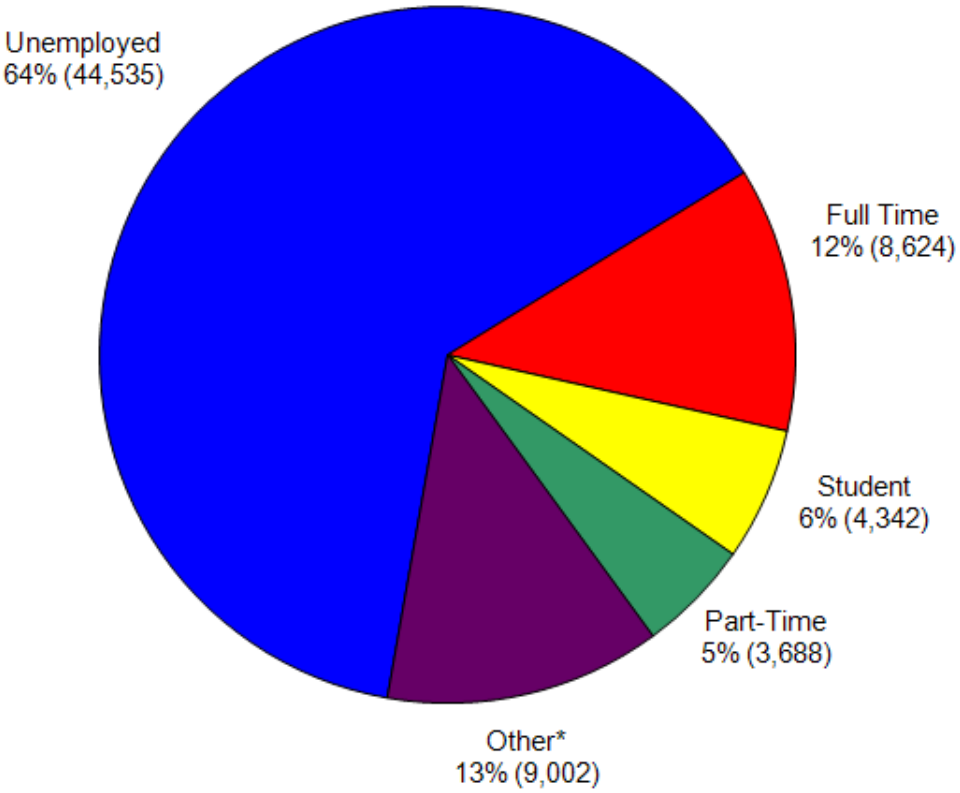
The majority (64 percent) of clients reported being unemployed. In addition, only 17 percent reported being employed on a full-time (12 percent) or part-time (5 percent) basis. The remaining admissions were of other employment statuses (Figure 6). Nearly three-fourths (74 percent) have never been married. 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]. Nearly one third (32 percent) of clients were admitted under non-voluntary circumstances (Figure 8). This means they were involved in the criminal justice system, and substance abuse treatment was mandated. Trending this data over the last three fiscal years, there have been no significant changes concerning state client admission characteristics.

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

Figure 6

CIS Admissions SFY 2009-2010

Employment Status

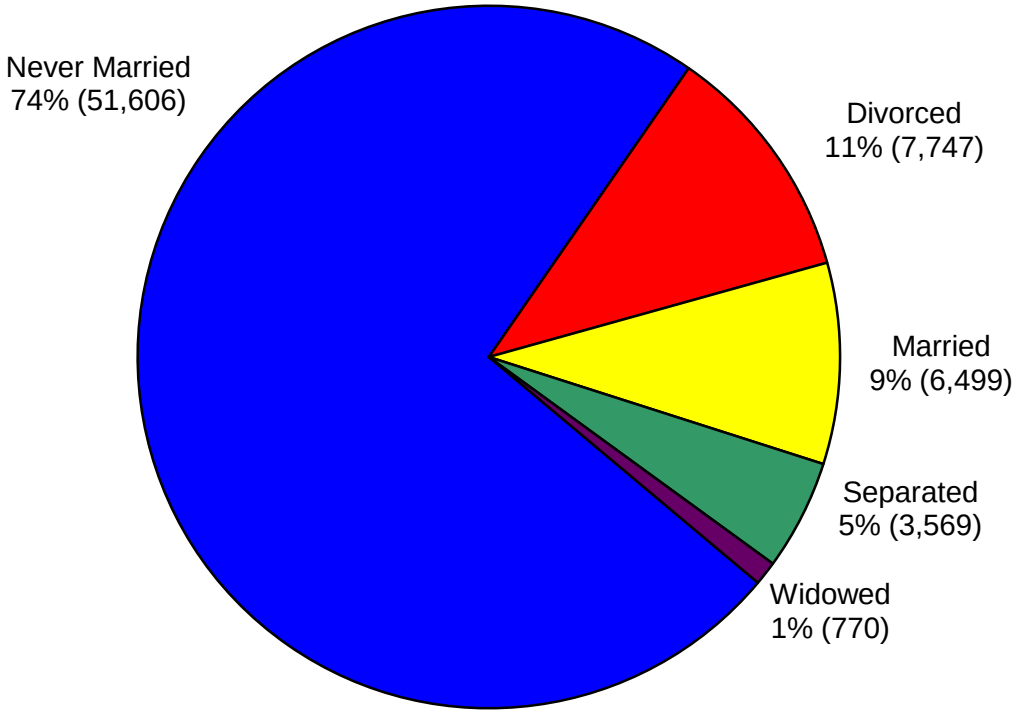


*Other includes: Disabled, Leave of Absence, Retired, Homemaker, Armed Forces, Unknown, and Other Employment Status
Total Admissions=70,191

Figure 7

CIS Admissions
SFY 2009-2010

Marital Status

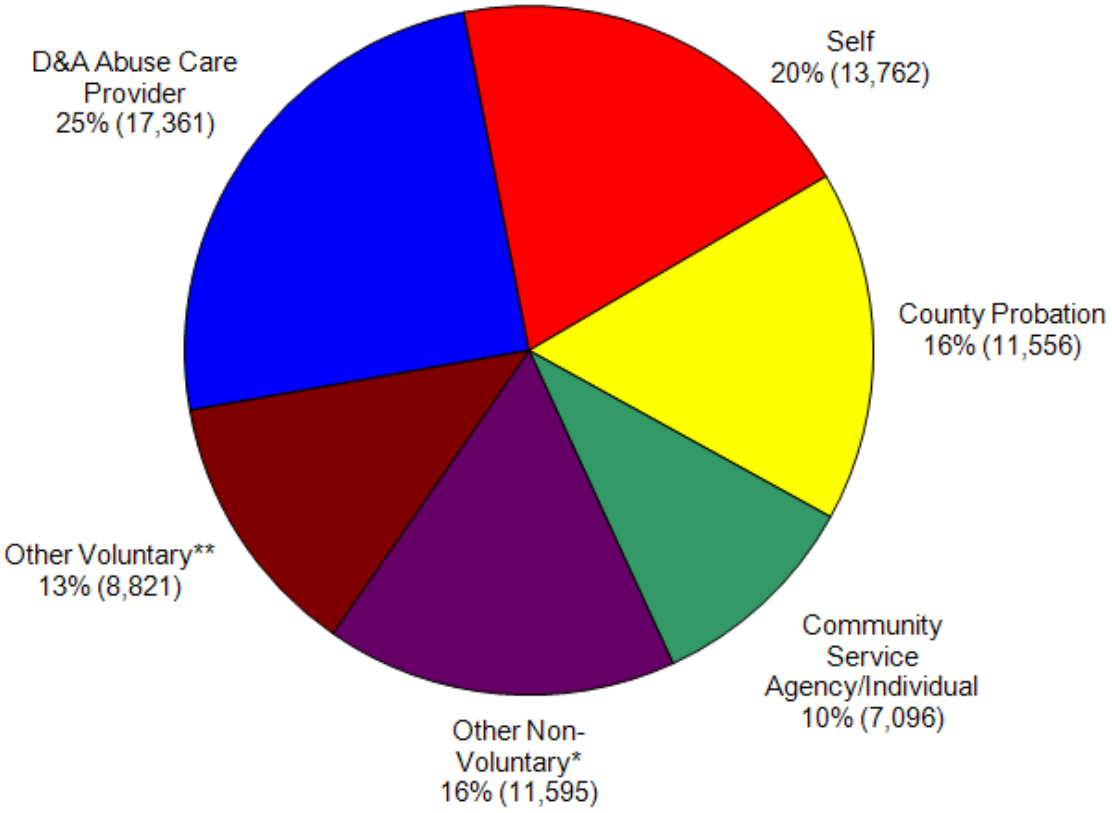


Total Admissions=70,191

Figure 8

CIS Admissions SFY 2009-2010

Referral Sources



*Other Non-Voluntary includes: Court (Judge), Federal Parole, State Parole, County Parole, Federal Probation, State Probation, and Other Non-Voluntary
**Other Voluntary includes: Hospital/Physician, Family/Friend, School, Diversion Programs, Employer/EAP, Clergy/Religious, and Other Voluntary
Total Admissions=70,191

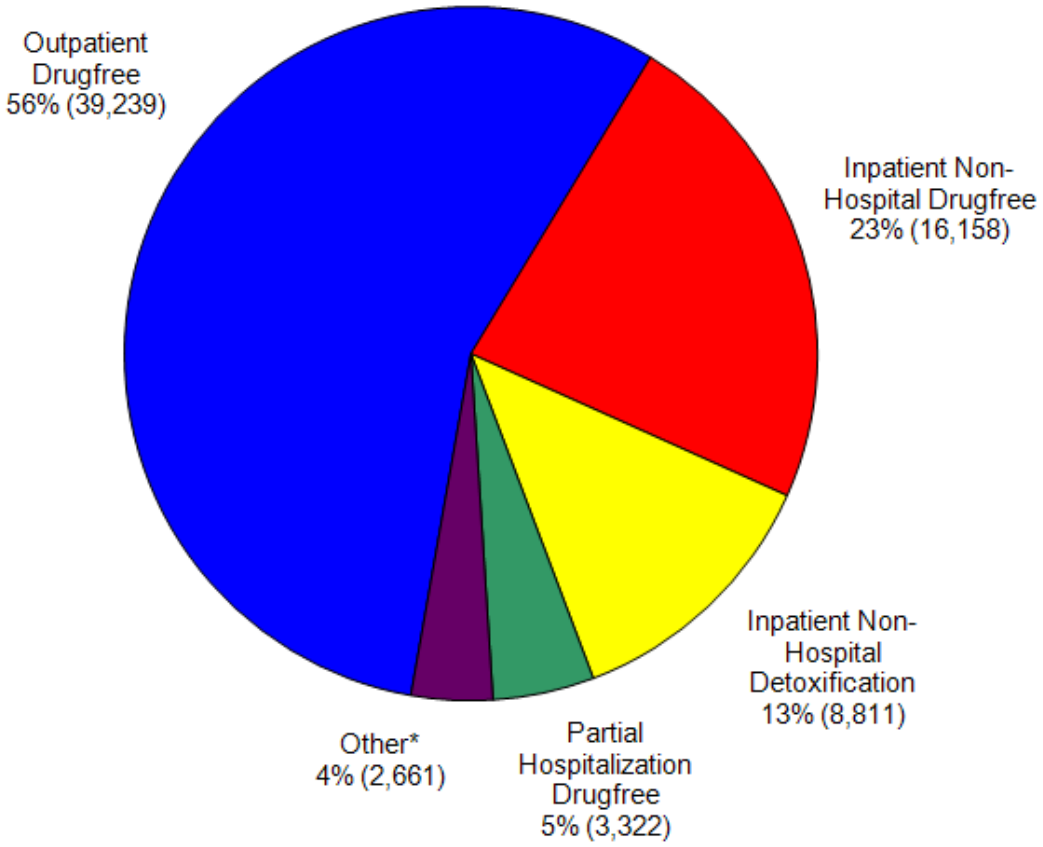
Types of Treatment

There are several different types of treatment available to clients in Pennsylvania. Treatment modality usage varies widely by SCA, so these statewide figures may not give an accurate representation of local area modality utilization. The most prevalent type of treatment received is of the Outpatient Drug-free type, with 56 percent of clients receiving this modality (Figure 9). This is also the least intensive, most inexpensive modality. Nearly a quarter (23 percent) of admissions was of the Inpatient, Non-Hospital Drug-free type. Such treatment is more intensive, with the client living and receiving treatment services at the facility. There have been no significant changes concerning treatment modalities trend data over the last four fiscal years.

Figure 9

CIS Admissions SFY 2009-2010

Treatment Modalities



*Other includes: Correctional Institution: Detox, Drug Free, Experimental. Inpatient Hospital: Detox, Drug Free, Experimental, Other Chemotherapy. Inpatient Non-Hospital: Experimental, Other Chemotherapy. Outpatient: Detox, Experimental, Maintenance, Other Chemotherapy. Partial Hospital: Detox, Experimental, Other Chemotherapy. Shelter: Drug Free, Experimental
Total Admissions=70,191

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 most common primary substance of abuse is alcohol (39 percent). Heroin (21 percent), marijuana/hashish (16 percent), cocaine/crack (10 percent) and other opiates/synthetics (11 percent) account for another 58 percent of admissions. The remaining 3 percent is composed of other drugs (Figure 10).

There has been little overall change in the primary drugs reported over the past five State Fiscal Years (Figure 11). However, marijuana/hashish demonstrated an increased spike in Fiscal Year 2008-2009. For Fiscal Year 2009-2010, heroin is demonstrating a similar increase in usage, while marijuana/hashish is on a downward trend. It will not be known if this trend is an anomaly until more data is available. The Bureau will continue to monitor and investigate. The only drug category that has shown substantial and consistent growth in the past six years is the other opiates/synthetics category (Figure 12). In State Fiscal Year 2004-2005, this category accounted for 5.2 percent of admissions. In State Fiscal Year 2009-2010, it accounted for 11 percent of admissions. This is an increase of over 100 percent over the past five years.

Admissions for particular primary drugs of abuse vary by gender, race, ethnicity and age group. Males are admitted for alcohol use more frequently (41 percent) than females (34 percent), as well as more frequently for marijuana/hashish (18 percent and 14 percent, respectively). Females are admitted for cocaine/crack use more frequently (13 percent) than males (9 percent). Both genders admitted for heroin use have shown an increase (females at 23 percent and males at 20 percent, respectively)[Figure 13].

Whites were admitted for alcohol use more frequently than African-Americans (39 percent and 37 percent), more than four times as frequently for heroin (24 percent and 6 percent) and over six times more frequently for other opiates/synthetics (13 percent and 2 percent). African-Americans were admitted over three times as often for cocaine/crack than whites (25 percent and 7 percent) and two times more frequently for marijuana/hashish (27 percent and 13 percent) [Figure 14].

Non-Hispanics were admitted for alcohol more frequently than Hispanics (40 percent and 33 percent) and over three times as frequently for other opiates/synthetics (11 percent and 3 percent). Hispanics were admitted more frequently for heroin than Non-Hispanics (26 percent and 19 percent). Both ethnicities admitted for cocaine/crack use have shown an equalizing effect (Hispanics at 10 percent and Non-Hispanics at 10 percent, respectively) [Figure 15].

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

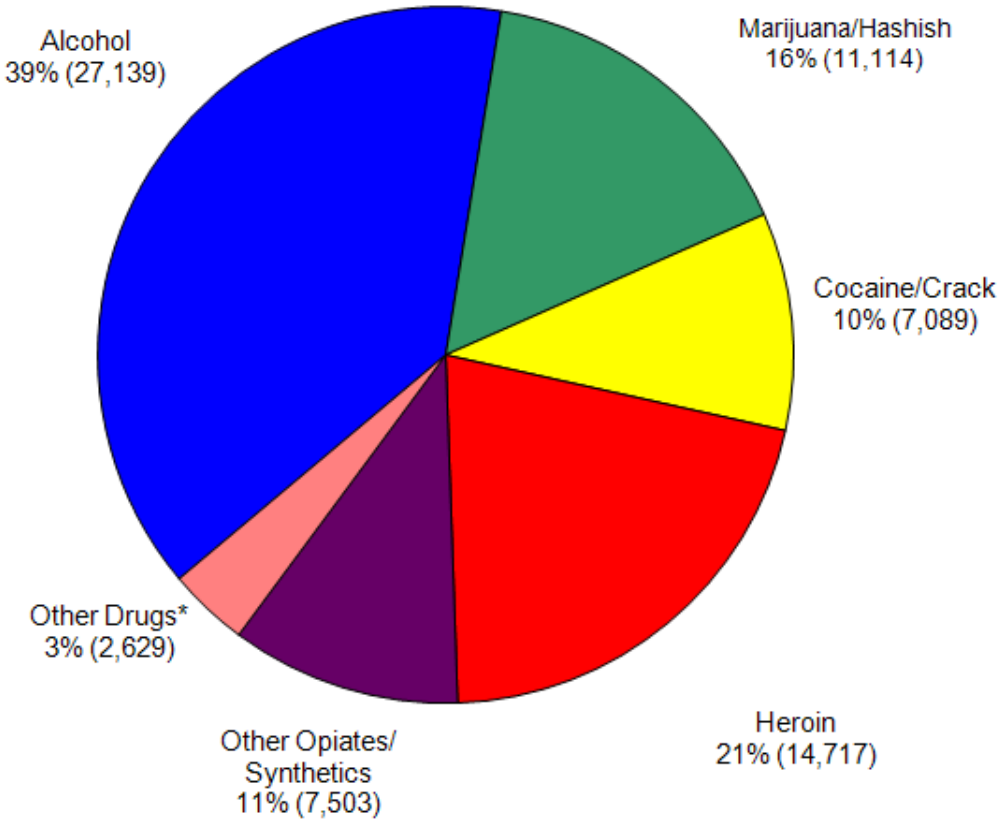
The age group 14 and under is admitted for marijuana/hashish use most frequently (54 percent), although this age group accounts for less than 1 percent of admissions. Many in this age category receive services through programs not reported in the CIS. Clients in this age group are of particular interest, because they require more specialized services than their older counterparts.
The age group 15-24 is also of particular interest, due to the transitional nature of this age category (Figure 17). This age group has been further broken down into ages 15-17 (2,836 admissions), 18-20 (5,254 admissions) and 21-24 (11,586 admissions).

Marijuana/hashish is the most prevalent drug of choice for the groups 15-17 and 18-20 (62 percent and 38 percent, respectively), but usage decreases by 40 percent between these two age groups as a person becomes progressively older. It decreases further to 39 percent of all admissions in the 21-24 age groups. Heroin begins to be seen much more in the 18-20 age groups (22 percent), and for age group 21-24, heroin makes up an even higher percentage (31 percent) of admissions. This is an increase of 41 percent in heroin use from 18-20 to 21-24.

Figure 10

CIS Admissions SFY 2009-2010

Primary Drug of Choice

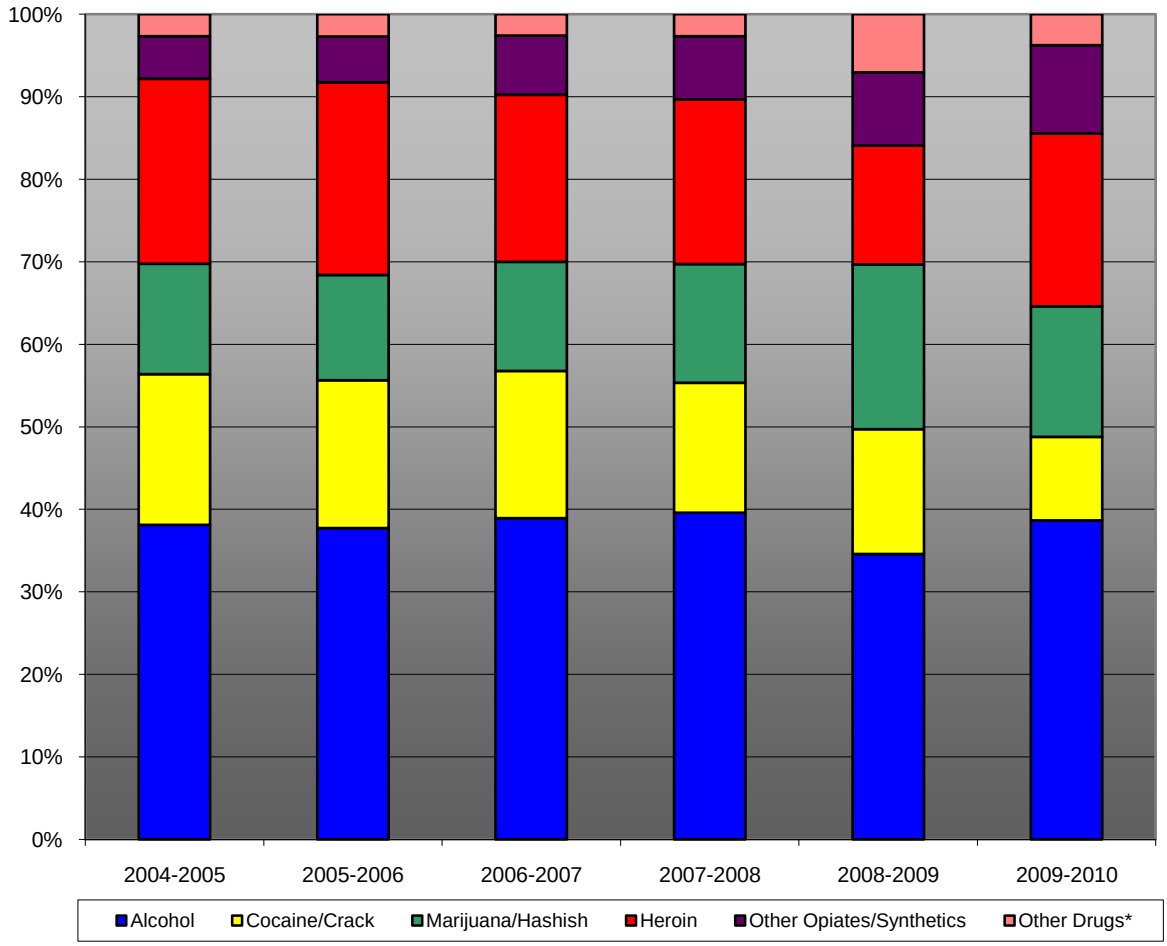


*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs
Total Admissions=70,191

Figure 11

CIS Admissions for State Fiscal Years 2004-2005 through 2009-2010

Primary Drug of Choice



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

Figure 12

CIS Admissions for Other Opiates/Synthetics State Fiscal Years 2004-2005 through 2009-2010

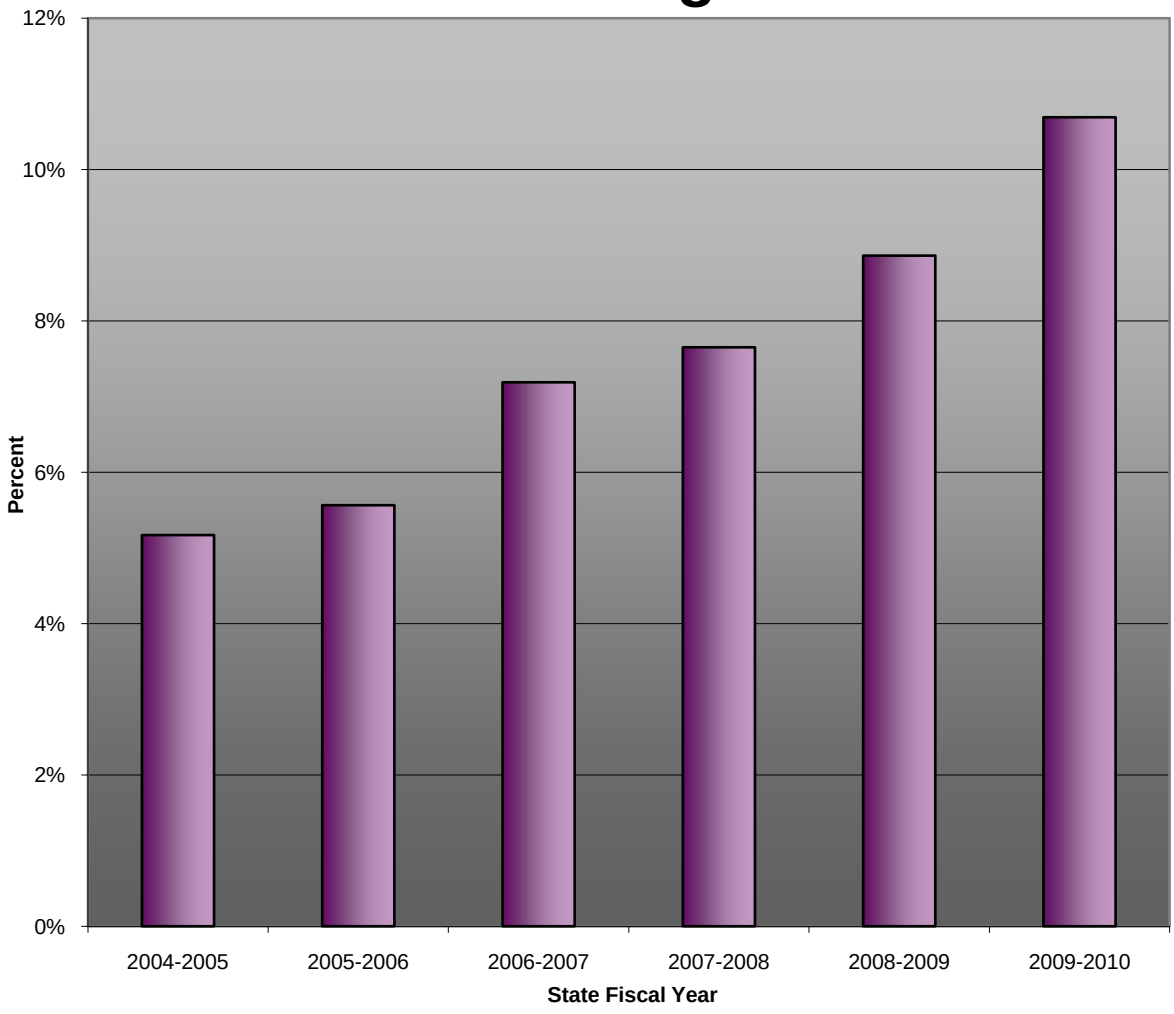
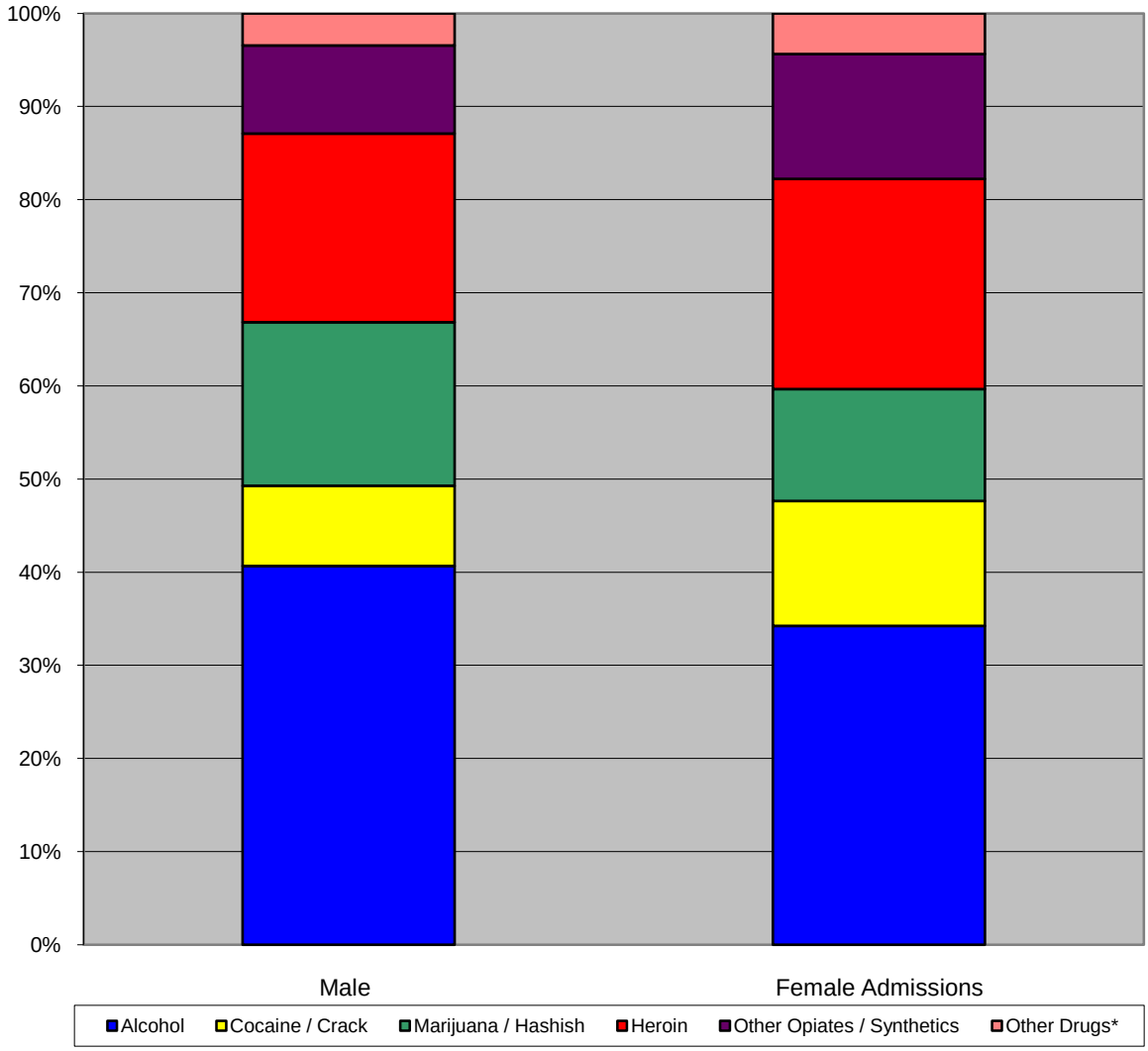


Figure 13

CIS Admissions
SFY 2009-2010

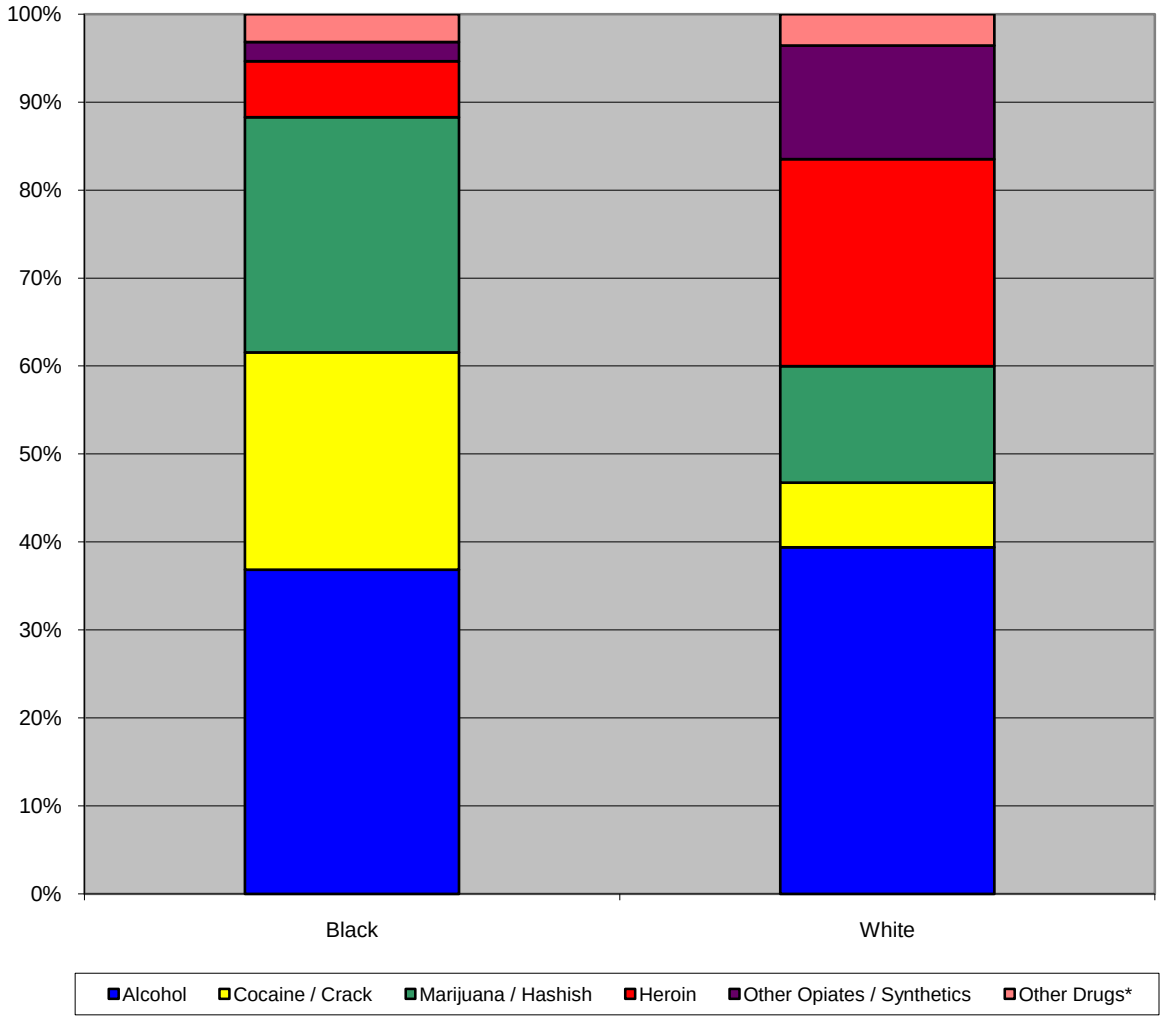
Primary Drug of Choice by Gender



*Other Drugs includes: Other Opiates/Synthetics, Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs
Total Admissions=70,191

Figure 14

CIS Admissions
SFY 2009-2010
Primary Drug of Choice by Race

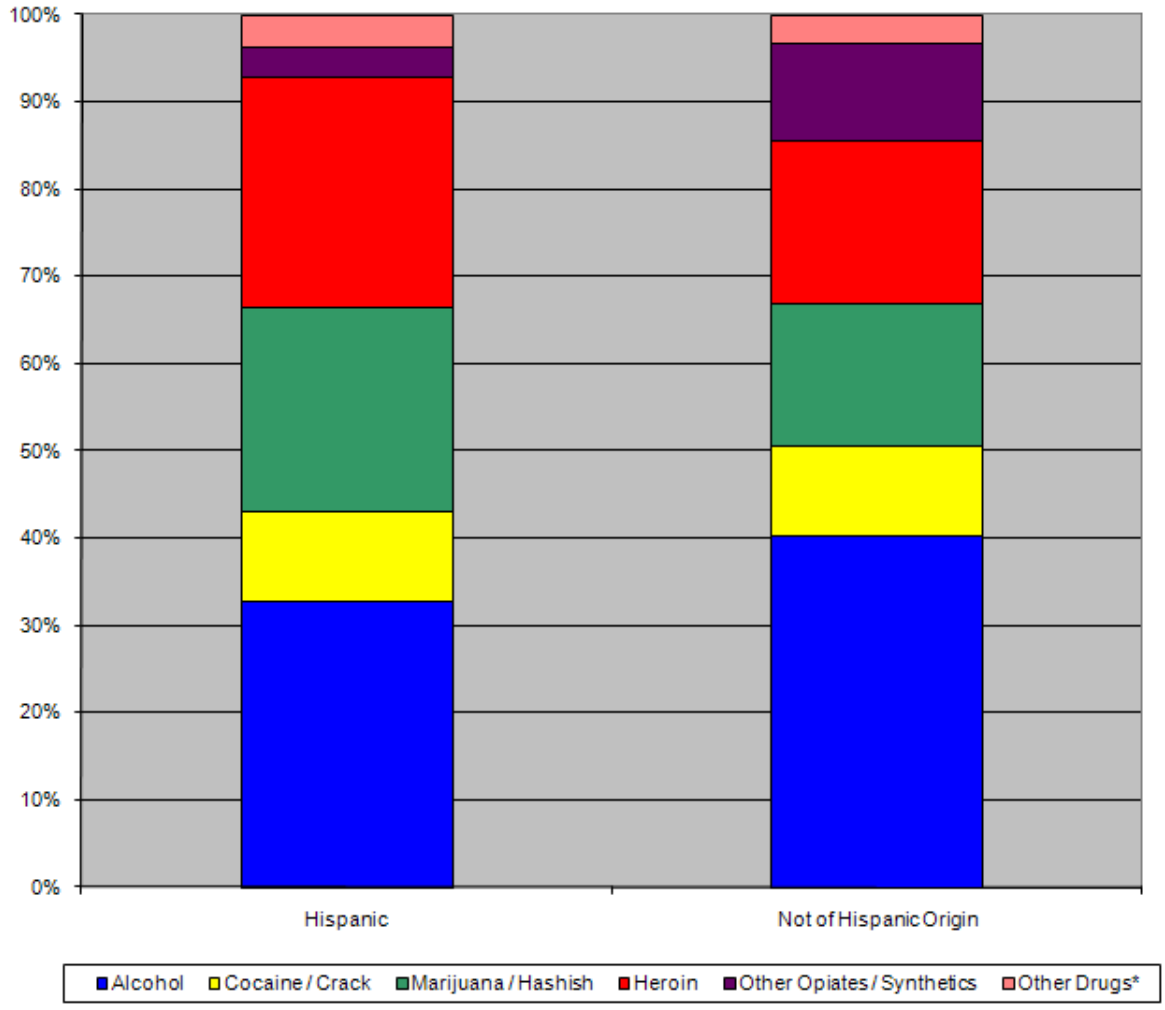


*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs
Total Admissions for Black and White=64,272 (92% of Total Admissions)

Figure 15

CIS Admissions
SFY 2009-2010

Primary Drug of Choice by Ethnicity

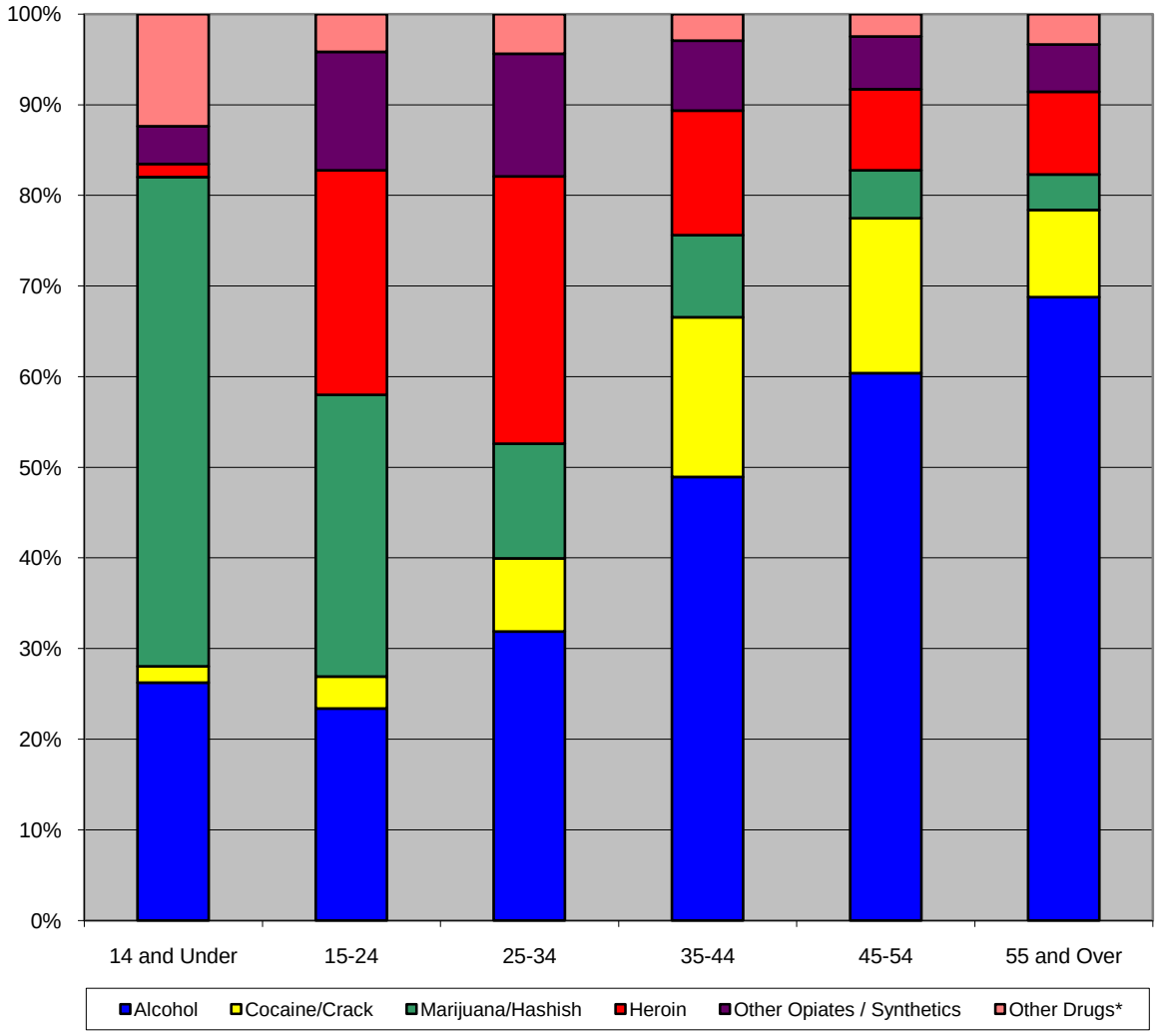


*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs
Total Admissions for Hispanic and Not of Hispanic Origin=56,380 (80% of Total Admissions)
The remaining 13,811 admissions are of unknown ethnicity.

Figure 16

CIS Admissions
SFY 2009-2010

Primary Drug of Choice by Age Group



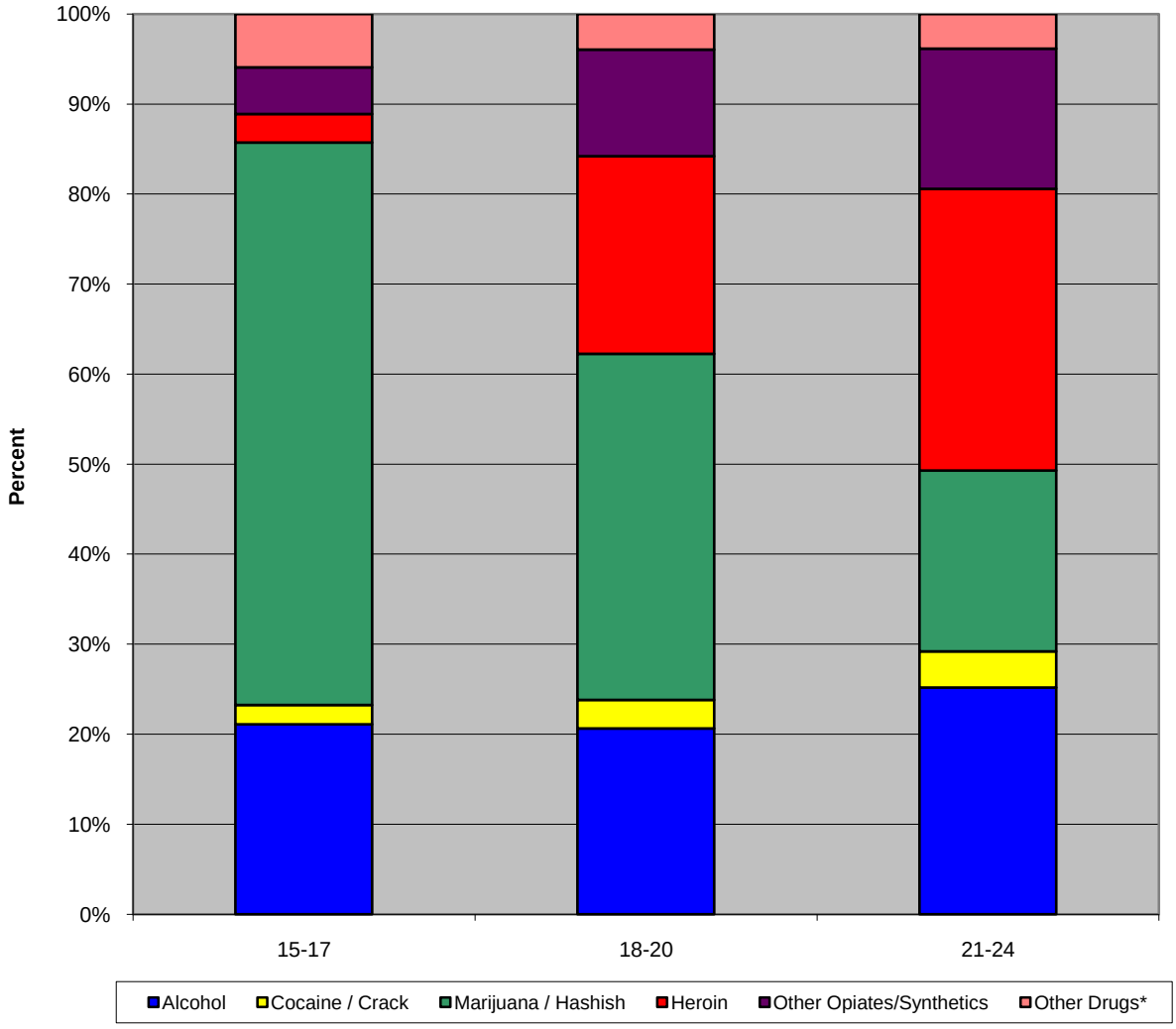
*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs
Total Admissions=70,191

Figure 17

CIS Admissions
SFY 2009-2010

Primary Drug of Choice by Age Group

Ages 15-24



*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs
Total Admissions=19,676

Discharges

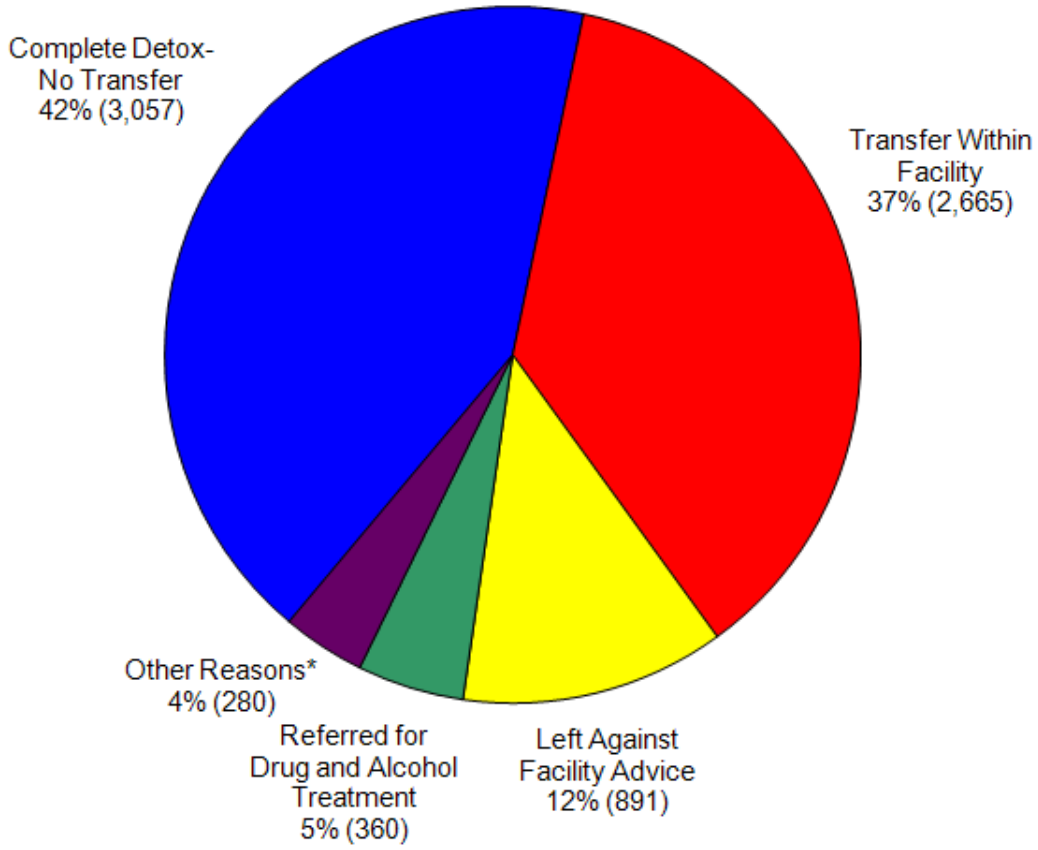
When a client has completed a particular type of treatment or changes treatment providers, a discharge record is submitted to the CIS with an associated reason for discharge. There are two main types of discharges: detoxification and non-detoxification. The kind of service rendered in detox and non-detox treatments is very different, so there are different reasons for being discharged from the two categories. The following discharge data is associated with admissions that occurred in state fiscal year 2009-2010. No significant changes occurred from previous years. Therefore, no trend data has been presented.

After detox treatment was completed, 42 percent of patients were either transferred within the facility or were referred to another facility for drug and alcohol treatment. However, 42 percent completed their detox and were not transferred (Figure 18). Half (50 percent) of those discharged from non-detox treatment completed their treatment and had not used substances (Figure 19).

Figure 18

CIS Discharges
SFY 2009-2010

Detox Reasons for Discharge

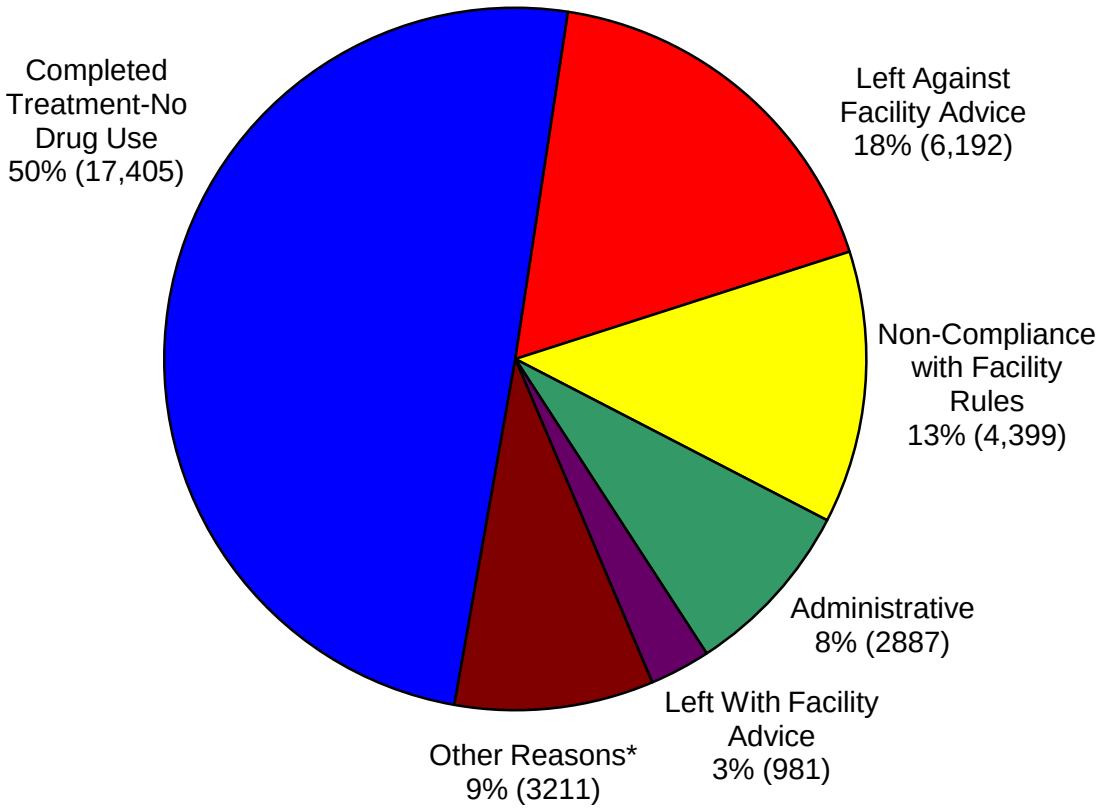


*Other Reasons includes: Left with Facility Advice, Non-Compliance with Facility Rules, and Jailed
Total Discharges=7,253

Figure 19

CIS Discharges
SFY 2009-2010

Non Detox Reasons for Discharge

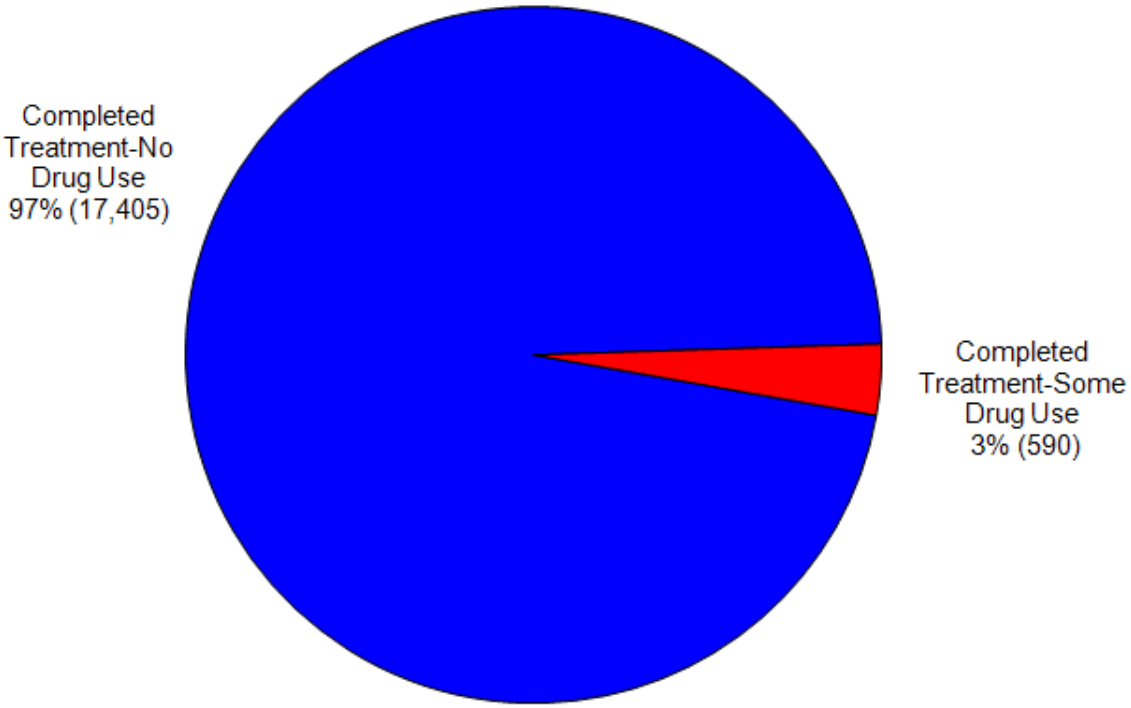


*Other Reasons includes: Referred to Another Drug and Alcohol Facility, Jailed, Completed Treatment-Some Drug Use, Relocation, Medical, Referred to a Non-Drug and Alcohol Facility, and Death.
Total Discharges=35,075

Figure 20

CIS Discharges
SFY 2009-2010

Non Detox Reasons for Discharge
for those who completed treatment



Total Discharges Completing Treatment=17,995

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.

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.

Half (50 percent) of those discharged completed their treatment goals (Figure 19). The vast majority (97 percent) of those completing their goals did not use substances, while 3 percent completed their treatment goals but still had some substance use (Figure 20). No significant changes occurred from previous years.

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

Employment

The employment outcome measure records if the client is employed (full-time, part-time or student) at admission and discharge. Overall, clients improved from 29 percent employed at admission to 30 percent employed at discharge (Figure 21). No significant changes occurred from previous years.

Arrests

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

Because of the large difference in period of time in which arrests could have occurred at admission versus discharge, the admission numbers are most likely artificially higher than the discharge numbers. This makes the admission numbers more of a classification status (involvement with criminal justice) than a baseline measurement to show change. However, only 2 percent of clients were arrested in the time they were engaged in treatment programs (Figure 22). No significant changes occurred from previous years.

Alcohol Abstinence

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

(primary, secondary or tertiary) are considered for the calculation. Overall, clients improved from 30 percent abstinent at admission to 65 percent abstinent at discharge (Figure 23). No significant changes occurred from previous years.

Other Drug Abstinence

The other drug abstinence outcome measure records whether the client is abstinent from other drugs in the 30 days prior to admission and discharge. Only those clients listing non-alcohol substances as a drug of choice (primary, secondary or tertiary) are considered for the calculation. Overall, clients improved from 23 percent abstinent at admission to 62 percent abstinent at discharge (Figure 24).

The somewhat high percentage of those already abstinent from alcohol and other drugs (30 percent and 23 percent, respectively) at admission occurs in part because the CIS requires a new admission each time a client changes type of service or provider. Many admissions (27 percent) were referred from a drug and alcohol service provider. Therefore, these clients have already been in drug and alcohol service and may have already begun abstaining from substances. No significant changes occurred from previous years.

Figure 21

Outcome Measure Employment Status State Fiscal Year 2009-2010

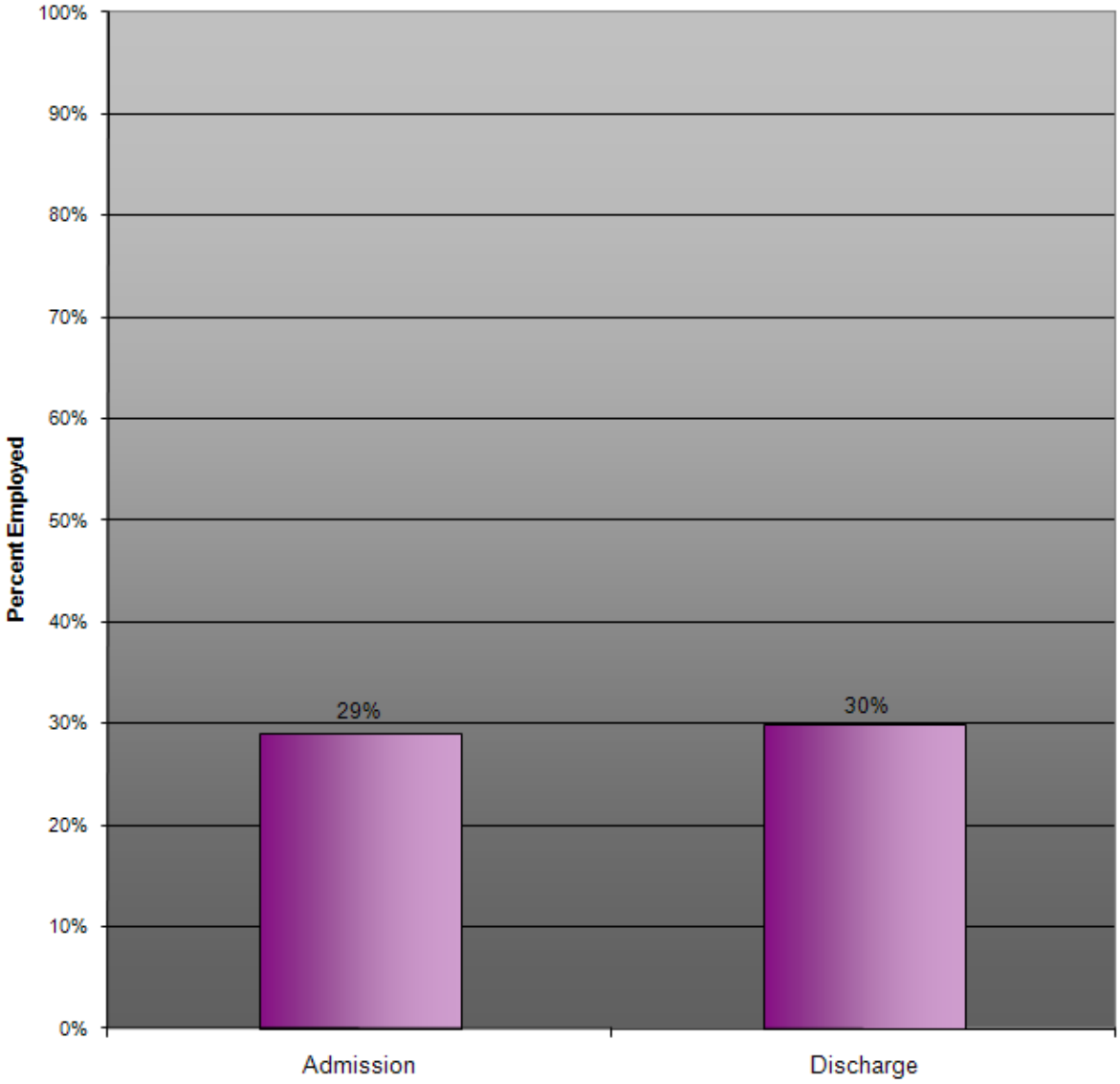


Figure 22

Outcome Measure
Arrests
State Fiscal Year 2009-2010

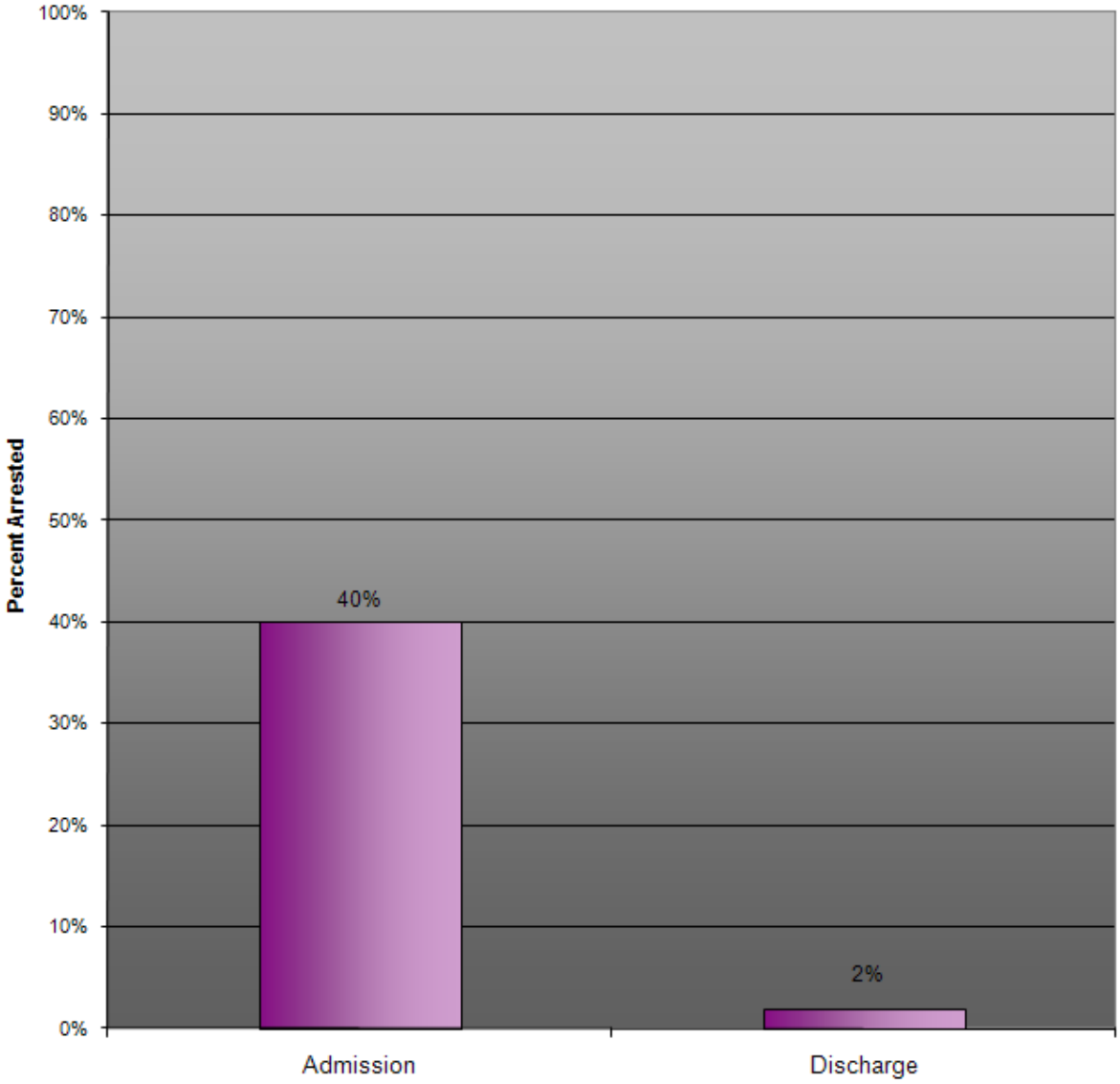


Figure 23

Outcome Measure
Alcohol Abstinence
State Fiscal Year 2009-2010

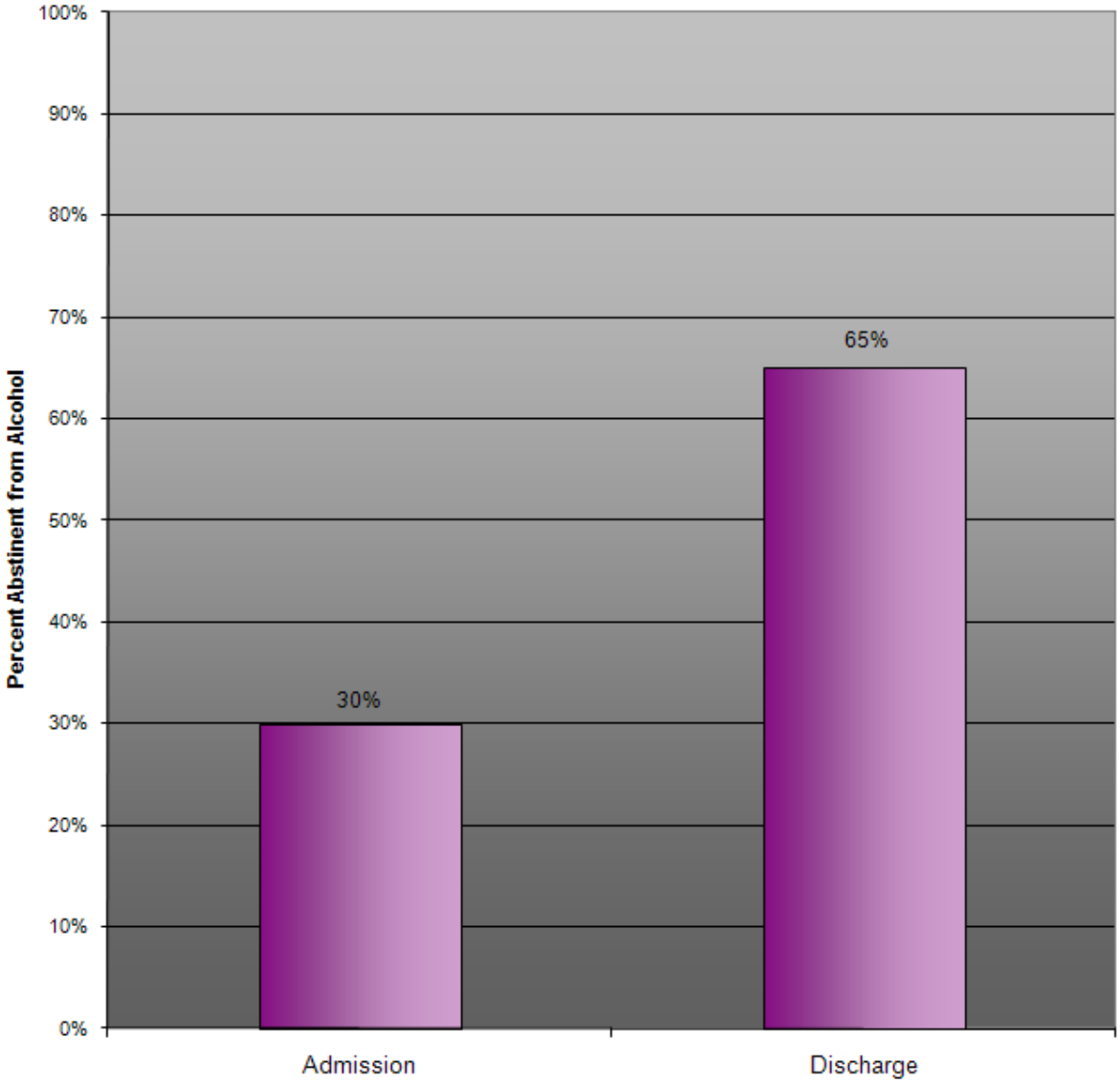
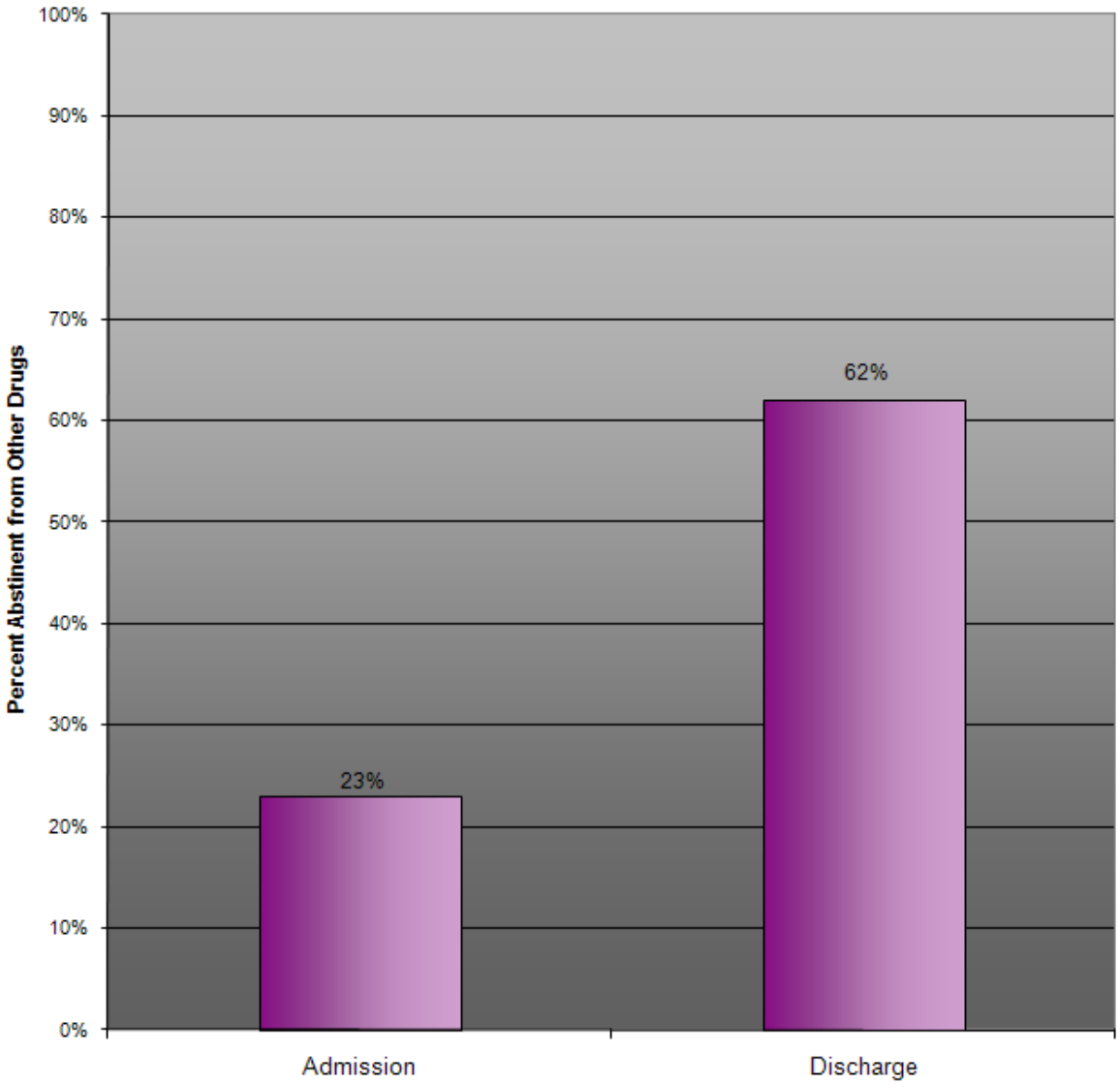


Figure 24

Outcome Measure
Other Drug* Abstinence
State Fiscal Year 2009-2010



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

Single County Authority Expenditures for Fiscal Year 2009-10 (All Sources)

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

Single County Authority Expenditures by Funding Level for Fiscal Year 2009-10 (All Sources)

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

For further information contact:

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

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Tom Corbett, Governor
Commonwealth of Pennsylvania

Eli N. Avila, Secretary of Health
Pennsylvania Department of Health