pennsylvania
DEPARTMENT OF HEALTH

BUREAU OF DRUG AND ALCOHOL PROGRAMS

DRUG AND ALCOHOL PROGRAM REPORTS

The following Fiscal Year 2012/13 State Plan was prepared in the ordinary course by the Department of Health, Bureau of Drug and Alcohol Programs. As a result of Act 50 of 2010 and beginning July 1, 2012, the Department of Drug and Alcohol Programs is statutorily responsible for and will be preparing the State Plan.

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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:

- Dr. Kenneth S. Ramsey, Ph.D
- Mr. Carmen F. Ambrosino
- Mr. Carlos E. Graupera
- Mr. Dickie Noles
- Ms. Marlene E. Burks
- Ms. Bonnie S. Summers
- Dr. George W. Dowdall, Ph.D
- Mr. Steven Saul, MA, CAC, CCDP, LPC

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 implementation of Act 50 of 2010 will occur July 1, 2012.

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, recovery support and recovery housing services.

CHAPTER TWO

ANNUAL REPORT

STATE FISCAL YEAR 2010-11

PROGRESS REPORT

STATE FISCAL YEAR 2011-12

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 2012-13

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 related to the overall management of the SCA as well as the SCA's ability to adhere to requirements identified in the Department's grant agreement with counties or independent commissions. This monitoring is also accomplished from a program perspective. BDAP's Division of Prevention and Division of Treatment reviews the SCA's need assessment and planning processes to evaluate what services are being delivered to meet local needs and to provide specific technical assistance that support the SCA's in developing new prevention, intervention and/or treatment programs or adapting existing ones to enhance the current service delivery system.

This section describes BDAP's major goals and objectives as defined within each Division/Section within the Bureau. Each section describes the responsibilities of the Division/Section and outlines the goals and objectives in a past, present and future format. The past is represented by the Annual Report for SFY 2010-11; the present consists of the progress occurring for SFY 2011-12, and the future is represented by the State Plan for SFY 2012-13.

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
- Performance-Based Prevention: Strategic Prevention Enhancement
    - Data Collection, Analysis and Reporting
    - Coordination of Services
    - Training and Technical Assistance
    - Performance and Evaluation
- Student Assistance Programs
- Underage Drinking Projects
    - Town Hall Meetings
    - 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 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 Programs.

Using a combination of Evidence-Based and State Approved Programs, along with the administering of State Approved 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 Programs and State Effective Strategies are defined as follows:

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

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

State Approved Programs meet the following criteria:

- Program/principle has been identified or recognized publicly and has received awards, honors or mentions.
- Program/principle has appeared in a non-referenced professional publication or journal. Note: It is important to distinguish between citations found in professional publications and those found in journals.
- Program/principle must have an evaluation that includes, but is not limited to, a pre/post test and/or survey

State Approved Effective Strategies are defined as programs which:

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

Each of the three program categories listed above must be delivered through single services and/or recurring services types and be recorded as such in the 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, and ATOD Free Activities Recurring).

There are approximately 55 evidence-based and 51 State Approved 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 2010-11, PROGRESS REPORT FY 2011-12 AND STATE PLAN FY 2012-13

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

ANNUAL REPORT FY 2010-11

BDAP continued to assist the Substance Abuse and Mental Health Services Administration (SAMHSA) 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 5,094 services in fiscal year 2010-11. Through these activities they served a total of 34,635 individuals (29,661 single service attendees and 4,974 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. The total number of individuals served appears to be less than the number served in fiscal year

2009-10. It should be noted that the manner in which data was collected changed from fiscal year 2009-10 to 2010-11. Data shows we reached 4,148,210 people through information dissemination, public campaigns to include radio and television spots and policy/practice change.

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. In addition to other highway safety issues, this group focuses on underage drinking and driving.

PROGRESS REPORT FY 2011-12

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. In September 2012, this grant will expire and an overall final evaluation will be completed.

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. The SPF SIG will end in September 2012.

BDAP continues 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. 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 the 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.

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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.

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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, 2011. During SFY 2010-11, 14,312 youth 12-18 years of age took the NOMs survey during their participation in BDAP-funded prevention services. During the same time period, 5,537 adults 18 and older completed the NOMs survey while participating in BDAP-funded prevention services.

SFY 2010-2011 Youth NOMs Survey Findings

- 87.18 percent of youth reported no alcohol use in the past 30 days, an increase of 3.18 percent, compared to SFY 2010-2011.
- 70.50 percent of youth report they have never used alcohol, an increase of 4.64 percent, compared to SFY 2010-2011.
- 3.93 percent of youth reported that during the past 12 months they drove a vehicle while under the influence, an increase of .16 percent, compared to SFY 2010-2011.
- 45.89 percent of youth who are working reported they would be more likely to work for an employer who randomly drug and alcohol tests his employees, an increase of 5.13 percent, compared to SFY 2010-2011.
- 85.40 percent of youth reported they have never used marijuana, an increase of 1.53 percent, compared to SFY 2010-2011.
- 93.05 percent of youth reported they have never used other illegal drugs, an increase of 1.35 percent, compared to SFY 2010-2011.
- 13.16 percent of youth reported they first used alcohol between the ages of 12-14, a decrease of 3.38 percent, compared to SFY 2010-2011.
- 43.19 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 3.38 percent, compared to SFY 2010-2011.
- 64.23 percent of youth strongly disapprove of someone their age trying marijuana or hashish once or twice, an increase of 4.61 percent, compared to SFY 2010-2011.

SFY 2010/2011 Adult NOMs Survey Findings

- 33.39 percent of the adults reported they took their first drink between the ages 15 and 17, a decrease of .52 percent, compared to SFY 2010-2011.
- 41.25 percent of the adults reported they have never used marijuana, a decrease of 2.30 percent, compared to SFY 2010-2011.
- 31.89 percent of adults reported they would be more likely to work for an employer who conducted random drug and alcohol tests on their employees, an increase of .18 percent, compared to SFY 2010-2011.
- 18.84 percent of adults reported that, during the past 12 months, they drove a vehicle while under the influence, a decrease of 1.25 percent, compared to SFY 2010-2011.
- 29.63 percent of adults with children of an appropriate age 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 2.98 percent, compared to SFY 2010-2011.
- 41.65 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 2.74 percent, compared to SFY 2010-2011.

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 2010, BDAP's Performance-Based Prevention System moved 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. In 2010-2011, BDAP continued to work with KIT to enhance the system. 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.

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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, 2011. 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.

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.

BDAP is continually enhancing the PBPS data system by, for example, developing additional reports and adding a report builder 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.

Additional enhancements to PBPS will be possible through the award to BDAP of a one year Strategic Prevention Enhancement (SPE) Grant. These enhancements will develop Pennsylvania's substance abuse prevention infrastructure by improving data collection, data analysis, and training of the prevention workforce. This will be valuable in increasing ability to efficiently and effectively assess needs and plan, implement, and evaluate prevention services across Pennsylvania.

- The priority goal of this grant project is to enhance PBPS to capture and present data that will improve the ability to use a data-driven process to identify needs and plan, provide, and evaluate prevention services.
- A second goal will be to improve the knowledge and capacity of the prevention workforce.
- A third goal of this grant project is to enhance capacity to improve fiscal management of prevention activities at the local level and improve planning for most cost-effective use of funds.

Specific infrastructure enhancements completed during this project that will help to reach these goals include: adding a Real-Time Data Visualization (RTDV) Dashboard to allow existing data elements in PBPS and other external data to be overlaid and presented in map, chart or table form; creation of a mobile web-based application for PBPS; addition of an evaluation plan module for creating and monitoring evaluation plans; creation of county epidemiological profiles based on data in PBPS; addition of a fiscal management module; addition of a client management module; and development of a variety of video-based online trainings for the prevention workforce. All residents of Pennsylvania will benefit from the infrastructure enhancements that will take place during this project. A better trained prevention workforce as well as new tools at the state, county and community level to collect data and better utilize and analyze data that is collected will increase both the effectiveness and efficiency of the services, programs, policies, and practices that are essential to effective substance abuse prevention.

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 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 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.

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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.

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.

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 to be enhanced in partnership 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 and report 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 2010-11

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 Club & Camp Ophelia: A Safe Place for Girls and Interrupted - High Risk Youth Intervention Program.

The Division participated in the PA Drug and Alcohol 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 PA Drug and Alcohol Coalition and met to discuss priority areas of focus for the committee.

PROGRESS REPORT FY 2011-12

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 Program and potential recommendation for participation in STS. In July of 2011, Interrupted - High Risk Youth Intervention Program, was nominated and further selected to participate in the Service to Science Program.

BDAP continues to enhance cross-agency prevention efforts through the SPF SIG. 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 providers have received 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 Division is participating in and funding the PA Drug and Alcohol Coalition through the SPE Grant. The Prevention Committee that was created under the PA Drug and Alcohol 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.

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.

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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 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 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, the Multi Agency Safety Team (which is coordinated by the Pennsylvania Department of Transportation, 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 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.

PROGRESS REPORT FY 2011-12

The Workforce Development Committee of the Pennsylvania Drug and Alcohol Coalition will continue to meet and address the issues of the field.

One of the specific goals of the SPE grant is to improve the knowledge and capacity of the prevention workforce. The grant will allow for enhancements to PBPS to include online video-based training of the prevention workforce. A better trained prevention workforce as well as new tools at the state, county and community level to collect data and better utilize and analyze data that is collected will increase both the effectiveness and efficiency of the services, programs, policies, and practices that are essential to effective substance abuse prevention.

STATE PLAN FY 2012-13

BDAP will continue its work with the PA Drug and Alcohol Coalition. BDAP will implement the video-based training developed under the SPE grant.

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 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 ongoing 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 2010-11, PROGRESS REPORT FY 2011-12 AND STATE PLAN FY 2012-13

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 2010-11

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 was tasked with reviewing and revising the special considerations papers that are included in the current PCPC.

With the revision of the special considerations papers completed, the CSC began to develop a framework within which the PCPC will be revised. Each subcommittee first created a table that summarized their work. The intent of this task was to create a quick-reference guide to placement considerations and coordination of care considerations for each of the special populations. Placement considerations are issues that affect the level of care or program to which a client is placed for services. Coordination of care considerations include the types of community resources that would be beneficial to a client (i.e., case management, recovery support services, etc.).

Once the special considerations tables were completed, a small group was formed to create a "guiding principles" section of the PCPC. Work on the guiding principles was begun with an effort to incorporate recovery-oriented language and evidence based practices to support the principles.

PROGRESS REPORT FY 2011-12

The CSC continues to meet on a regular basis. The CSC continues its work in revising the PCPC regarding implementation, utilization, content and structure for relevance and merit. The guiding principles continue to be revised based on feedback from CSC members. Two new subcommittees, Re-write and Review, have been formed in order to complete the PCPC revision.

The Re-write Subcommittee's work continues as follows:

- Revise the introduction section of the PCPC
- Finalize the guiding principles
- Revise each section of the placement criteria, incorporating the changes as recommended by the subcommittees

The Review Subcommittee has been formed with the task of reviewing the content of the revised PCPC. The Review Subcommittee will begin its work when the Re-Write group has completed its tasks.

In anticipation of completing the revision of the PCPC, the CSC chairs are investigating the possibility of engaging a technical writer in order to ensure cohesiveness of the revised PCPC document.

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The CSC and the subcommittees will meet throughout the fiscal year to continue their efforts related to the revision of the PCPC. It is the intent of the CSC to have a draft of the revised PCPC completed by September, 2012. Once PCPC revisions are completed, a training curriculum and plan will be developed to educate the field on the new edition of the PCPC.

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 2010-11

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. The Bureau of Drug and Alcohol Programs (BDAP) has been moving in this direction since attending CSAT's National Summit on Recovery in 2005. To further support this transition, BDAP 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 SCAs. Beginning in its 2010-2015 Grant Agreements with the SCAs, BDAP 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. BDAP held a ROSC training event in the Harrisburg area for various state stakeholders, as well as 2 regional trainings for stakeholders at the county and local levels. A ROSC Internal Planning Team was convened in order to establish a strategic plan for statewide implementation and various internal learning opportunities regarding ROSC were provided to BDAP staff.

In conjunction with the Department of Public Welfare's (DPW) Office of Mental Health and Substance Abuse Services (OMHSAS), BDAP supported two committees to facilitate the implementation of ROSC. The Recovery Based Issues Committee of the PA Drug and Alcohol Coalition and The Persons in Recovery Committee, a subcommittee of the OMHSAS Advisory Council. These committees serve to provide OMHSAS and BDAP with feedback, dialogue, input and recommendations on systemic issues pertaining to drug and alcohol program development and implementation of recovery-oriented systems of care.

PROGRESS REPORT FY 2011-12

BDAP continues its efforts in the statewide implementation of ROSC. A third BDAP sponsored training on the subject was held for stakeholders at the county and local levels and additional technical assistance to be provided to the SCAs has been planned.

BDAP's ROSC Internal Planning Team continues to meet to consider the best strategies for statewide implementation of ROSC. A number of implementation plans established by other states were reviewed by the team in order to benefit from lessons learned and to gain information about what may work best for implementing ROSC in Pennsylvania. Additional stakeholders will be invited to give input into ROSC implementation as BDAP moves forward with its strategic plan.

A ROSC Internal Planning Team Retreat was held in February 2012 to help BDAP further the statewide implementation of ROSC.

OMHSAS and BDAP continue to support two committees to facilitate the implementation of ROSC. The Recovery Based Issues Committee of the PA Drug and Alcohol Coalition and The Persons in Recovery Committee, a subcommittee of the OMHSAS Advisory Council, both of which continue their work and serve to provide OMHSAS and BDAP with feedback, dialogue, input and recommendations on systemic issues pertaining to drug and alcohol program development and implementation of recovery-oriented systems of care.

STATE PLAN FY 2012-13

BDAP 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 strategic plan will be established through the efforts of the ROSC Internal Planning Team and various stakeholder groups and the plan will be communicated throughout the state. A training plan will also be developed in order to support regional implementation efforts and to best meet the needs of local stakeholders.

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.

ANNUAL REPORT FY 2010 - 2011

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) presented their formal recommendations to the Health and Human Services Committee on November 16, 2009 but opted to remain intact in an effort to put forth their recommendations on an ongoing basis and to encourage their implementation.

PPAC continued to meet to provide input to BDAP regarding implementation of its recommendations as well as to inform various stakeholder groups regarding their work. In so doing, 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 assisted in singing the National Anthem and were recognized during the pre-game events.

PPAC also 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.

Recruitment for additional panel members was conducted to fill vacancies which resulted from member resignation. Five new parents were added to the panel in December 2010.

PROGRESS REPORT FY 2011-12

PPAC continued to meet in order to provide continued feedback to BDAP. Many of the members are involved in local initiatives or are involved in other state affiliated workgroups which parallel or support their official recommendations made to the Health and Human Services Committee. Furthermore, the Pennsylvania Drug and Alcohol Advisory Council and PPAC established a working partnership this past year in which each council will inform and advise the other regarding ideas for improving the substance abuse service system. They have agreed to meet together at least twice annually.

STATE PLAN FY 2012-13

The members of PPAC plan to recruit additional members on an as needed basis and will continue to meet periodically throughout the year. They will meet with the Pennsylvania Drug and Alcohol Advisory Council and members will continue their individual involvement in various workgroups, both at the state level and within their communities.

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

ANNUAL REPORT FY 2010-11

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.

BDAP 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 obstetric gynecology offices and 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. BDAP also provided resources to 24 Women Infant and Children's (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's, 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 BDAP staff 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.

PROGRESS REPORT FY 2011-12

BDAP conducted various initiatives regarding FASD Awareness. These events have historically been conducted during the week in which FASD Awareness is observed nationally; however, this year, BDAP advocated that observance be extended from a week to a month. This allowed many of the BDAP's community partners to expand their efforts, especially in regards to activities delivered within school districts.

Those activities supported directly by BDAP included The Baby Bottle Distribution Project which was conducted for the fifth consecutive year, with 53 obstetric gynecology offices and pregnancy centers distributing 5,472 baby bottles with prevention message inserts to expectant mothers in 41 counties across the Commonwealth. These figures represent an increase in project activity from 2010, as follows:

- A 32 percent increase in the number of bottles distributed;
- A 17 percent increase in the number of obstetric gynecology offices and pregnancy centers participating; and,
- A 24 percent increase in the number of counties represented in the project catchment area.

BDAP also distributed over 90,000 pieces of materials obtained through its agreement with the NineZero Project in an effort to relay a unified awareness message across the state. This information was disseminated primarily through SCAs and their community treatment and prevention provider organizations. Women, Infant and Children's (WIC) Programs and some municipal health offices also participated by providing information to their service recipients.

BDAP also worked with partners in the Philadelphia area where the FASD Awareness Month Kickoff Event was held on September 9, in the Mayor's Reception Room, City Hall. While office closures resulting from area flooding prohibited BDAP staff from being in attendance, the event was held as scheduled with notable speakers such as Deputy Mayor for Health and Opportunity, Health Commissioner Donald F. Schwarz, MD, MPH, MBA; Commissioner of Philadelphia's Department of Behavioral Health & Intellectual disability Services Arthur Evans Jr., PhD; Representatives from the Philadelphia FASD Initiative: St. Christopher's Hospital for Children Renee Turchi, MD, MPH, FAAP, and COMHAR's Linda Bamberger, MSW; and keynote speaker and birth mother, Mary DeJoseph, DO and her son Stephen DeJoseph. About 40 individuals were present at this event.

Overall, awareness initiatives and activities occurred in 63 of Pennsylvania's 67 counties. BDAP also conducted various FASD training opportunities throughout the year.

STATE PLAN FY 2012-13

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 Month activities will continue during September 2012 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 continue as will targeted campaigns to high risk populations such as pregnant and college-aged women. Training efforts will continue through the BDAP training system.

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

ANNUAL REPORT FY 2010-11

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

BDAP continued to collaborate with the Department's Division of Drug and Alcohol Program Licensure to further explore the feasibility of expanding the scope of the exception to 28 Pa. Code Chapter 715 §715.1 for residential levels of care and to modify the exception for outpatient level of care.

Seven hundred and thirty-eight physicians have been approved for administration of Buprenorphine and 54 narcotic treatment programs have been approved to use Buprenorphine as of December 31, 2011.

PROGRESS REPORT FY 2011-12

An action memorandum describing the Buprenorphine Workgroup recommendations for expanding/modifying the exception to 28 Pa. Code Chapter 715 was sent to the Secretary of Health for review and approval.

BDAP will continue to hold meetings of the Buprenorphine Workgroup, to: 1) monitor the response from the Secretary of Health to the action memorandum describing the Buprenorphine Workgroup recommendations for expanding/modifying the exception to 28 Pa. Code Chapter 715; 2) discuss implementation plans for approved parts of the action memorandum, as well as plan to evaluate the impact the changes have on delivery of Buprenorphine services; 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.

STATE PLAN FY 2012-13

BDAP plans to continue holding meetings of the Buprenorphine Workgroup to: 1) monitor the impact the changes approved in the action memorandum have had on delivery of Buprenorphine services; 2) monitor progress on any recommendations made by the specific workgroups in regards to physician education/training, reimbursement and expansion of access to treatment services; 3) discuss any emerging issues surrounding access to Buprenorphine treatment that are identified as barrier to treatment access.

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

ANNUAL REPORT FY 2010-11

In Fiscal Year (FY) 2010-2011, a total of $564,000 was allocated to four SCAs through the drug and alcohol appropriation for the Hepatitis C Project. This included $212,935 to Philadelphia, $122,280 to Allegheny, $106,165 to Clearfield/Jefferson and $122,620 to Northampton counties. Coordinated through Mercy Behavioral Health, Allegheny's Hepatitis C Project consisted of 27 sites, six of which were methadone providers. Clearfield/Jefferson's project consisted of 10 sites, including one methadone provider. Northampton's project was operated through New Directions Treatment Services and consisted of 10 sites, one of which was a methadone provider. Philadelphia's project consisted of 13 project sites, six of which were methadone providers.

Through annual meetings with all the Hepatitis C Project sites, the Department's Bureau of Communicable Diseases, the Bureau of Epidemiology, Genentech Inc., and the Philadelphia Department of Public Health, 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 continued screening, testing, counseling and case management services for clients at risk for Hepatitis C. All sites were fully operational and compliant with all reporting requirements.

In FY 2010-11, the Hepatitis C Project encompassed three service areas: Outreach, Testing and Case Management. The following State Fiscal Year 2010-2011 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 3,174 persons were contacted in the three SCAs that collected the data. In addition, 1,033 persons were referred for testing. Pre-test counseling was provided to 7,401 clients in the four SCAs. One hundred percent of the persons tested received pre-test counseling. Overall, 3,623 individuals or 49 percent tested positive. Also, 6,967 persons or 94 percent received post-test counseling. Case management data indicate that 3,705 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. One hundred seventy-nine persons received Hepatitis A and B vaccines, representing an increase of 17 clients as compared to last year.

All four SCAs provided testing and case management services in FY 2010-11. 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 clinics; arranged for guest speakers at several sites; counseled and made referrals for patients who were seen in Allegheny County but resided outside of the county; collaborated with Genentech Clinical Specialists to promote Hepatitis C Virus awareness; and supported the "Community C" community based liver wellness clinic. The Clearfield/Jefferson SCA provided Hepatitis C materials at local community health fairs, college campuses, and social service agencies; facilitated the first Hepatitis Education class offered to individuals involved with Clearfield County probation; attended meetings of the Rural Health Consortium; purchased and received tele-video units that were obtained through the Rural Health Outreach Grant Program; and distributed an educational video addressing opiate addicted pregnant women to social service and medical agencies. Northampton SCA conducted Hepatitis C presentations, collaborated with treatment providers, distributed brochures and assisted clients with service linkages, transportation, interpretation services and advocacy.

PROGRESS REPORT FY 2011-12

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 Department's Bureau of Communicable Diseases, the Bureau of Epidemiology, Genentech Inc., and the Philadelphia Department of Public Health, continues to ensure that sites in the Commonwealth of Pennsylvania adhere to established Hepatitis C service protocols.

STATE PLAN FY 2012-13

BDAP will continue to collaborate with the Department's Bureaus of Epidemiology and Communicable Diseases, as well as Genentech Inc., and other pharmaceutical corporations, 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 will be provided via quarterly reports.

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 2010-11

In September 2010, BDAP was awarded a four-year grant totaling $11,889,262 for the period September 30, 2010 to September 29, 2014 from the Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Treatment (CSAT) to implement an Access to Recovery (ATR) program in Philadelphia County. The grant required a specific number of clients to be served with the designated annual funding amounts varying for each year of the project. Funding by year for the four-year project included $2,617,201 for the first year which began September 30, 2010 and ended September 29, 2011. The second year was funded $3,249,418 from September 30, 2011 through September 29, 2012. If the third year is funded, it would include $3,221,322 from September 30, 2012 through September 29, 2013. If the fourth year is funded, it would include $2,801,321 from September 30, 2013 through September 29, 2014. Throughout the entire four-year project, 10,705 clients will receive ATR services with this grant funding.

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

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

PROGRESS REPORT FY 2011-12

BDAP continues to work closely with ATR project partners including the Philadelphia SCA and the VMS vendor Knowledge Information Technology (KIT) Solutions to maintain project services. During the first grant year of the project which began September 30, 2010 and ended September 29, 2011 a total of 1,423 clients received ATR services via a network of 30 evaluation and recovery support service providers. This exceeds the annual target of 1,314 clients for the first year. A six month follow-up Government Performance and Results Act (GPRA) survey rate of 128% was also achieved which exceeds the mandatory 80% GPRA follow-up rate required by SAMHSA.

ATR continuation grant funding for the second year was secured in July 2011. The second year of the project began September 30, 2011 and progress is underway for achieving the current annual target of providing ATR services to 3,642 clients. During this year, the SCA provider network was expanded to forty-eight evaluation and recovery support service providers. This expanded provider network is comprised of additional faith-based and community-based providers aimed at reaching individuals that might not otherwise receive treatment or recovery support services. This expansion facilitated the inclusion of additional recovery support services which currently includes an assortment of fifteen services. Also, project advancements were made to improve training and service structures, voucher and fiscal management, assertive outreach and engagement as well as collaborative partnership development.

STATE PLAN FY 2012-13

BDAP will continue to work with ATR project partners to maintain ATR services within the Philadelphia service area. Additional provider and service options are expected to become available during this time. Approximately 3,542 clients will receive ATR project services during the third year of the project. The project will continue to improve access to services, promote recovery, expand client choice, increase service capacity, and improve outcomes within Philadelphia County.

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.

ANNUAL REPORT FY 2010-11, PROGRESS REPORT FY 2011-12 AND STATE PLAN FY 2012-13

GOAL: On-site Quality Assurance Assessment Review Monitoring of Single County Authorities (SCAs).

ANNUAL REPORT FY 2010-11

The Department's five-year grant agreement began July 1, 2010. The Division began monitoring SCAs on the new requirements in April 2011, and planned to complete all on-site visits by October 1, 2011 for all 47 SCAs. The original decision was to move to an 18-month monitoring process given the amount of information now being reviewed to verify adherence to the Department's grant agreement; however, after further internal discussion, the decision was made to continue monitoring on an annual basis and complete on-site visits between April and October 1st each calendar year. BDAP decided to focus the review from a management perspective and not only on the basis of compliance to grant agreement requirements. Since the on-site QAA visits did not begin until April 2011, BDAP's monitoring of the SCA's adherence to Federal Block Grant requirements took place in the second quarter of fiscal year 2011-12, and the results of such reviews were delineated in a separate report provided to the SCA.

PROGRESS REPORT FY 2011-12

The Division completed the monitoring review process of all SCAs that began in April 2011. The intent was to complete all on-site monitoring visits by October 1st; however, due to scheduling issues, the monitoring process was not completed until December 2011. The Division is meeting in early January 2011 to assess the monitoring process and make improvements in the process as needed. The purpose of the monitoring visits beginning in April 2012 will remain focused on how the SCAs manage the delivery of D&A services in their geographic area. The Division does not plan to do separate federal block grant reviews; rather, that component of the QAA process will be built back into the on-site QAA visits to begin again in April 2012.

STATE PLAN FY 2012-13

The Division will continue annual monitoring of SCAs based on grant agreement requirements and with a focus on the SCA's ability to effectively manage the delivery of D&A services in their geographic area.

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/.

GOAL: Better Utilization of Training Resources.

ANNUAL REPORT FY 2010-11

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. A Regional Training Institutes was held November 2010 in State College, PA, attendance was relatively low due to marketing of the Institute and the fact that there had not been one in several years. 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	
	09-10	10-11	09-10	10-11
On-site		433	7,797	10,440
Mini-Regional Trainings		144	2,738	2,849
Specialized		45	604	1327
Training of Trainers		7	10	50
Regional Training Institute	0	11	0	107
Total	**523**	**640**	**11,149**	**14,773**

PROGRESS REPORT FY 2011-12

One major recommendation made by the Training Advisory Workgroup was to implement online training. The Department of Health has been working to contract for an online training package, which will be used to present some of our didactic courses.

The Regional Training Institute was held in October 2011 in Pittsburgh. A total of 15 courses were offered to 209 attendees.

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.

STATE PLAN FY 2012-13

BDAP is continually exploring a variety of ideas to improve utilization of training resources. It is anticipated that issues regarding procurement of a distance learning system can be addressed and an online system could be fully implemented during calendar year 2012.

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, BDAP 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, BDAP 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.

BDAP 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 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 gauge 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 as BDAP begins data capture with the 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 Grant. 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 portal website and Listserve 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 2010-11, PROGRESS REPORT FY 2011-12 AND STATE PLAN FY 2012-13

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

ANNUAL REPORT FY 2010-11

For FY 2010-2011, the BDAP Listserve reached 2,432 registered members. This accounted for 137,241 emails sent, with 98 percent delivered successfully to include a 37 percent open rate and a 34 percent read rate. During January 2012, there were 2,572 registered email addresses in the ListServe. BDAP surpassed our targeted 5 percent annual email subscription growth.

BDAP continued to use the BDAP Communicator as its main communication with SCAs and key stakeholders. For FY 2010-2011, the BDAP Communicator introduced 103 posts and delivered 4,198 messages to SCA Administrators. BDAP also expanded the use of the BDAP Communicator so that providers could directly access current BDAP Manuals.

PROGRESS FY 2011-12

In January 2012, as part of our ongoing effort to increase membership to the BDAP ListServe, we began to segment our list into topically specific sends. At approximately halfway through the 2011-12 fiscal year, 56,239 emails have been delivered, with a 98 percent delivery rate. Of that number, 22 percent were opened and 18 percent of those emails were read. By segmenting the list, BDAP 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. Later this year, BDAP will be taking measures to 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.

STATE PLAN FY 2012-13

BDAP will continue to use the ListServe and the BDAP Communicator to provide information to the field and the community. In 2012-2013, BDAP hopes to increase our outreach in subscriptions by five percent. One approach to improving our communications and outreach is to direct more targeted messaging that is more pertinent and relative to our stakeholder groups. This will be accomplished by assessing our new rebrand and navigation strategy by analyzing the statistics produced by reads and click throughs.

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 2010-11

In FY 2010-2011, the Performance-Based Prevention System (PBPS) was successfully moved 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. The new PBPS is leading the transition to outcome-based planning and accountability to ensure appropriate use of funds for prevention programs.

The FY 2010-11 State Report includes many new adult and expanded youth Prevention NOMs for the first time, and BDAP is excited to share this valuable information with the field.

PROGRESS FY 2011-12

During FY 2011- 2012, BDAP will continue to advance the PBPS. This will be accomplished as a result of the successful acquisition of the Strategic Prevention Enhancement (SPE) Grant, 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.

The Prevention Division and Data Section are also working towards the successful procurement of KIT Solutions services for the SPE.

STATE PLAN FY 2012-13

In FY 2012-2013, BDAP will continue to advance PBPS by utilizing all resources. Features finally realized will be the 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 assessing 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 2010-11

During FY 2010-2011, BDAP continued to work collaboratively with the SCAs, providers, related associations and internal commonwealth stakeholders regarding the discovery, development and testing phases of the new system. Application development was completed in February 2011, and user acceptance testing (UAT) began in April 2011 and was completed by December 2011. BDAP submitted the PA Treatment Episode Datasets (TED) Crosswalk for data submission to SAMHSA's vendor, Synectics for Management Decisions, Inc., (SMDI) as well.

PROGRESS FY 2011-12

In January 2012, the system rollout of a pilot region and regional trainings took place. Data collection will commence for each region when that region has successfully signed onto the system and training is complete. BDAP continues to work collaboratively with the SCAs, providers, related associations and internal commonwealth stakeholders regarding the deployment phases of the new system. While all regions will be trained on the STAR Data System by July 1, 2012, BDAP realizes providers being trained in the month of June will not be fully reporting within the month. BDAP anticipates a lag of data reporting and system acceptance. In preparation of this the Client Information System (CIS) will continue to be utilized for data capture as well. Data in STAR 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 test client data to SAMHSA's vendor SMDI.

STATE PLAN FY 2012-13

Currently, BDAP is targeting full deployment for Phase 1 of the project by July 1, 2012. This July 1 date deployment is to coincide with the State Fiscal Year to make the transition smoother. 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 the Drug & Alcohol Programs portal (the commonwealth website).

ANNUAL REPORT FY 2010-11

In July 2010, the Pennsylvania Department of Health's 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 operated as the

information clearinghouse for the Pennsylvania Department of Health through the web portal. 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.

In January 2011, BDAP integrated training courses and training course descriptions, as well as course registration from the BTMS into the BDAP web portal. 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.

PROGRESS FY 2011-12

Web portal maintenance and updates continue to be performed by appropriate BDAP staff. Staff are trained and assigned according to ongoing content familiarity.

In December 2011, a new STAR Support web portal was established for the support of the new STAR Data System. The purpose of this support arm for STAR is to support STAR users with questions about the data system. Areas on the portal include an About STAR, New Releases, FAQ, Resources, Training Registration, and Contact us page.

STATE PLAN FY 2012-13

In FY 2012-2013, BDAP anticipates many new web portal needs and challenges. Our goal is about making it easier for the substance abuse field and all our stakeholders to interface with BDAP better.

GOAL: Utilize technology to improve operations.

ANNUAL REPORT FY 2010-11

A change to the SCA Data System (SDS) made it easier for the SCAs to update their contractual information with their business partners was deployed. This new update provided 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 BDAP allows a seamless monitoring of the contract process.

In FY 2010-11 the BTMS usability was enhanced from its current state with several more reports added and new features to assist in administration validation.

PROGRESS FY 2011-12

The Data Section is always looking for a way to make it easier for SCAs and stakeholders to work with BDAP. A technology assessment is in process to evaluate all BDAP technology currently in use and to assess whether separate applications can be integrated. The Case Management Resource Report (CMRR) and CIS will be phased out.

STATE PLAN FY 2012-13

Beginning FY 2012-2013, the phasing out of CIS will commence. This will be implemented by the use of the STAR Data System's first set of performance measures. Reports within STAR will indicate to providers and SCAs their reporting status and readiness to move fully to reporting in STAR. The reports themselves will provide SCAs a monthly trend analysis of the admission, discharge and CMRR counts being reported in the new system. The last three years of CIS admissions and CMRR counts will be provided to the SCAs to benchmark their own progression out of CIS.

Throughout FY 2012-2013, BDAP plans 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 and 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 2010-11

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 or family reunification and other activities related to their rehabilitation. Children are given age appropriate education regarding substance abuse, and, if school age, they are enrolled in a nearby school. Women and children programs across the commonwealth have worked diligently to establish a positive working relationship with staff from the local school districts so that the children are served in the best possible way. Additionally, programs across the continuum of care have been developed within individual SCAs by willing providers that offer similar services at a level of intensity appropriate to individual types of service.

During the course of FY 2010-11, service capacity for women and women with children was as follows: *(Note: The following numbers are conditional upon space and the number of people residing at each facility at any given time.)*

- Programs providing residential treatment services exclusively for pregnant women or women with dependent children = 15
  - Total Capacity for Women = 247
  - Total Capacity for Children = 427
- Residential Programs for Women = 13
  - Total Capacity = 526
- Transitional Living Facility Program = 1
  - Total Capacity = 12, with the ability to accommodate women with their newborns
- Halfway House Programs = 18, two of which allow women to bring their children
  - Total Capacity for Women = 405
  - Total Capacity for Children = 53

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 and education for accompanying children;
- Reduction in perinatal addictive disorders;
- Reduction in acute health care costs;
- Reduction in legal system involvement and criminal behavior;
- Reduction in unemployment;
- Reduction in homelessness;
- Development of parenting skills for mothers; and,
- Improved communication skills for mothers and children.

During FY 2010-11, the following residential women with children programs were in operation:

- Family Links, Inc., in Allegheny County
- Family Links, Inc., in Fayette County
- Family Links, Inc., – Family Treatment Center in Allegheny County
- Gaudenzia, Inc., – Fountain Springs in Schuylkill County
- Gaudenzia, Inc., – Vantage in Lancaster County
- Gaudenzia, Inc., Winner Co-occurring Women and Children Program in Philadelphia County
- Gaudenzia New Image in Philadelphia County
- Genesis II, Inc., DBA Caton Village in Philadelphia County
- Interim House West in Philadelphia County
- Libertae Family House Libertae, Inc., in Bucks County
- My Sister's Place, Thomas Jefferson University in Philadelphia County
- RHD Family House in Montgomery County
- RHD Family House NOW (New Options For Women) in Philadelphia County
- Samara House of CYWA in Chester County
- Sojourner House, Inc., in Allegheny County

In addition, there were 18 halfway house programs that specifically provided services to women. Some of these facilities can accommodate pregnant women and two facilities are able to accommodate women with their children:

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

- The Lighthouse for Women of Greenbriar Treatment Center in Washington County
- Treatment Trends, Inc., Half-way Home of the Lehigh Valley in Lehigh County

There was one licensed transitional living facility which specifically provided services to women. This facility can accommodate pregnant women as well as mothers with newborns:

- Abstinent Living at the Turning Point at Washington, Inc., in Washington County

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

- Clem-Mar House, Inc., in Luzerne County
- Eagleville Hospital in Montgomery County
- Gaudenzia, DRC, Inc., in Philadelphia County
- Gaudenzia Together House in Philadelphia County
- Greenbriar Treatment Center in Washington County
- Interim House, Inc., in Philadelphia County
- Mary E. Steratore Addiction Treatment Center in Fayette County
- Mirmont Treatment Center in Delaware County
- RHD – Womanspace in Montgomery County
- RHD – Womanspace in Philadelphia County
- Roxbury in Cumberland County
- Turning Point Chemical Dependency Treatment Center (Freedom Center) in Venango County
- UHS Recovery Foundation, Inc., (dba Keystone Center) in Delaware County

BDAP continued to support the provider organization, Women and Their Children Heal (WATCH). This organization 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 continued to serve 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. WATCH's revised "Gender-Responsive Treatment for Women with Substance Abuse Disorders" white paper, included recommendations to BDAP relative to women's treatment needs. Subsequently, this document, along with other resources for treatment providers serving women and women with children, has been posted on BDAP's website to increase access to gender-informed service provision information, best practices, and recommendations. In cooperation with BDAP, WATCH developed a training comprised of best practices for the provision of treatment services to women. During the state fiscal year, this gender-responsive training entitled "Gender-Responsive: Treatment that Matters for Women with Substance Use Disorders," was finalized, approved for inclusion into BDAP's training management system, and officially rolled out at BDAP's regional training institute in October 2011 in Pittsburgh. BDAP will continue to provide technical assistance to WATCH as they continue to facilitate this

training throughout the commonwealth and modify the curriculum as needed. 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 surrounding the women they serve as well as possible resources to assist with such practices. It is an opportunity to bring treatment providers together annually to discuss women-centered and need-specific programming for women and children, as well as share best practices for the provision of treatment services to women. This year, the treatment forum included renowned guest speakers Miss USA 2006, Tara Conner, and author/activist, Sil Lai Abrams who shared their stories of addiction, recovery and inspiration. Following the keynote presentations, an expert panel of treatment provider staff, people in recovery, and recovery support service provider staff answered questions and provided resource information. The next treatment forum, slated for May 2012, will focus on women's behavioral health and wellness needs.

PART 2

PREVENTION / TREATMENT DATA

AND

FINANCIAL INFORMATION

Data Analysis Compiled from the Performance Based Prevention System (PBPS)
State Fiscal Year 2010-2011

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. State Fiscal Year 2010-2011's increase of 18,428 services overall is mainly attributed to an increase in additional recurring 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 recurring reinforcement approach to service delivery. This increase in the number of recurring services is in part due to a more defined policy requirement, specifically, 20 percent of all prevention services provided must be recurring in nature. 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 increased over the last five State Fiscal Years (SFYs). Figure 3 further illustrates this change in policy by showing the number of people served in single services (attendees) and recurring services (participants). In the SFYs following the new policy, total attendees and total participants numbers have been increasing steadily.

The following defines single and recurring services:

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

- **Recurring Service Type** – Recurring prevention services are a pre-planned series of structured program lessons and/or activities. These types of services are intended to inform, educate, develop skills and identify/refer individuals who may be at risk for substance use or abuse. A recurring prevention activity needs to have an anticipated measurable outcome, which may include pre- and post-testing (examples: Classroom Education, Peer Leadership Programs, Peer Mentoring, Alcohol, Tobacco and Other Drug (ATOD) Free Activities Recurring).

Figure 1

Total Prevention Services as Reported to PBPS State Fiscal Years 2006-2007 through 2010-2011

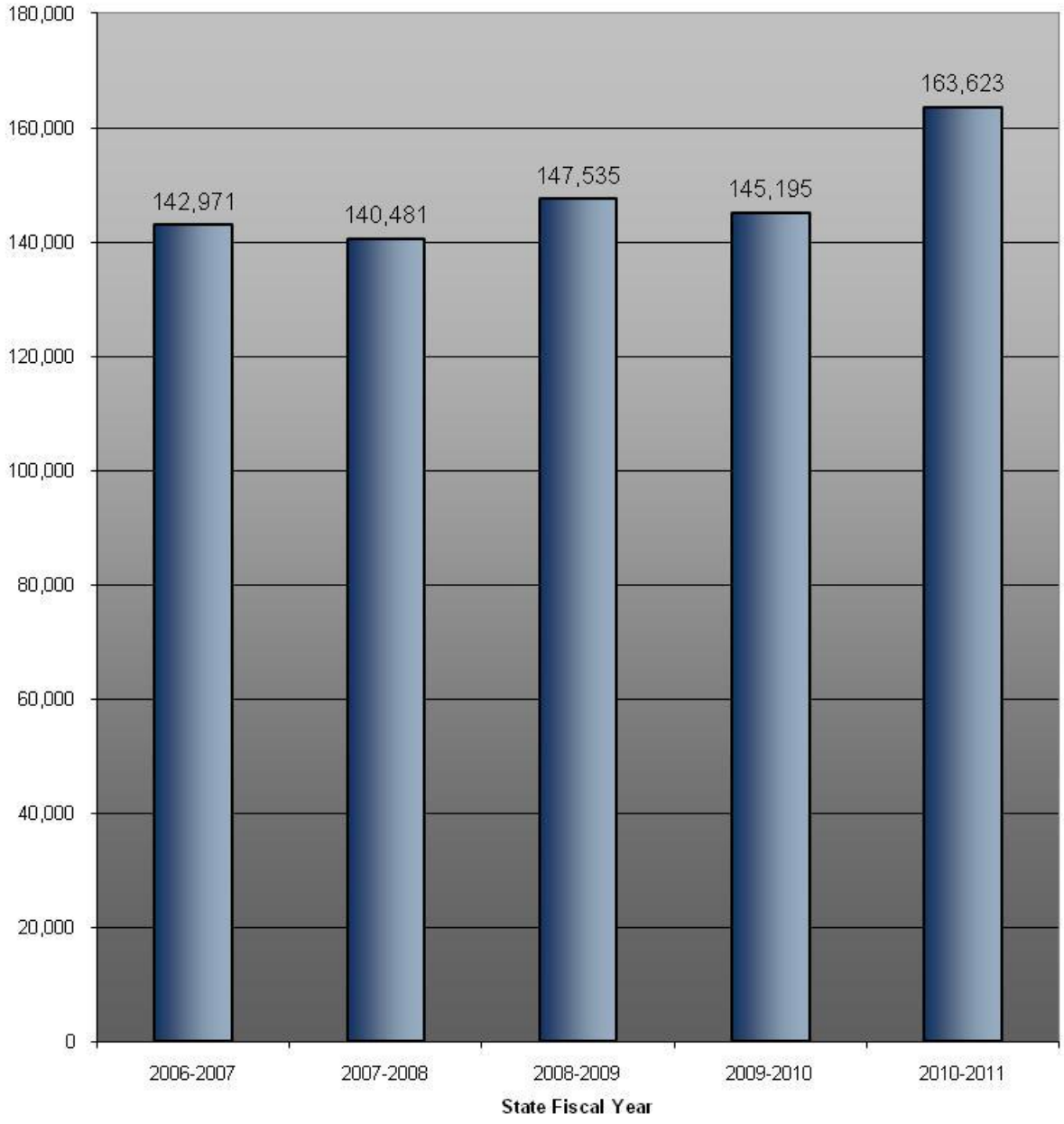


Figure 2

Single and Recurring Prevention Services as Reported to PBPS State Fiscal Years 2006-2007 through 2010-2011

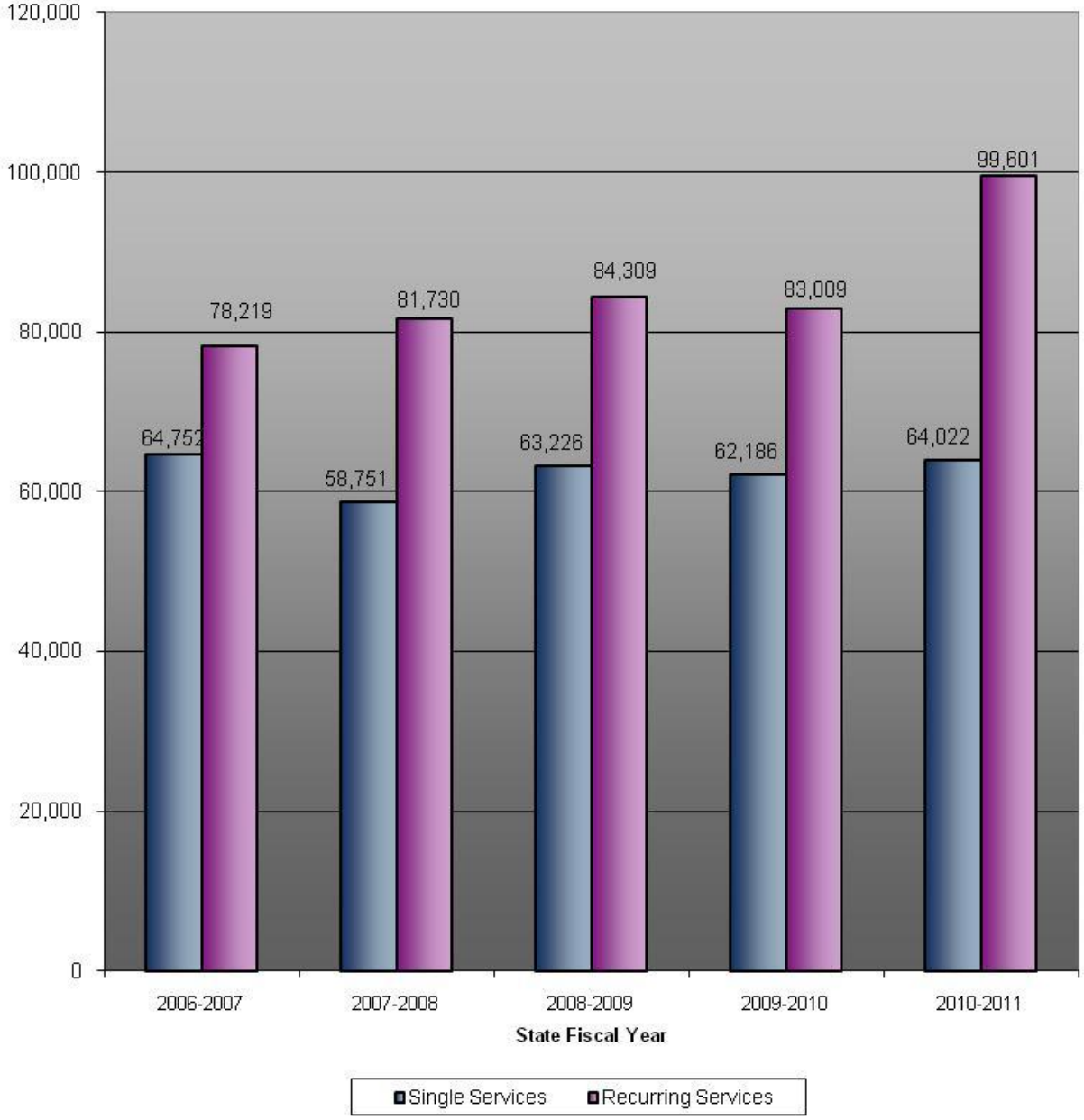
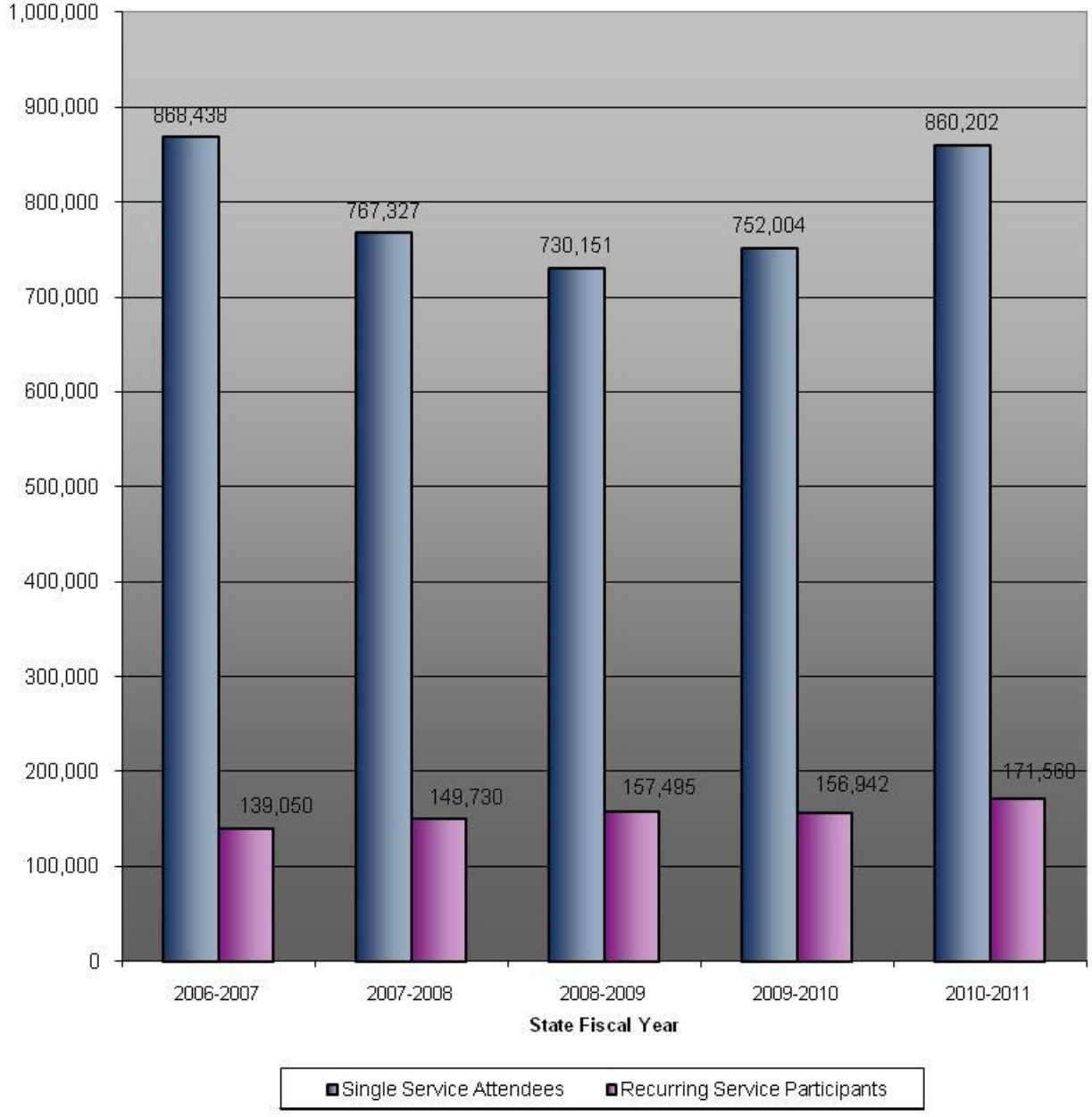


Figure 3

Prevention Service Attendees and Participants State Fiscal Years 2006-2007 through 2010-2011



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

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

The programs are defined as follows:

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

- Shown through research and evaluation to be effective in the prevention and/or delay of substance use/abuse
- Grounded in a clear theoretical foundation and carefully implemented
- Evaluation findings have been subjected to critical review by other researchers
- Replicated and produced desired results in a variety of settings

State Approved Programs meet the following criteria:

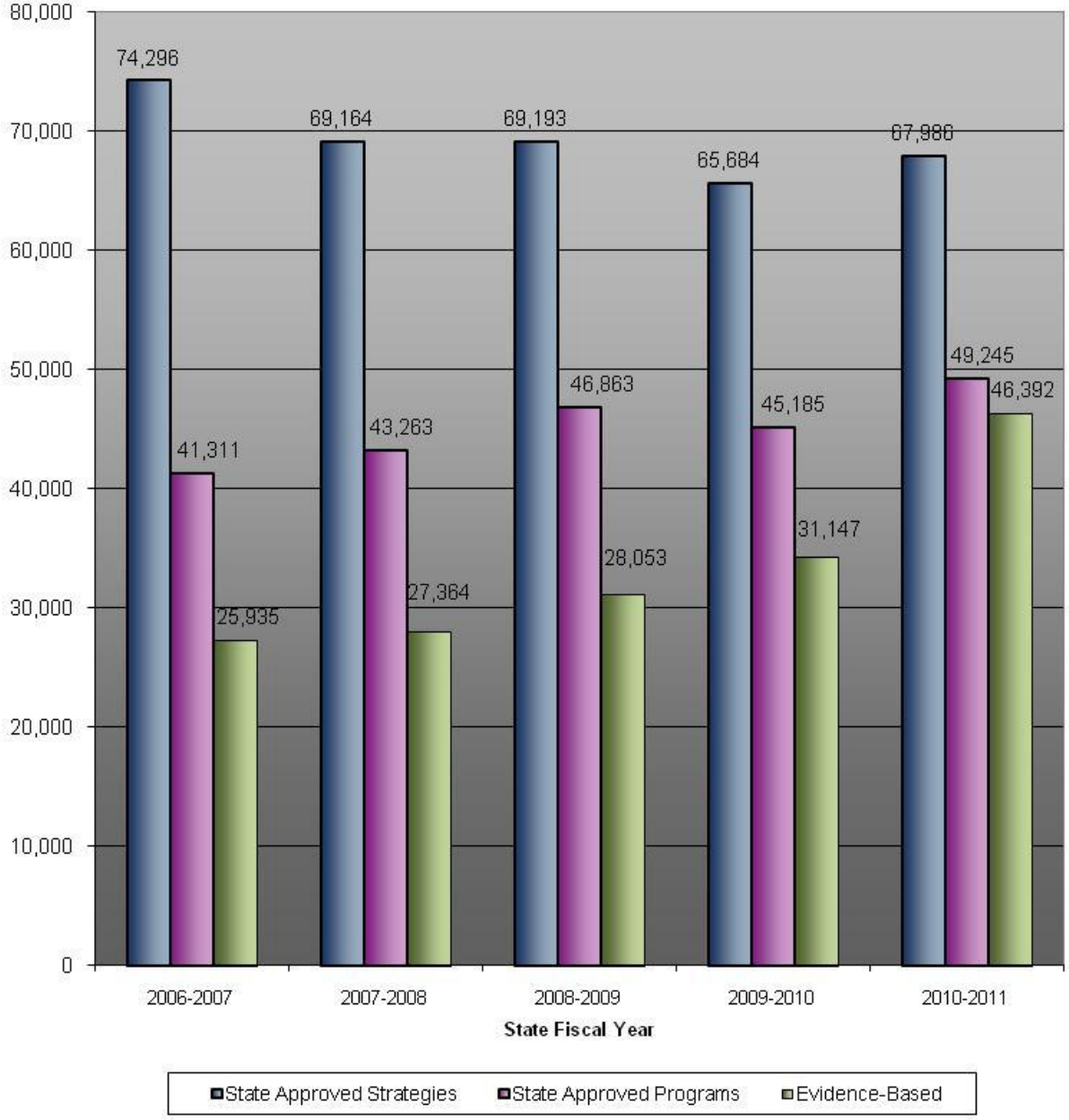
- Program/principle has been identified or recognized publicly and has received awards, honors or mentions
- Program/principle has appeared in a non-referenced professional publication or journal
- Programs/Principle must have an evaluation that includes, but is not limited to, a pre/post test and/or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

State Approved Strategies are defined as programs which:

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

Figure 4

Prevention Services by Program Category as Reported to PBPS State Fiscal Years 2006-2007 through 2010-2011



Institute of Medicine (IOM) and Prevention

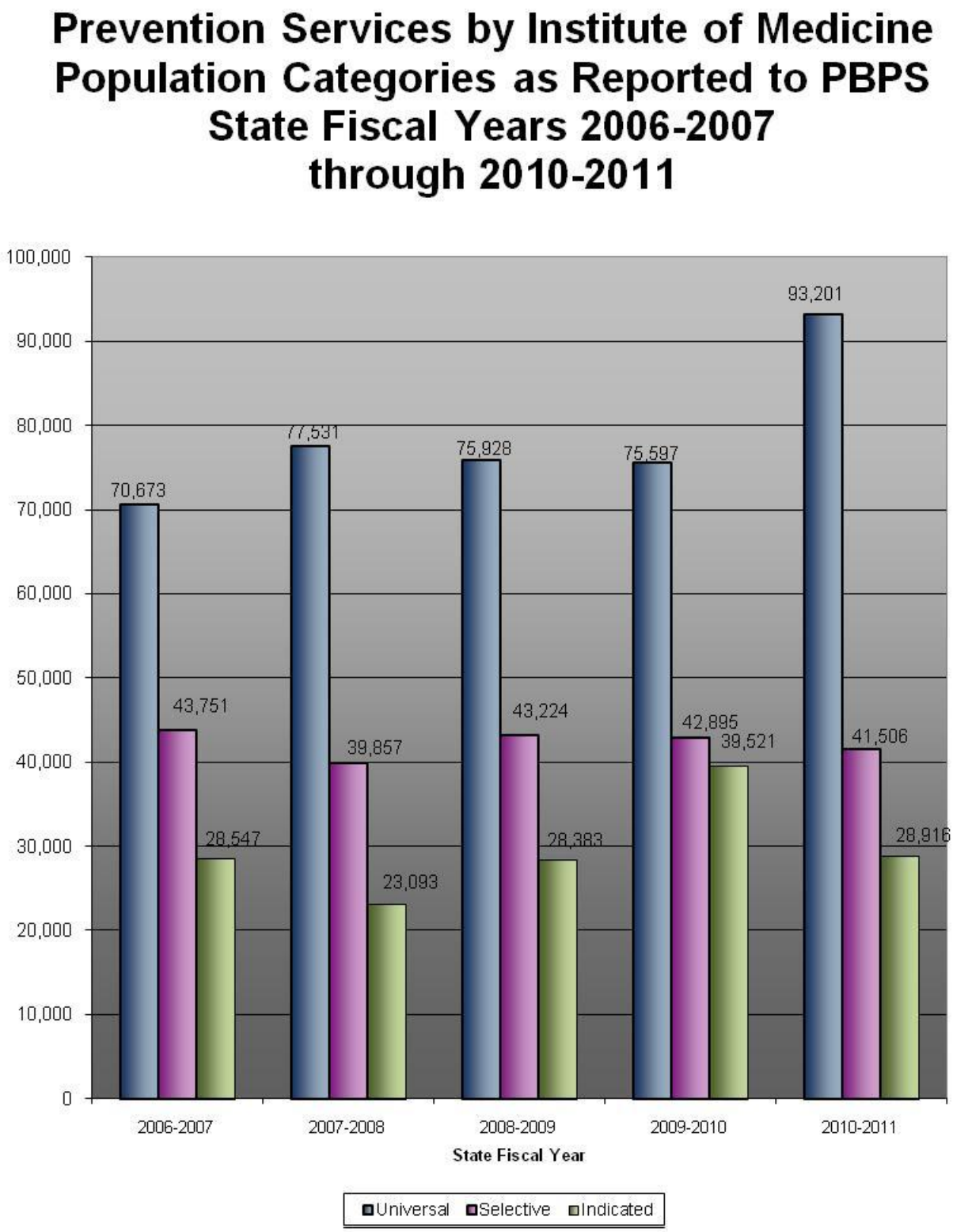
In 1994, the Institute of Medicine (IOM) developed a model to show the effectiveness of a continuum of care. The IOM model includes three prevention classifications based on the degree of risk factors in the target population: universal, selective and indicated**.** They are defined as follows:

- 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 (CSAP) and the Centers for the Application of Prevention Technologies.

Figure 5 shows a five-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 Universal populations with a substantial increase of 17,604, while Selective and Indicated populations decreased respectively, 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



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 increase in the Community-Based Processes indicating a more holistic approach thus fulfilling a previous goal. Approximately 50 percent of all strategies are education oriented, and the remaining 50 percent are in support of the education strategies. Overall, this trend data shows a balanced approach to prevention services.

The six Federal Strategies are defined as:

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

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

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

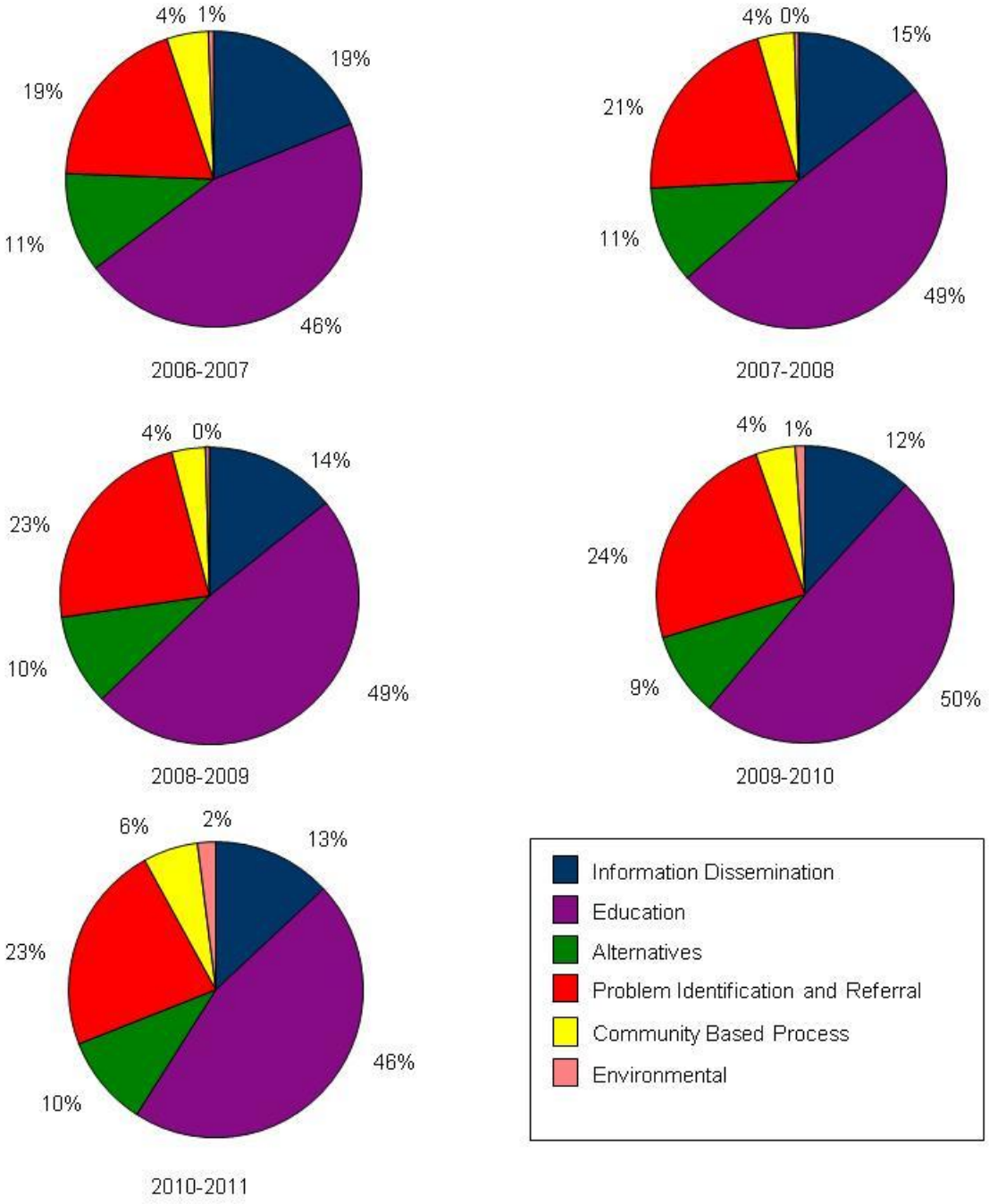
- **Problem Identification and Referral** – targets those persons who have experienced illicit/age-inappropriate use of alcohol, tobacco or other drugs in order to assess if their behavior can be reversed through education.

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

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

Figure 6

Prevention Services by Federal Strategy as Reported to PBPS State Fiscal Years 2006-2007 through 2010-2011



IOM Population Categories

The six Federal Strategies are applicable and are utilized by each IOM population category. Figure 7 shows these population categories broken out by Federal Strategy for state fiscal year 2010-2011. Defined below are the three IOM population categories. Included in the definitions are examples of activities that comprise the overall concept of services that prevent or reduce the use and abuse of alcohol, tobacco and other drugs. While Education services play a large role in all Universal prevention service activities to large diverse groups, the indicated target population covering high-risk individuals is now showing well over 50 percent Problem Identification and Referral services. Based on Federal guidelines this makes for more effective prevention programs statewide.

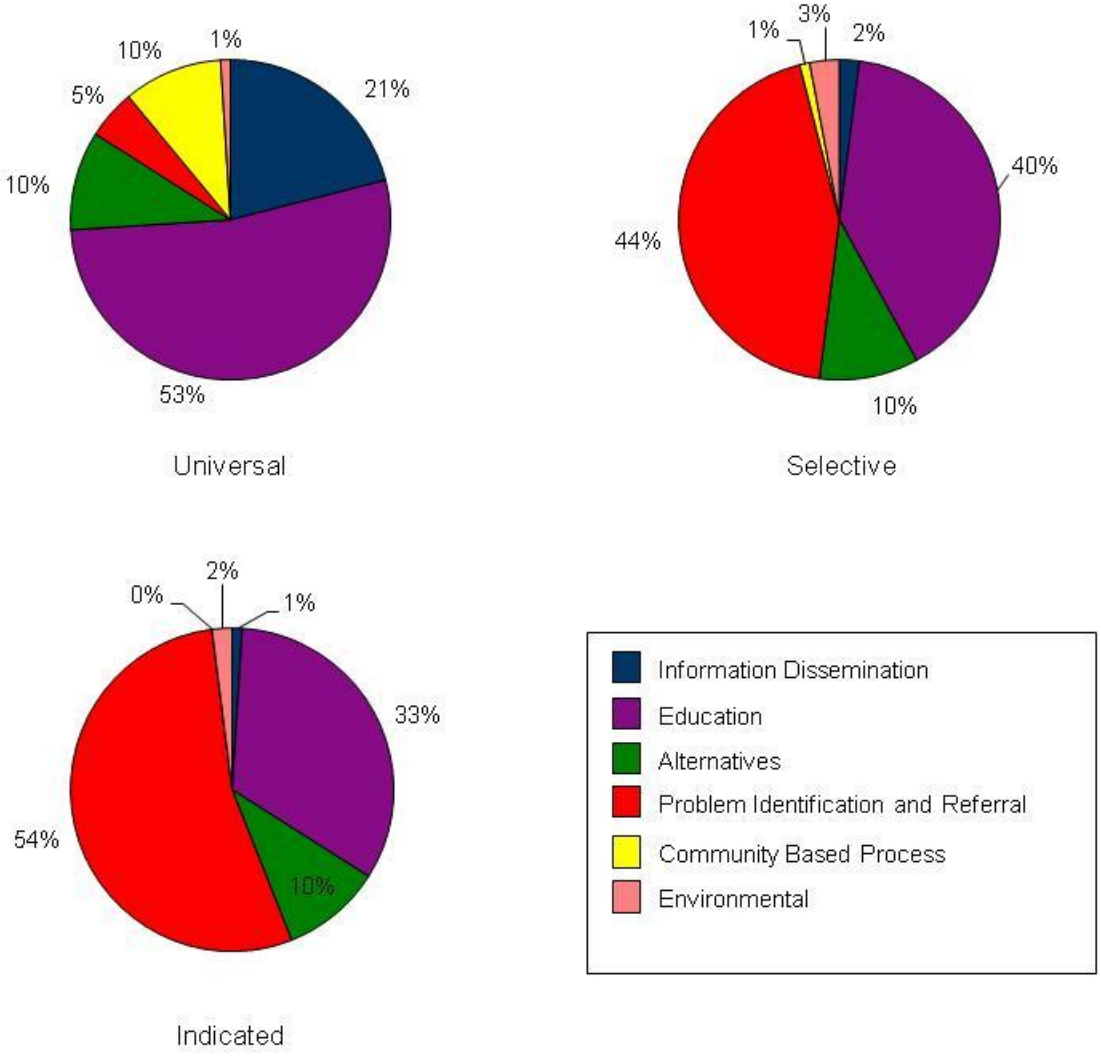
Universal Preventive Interventions are activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk. Information Dissemination is a large part of informing large general audiences successfully. Education to the universal population is also an important aspect of prevention programming. The Division of Prevention has the goal of increasing Community-Based Processes and is succeeding (see Figure 6).

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

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

Figure 7

Institute of Medicine Population Categories by Federal Strategy Prevention Services as Reported to PBPS in 2010-2011



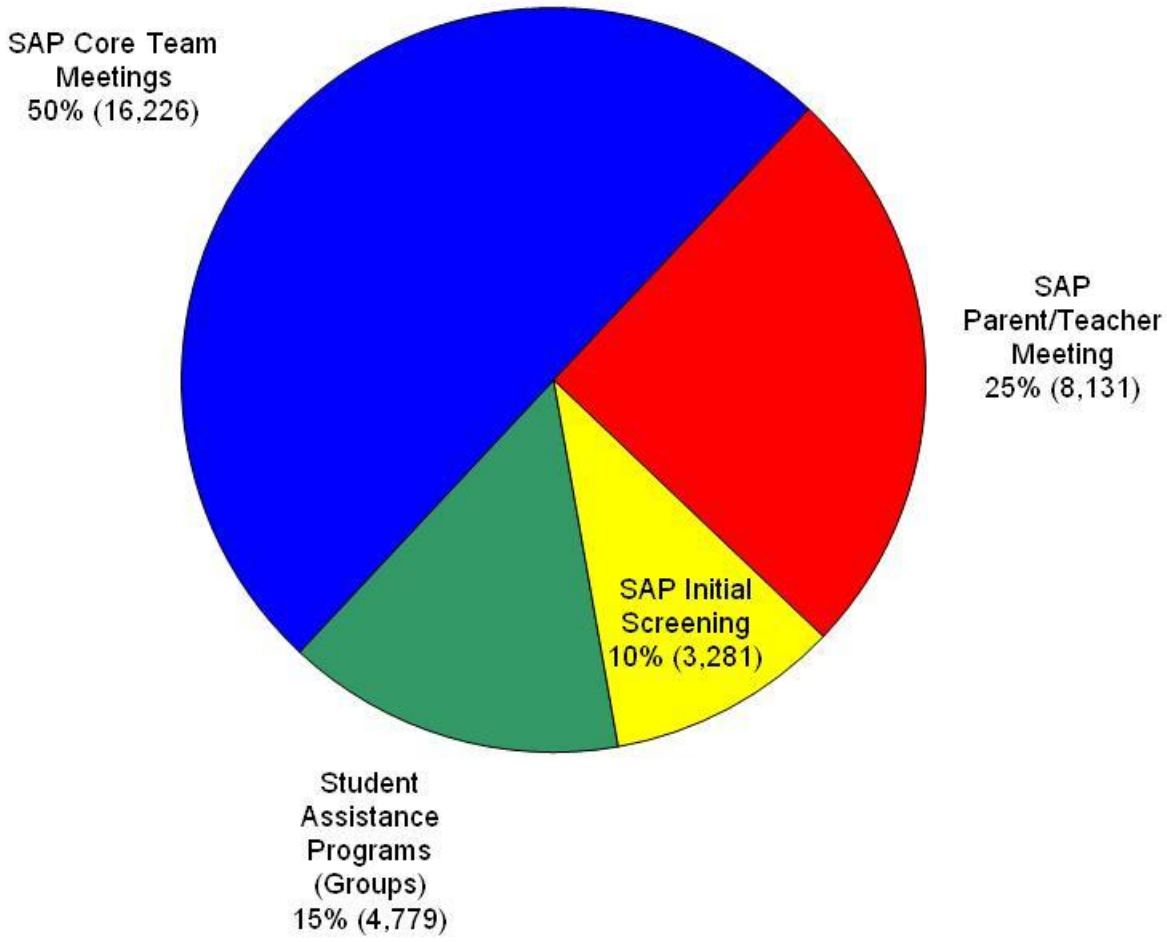
Student Assistance Data

The Student Assistance Program (SAP) is an important intervention for the youth in Pennsylvania. Figure 8 shows a total of 32,417 SAP services for Fiscal Year 2010-2011 broken down into their specific approach (service code). The SAP referrals were initiated by teachers, parents or counselors. These are recurring educational services that are provided to SAP-identified students only. SAP assists school personnel in identifying issues like alcohol, tobacco and other drugs, as well as mental health issues which can impede students' success. Services include assessment, consultation, referral and/or small group education for SAP-identified youth. SAP is mandated to all SCAs to complement their prevention initiatives.

Figure 8

Student Assistance Programs (SAP) as Reported to PBPS SFY 2010-2011

Service Codes

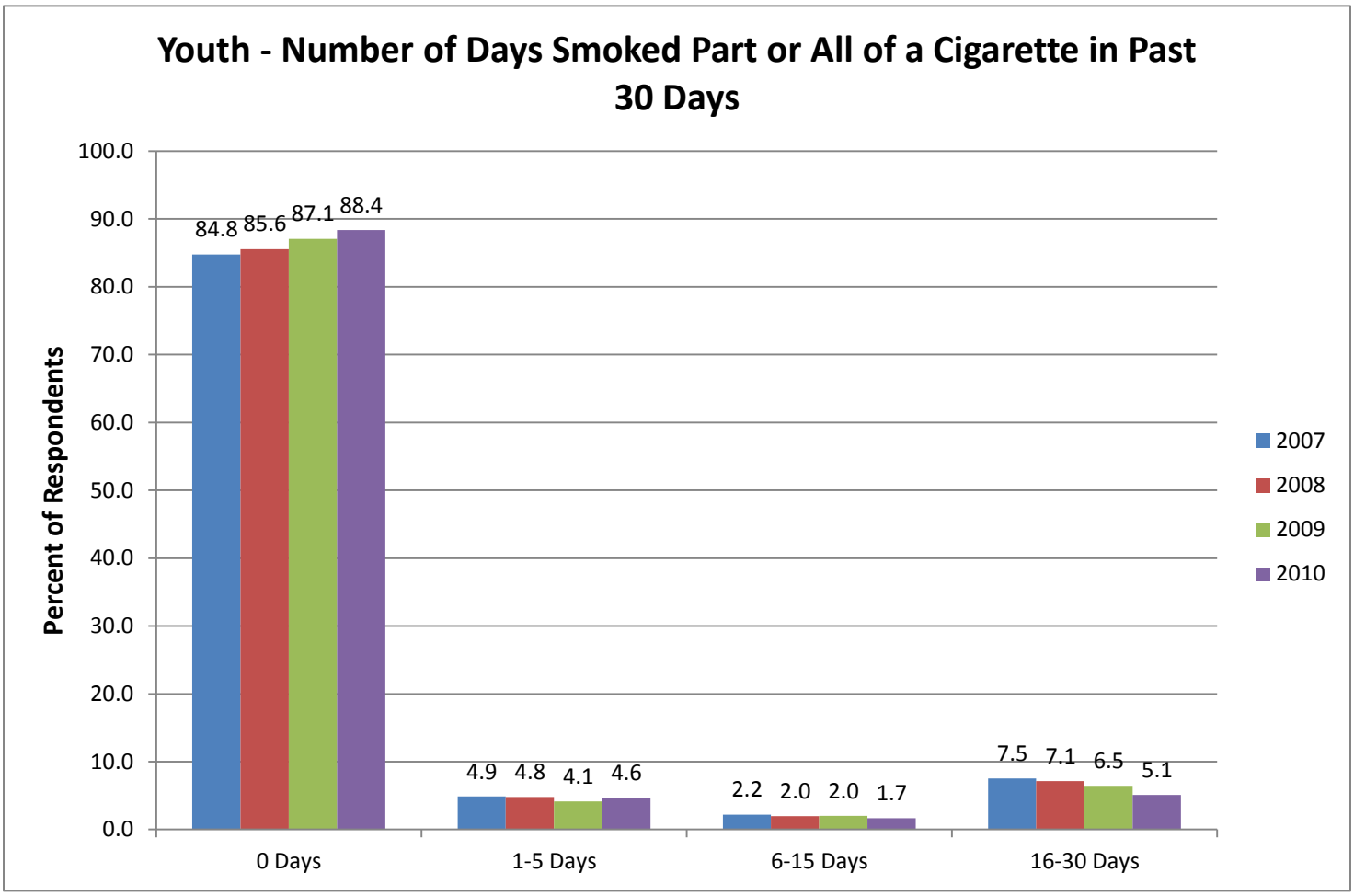


Total SAP Services: 32,417

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

The following surveys were gathered from Pennsylvania youth who attended selected single prevention services and recurring prevention services from October 1st to November 30th of 2007 (n=12,096), 2008 (n=10,993), 2009 (n=11,226), and 2010 (n=14,312). 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.

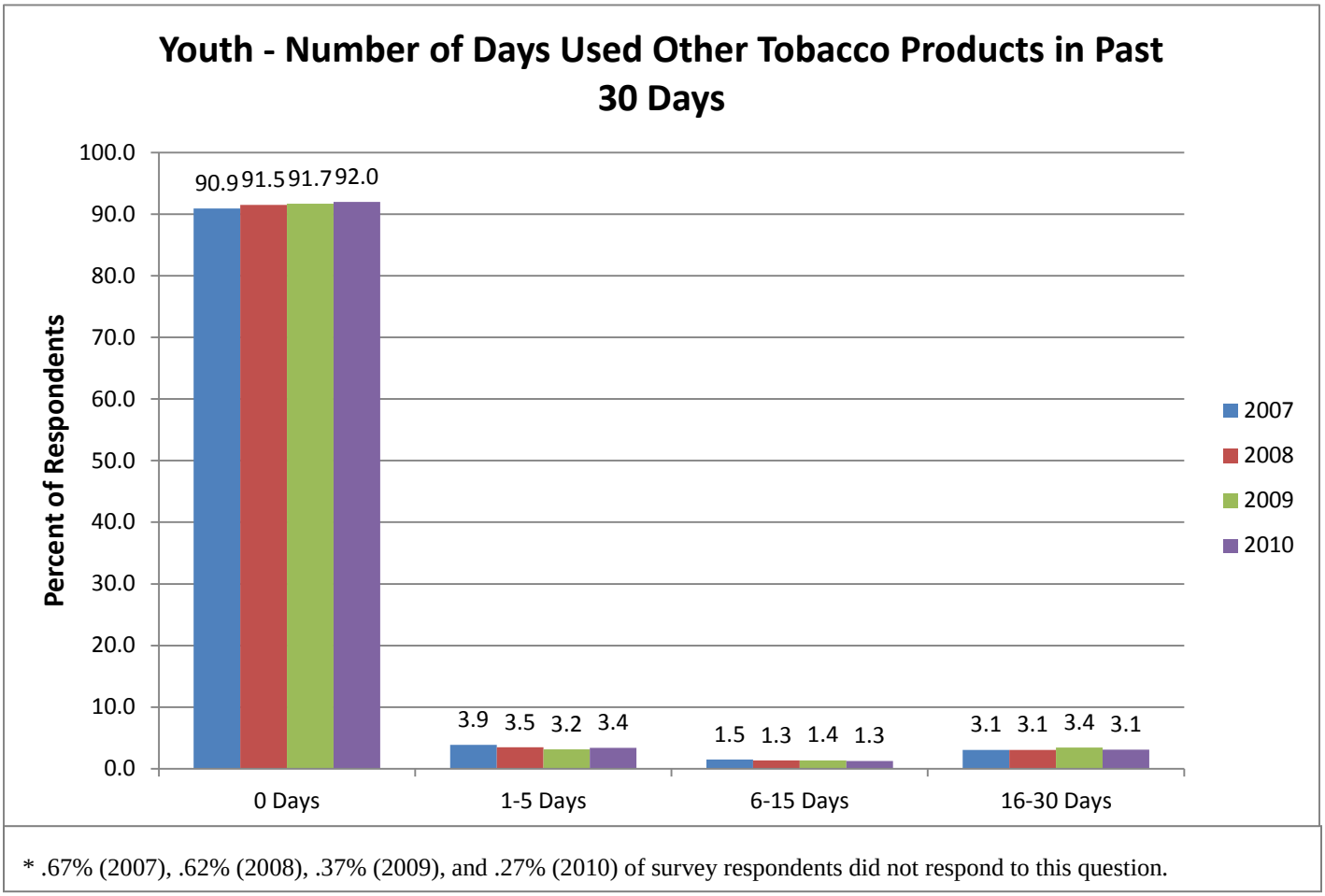
Question 1: During the past 30 days, on how many days did you smoke part or all of a cigarette?



* .61% (2007), .52% (2008), .34% (2009), and .25% (2010) of survey respondents did not respond to this question.

Past 30 day cigarette use among youth respondents has shown positive trends over the four years depicted above. The percent reporting no past 30 day use has increased every year from 2007-2010. This reduction has been accompanied by a 2.4 percent decrease from 2007 to 2010 in the number of respondents reporting cigarette use on 16-30 days out of the past 30 days. Declines in past 30 day cigarette use were also reported on the 2010 National Survey on Drug Use and Health for youth aged 12-17 every year from 2002-2010.

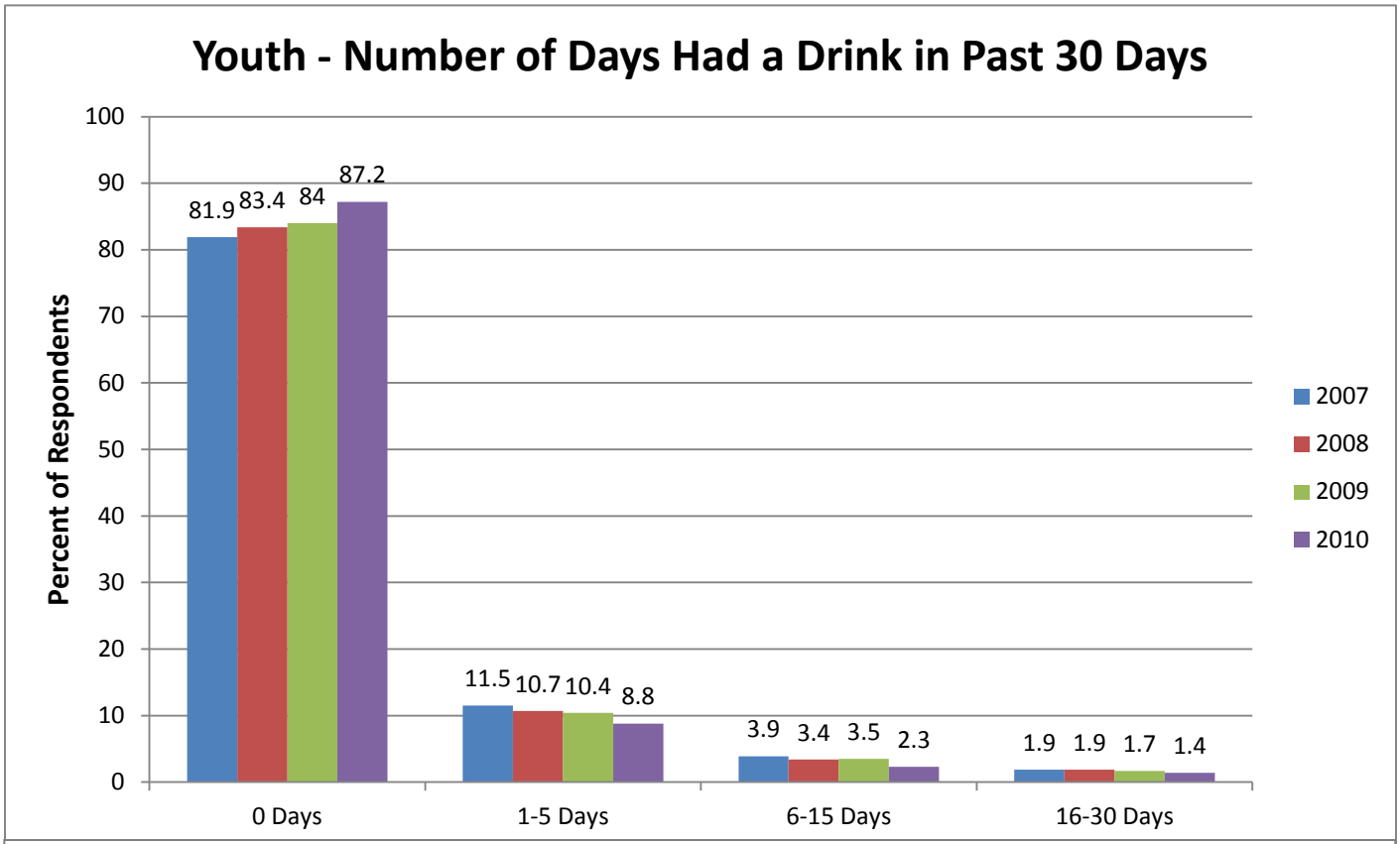
Question 2: During the past 30 days, on how many days did you use other tobacco products?



* .67% (2007), .62% (2008), .37% (2009), and .27% (2010) of survey respondents did not respond to this question.

Past 30 day use of other tobacco products among youth respondents has shown positive trends over the four years depicted above. The percent reporting no past 30 day use has increased slightly every year from 2007-2010.

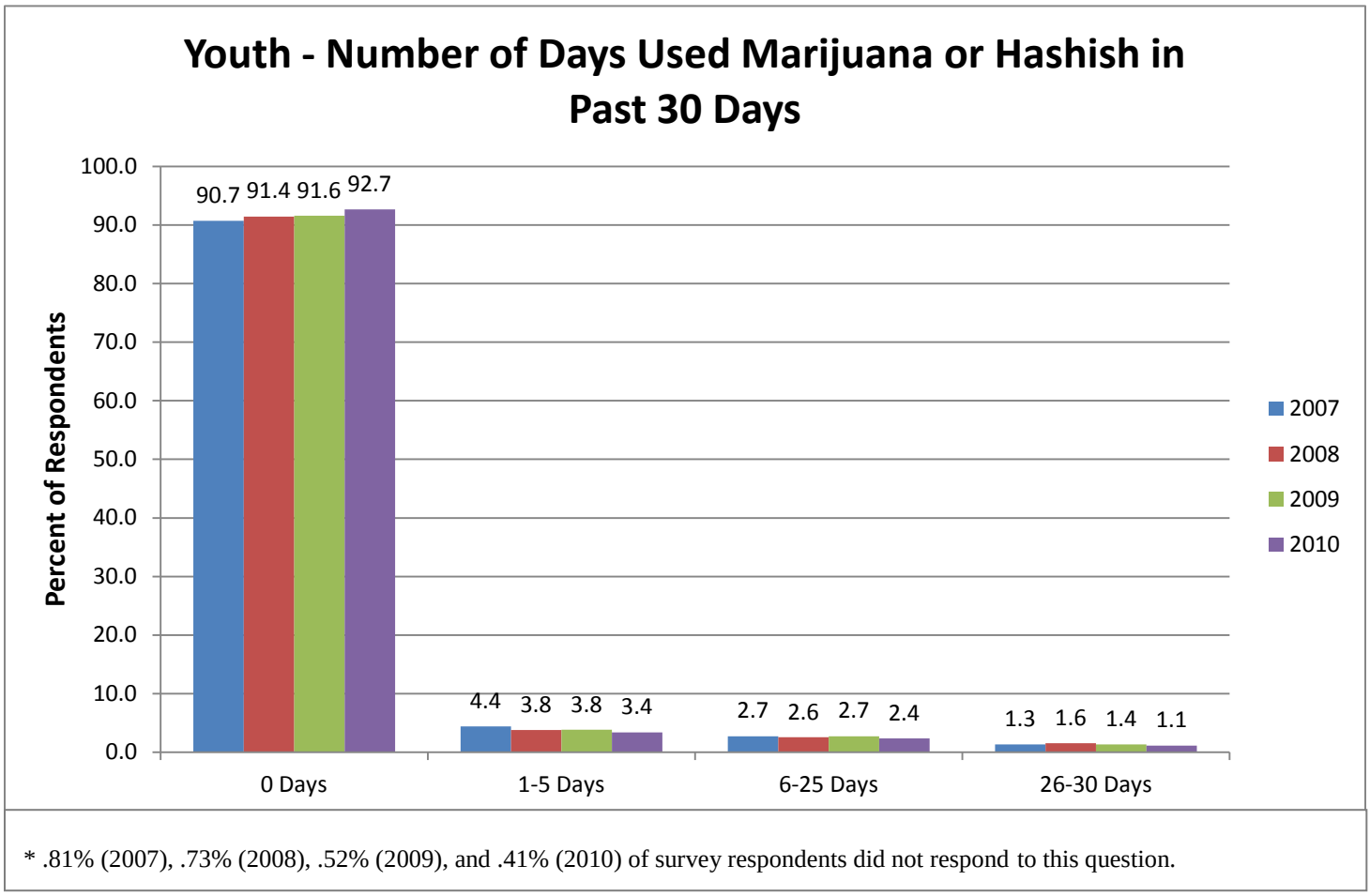
Question 3: During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?



* .74% (2007), .69% (2008), .45% (2009), and .38% (2010) of survey respondents did not respond to this question.

There has been a steady increase in the percent of youth reporting no use of alcohol in the past 30 days from 2007-2010. Alcohol is the substance that was most commonly reported to have been used in the past 30 days by youth respondents. These survey results are similar to the national trend reported on the 2010 National Survey of Drug Use and Health in which past 30 day alcohol use among youths aged 12 to 17 was 13.6 percent in 2010, which was lower than the 2009 rate (14.7 percent).

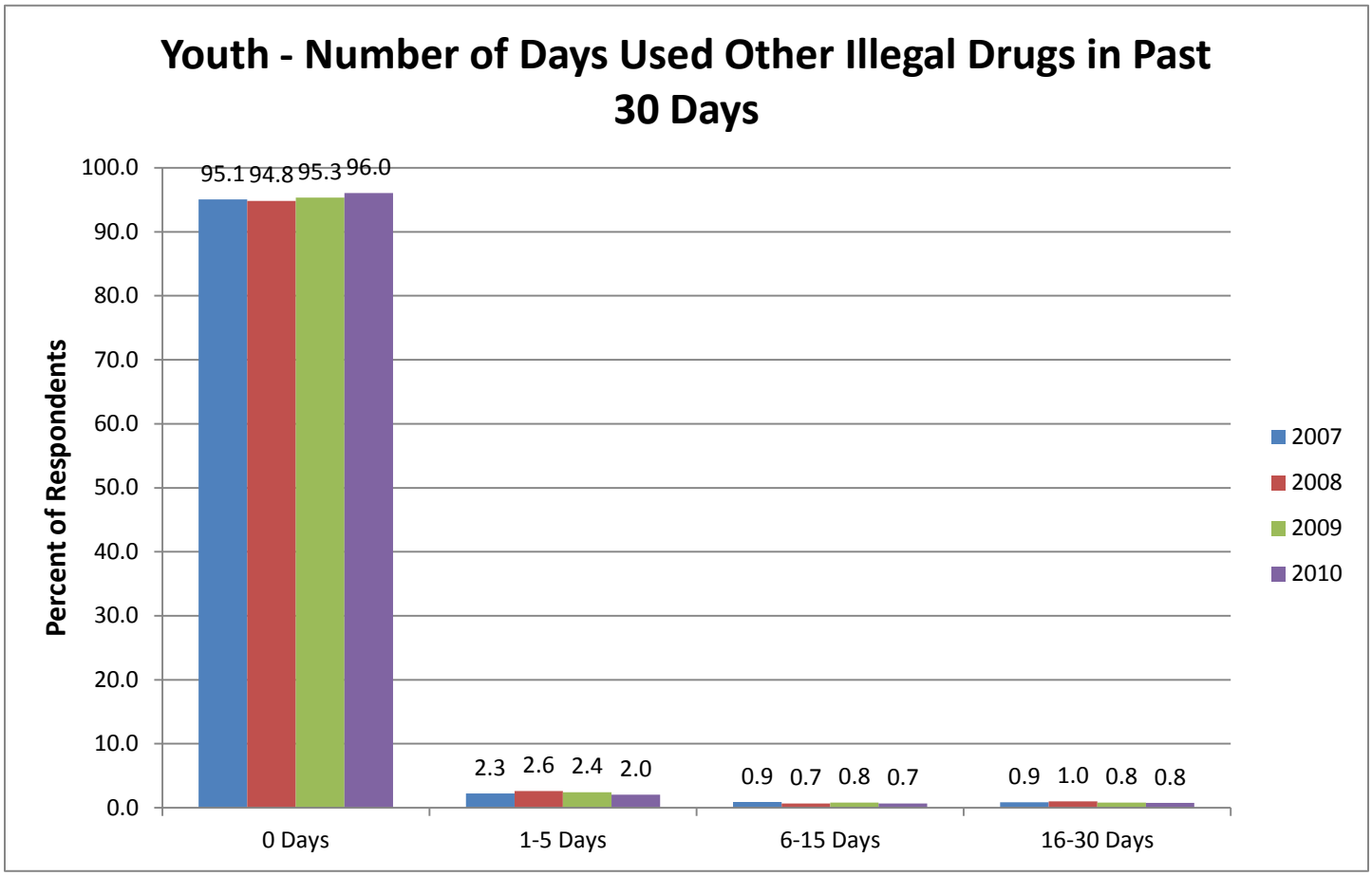
Question 4: During the past 30 days, on how many days did you use marijuana or hashish?



* .81% (2007), .73% (2008), .52% (2009), and .41% (2010) of survey respondents did not respond to this question.

There has been a slight increase (2 percent) in the percent of youth respondents reporting no use of marijuana or hashish in the past 30 days. In 2010, the percent of youth reporting past 30 day marijuana use had decreased to 7 percent. This trend is in contrast to the national trend reported on the 2010 National Survey on Drug Use and Health which reports that past 30 day marijuana use among youth aged 12-17 increased from 6.7 percent in 2008 to 7.4 percent in 2010.

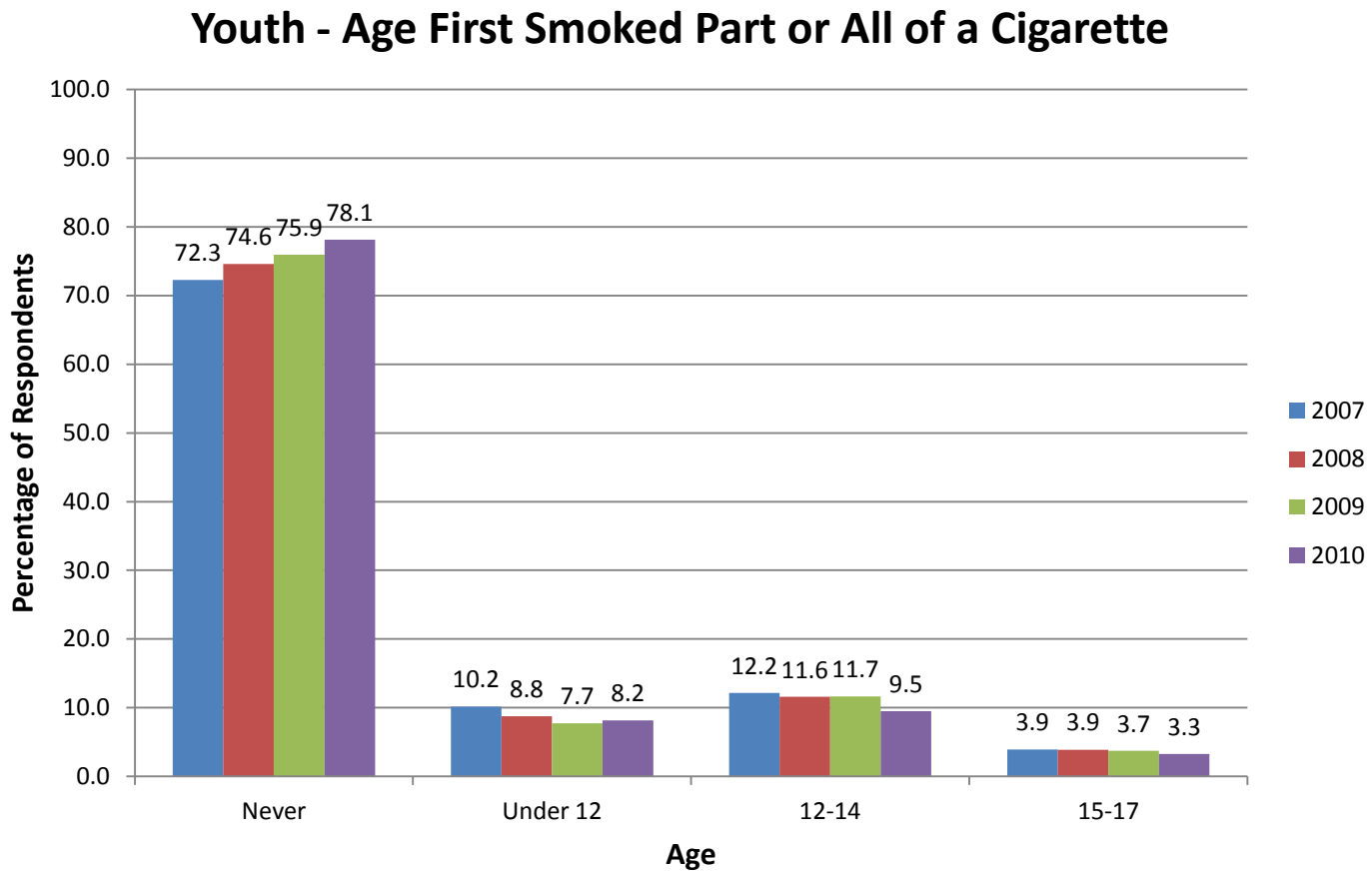
Question 5: During the past 30 days, on how many days did you use any other illegal drug? Other illegal drugs include substances like: heroin, crack or cocaine, methamphetamine; hallucinogens (such as LSD, Ecstasy, PCP or peyote); inhalants or sniffed substances such as glue, gasoline, paint thinner, cleaning fluid or shoe polish; prescription drugs without a doctor's orders.



* .93% (2007), .99% (2008), .58% (2009), and .49% (2010) of survey respondents did not respond to this question.

The percent of youth reporting no use of other illegal drugs during the past 30 days has stayed consistently high at about 95 percent. The 2010, National Survey on Drug Use and Health reports that 10.1 percent of youth aged 12-17 used illicit drugs (includes marijuana) during the past 30 days.

Question 6: How old were you the first time you smoked part or all of a cigarette?

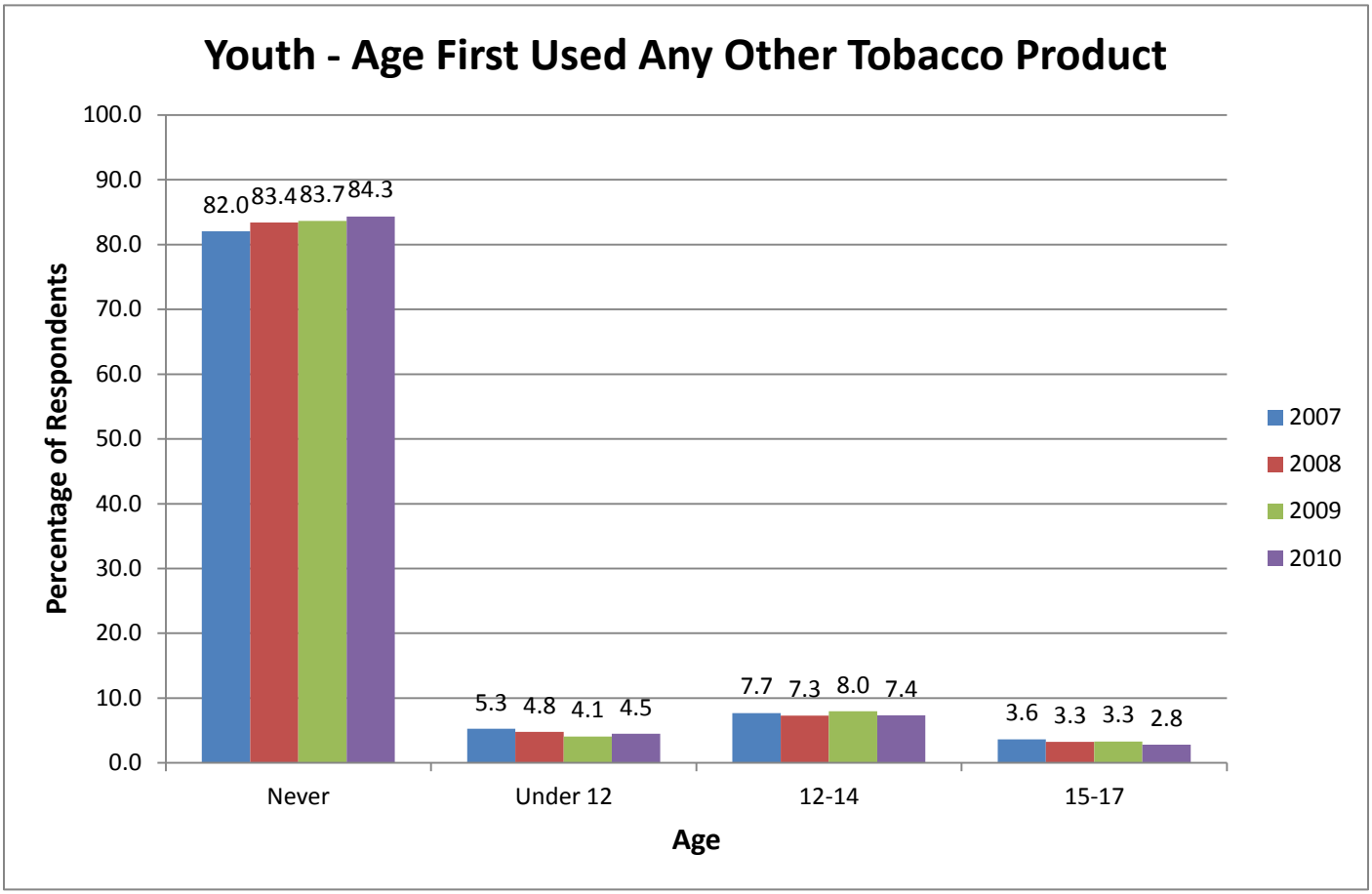


* The graph above shows only three of the categories of responses to the question. The table below shows the percent of respondents who selected 18-21 and who did not respond. Note that the Youth NOMs Survey is designed to survey individuals under age 18. Since the NOMs survey is often administered in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

	2007	2008	2009	2010
18-21	0.36%	0.38%	0.34%	0.36%
No Response	1.08%	0.81%	0.57%	0.52%

Age at first use of cigarettes among youth respondents has shown positive trends over the past four years. The percent reporting no lifetime use has increased every year from 2007-2010 with an overall increase of 5.8 percent from 2007 to 2010.

Question 7: How old were you the first time you used any other tobacco product?

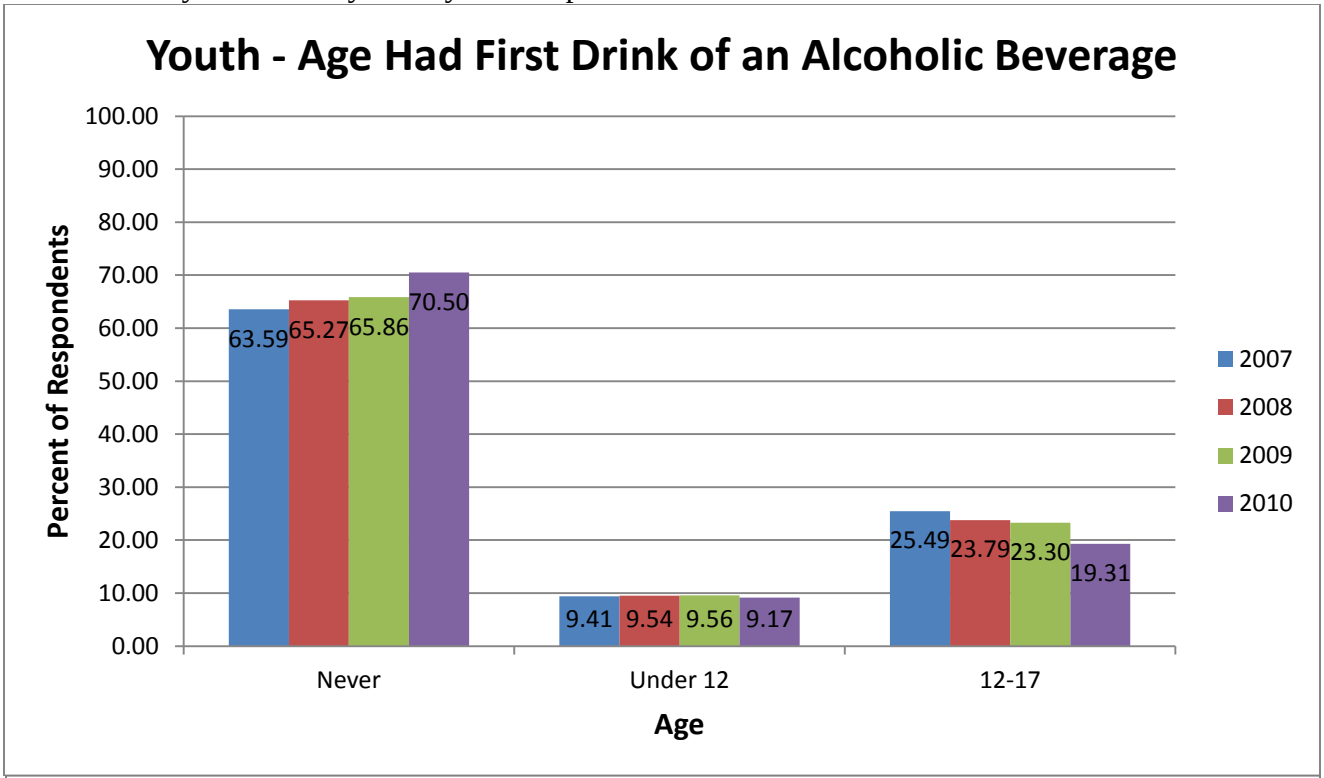


* The graph above shows only three of the categories of responses to the question. The table below shows the percent of respondents who selected 18-21 and who did not respond. Note that the Youth NOMs Survey is designed to survey individuals under age 18. Since the NOMs survey is often administered in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

	2007	2008	2009	2010
18-21	0.26%	0.43%	0.30%	0.31%
No Response	1.12%	0.88%	0.67%	0.68%

Age at first use of other tobacco products among youth respondents has shown positive trends over the past four years. The percent reporting no lifetime use has increased slightly every year from 2007-2010.

Question 8: 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.

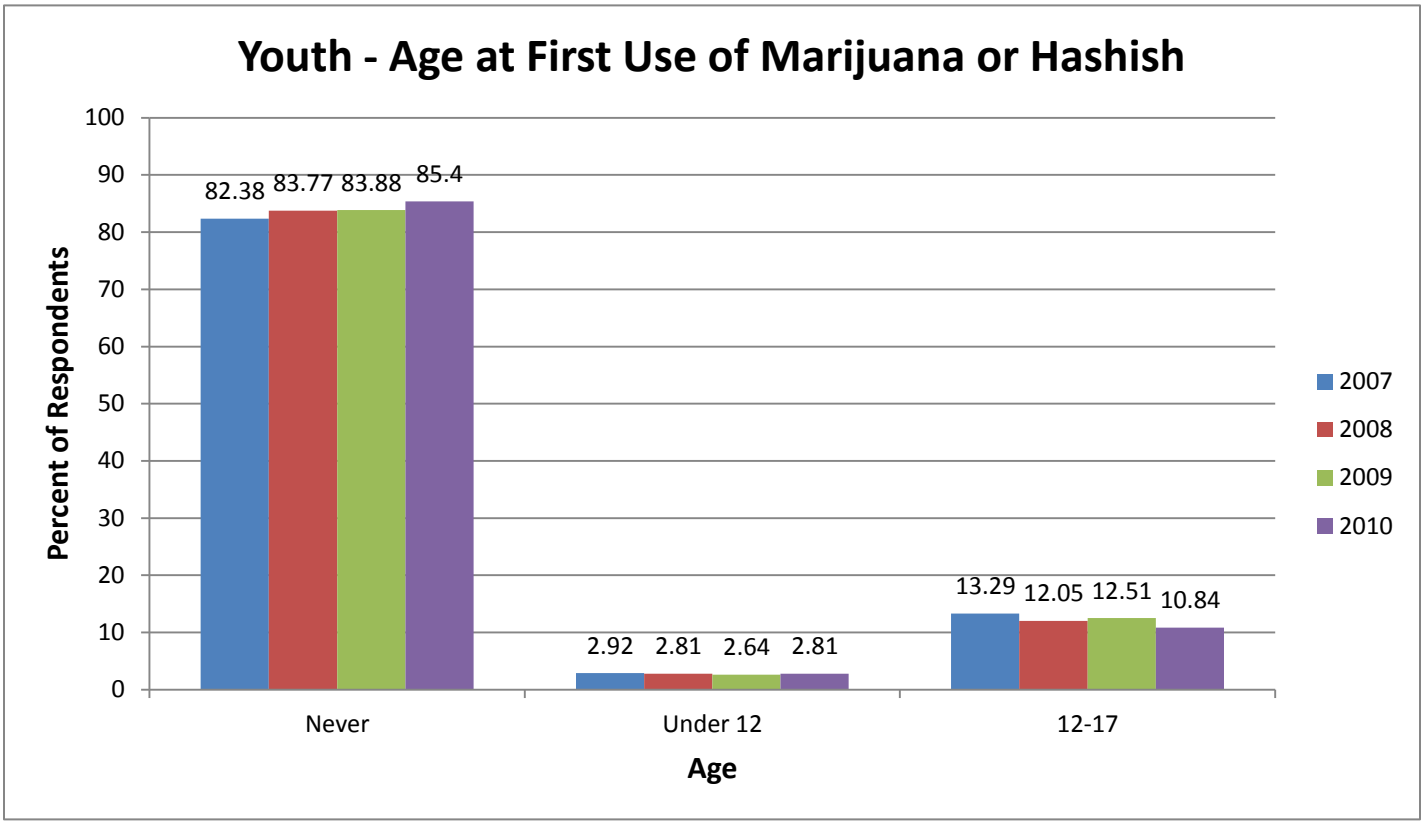


* The graph above shows only three of the categories of responses to the question. The table below shows the percent of respondents who selected 18-21 and who did not respond. Note that the Youth NOMs Survey is designed to survey individuals under age 18. Since the NOMs survey is often administered in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

	2007	2008	2009	2010
18-21	0.36%	0.55%	0.45%	.36%
No Response	1.16%	0.86%	0.82%	.64%

The percent of youth respondents reporting they never drank alcohol has increased each year from 2007-2010 with an overall increase of 7 percent over those four years. Alcohol is the substance that was most commonly reported to have ever been used by youth respondents.

Question 9: How old were you the first time you used marijuana or hashish?

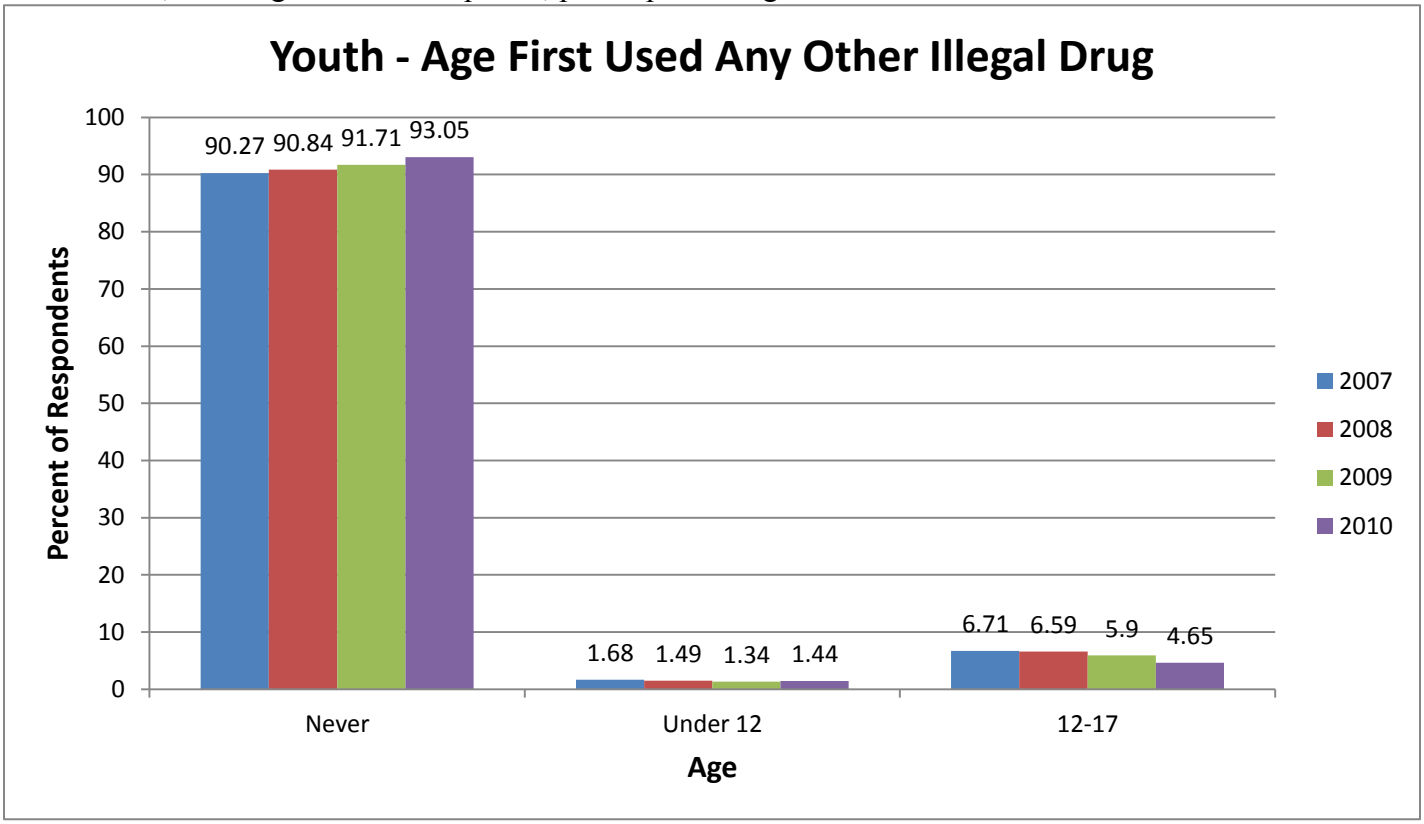


* The graph above shows only three of the categories of responses to the question. The table below shows the percent of respondents who selected 18-21 and who did not respond. Note that the Youth NOMs Survey is designed to survey individuals under age 18. Since the NOMs survey is often administered in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

	2007	2008	2009	2010
18-21	0.22%	0.45%	0.29%	0.31%
No Response	1.17%	0.93%	0.67%	0.64%

The percent of youth reporting that they have never used marijuana or hashish has increased slightly each year from 2007-2010. Looking across the past four years approximately 15 percent of youth respondents reported using marijuana or hashish at least once in their lifetime.

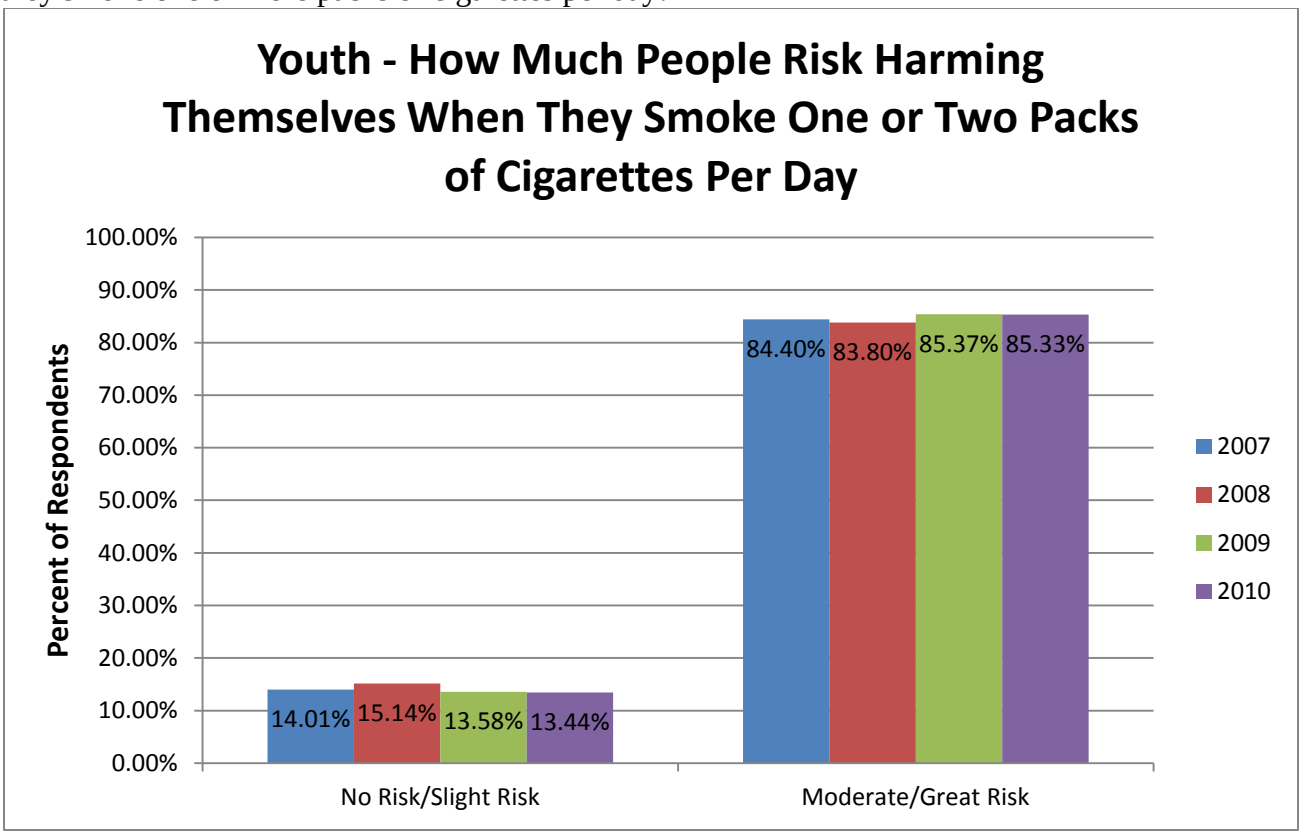
Question 10: How old were you the first time you used any other illegal drug? Other illegal drugs include substances like: heroin, crack or cocaine, methamphetamine; hallucinogens (such as LSD, Ecstasy, PCP or peyote); inhalants or sniffed substances such as glue, gasoline, paint thinner, cleaning fluid or shoe polish; prescription drugs without a doctor's orders.



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

	2007	2008	2009	2010
18-21	0.17%	0.30%	0.34%	0.22%
No Response	1.17%	0.80%	0.70%	0.61%

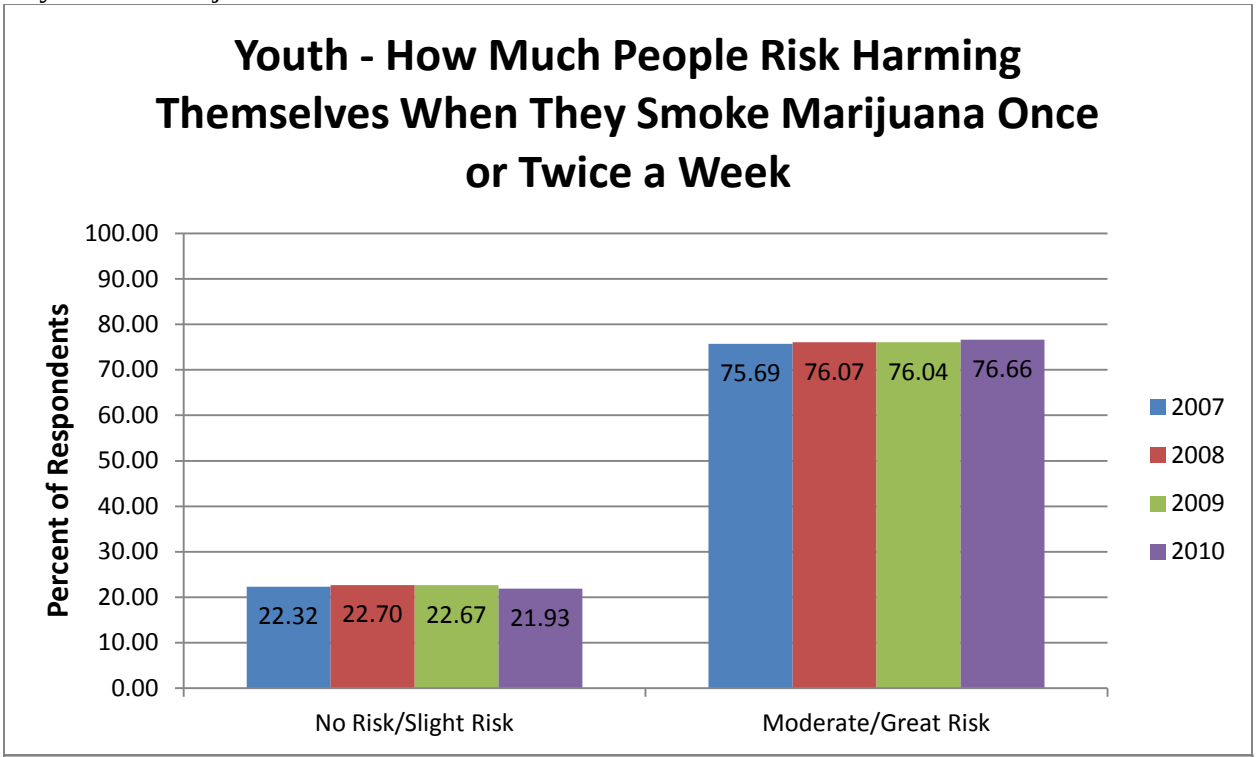
Question 11: How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?



* 1.59% (2007), 1.07% (2008), 1.02% (2009), and 1.17% (2010) of survey respondents did not respond to this question.

The percent of youth respondents reporting that smoking one or two pack of cigarettes per day poses a moderate or great risk of harm has remained nearly the same every year from 2007-2010. Each year more respondents reported that smoking one or two packs of cigarettes per day posed a moderate or great risk of harm than reported that smoking marijuana and drinking alcohol posed a moderate or great risk of harm. In 2010, 64 percent of respondents reported great risk which is close to the 65.5 percent reported on the 2010 National Survey on Drug Use and Health for youth aged 12-17.

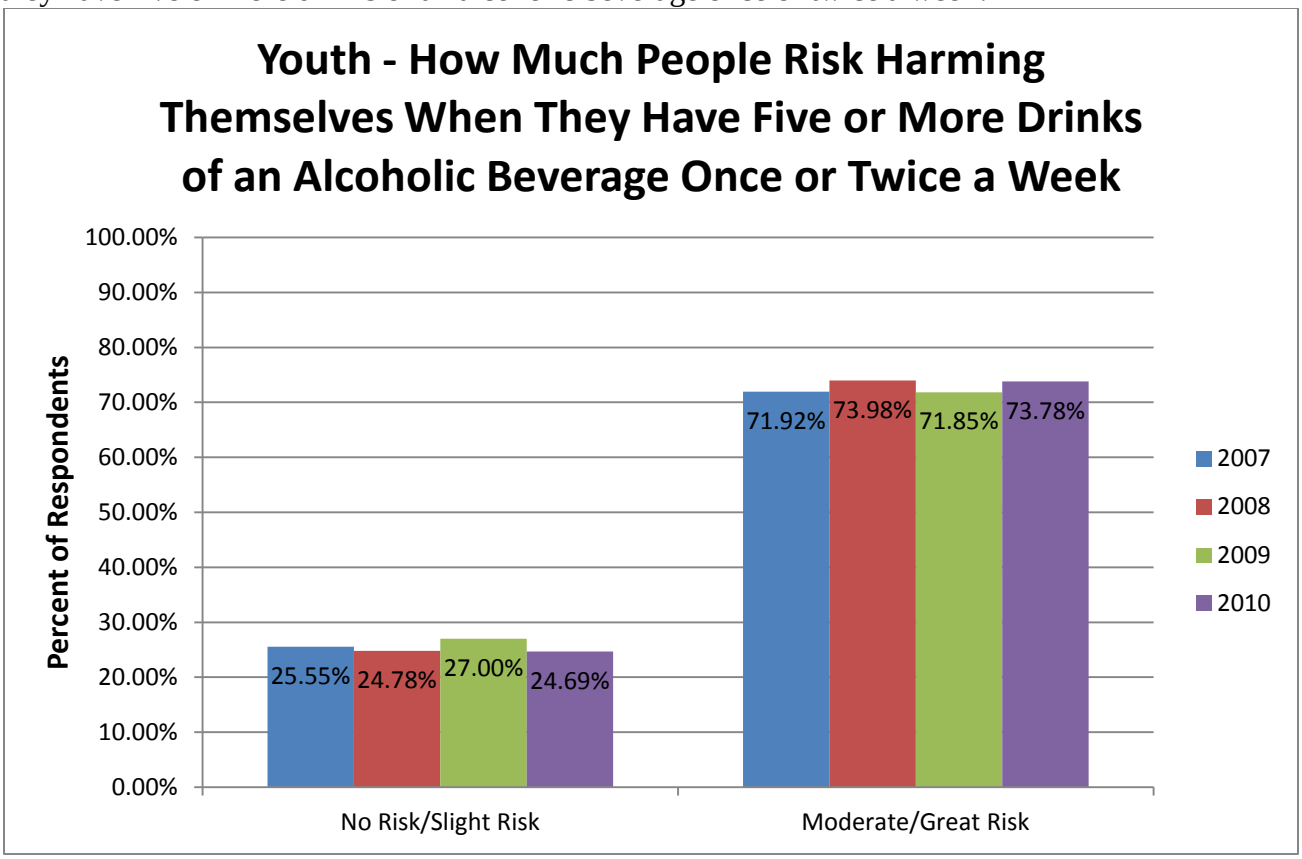
Question 12: How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?



* 1.98% (2007), 1.24% (2008), 1.25% (2009), and 1.34% (2010) of survey respondents did not respond to this question.

The percent of youth respondents reporting that smoking marijuana once or twice a week poses a moderate or great risk of harm has remained nearly the same every year from 2007-2010. A high percentage (approximately 22 percent each year) reported no or slight risk from smoking marijuana once or twice a week. In 2010, 51 percent of respondents reported great risk, which is slightly higher than the 47.5 percent reported on the 2010 National Survey on Drug Use and Health for youth aged 12-17.

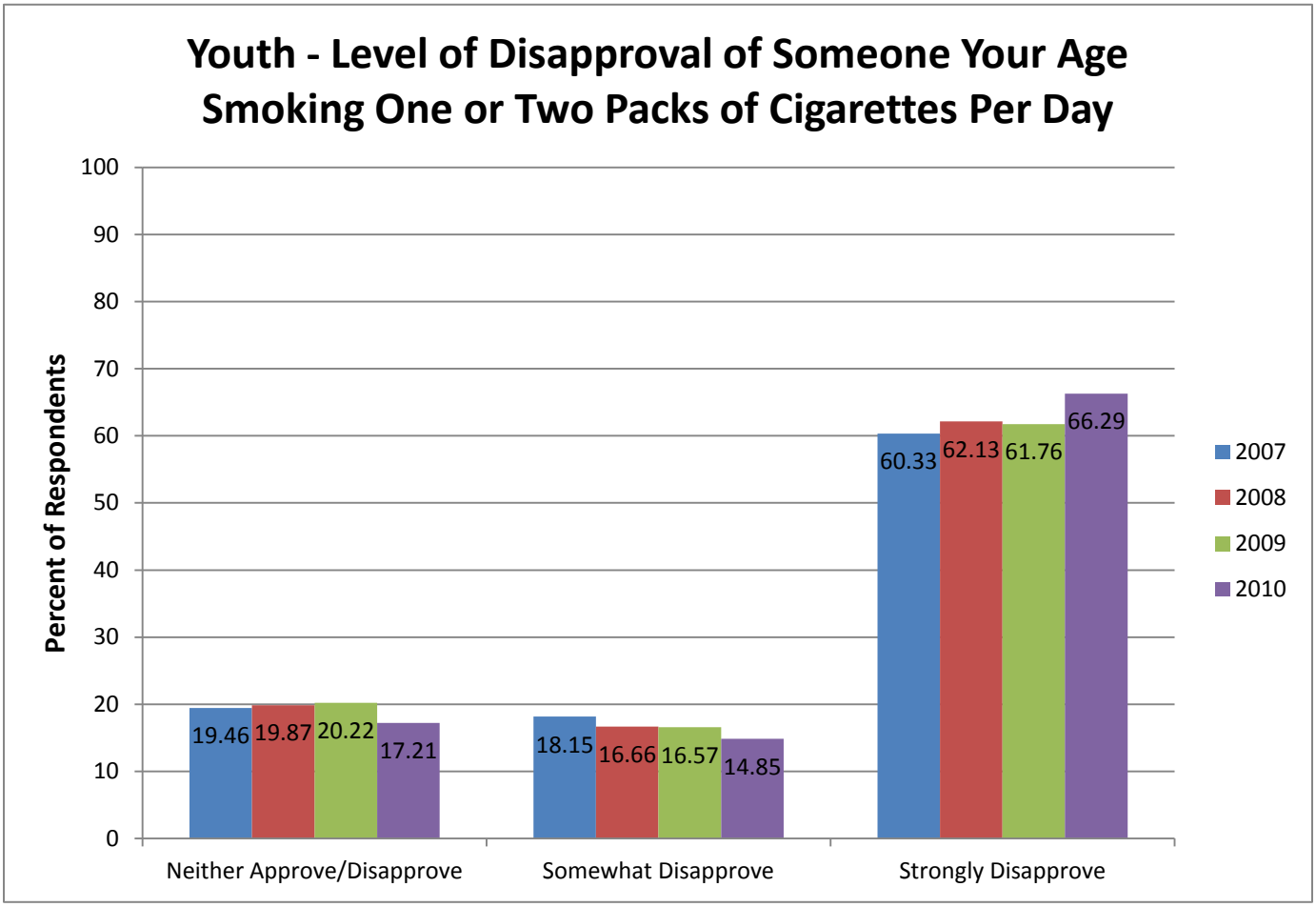
Question 13: How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?



* 2.53% (2007), 1.26% (2008), 1.14% (2009), and 1.47% (2010) of survey respondents did not respond to this question.

The percent of youth respondents reporting that having five or more drinks of an alcoholic beverage once or twice a week poses a moderate or great risk of harm has fluctuated slightly each year between approximately 72 percent and 74 percent. Of the three questions on the survey regarding the potential harm posed by use of certain substances (i.e., cigarettes, marijuana, and alcohol), this question on alcohol use had the highest percent of respondents reporting no or only slight risk. In 2010, 43 percent of respondents reported great risk, which is close to the 41 percent reported on the 2010 National Survey on Drug Use and Health for youth aged 12-17.

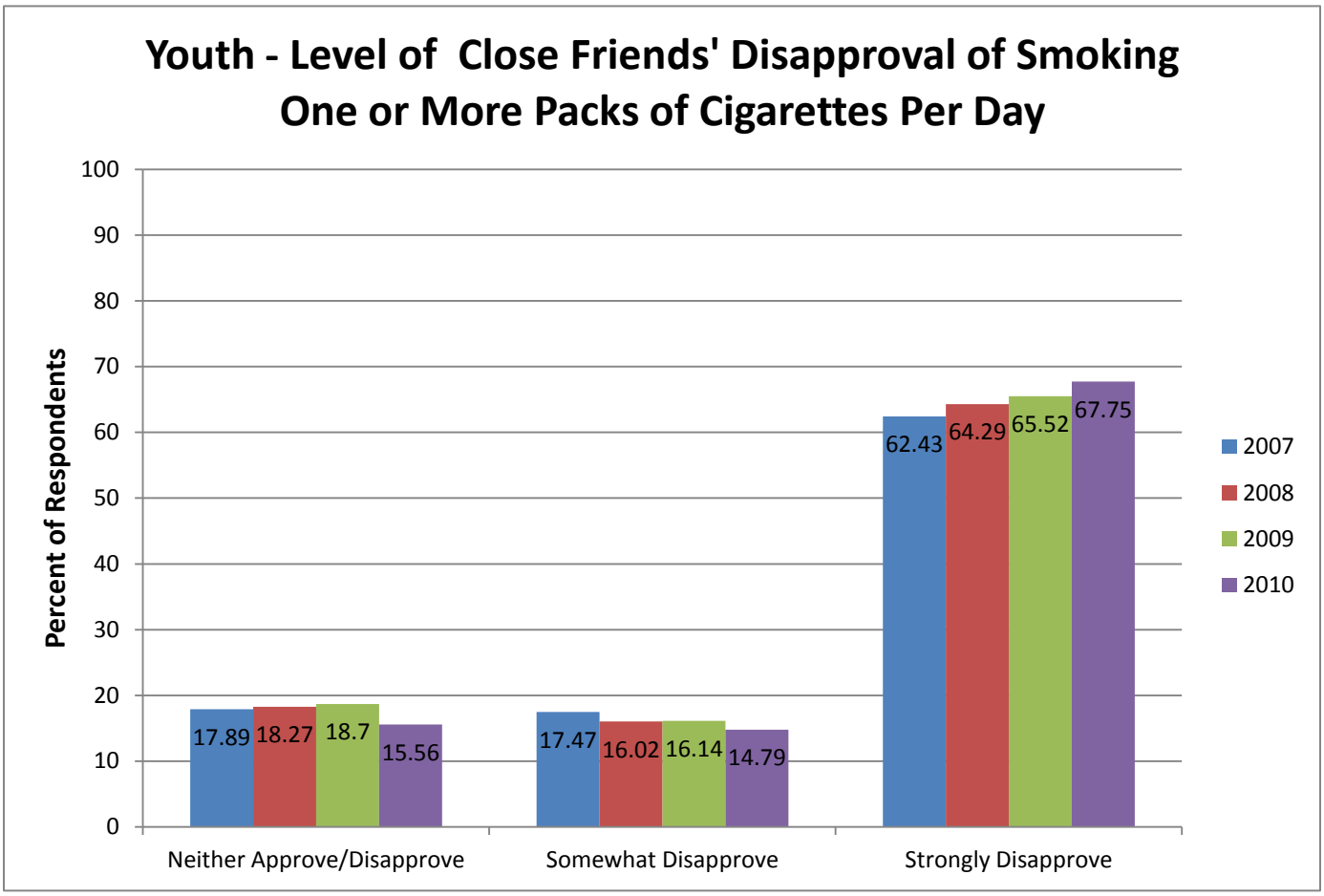
Question 14: How do you feel about someone your age smoking one or more packs of cigarettes a day?



* 2.06% (2007), 1.35% (2008), 1.43% (2009), and 1.59% (2010) of survey respondents did not respond to this question.

The percent of youth respondents who reported that they strongly disapproved of someone their age smoking one or two packs of cigarettes per day has increased by 6 percent from 2007 to 2010. However, from 2007-2009 the percent of respondents reporting that they neither approved nor disapproved also increased. Although the strength of disapproval has shown positive trends over the past four years, the overall percent who disapprove had not decreased until 2010.

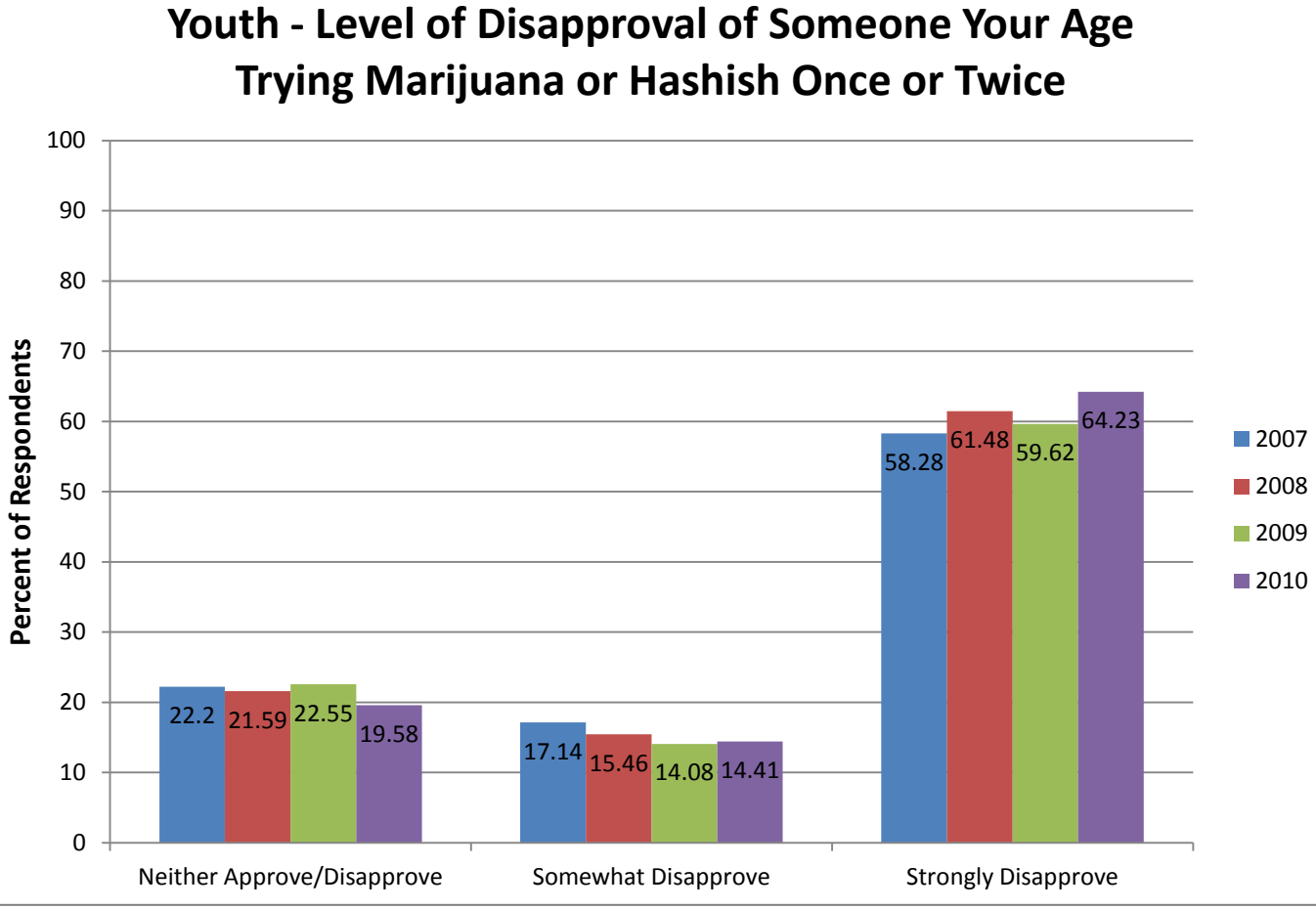
Question 15: How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?



* 2.22% (2007), 1.44% (2008), 1.62% (2009), and 1.83% (2010) of survey respondents did not respond to this question.

The percent of youth respondents who reported that they strongly disapproved of a close friend smoking one or two pack of cigarettes per day has increased every year from 2007-2010. However, from 2007-2009 the percent of respondents reporting that they neither approved nor disapproved also increased. Although the strength of disapproval has shown positive trends over the past four years, the overall percent who disapprove had not decreased until 2010.

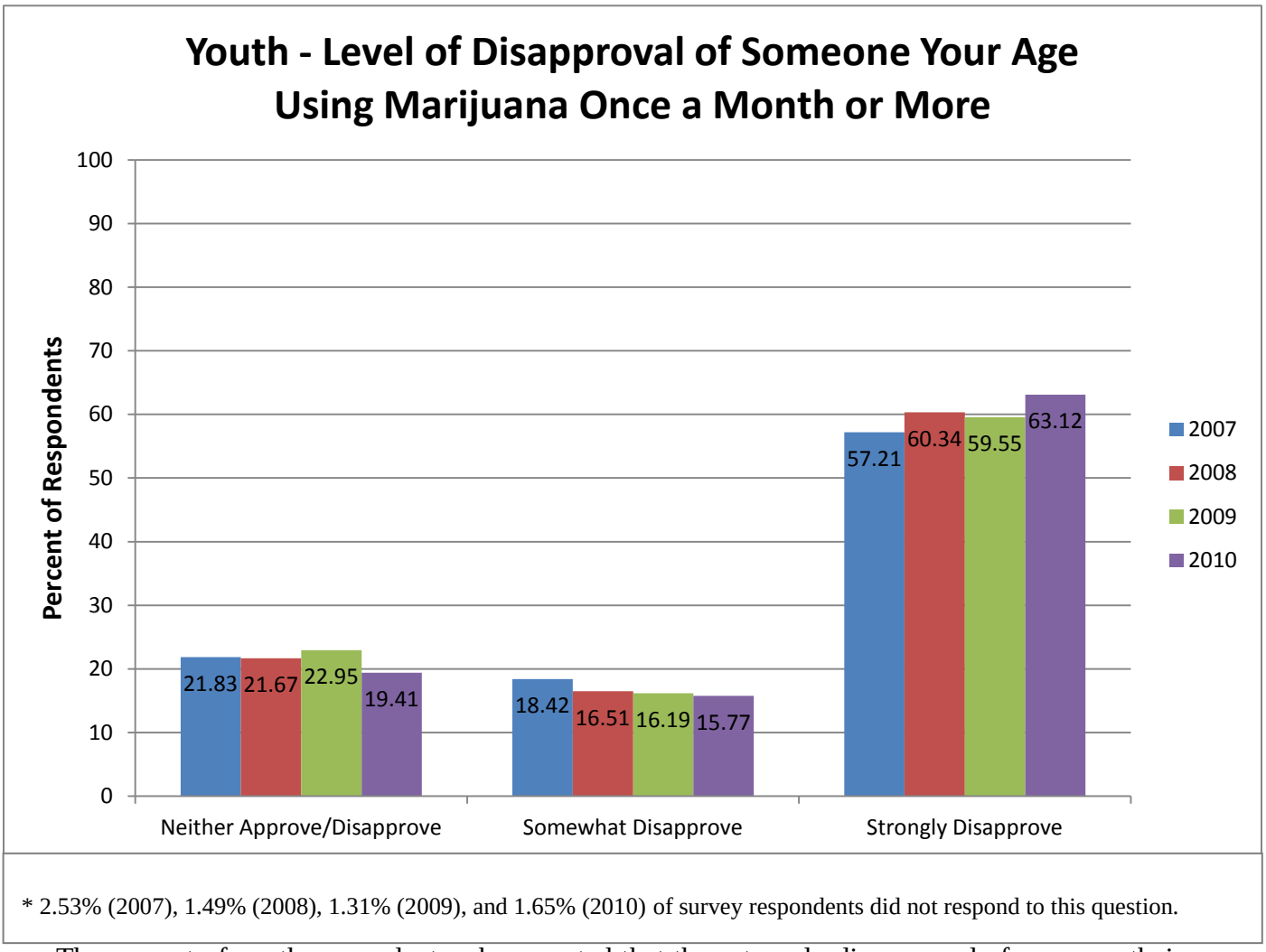
Question 16: How do you feel about someone your age trying marijuana or hashish once or twice?



* 2.37% (2007), 1.48% (2008), 3.72% (2009), and 1.72% (2010) of survey respondents did not respond to this question.

The percent of youth respondents who reported that they strongly disapproved of someone their age trying marijuana or hashish once or twice has increased by 6 percent from 2007 to 2010.

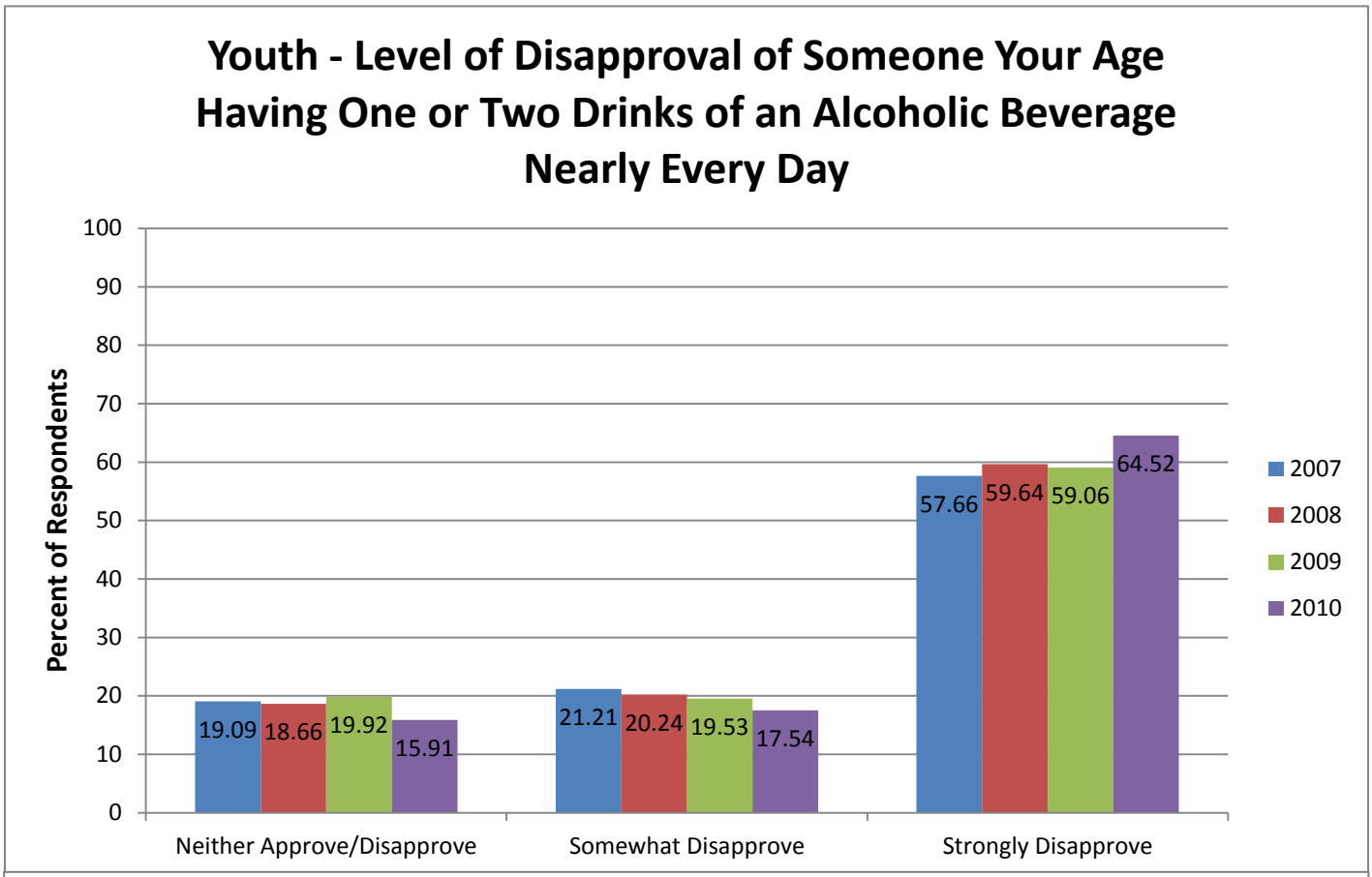
Question 17: How do you feel about someone your age using marijuana once a month or more?



* 2.53% (2007), 1.49% (2008), 1.31% (2009), and 1.65% (2010) of survey respondents did not respond to this question.

The percent of youth respondents who reported that they strongly disapproved of someone their age using marijuana once a month or more has increased by 6 percent from 2007 to 2010. When comparing this table to the previous table on disapproval of trying marijuana once or twice the percents in all categories for all years are very similar. This may indicate that respondents' disapproval of use was not related to how frequent the use was.

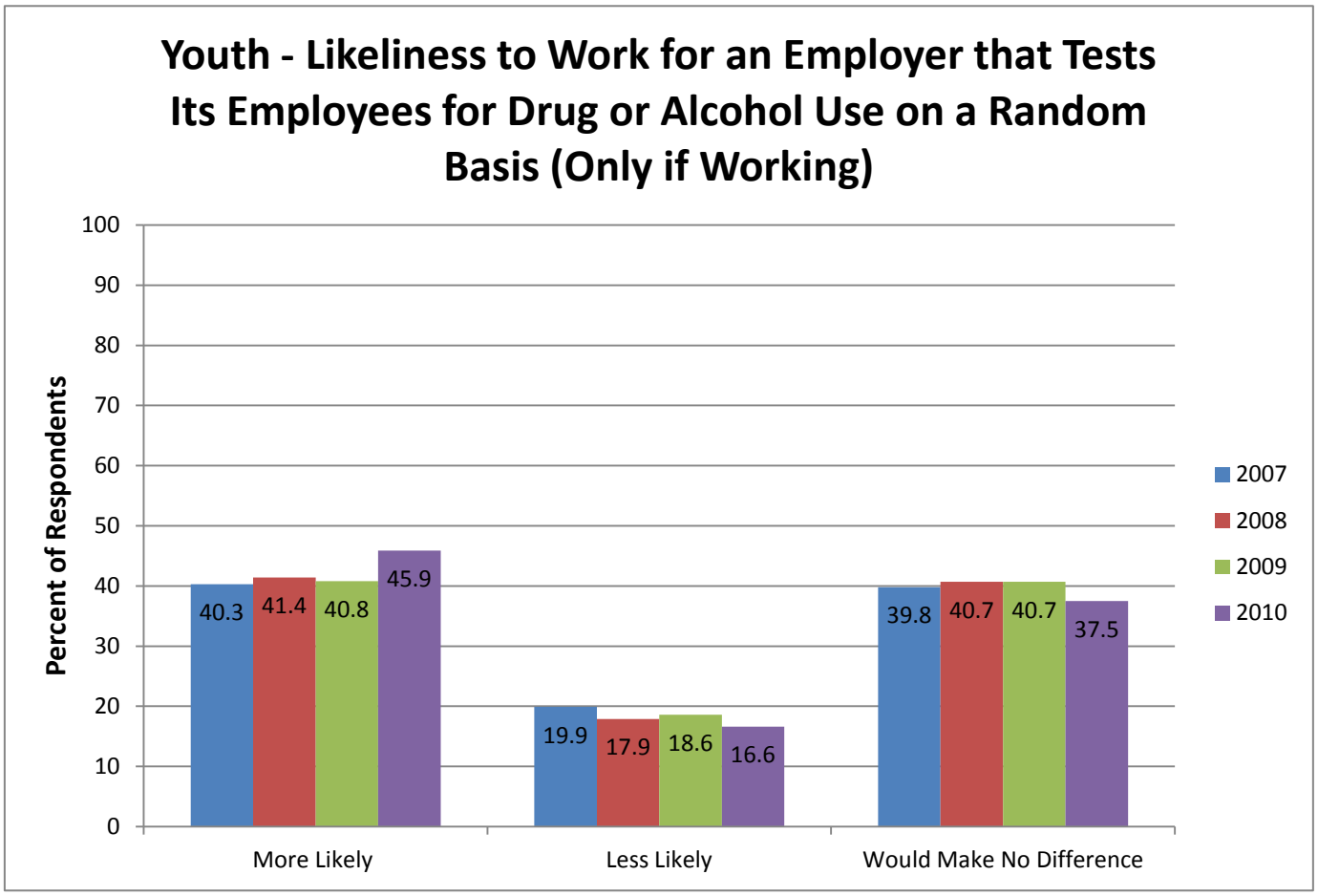
Question 18: How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?



* 2.03% (2007), 1.48% (2008), 1.47% (2009), and 1.94% (2010) of survey respondents did not respond to this question.

The percent of youth respondents who reported that they strongly disapproved of someone their age having one or two drinks of an alcoholic beverage nearly every day has increased by almost 7 percent from 2007 to 2010.

Question 19: Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? (Only if Working)

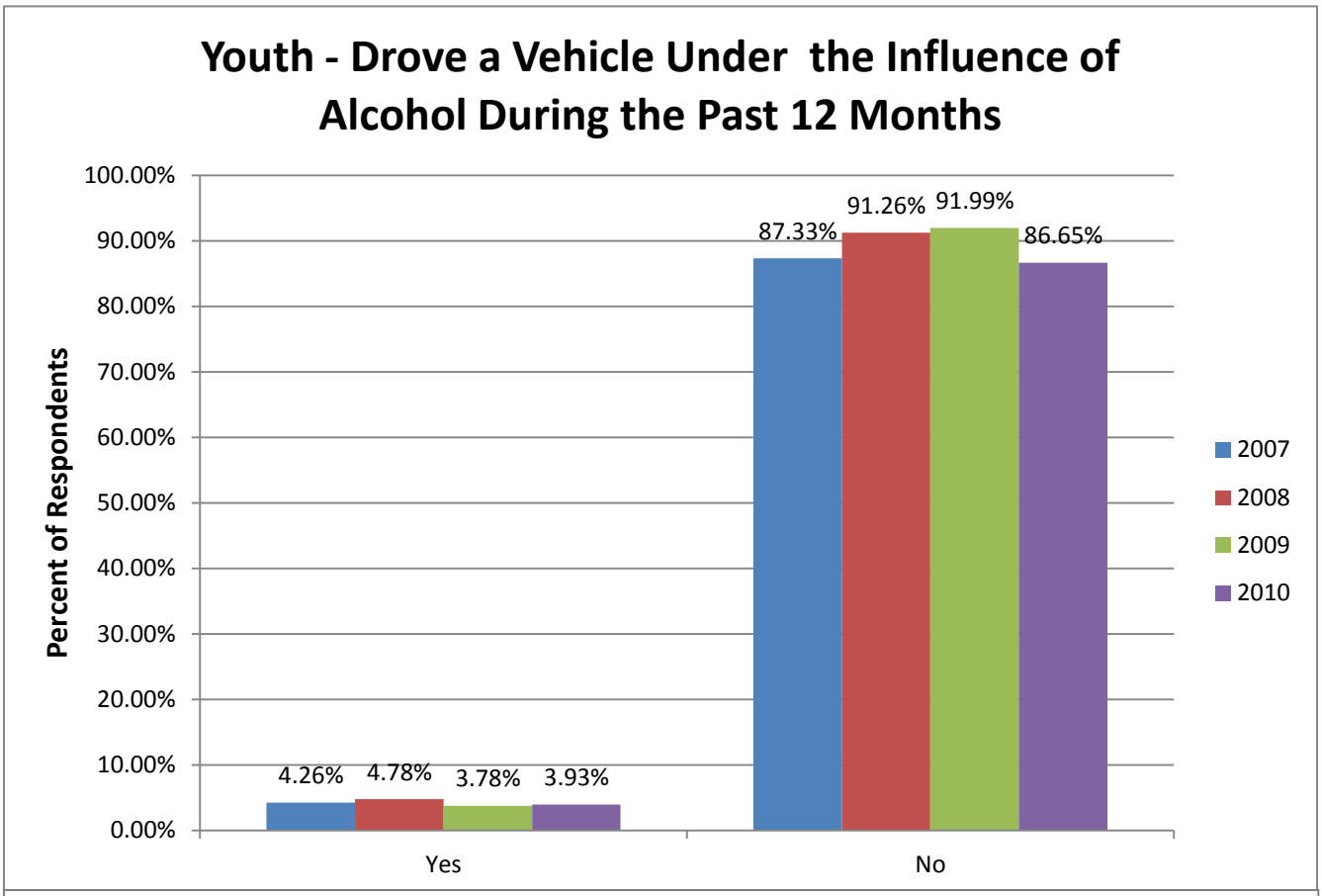


* The percentages in the graph above were calculated out of the total number of respondents who chose one of the three answer choices shown (n=7293 for 2007, n=7135 for 2008, n=6965 for 2009, n=9325 for 2010). Those who selected not applicable or did not answer this question were not included in the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

	2007	2008	2009	2010
Not Applicable	31.83%	27.88%	30.38%	24.94%
No Response	7.88%	7.23%	7.56%	9.83%

The percent of youth reporting that they would be more likely to work for an employer that randomly tests it employees for drug and alcohol use remained nearly the same from 2007-2009, but increased about 5 percent in 2010.

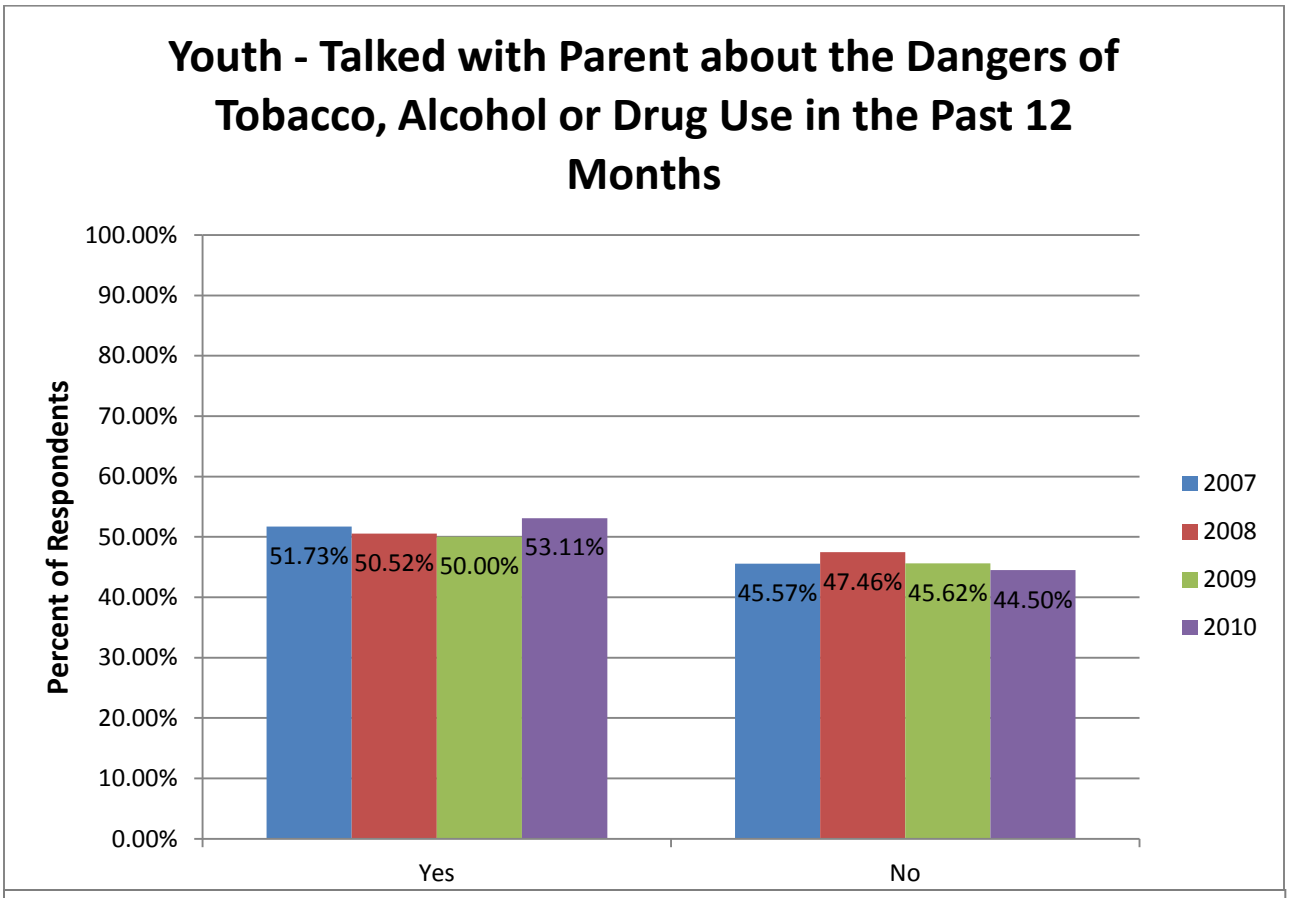
Question 20: During the past 12 months, have you driven a vehicle while you were under the influence of alcohol only?



* 8.37% (2007), 3.95% (2008), 4.21% (2009), and 9.32% (2010) of survey respondents did not respond to this question.

The percent of youth reporting that they drove under the influence has stayed relatively low at approximately 4 percent from 2007-2010.

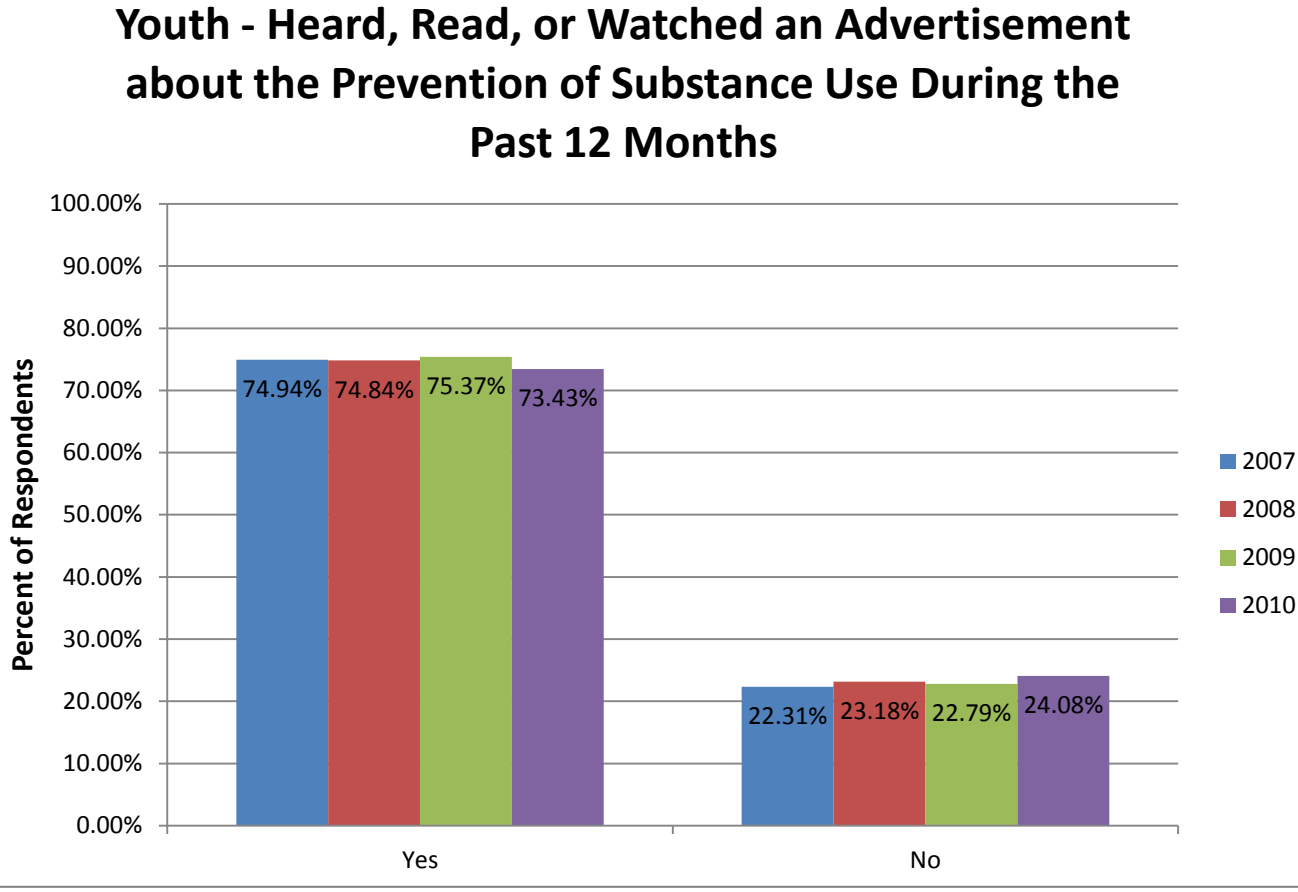
Question 21: During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians – whether or not they live with you.



* 2.70% (2007), 2.02% (2008), 4.37% (2009), and 2.20% (2010) of survey respondents did not respond to this question.

The percent of youth reporting they have talked with their parents about the dangers of tobacco, alcohol, or drug use remained close to just 50 percent for 2007-2010. 2010 was the first year during the four-year period that the percent of youth reporting talking to their parents increased, and the hope is that this increase will continue.

Question 22: During the past 12 months, do you recall hearing, reading, or watching an advertisement about the prevention of substance use?



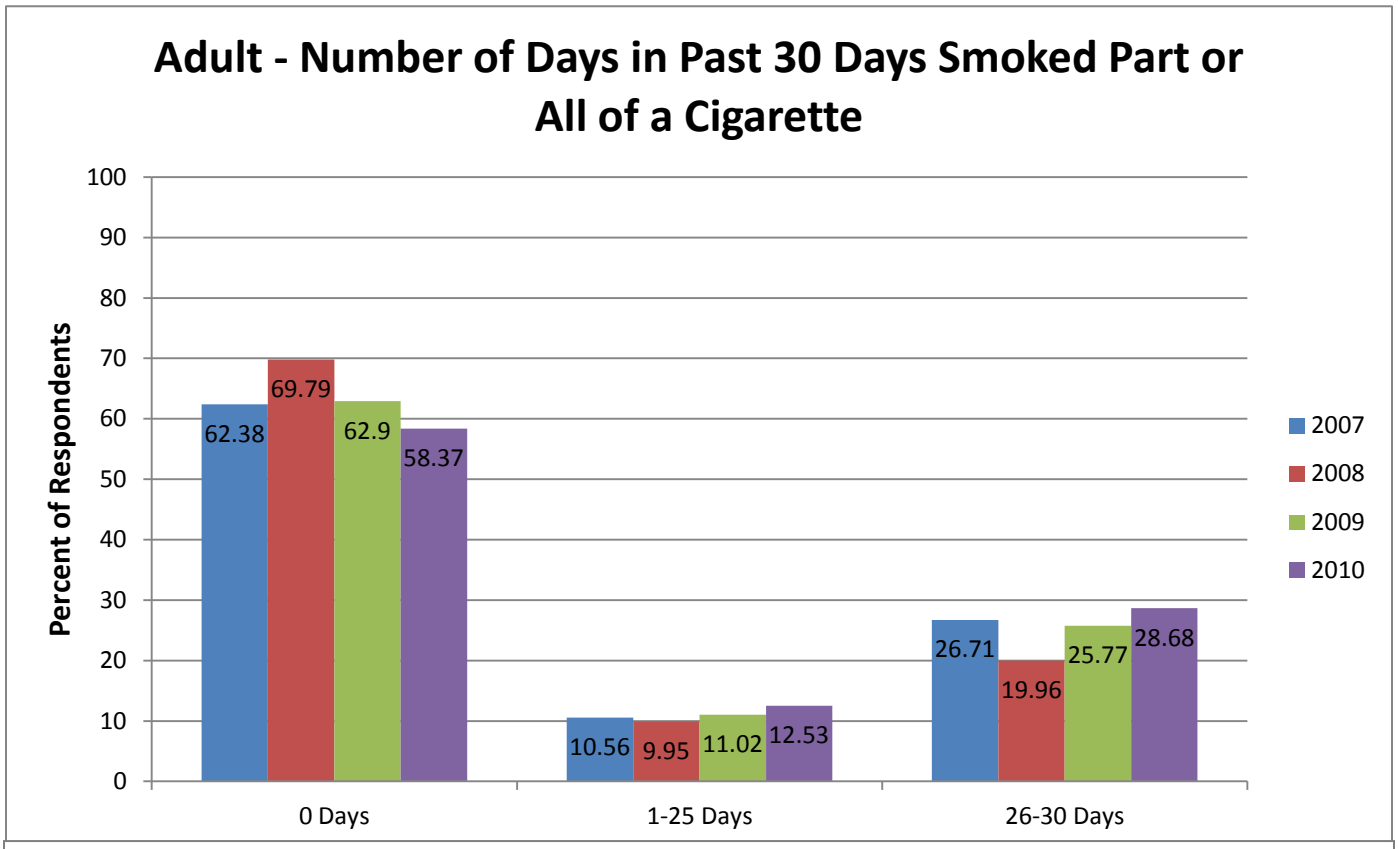
* 2.74% (2007), 2.00% (2008), 1.84% (2009), and 2.31% (2010) of survey respondents did not respond to this question.

The percent of youth reporting hearing, reading, or watching an advertisement about the prevention of substance use stayed nearly the same from 2007-2009 (approximately 75 percent), but decreased very slightly in 2010.

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

The following surveys were gathered from Pennsylvania adults who attended selected single prevention services and recurring prevention services from October 1st to November 30th of 2007 (n=3145), 2008 (n=3558), 2009 (n=4765), and 2010 (n=5537). 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.

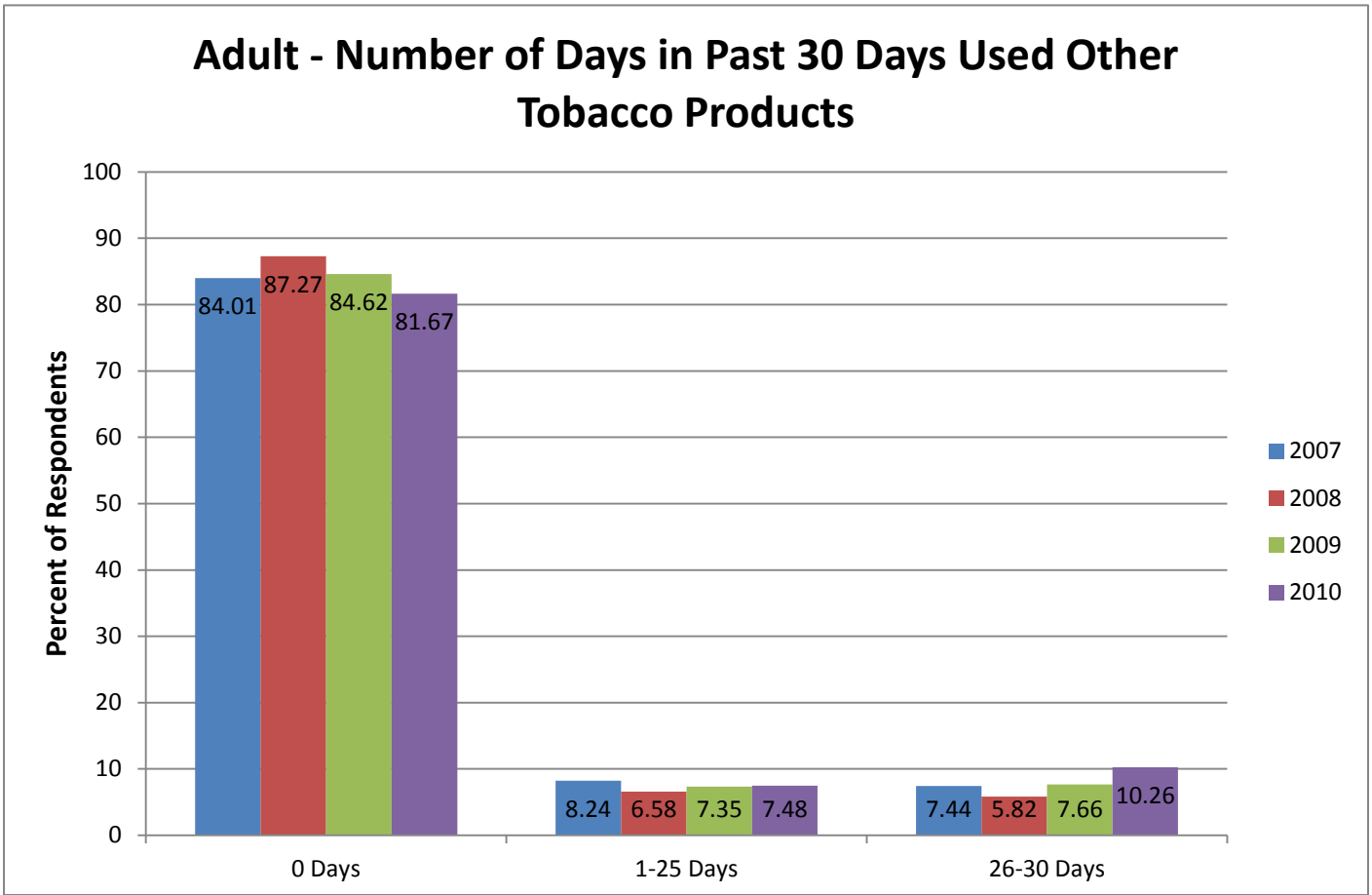
Question 1: During the past 30 days, on how many days did you smoke part or all of a cigarette?



* .35% (2007), .31% (2008), .31% (2009), and .42% (2010) of survey respondents did not respond to this question.

Past 30 day cigarette use among adult respondents has shown negative trends over the fours year depicted above. The percent of adult respondents who reported no past 30 day use of cigarettes has declined by 4 percent from 2007-2010. In 2010, 41.2 percent of adults reported past 30 day use of cigarettes.

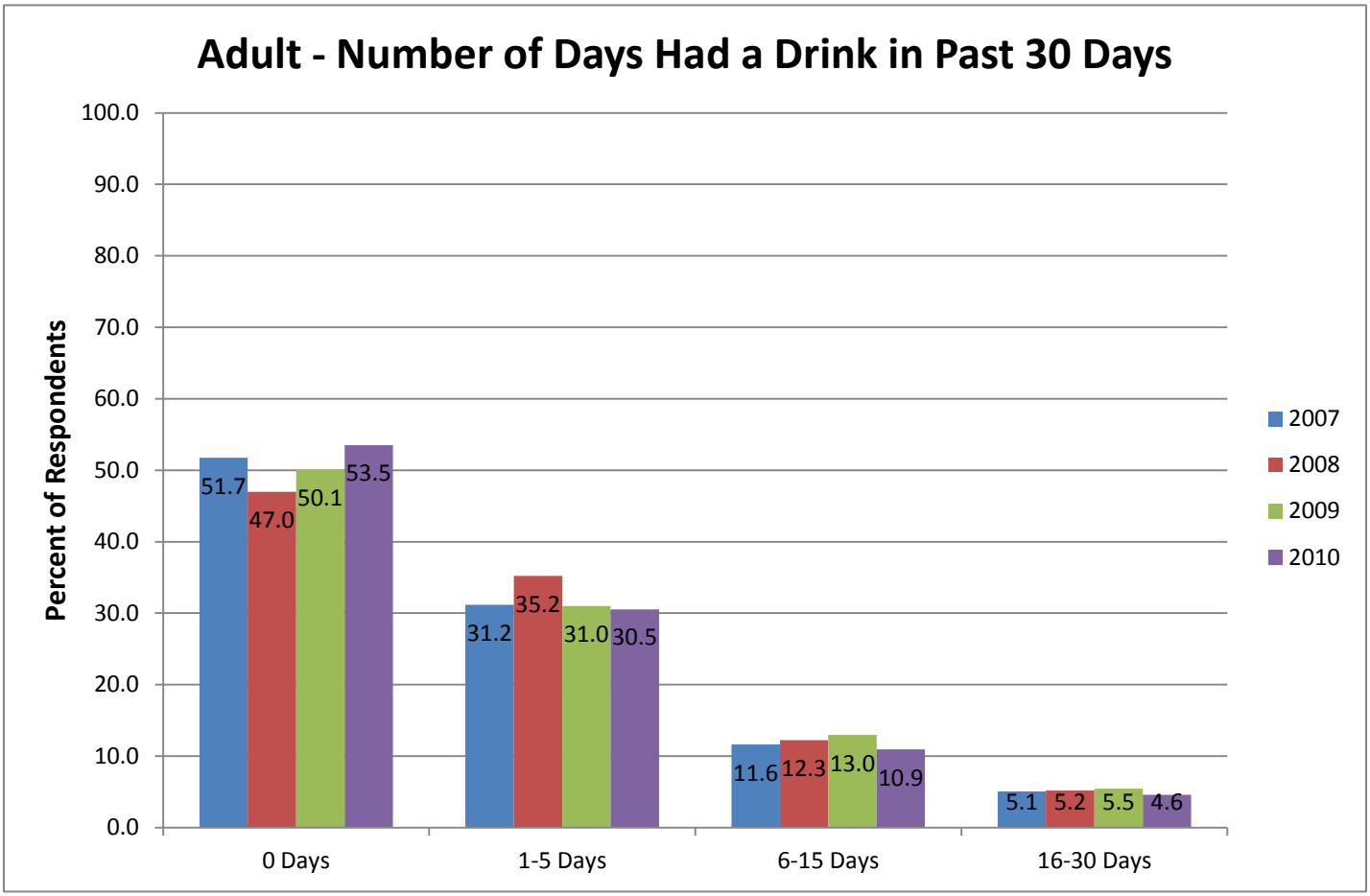
Question 2: During the past 30 days, on how many days did you use other tobacco products?



* .32% (2007), .34% (2008), .38% (2009), and .49% (2010) of survey respondents did not respond to this question.

Past 30 day use of other tobacco products among adult respondents has shown negative trends over the four years depicted above. The percent of adult respondents who reported no past 30 day use of other tobacco products increased in 2008 but decreased in both 2009 and 2010. In 2010, 17.7 percent of adults reported past 30 day use of other tobacco products.

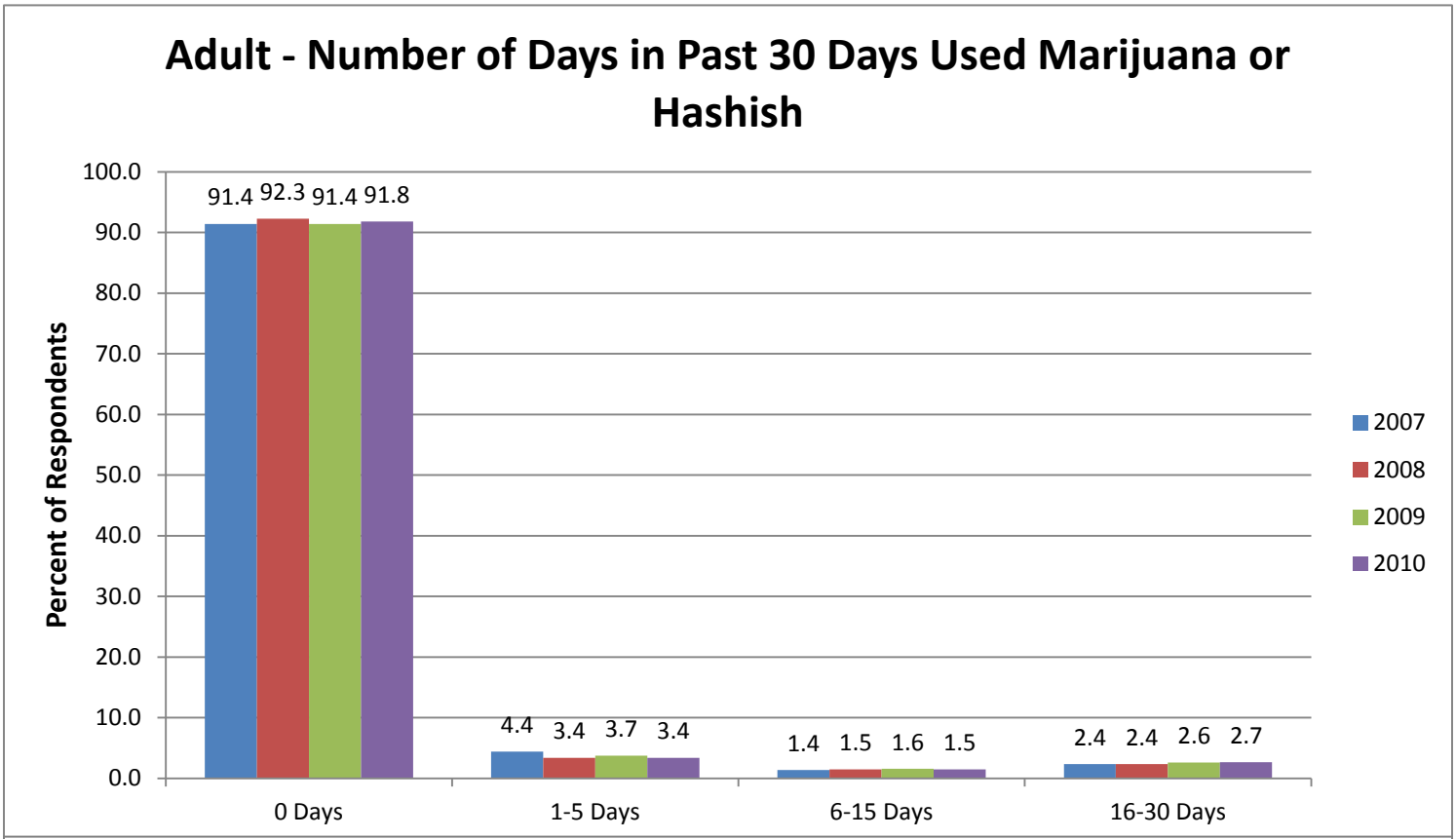
Question 3: During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?



* .41% (2007), .39% (2008), .52% (2009), and .43% (2010) of survey respondents did not respond to this question.

The percent of adults reporting that they had a drink on 5 or less days out of the past 30 days has remained above 80 percent for 2007-2010 with a high of 84 percent in 2010 and a low of 81 percent in 2009.

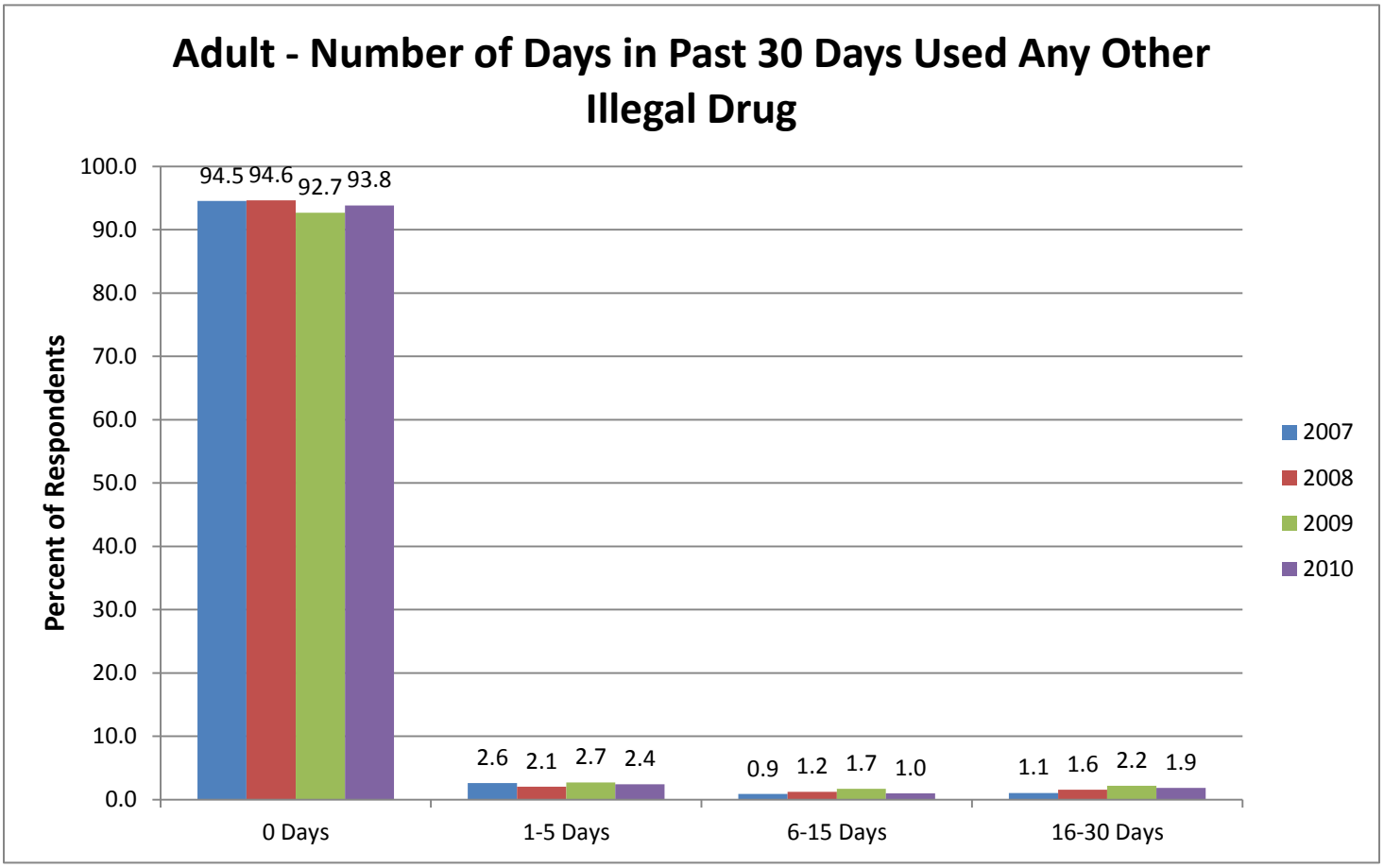
Question 4: During the past 30 days, on how many days did you use marijuana or hashish?



* .48% (2007), .48% (2008), .67% (2009), and .69% (2010) of survey respondents did not respond to this question.

The percent of adults reporting no past 30 days use of marijuana or hashish has remained at approximately 92% for every year from 2007-2010. In 2010, 7.6 percent of adults reported past 30 day use of marijuana or hashish.

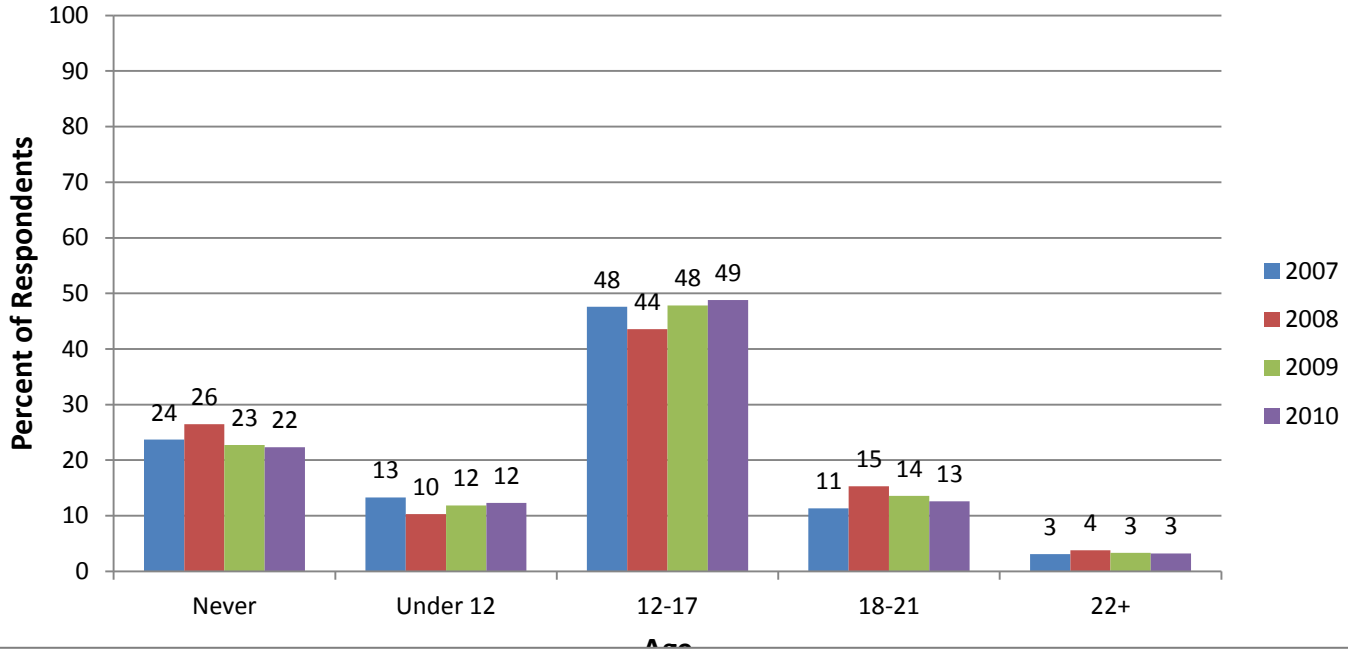
Questions 5: During the past 30 days, on how many days did you use any other illegal drug? Other illegal drugs include substances like: heroin, crack or cocaine, methamphetamine; hallucinogens (such as LSD, Ecstasy, PCP or peyote); inhalants or sniffed substances such as glue, gasoline, paint thinner, cleaning fluid or shoe polish; prescription drugs without a doctor's orders.



* .92% (2007), .56% (2008), .67% (2009), and .83% (2010) of survey respondents did not respond to this question.

The percent of adults reporting no past 30 day use of any other illegal drug has fluctuated slightly from 2007-2010, but has remained above 92 percent all four years. In 2010, 5.3 percent of adults reported past 30 day use of other illegal drugs.

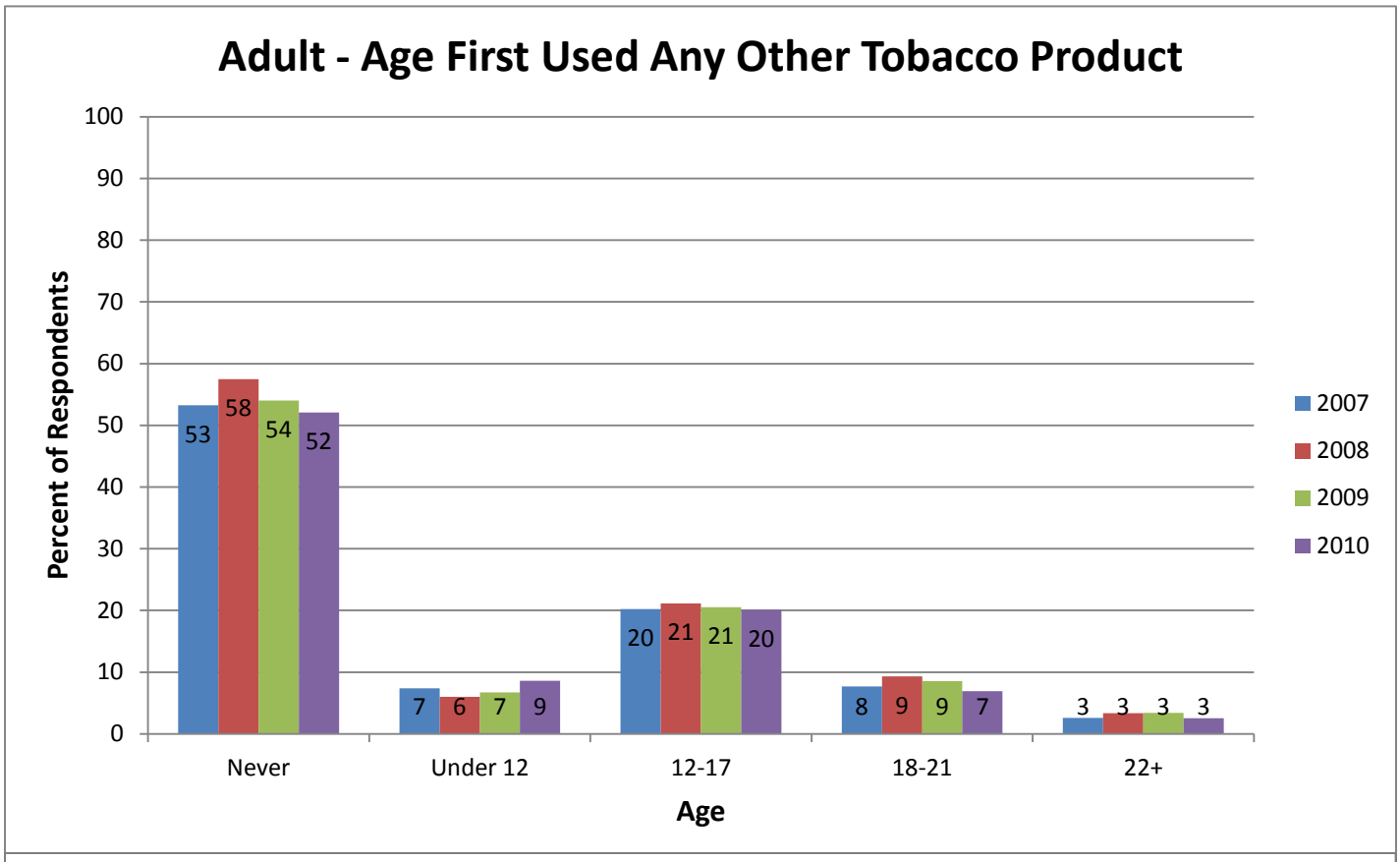
Question 6: How old were you the first time you smoked part or all of a cigarette?



* .92% (2007), .56% (2008), .67% (2009), and .69% (2010) of survey respondents did not respond to this question.

Each year just slightly less than half of the adult respondents reported that they first smoked a cigarette between the ages of 12 and 17. The percent of adults reporting that they have never smoked decreased by 2 percent from 2007 to 2010.

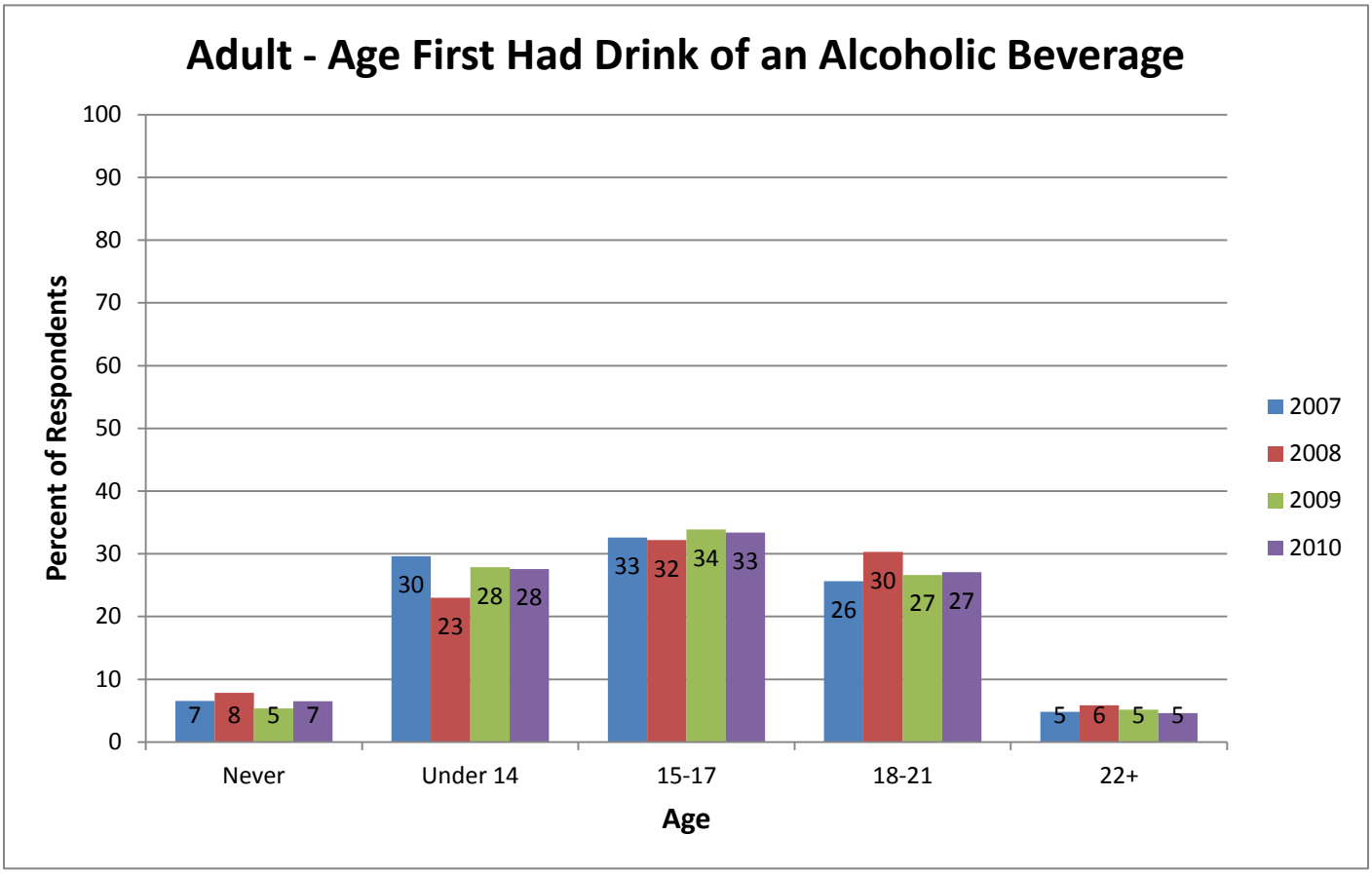
Question 7: How old were you the first time you used any other tobacco product?



* ..86% (2007), .82% (2008), .1.30% (2009), and 1.50% (2010) of survey respondents did not respond to this question.

The percent of adults reporting that they have never used any other tobacco product increased in 2008, but decreased in 2009 and 2010. Across the four years shown in the graph above, approximately 54 percent of respondents reporting never using any other tobacco product. The most commonly reported age of first use for all years was 12-17 years.

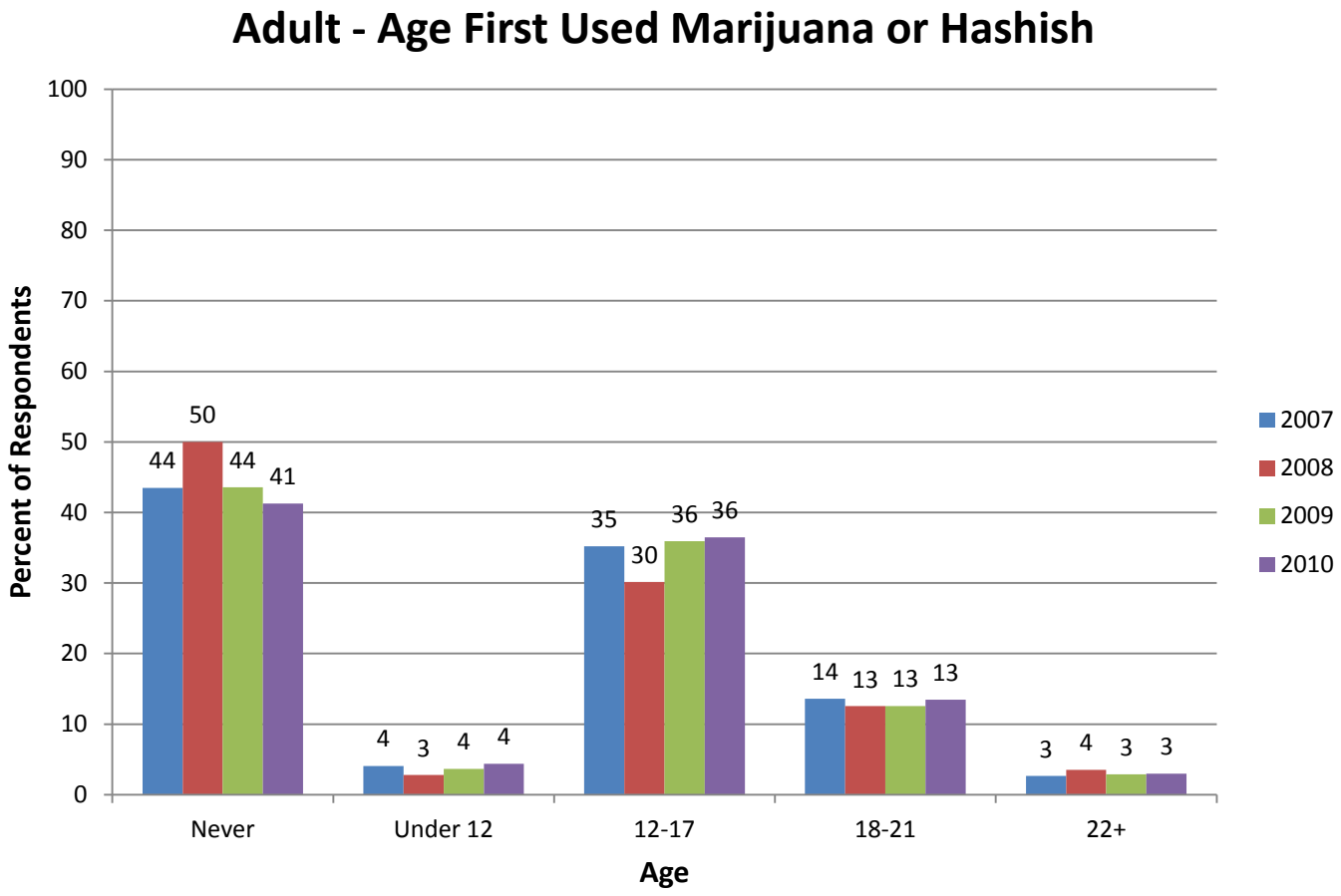
Question 8: How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink.



* .76% (2007), .79% (2008), 1.07% (2009), and .88% (2010) of survey respondents did not respond to this question.

For each year from 2007-2010 about 33 percent of adult respondents reported that they had their first drink of an alcoholic beverage between the ages of 15 and 17.

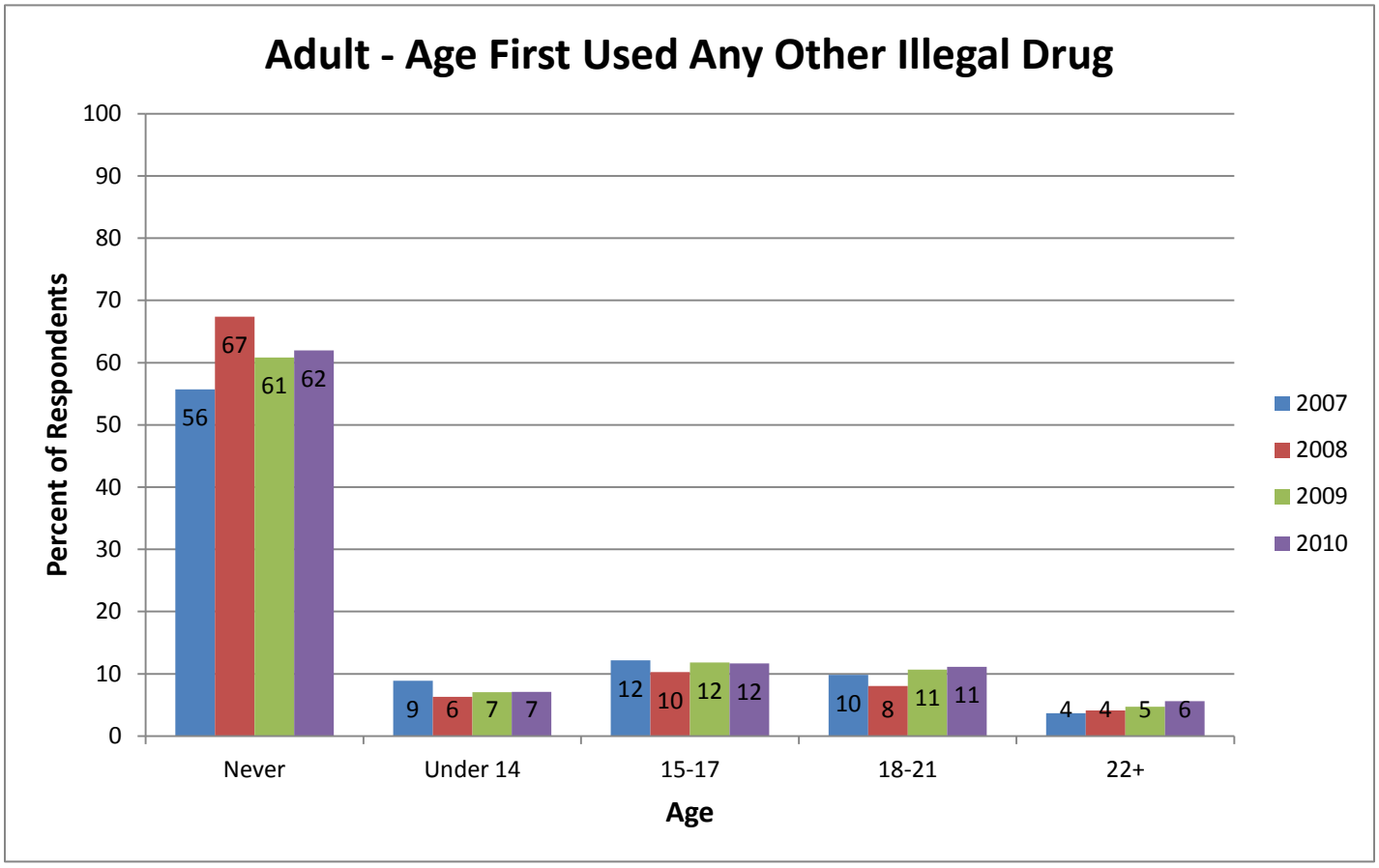
Question 9: How old were you the first time you used marijuana or hashish?



* .99% (2007), .98% (2008), 1.39% (2009), and 1.46% (2010) of survey respondents did not respond to this question.

The percent of adults reporting that they have never used marijuana or hashish increased in 2008 but decreased in 2009 and 2010. In 2010, approximately 59 percent of adult respondents reported that they had used marijuana or hashish. The most commonly reported age at first use was between 12 and 17.

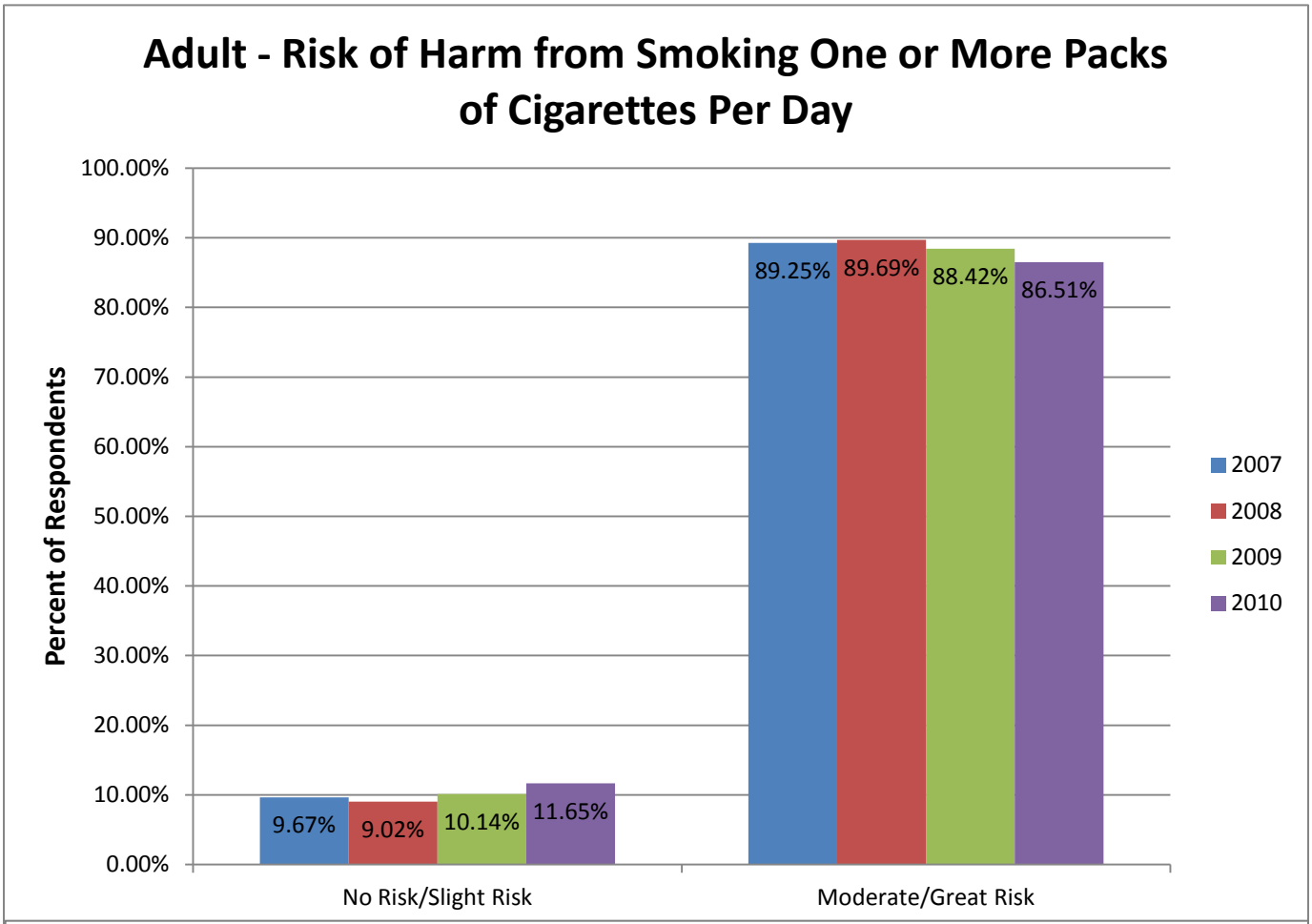
Question 10: How old were you the first time you used any other illegal drug? Other illegal drugs include substances like: heroin, crack or cocaine, methamphetamine; hallucinogens (such as LSD, Ecstasy, PCP or peyote); inhalants or sniffed substances such as glue, gasoline, paint thinner, cleaning fluid or shoe polish; prescription drugs without a doctor's orders.



* 9.76% (2007), 3.88% (2008), 4.89% (2009), and 2.56% (2010) of survey respondents did not respond to this question.

The percent of adults reporting that they have never used any other illegal drug has fluctuated from 2007-2010 with a high of 67 percent in 2008 and a low of 56 percent in 2007. In 2010, approximately 38 percent of adults reported that they had used any other illegal drug. The most commonly reported age at first use was 15-17.

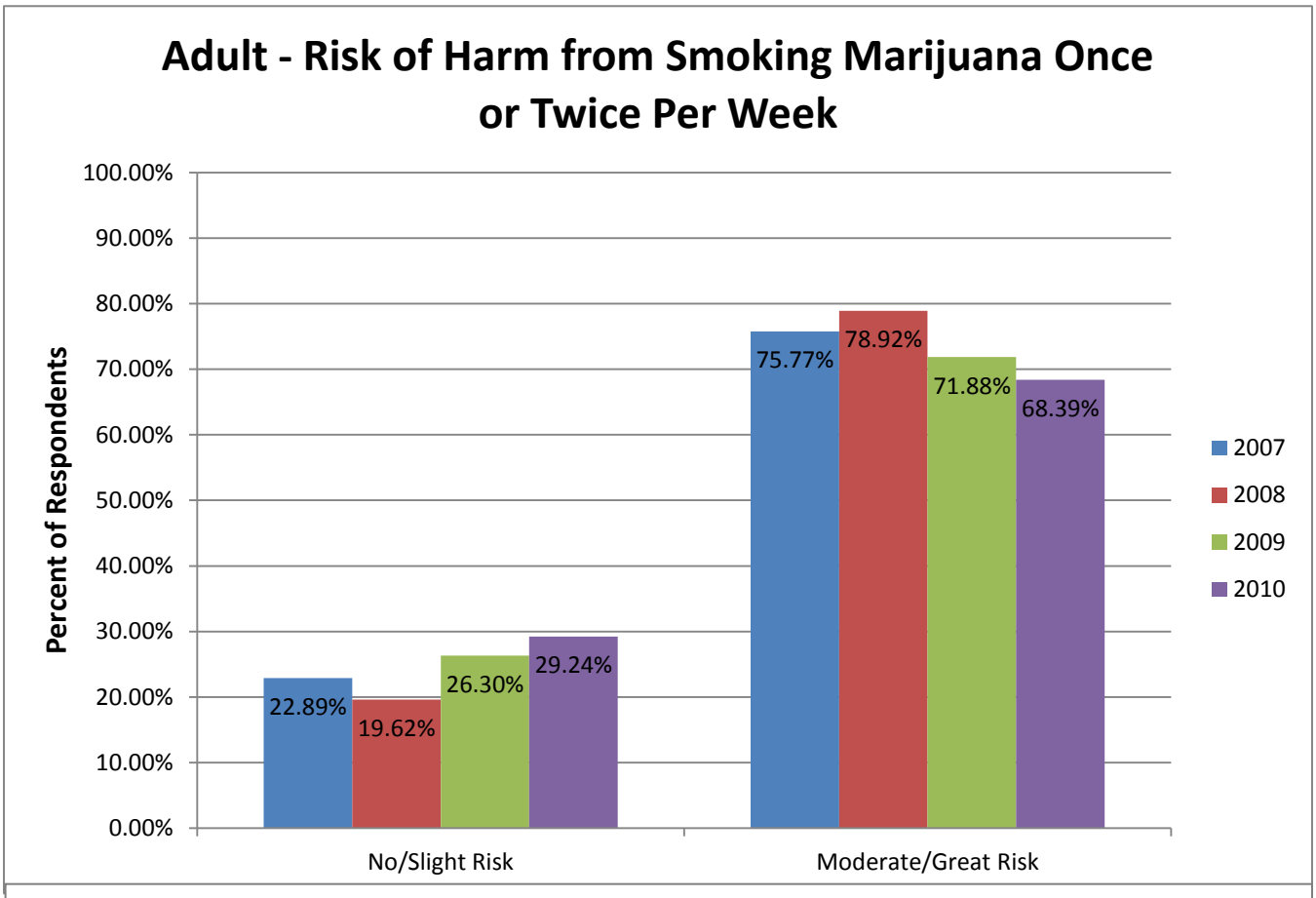
Question 11: How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?



* 1.08% (2007), 1.29% (2008), 1.43% (2009), and 1.82% (2010) of survey respondents did not respond to this question.

The number of adults reporting moderate or great risk of harm from smoking one or more packs of cigarettes per day has decreased slightly from 2007-2010. Each year more adults reported that smoking one or two packs of cigarettes per day posed a moderate or great risk of harm than reported that smoking marijuana and drinking alcohol posed a moderate or great risk of harm.

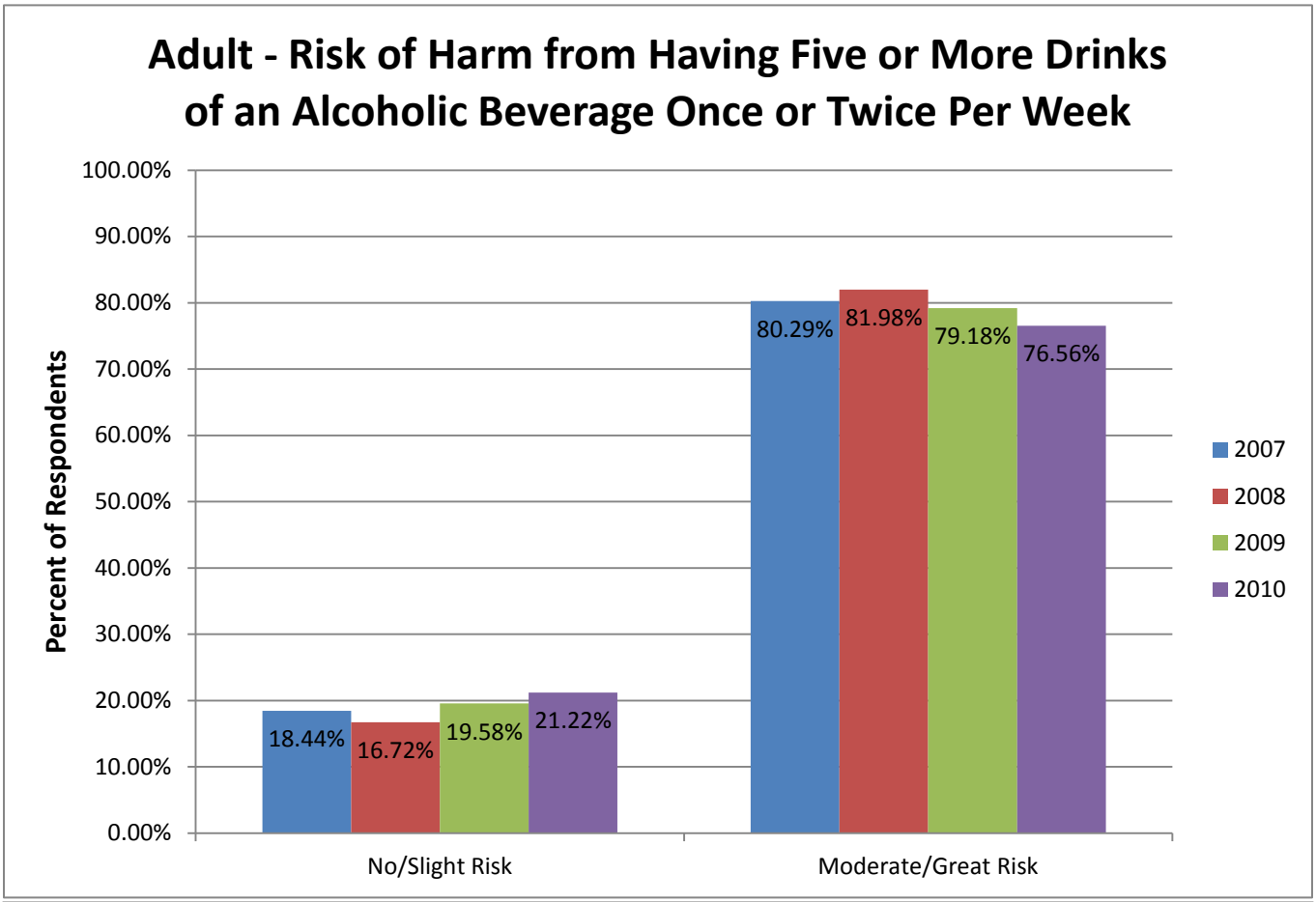
Question 12: How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?



* .25% (2007), 1.46% (2008), 1.78% (2009), and 2.35% (2010) of survey respondents did not respond to this question.

Adult perception of risk of smoking marijuana once or twice per week has shown a negative trend over the four years depicted above. The percent of adults reporting moderate/great risk has decreased by over 7 percent from 2007 to 2010. Of the three questions on the survey regarding the potential harm posed by use of certain substances (i.e., cigarettes, marijuana, and alcohol), this question on marijuana use had the highest percent of respondents reporting no or only slight risk.

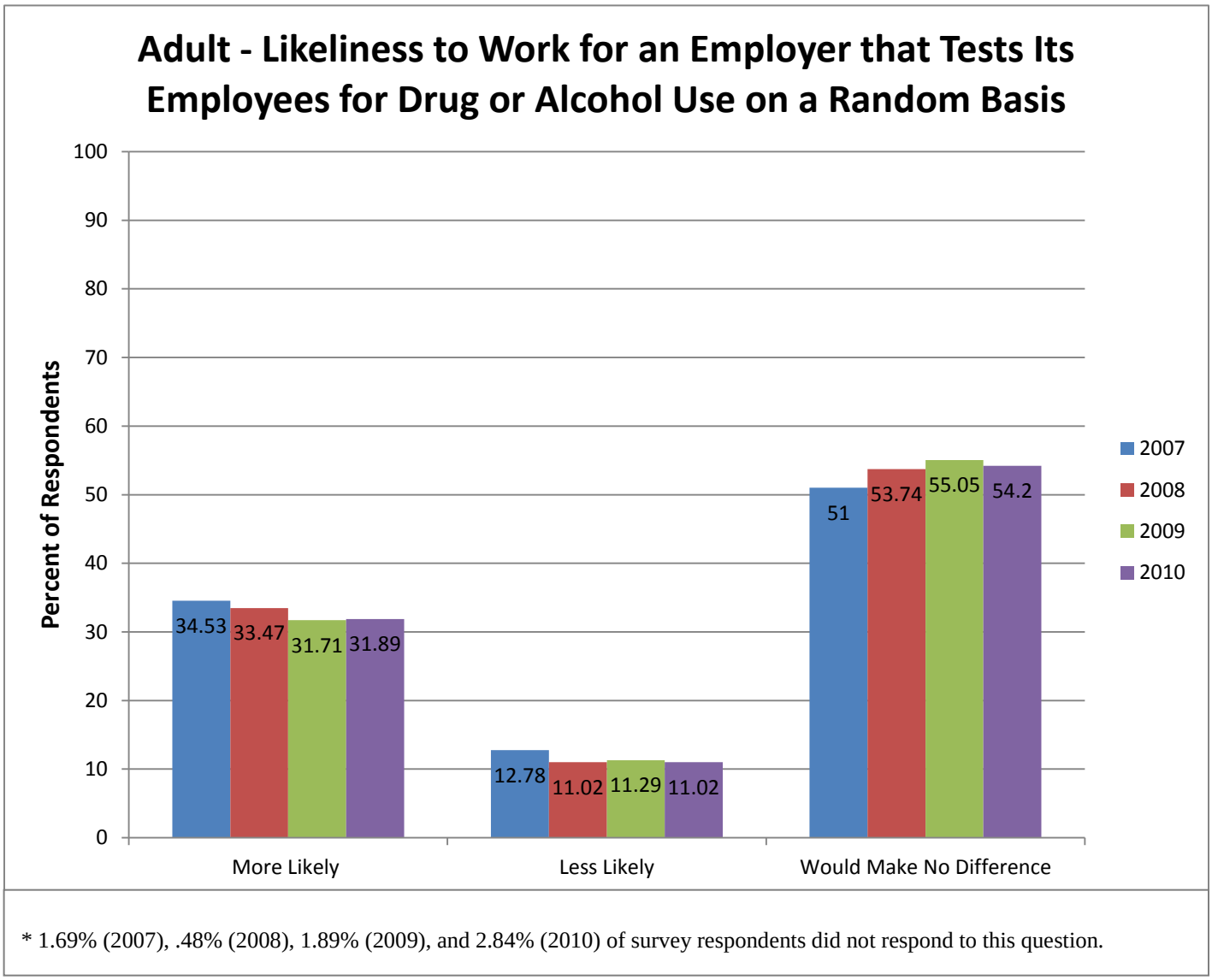
Question 13: How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?



* 1.27% (2007), 1.29% (2008), 1.22% (2009), and 2.20% (2010) of survey respondents did not respond to this question.

Adult perception of risk of smoking marijuana once or twice per week has shown a negative trend over the four years depicted above. The percent of adults reporting moderate/great risk has decreased by nearly 4 percent from 2007 to 2010.

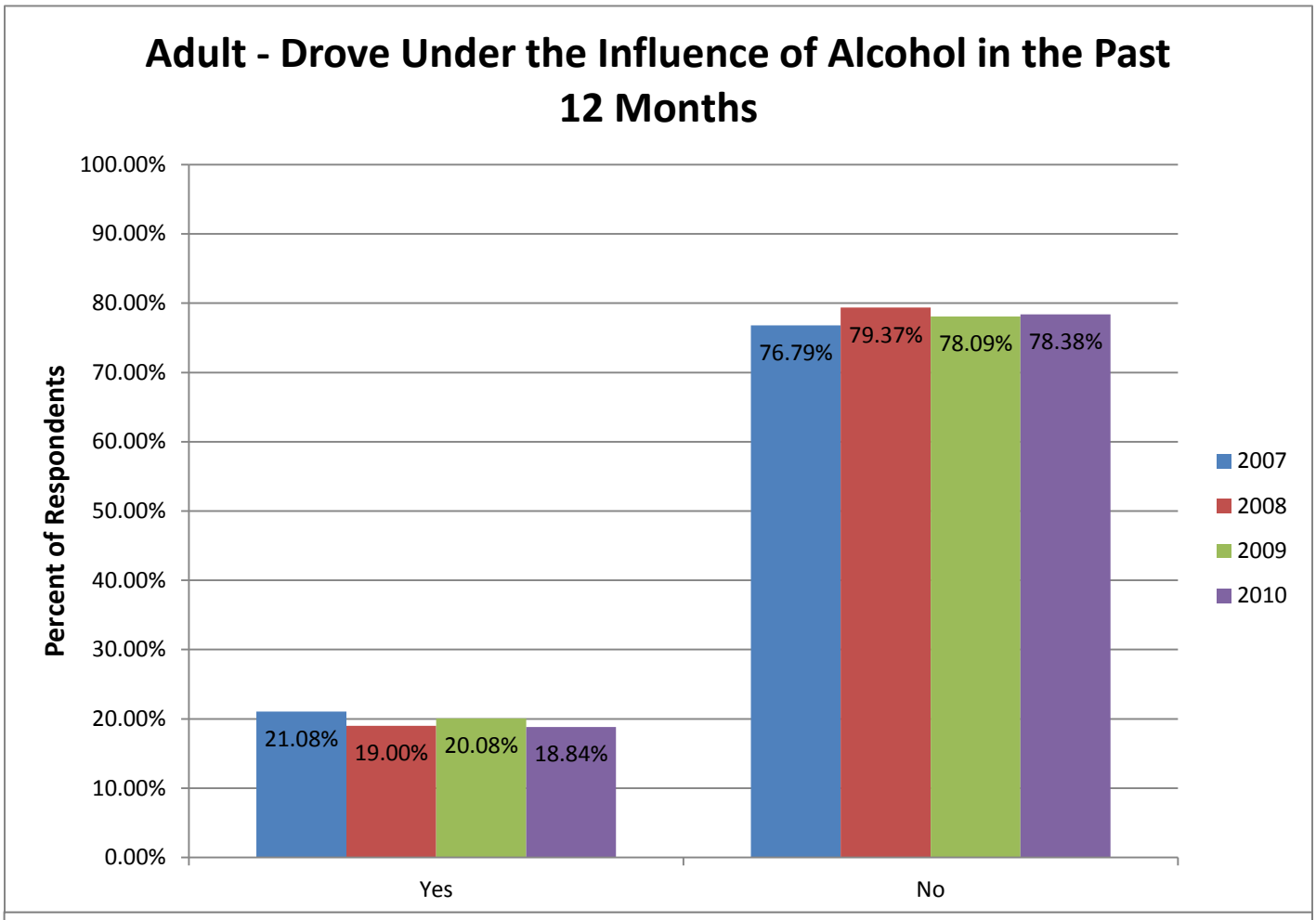
Question 14: Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis?



* 1.69% (2007), .48% (2008), 1.89% (2009), and 2.84% (2010) of survey respondents did not respond to this question.

The percent of adults reporting that they would be more likely to work for an employer that tests its employees for drug or alcohol use on a random basis has decreased by approximately 2.5 percent from 2007 to 2010. This was accompanied by an increase in the percent reporting that it would make no difference. Each year just over 50 percent of respondents reported that they would not be more likely or less likely to work for an employer that does random drug and alcohol tests.

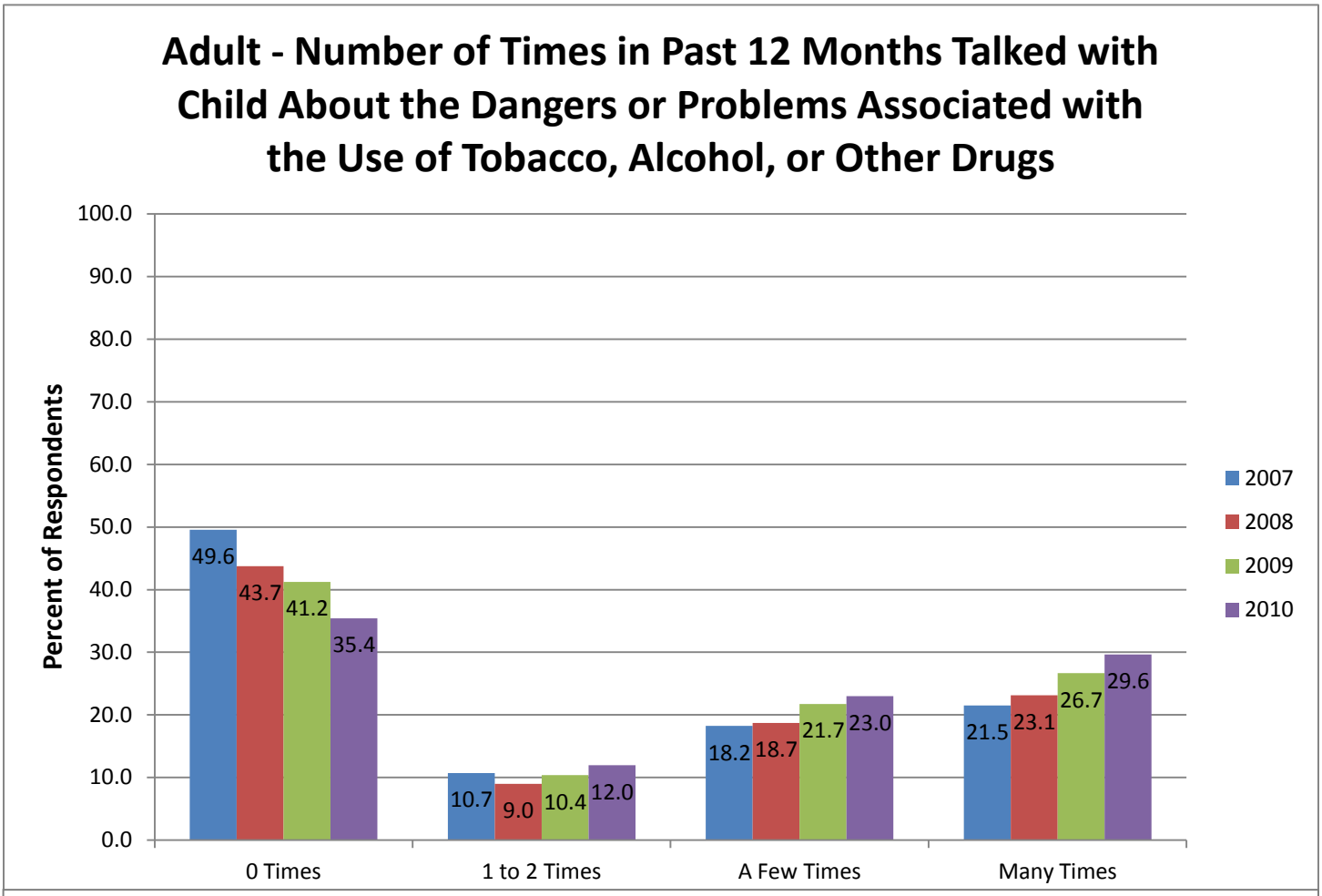
Question 15: During the past 12 months, have you driven a vehicle while you were under the influence of alcohol only?



* 2.13% (2007), 1.63% (2008), 1.76% (2009), and 2.65% (2010) of survey respondents did not respond to this question.

The percent of adults reporting that they drove under the influence has fluctuated slightly each year, but shows an overall downward trend. In 2010, nearly 19 percent of respondents reported that they drove under the influence in the past 12 months.

Question 16: During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?



* The percentages in the graph above were calculated out of the total number of respondents who chose one of the four answer choices shown (n=2852 for 2007, n=3165 for 2008, n=3317 for 2009, n=3490 for 2010). Those who selected not applicable (no children or children are not age appropriate) or did not answer this question were not included in the denominator when calculating the percentages. The percent who selected Not Applicable and who did not respond, calculated out of the total number of respondents, is 9.32% (2007), 5.90% (2008), 30.39% (2009), and 36.84% (2010).

The percent of adults reporting that they have not talked with their child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs in the past 12 months has decreased steadily from 2007-2010. This has been accompanied by an increase in the number reporting that they talked with their child many times. In 2010, 65 percent of respondents reporting talking with their child at least once.

Data Analysis Compiled from the Client Information System (CIS)
State Fiscal Year 2010-2011

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

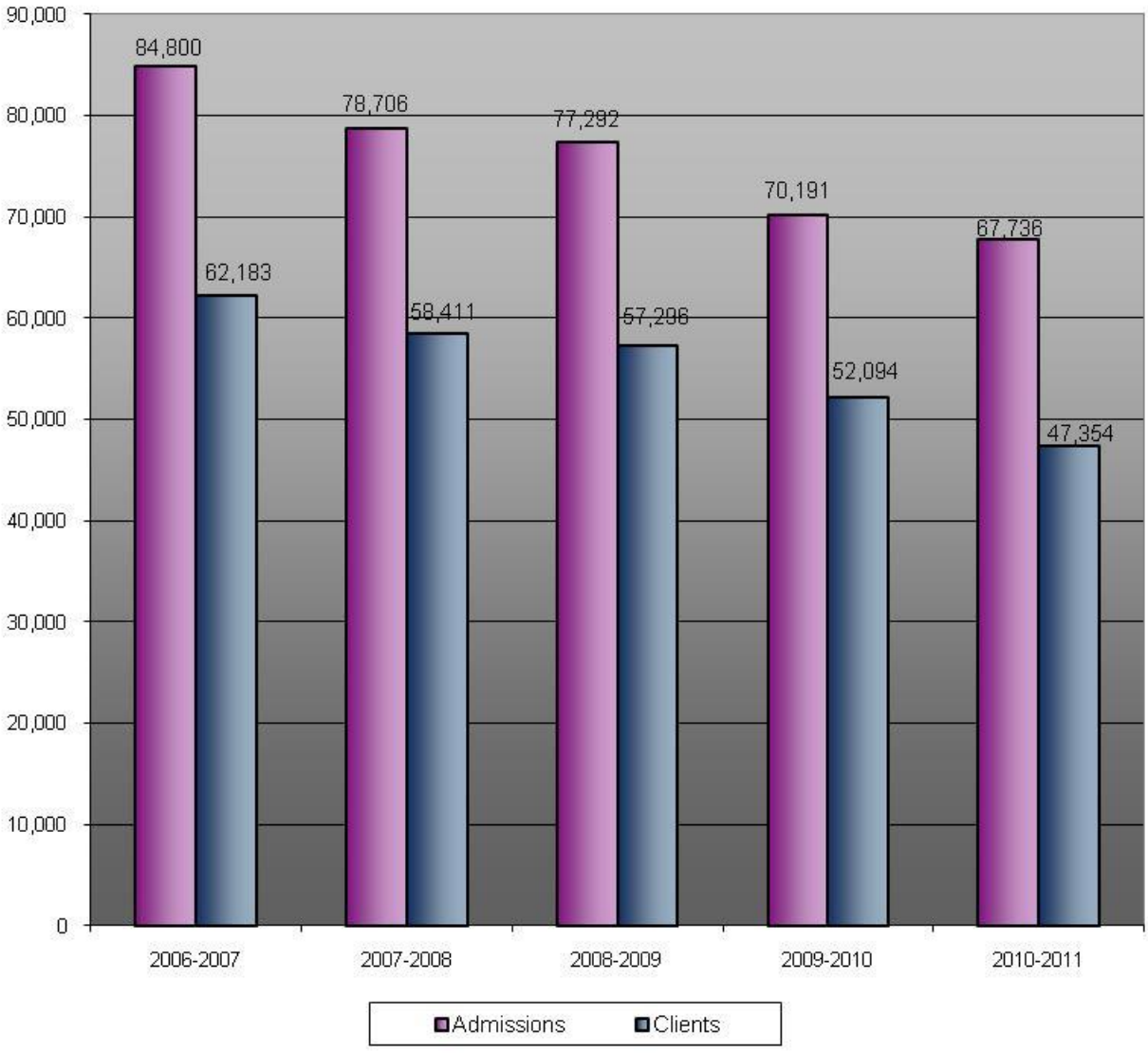
Figure 1 shows total admissions and total unique clients served for the past five state fiscal years. A unique client is a single person who has been admitted and has received any substance abuse treatment at a licensed provider during the given state fiscal year. An admission occurs when a client is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

The graph shows that admission totals and unique client totals are closely related. Both totals change in a similar pattern. In the past five state fiscal years (2006-2007 through 2010-2011), 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 Single County Authorities (SCAs) and providers have reported treating fewer clients as a direct result of less funding to provide services. Also, the CIS is an antiquated 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. BDAP is in the process of remedying these issues.

Figure 1

CIS Admissions and Unique Clients for State Fiscal Years 2006-2007 through 2010-2011



Clients are unique admissions counted once in the time period.

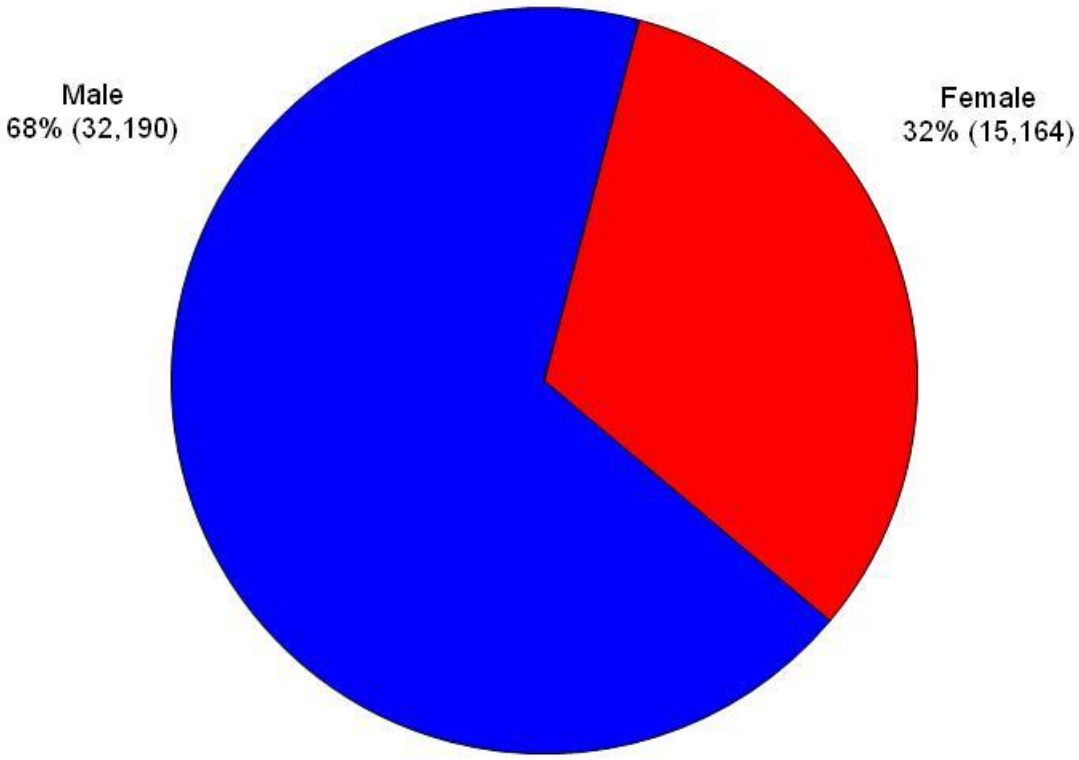
Client Demographics

Clients that are treated by programs funded by the Department are quite different from the general population in many ways. The following charts and narrative describe these differences. The majority (69 percent) of clients are male (Figure 2), while the general population is 49 percent male. Over half (51 percent) of all clients 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 (15 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 (0.03 percent and 2.7 percent, respectively) [Figure 4]. There is a greater percentage of Hispanics in treatment compared to the general population (5.8 percent and 5.6 percent, respectively) [Figure 5]. Nearly one in five (18 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 2010 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 2010-2011

Gender

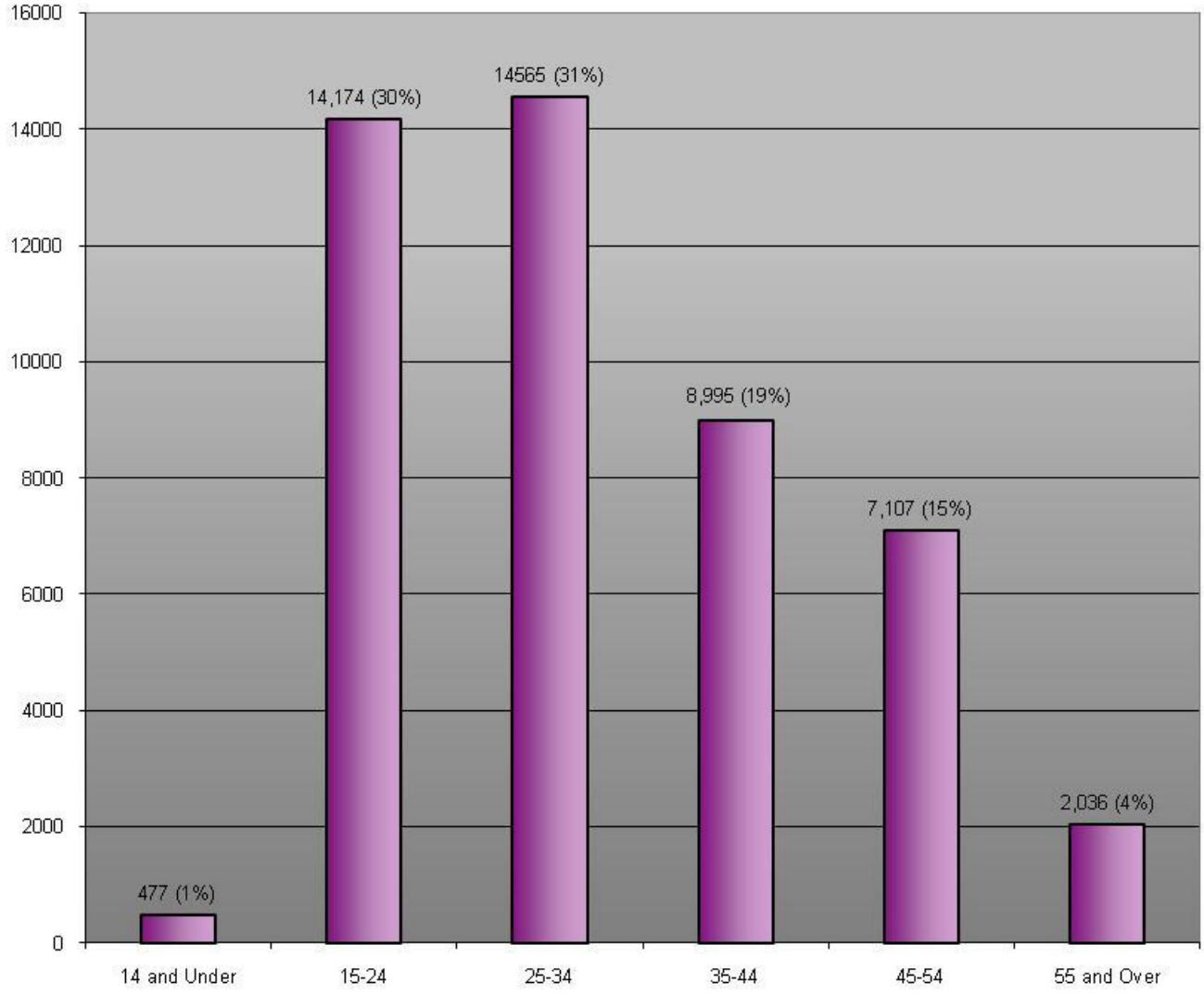


Clients are unique admissions counted once in the time period.
Total Clients=47,354

Figure 3

CIS Unique Client Admissions SFY 2010-2011

Age Groups

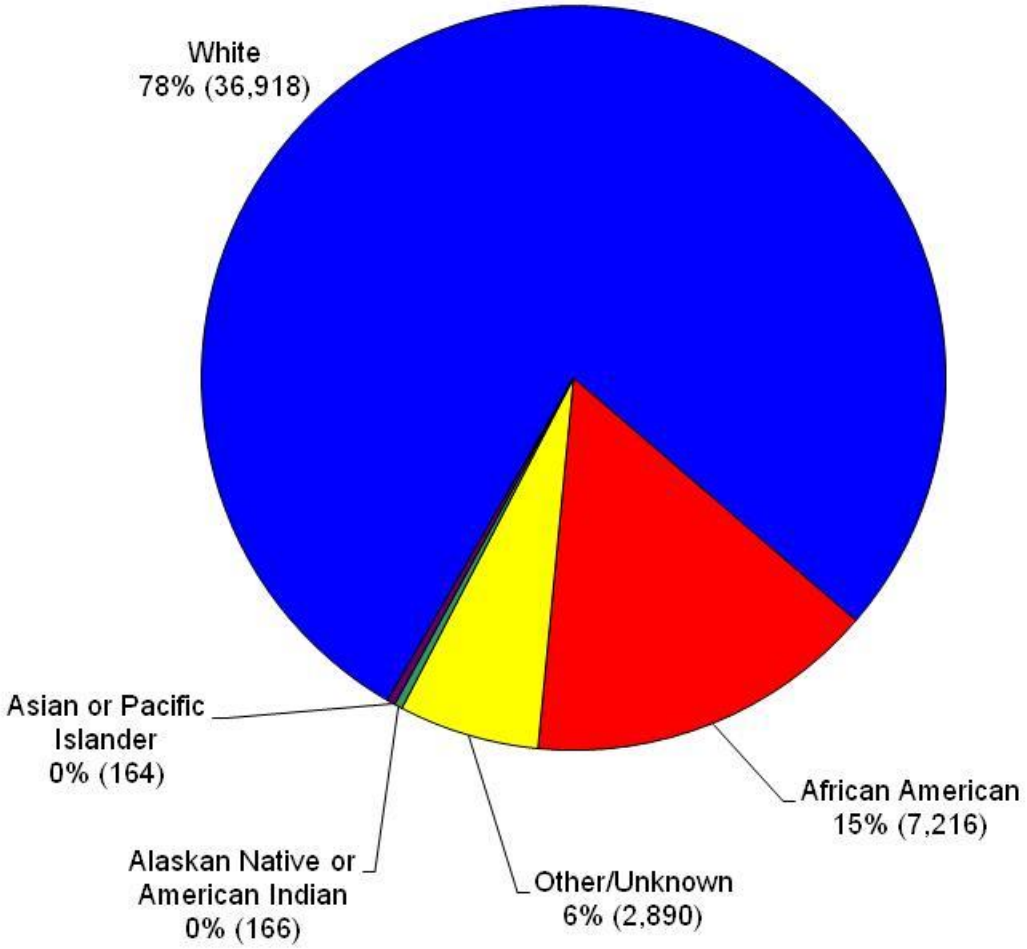


Clients are unique admissions counted once in the time period.
Total Clients=47,354

Figure 4

CIS Unique Client Admissions SFY 2010-2011

Race

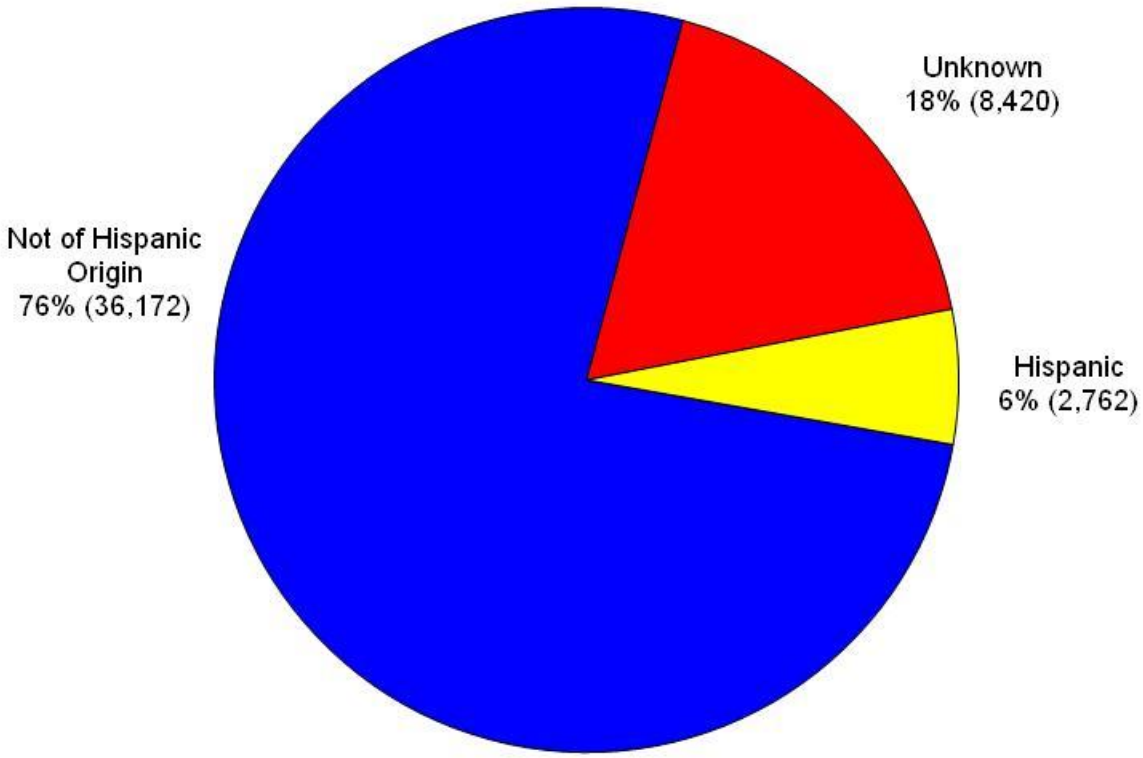


Clients are unique admissions counted once in the time period.
Total Clients=47,354

Figure 5

CIS Unique Client Admissions SFY 2010-2011

Ethnicity



Clients are unique admissions counted once in the time period.
Total Clients=47,354

Admissions Characteristics

The Department of Health is a payer of last resort; therefore, many clients are unable to pay for the substance abuse treatment services they require. 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.

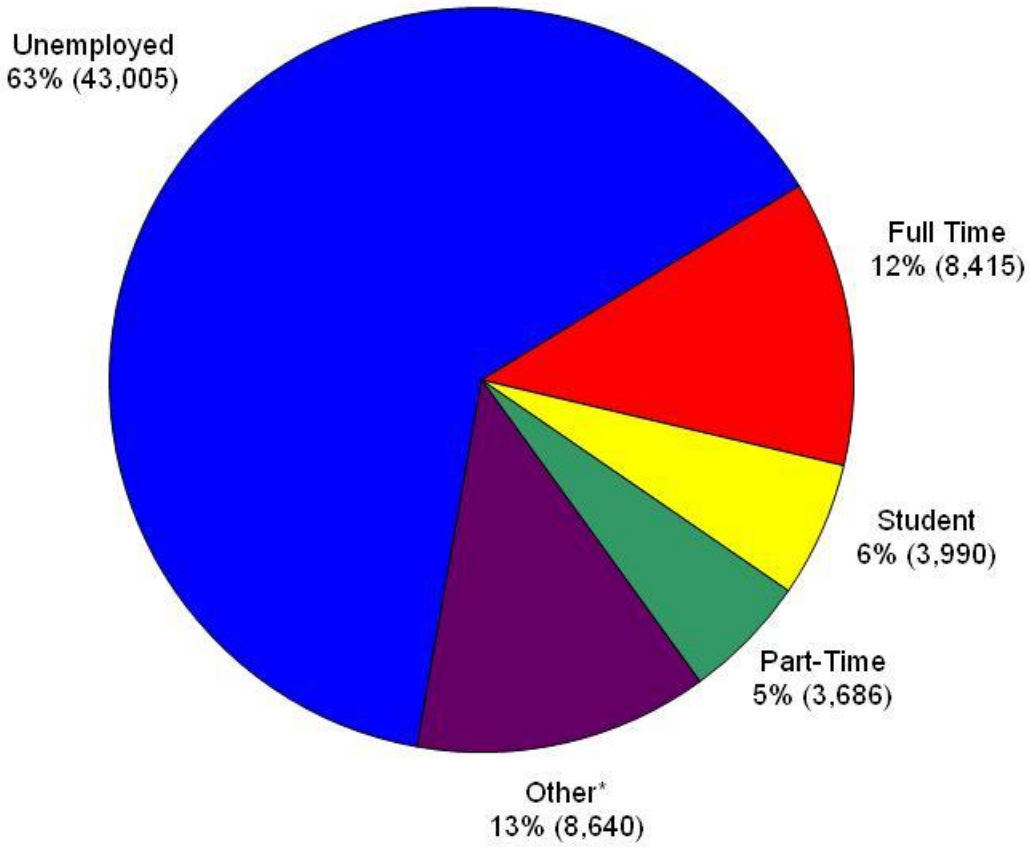
The majority (63 percent) of clients reported being unemployed. In addition, only one in six clients reported being employed on a full-time (12 percent) or even fewer on a part-time (5 percent) basis. The remaining admissions were of other employment statuses (Figure 6). Nearly three-fourths (74 percent) 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 2010-2011

Employment Status

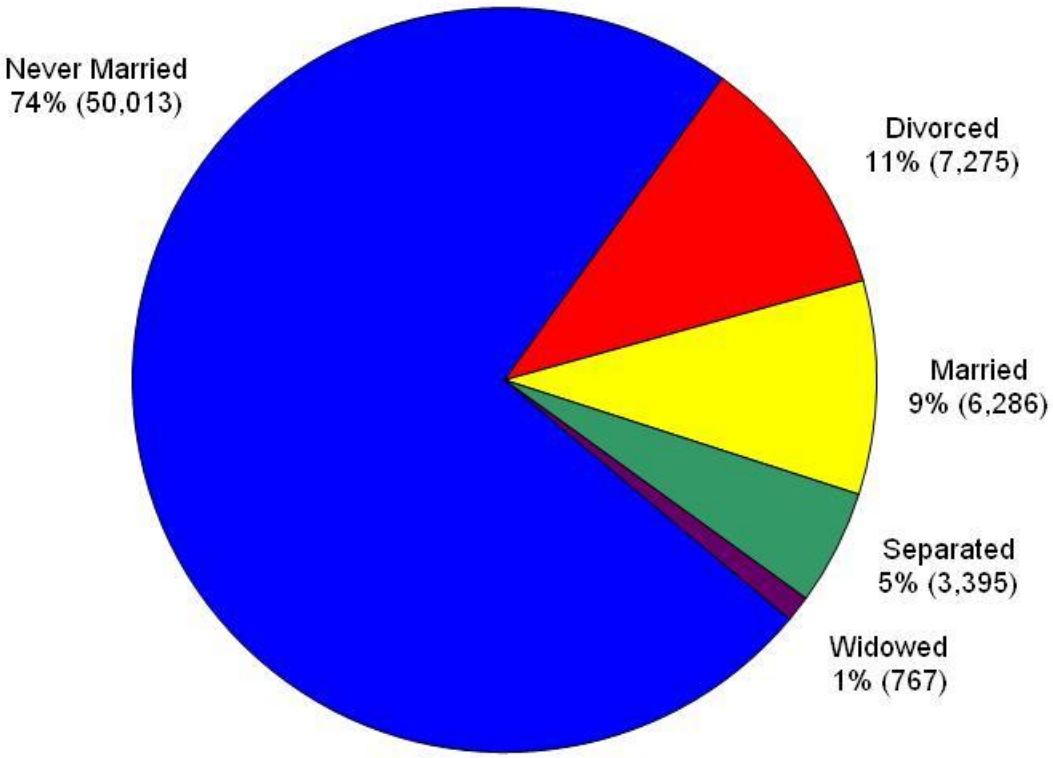


*Other includes: Disabled, Leave of Absence, Retired, Homemaker, Armed Forces, Unknown, and Other Employment Status.
Total Admissions=67,736

Figure 7

CIS Admissions
SFY 2010-2011

Marital Status

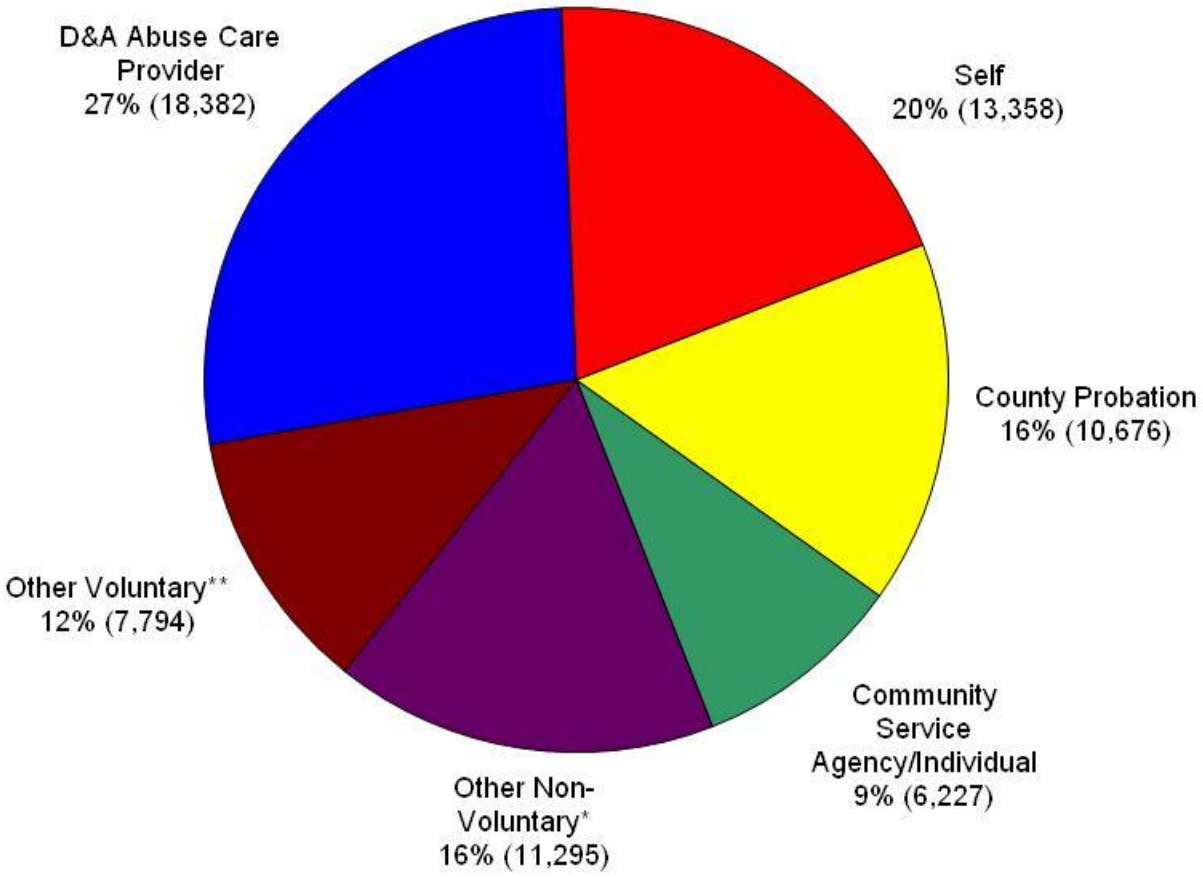


Total Admissions=67,736

Figure 8

CIS Admissions SFY 2010-2011

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=67,736

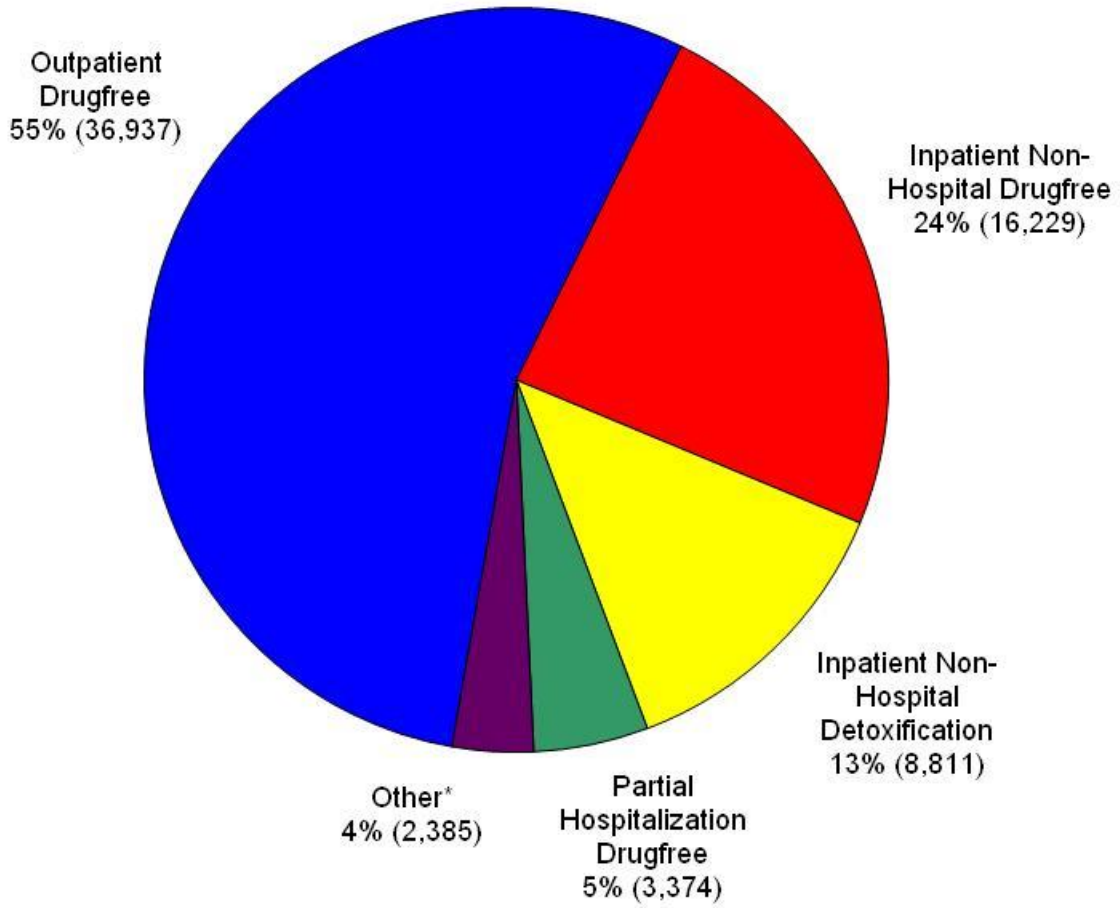
Types of Treatment

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 55 percent of clients receiving this modality (Figure 9). This is also the least intensive, most inexpensive modality. Nearly a quarter (24 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 five fiscal years.

Figure 9

CIS Admissions SFY 2010-2011

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=67,736

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 (37 percent). Heroin (21 percent), marijuana/hashish (16 percent), cocaine/crack (9 percent) and other opiates/synthetics (12 percent) account for another 96 percent of admissions. The remaining 4 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 2010-2011, marijuana/hashish appears to be now trending downward. It will not be known if this trend is an anomaly until more data is available. 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 5.5 percent of admissions. In State Fiscal Year 2010-2011, it accounted for 12.4 percent of admissions. This is an increase of over 100 percent over the past six years.

Admissions for particular primary drugs of abuse vary by gender, race, ethnicity and age group. Males are admitted for alcohol use more frequently (40 percent) than females (33 percent), as well as more frequently for marijuana/hashish (18 percent and 12 percent, respectively). Females are admitted for cocaine/crack use more frequently (12 percent) than males (8 percent). Females are also admitted more often for other opiates/synthetics more frequently (15 percent) than males (11 percent). Both genders admitted for heroin use have leveled (females at 23 percent and males at 20 percent, respectively) [Figure 13].

Whites were admitted for alcohol use more frequently than African-Americans (38 percent and 34 percent), more than three times as frequently for heroin (23 percent and 7 percent) and over seven times more frequently for other opiates/synthetics (14 percent and 2 percent). African-Americans were admitted over three times as often for cocaine/crack than whites (23 percent and 7 percent) and over two times more frequently for marijuana/hashish (29 percent and 12 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 (61 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 oriented towards youth.

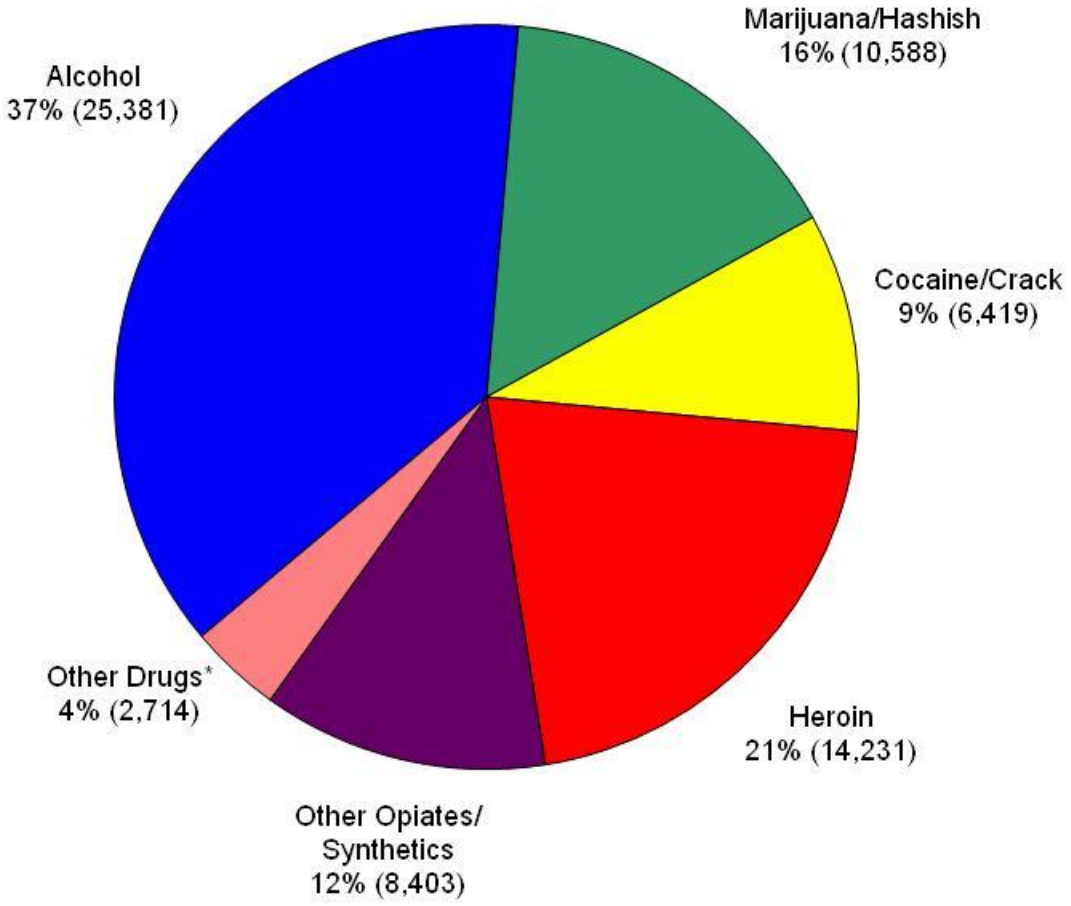
The age group 15-24 is also of particular interest, due to the transitional nature of this age category (Figure 17). The total admissions for this age group has been further broken down into ages 15-17 (3,055 admissions), 18-20 (5,008 admissions) and 21-24 (11,090 admissions).

Marijuana/hashish is the most prevalent drug of choice for the groups 15-17 and 18-20 (68 percent and 35 percent, respectively), but usage decreases by 40 percent between these two age groups as a person becomes progressively older. It decreases further to 18 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.

Figure 10

CIS Admissions
SFY 2010-2011

Primary Drug of Choice

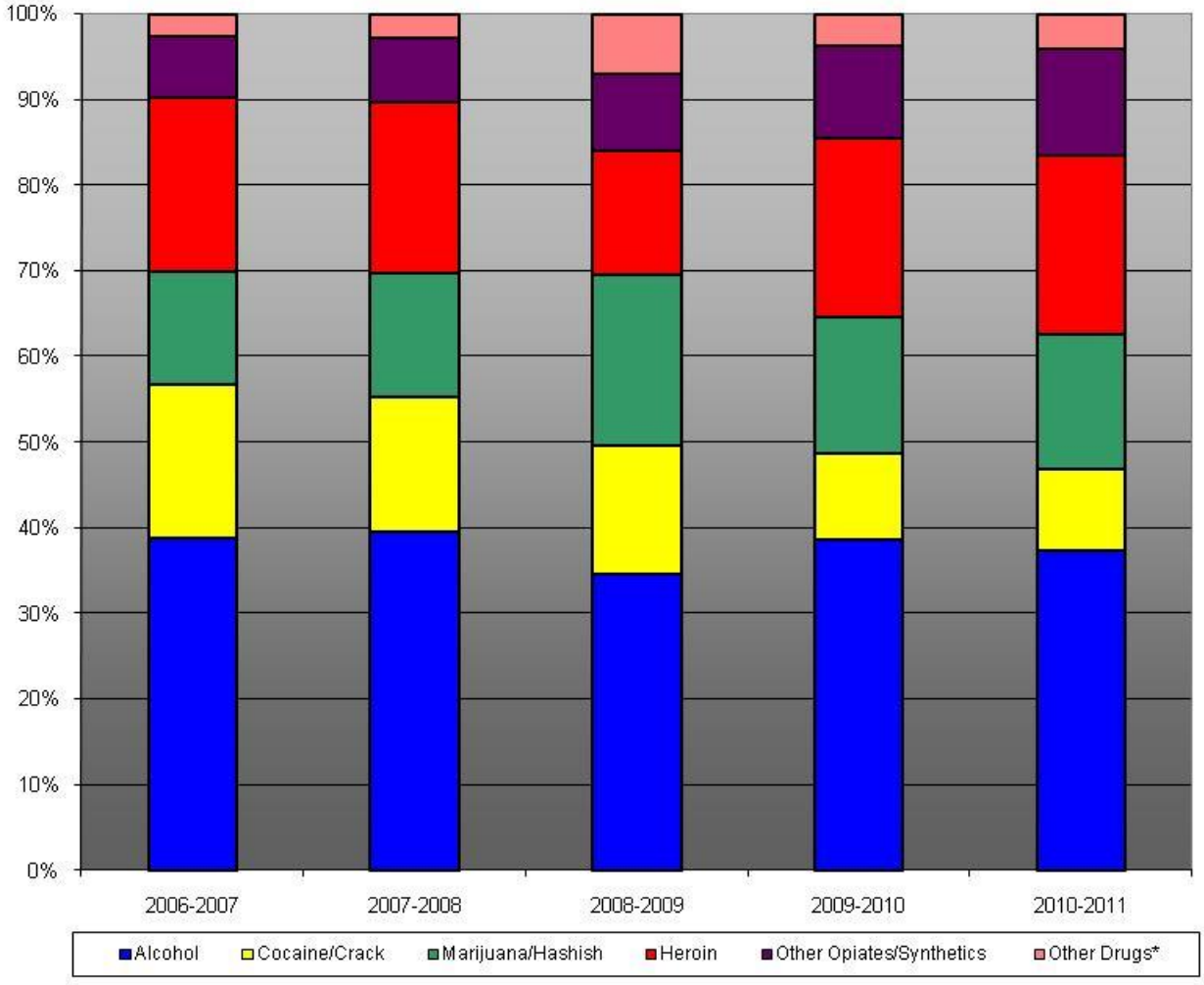


*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.
Total Admissions=67,736

Figure 11

CIS Admissions for State Fiscal Years 2006-2007 through 2010-2011

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 2005-2006 through 2010-2011

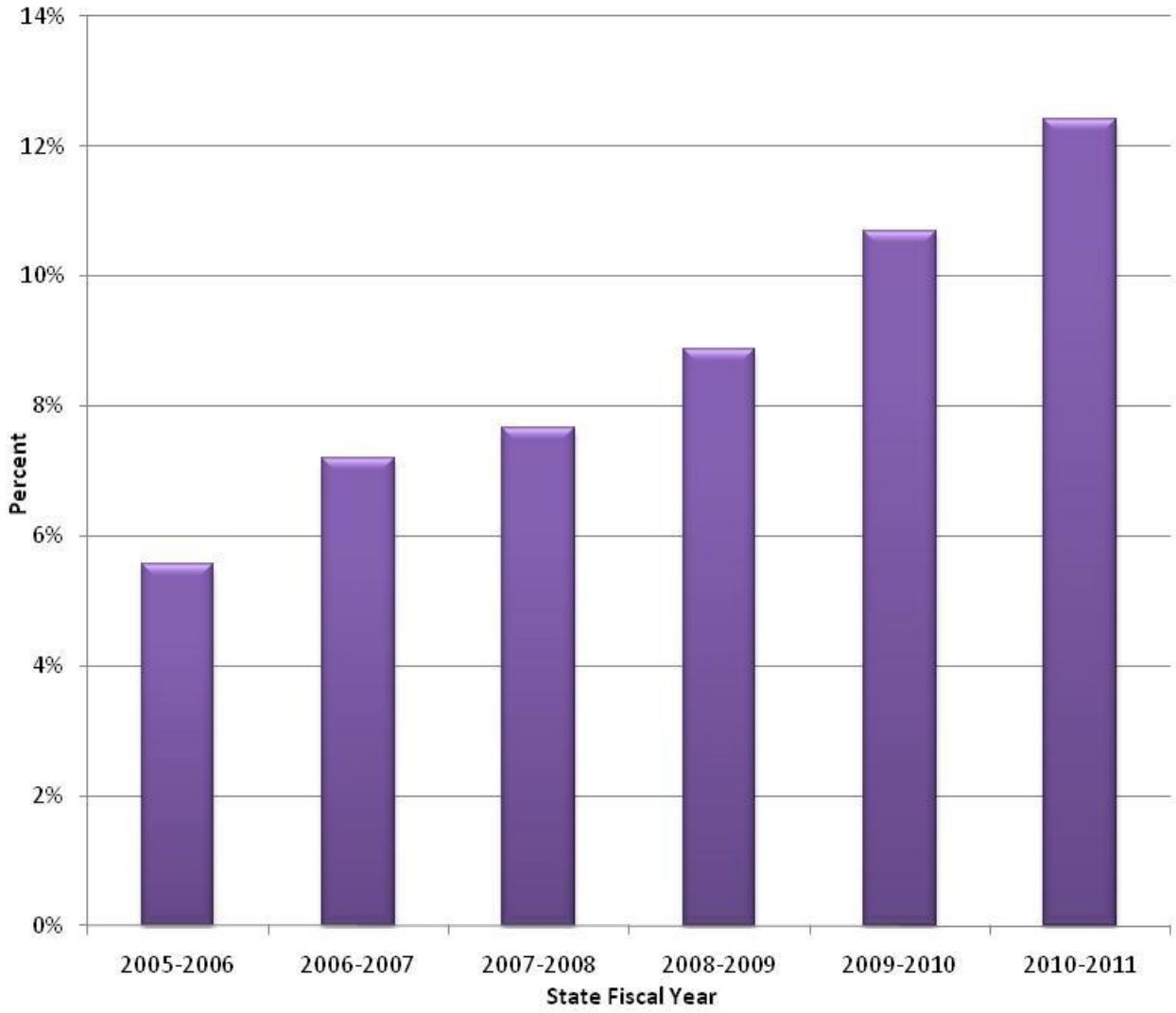
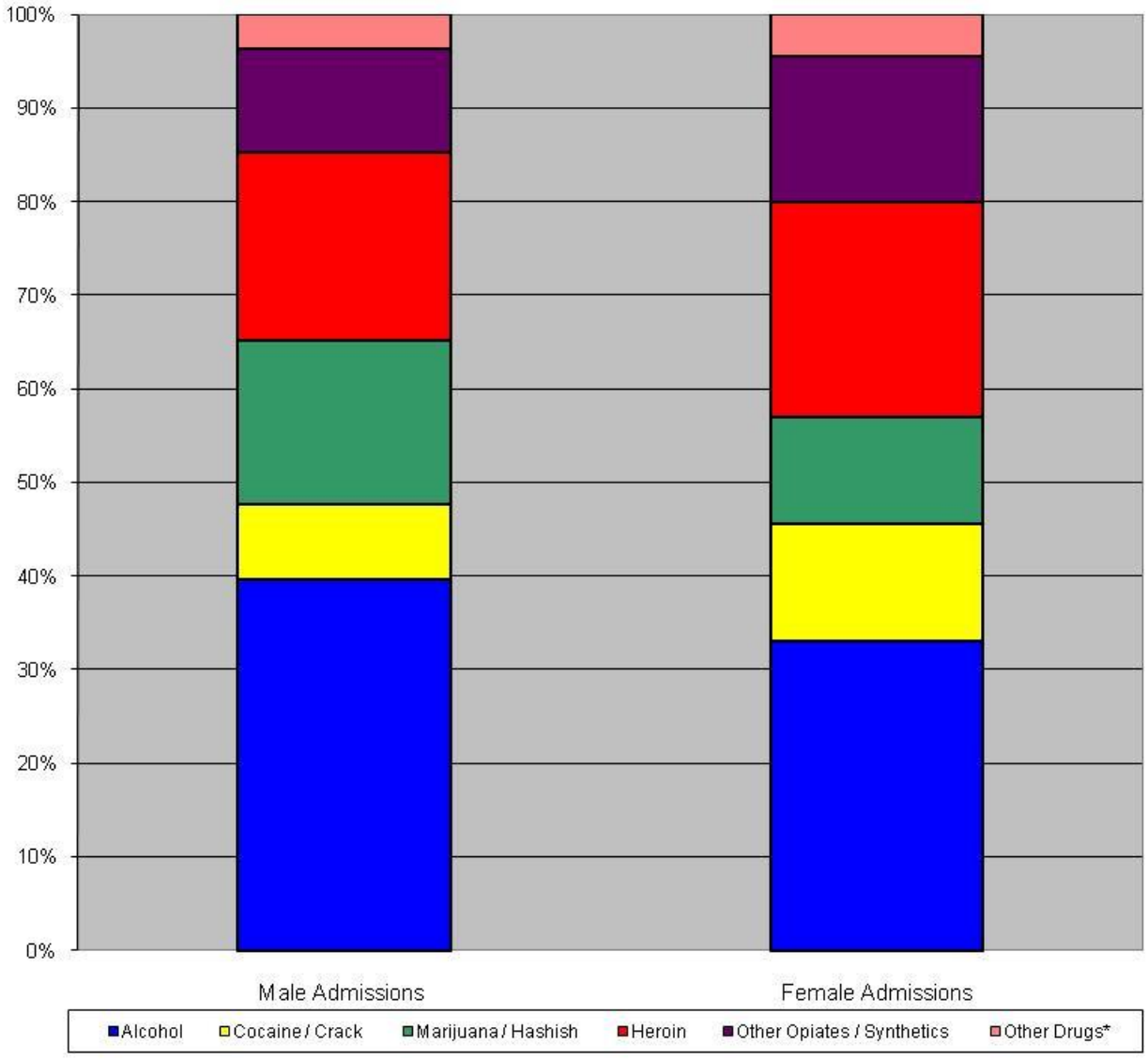


Figure 13

CIS Admissions
SFY 2010-2011

Primary Drug of Choice by Gender

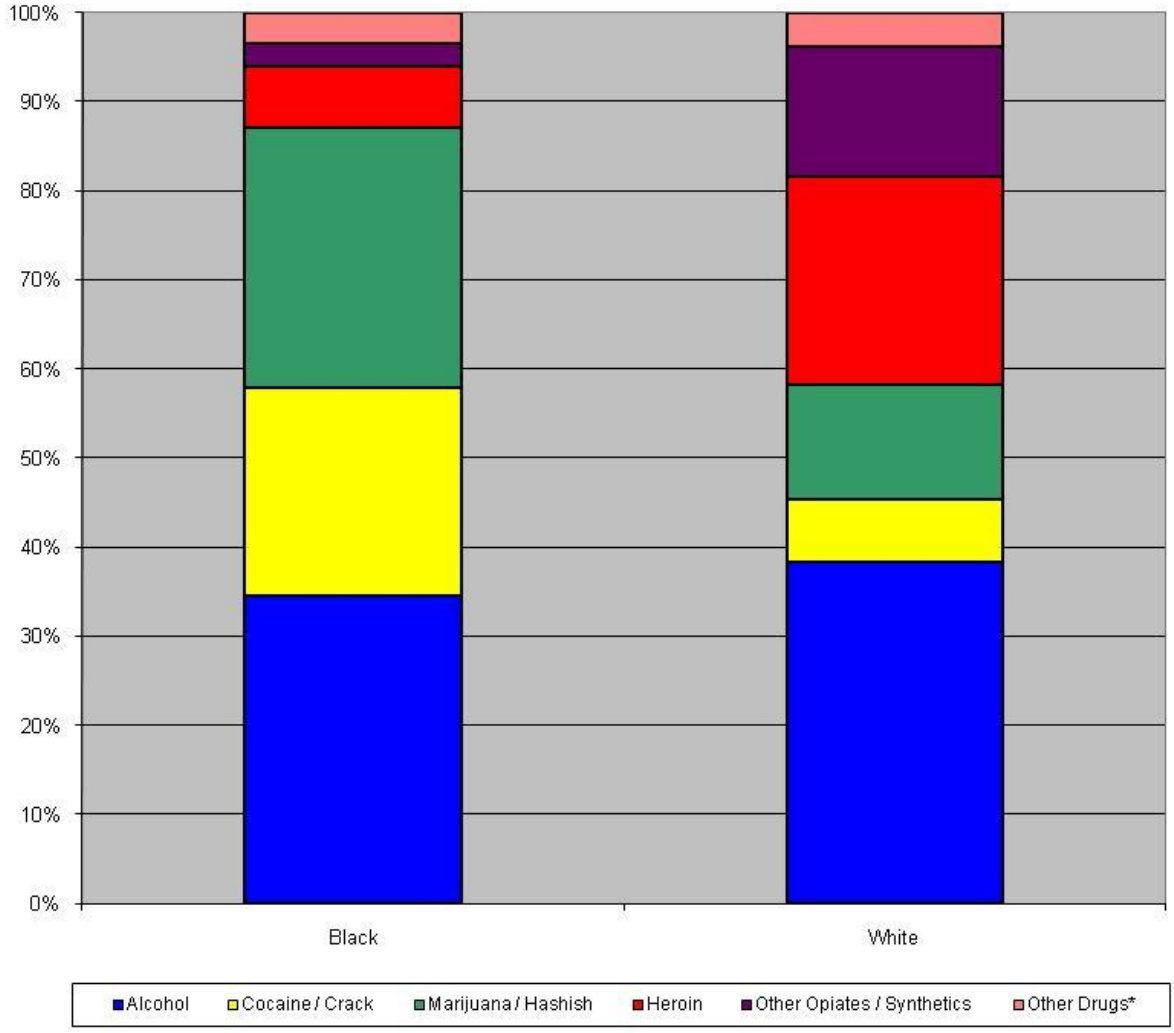


*Other Drugs includes: Other Opiates/Synthetics, Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.
Total Admissions=67,736

Figure 14

CIS Admissions
SFY 2010-2011

Primary Drug of Choice by Race

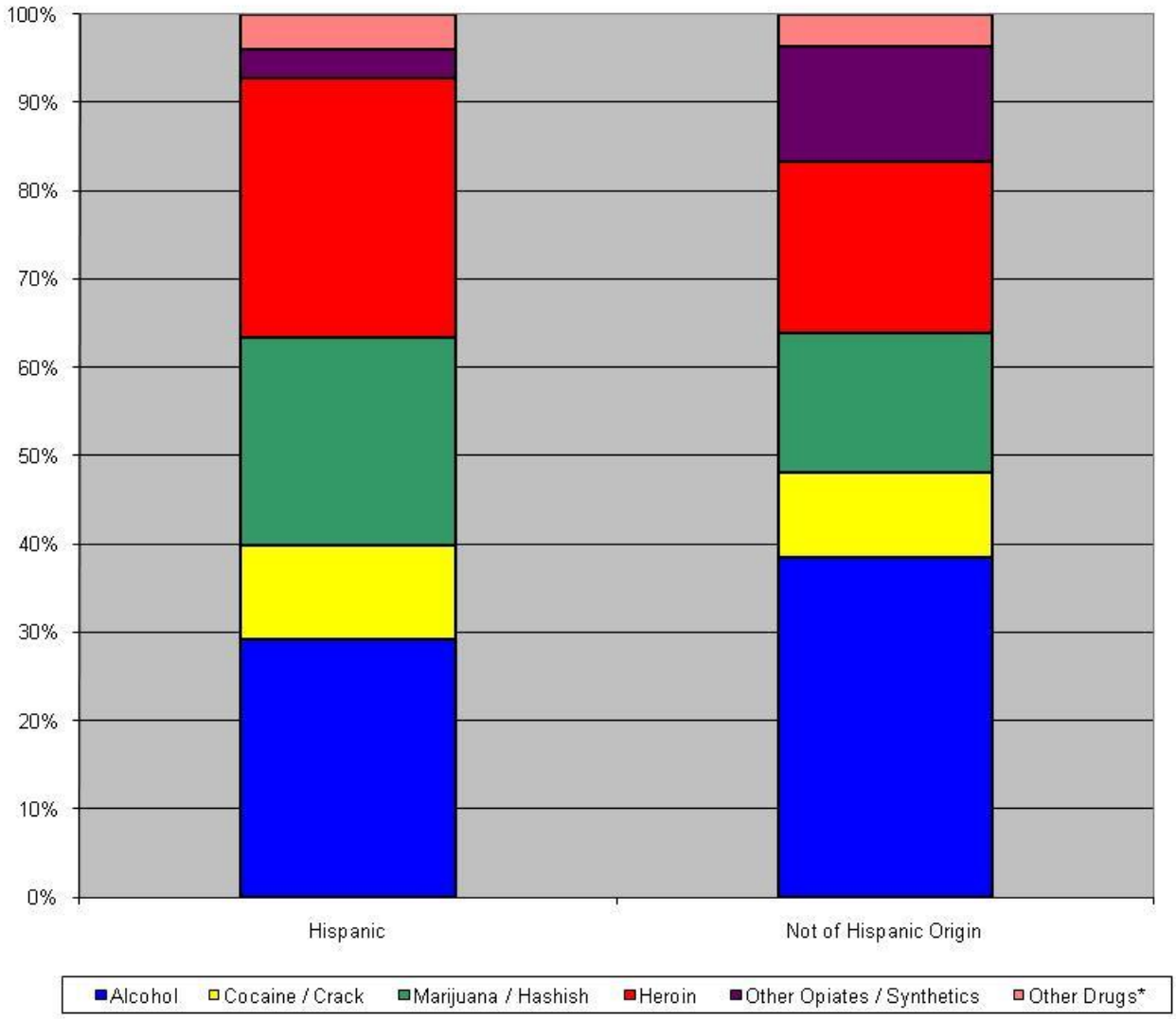


*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.
Total Admissions for Black and White=63,308 (93% of Total Admissions)

Figure 15

CIS Admissions
SFY 2010-2011

Primary Drug of Choice by Ethnicity

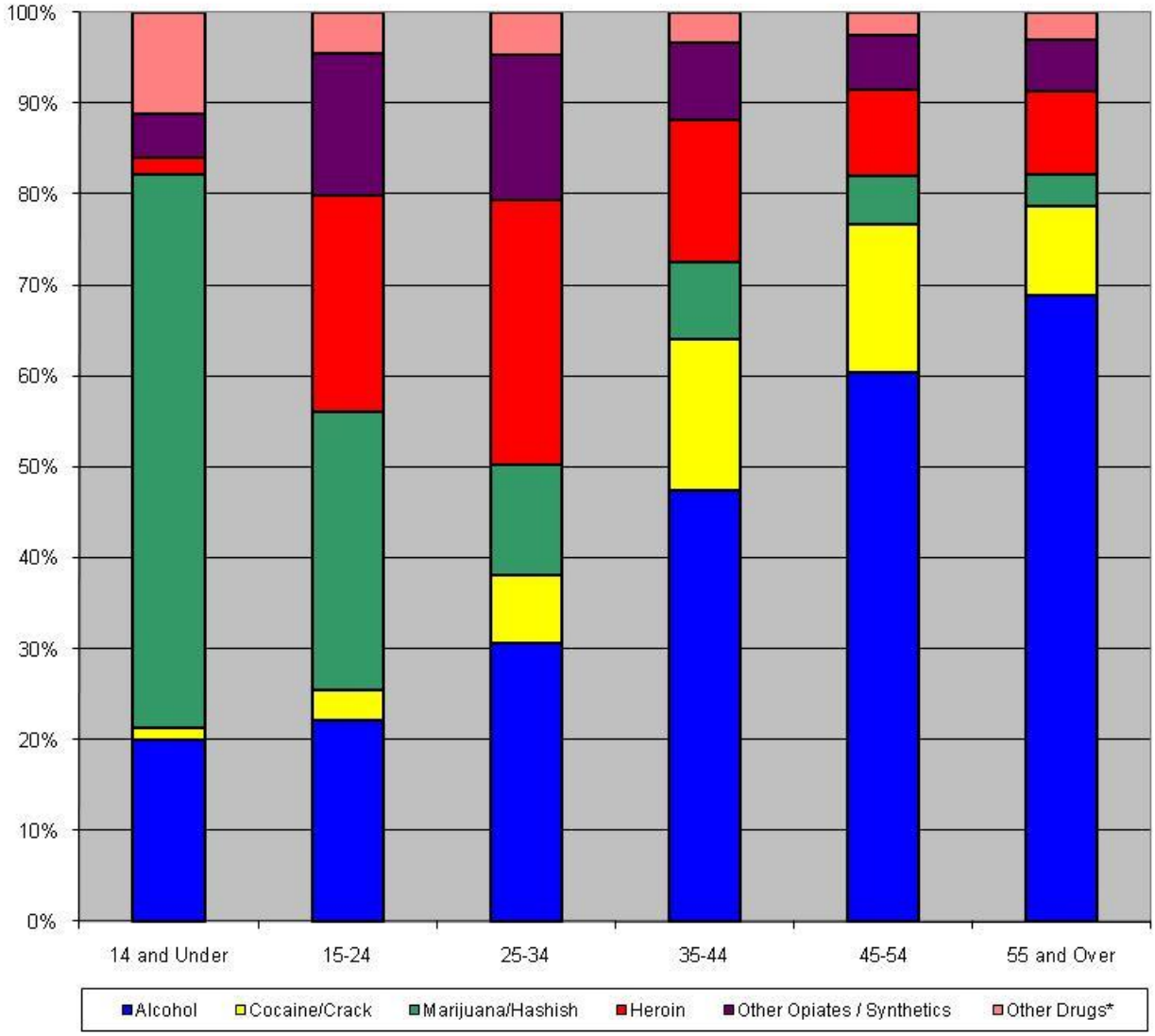


*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.
Total Admissions for Hispanic and Not of Hispanic Origin=55,031 (81% of Total Admissions)
The remaining 12,705 admissions are of unknown ethnicity.

Figure 16

CIS Admissions
SFY 2010-2011

Primary Drug of Choice by Age Group



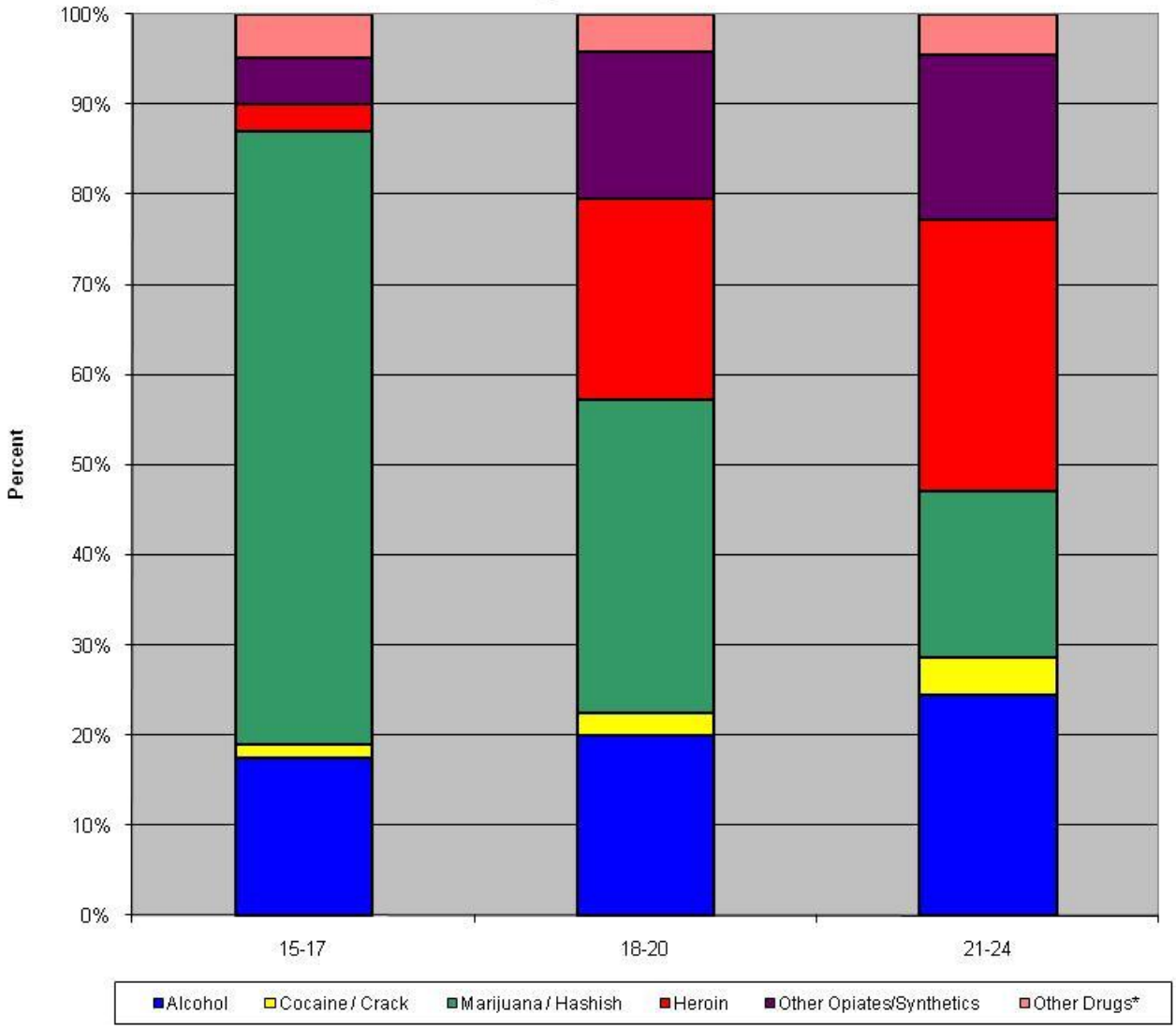
*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.
Total Admissions=67,736

Figure 17

CIS Admissions
SFY 2010-2011

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=19,153

Discharges

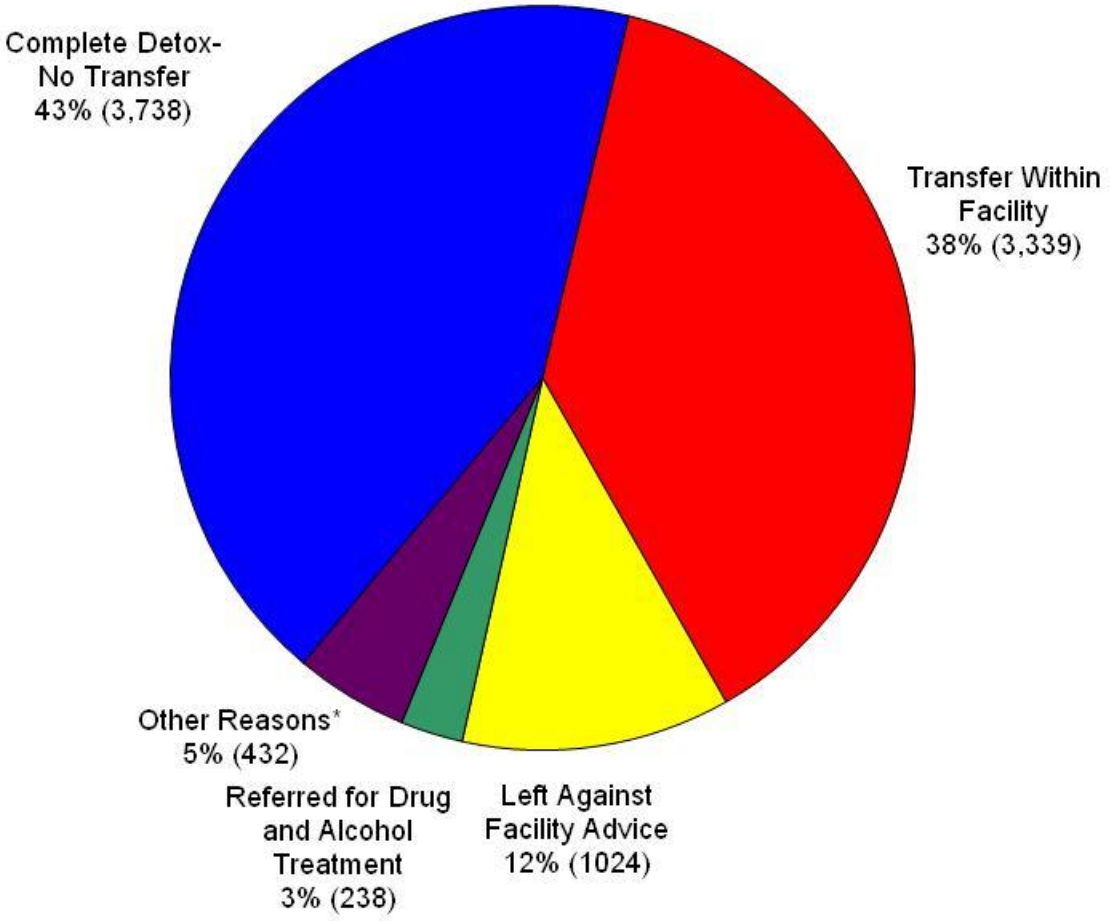
When a client has completed a particular type of treatment or changes treatment providers, a discharge record is submitted to the CIS with an associated reason for discharge. There are two main types of discharges: detoxification and non-detoxification. The kind of service rendered in detox and non-detox 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 2010-2011. No significant changes occurred from previous years. Therefore, no trend data has been presented.

After detox treatment was completed, 43 percent of patients were either transferred within the facility or were referred to another facility for drug and alcohol treatment. However, 43 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). For those who completed treatment (97 percent) did so with no drug use, while (3 percent) completed with some drug use (Figure 20).

Figure 18

CIS Discharges
SFY 2010-2011

Detox Reasons for Discharge

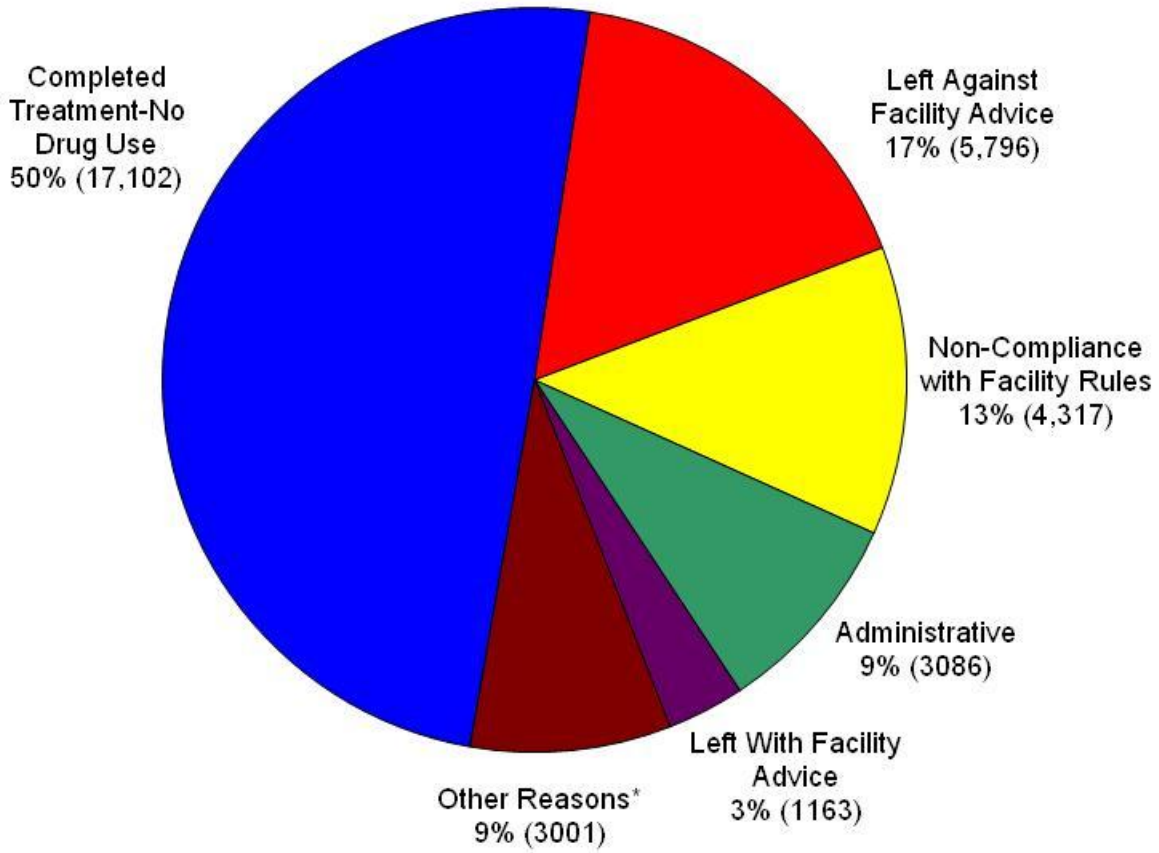


*Other Reasons includes: Left with Facility Advice, Non-Compliance with Facility Rules, Jailed and Death.
Total Discharges=8,771

Figure 19

CIS Discharges
SFY 2010-2011

Non Detox Reasons for Discharge

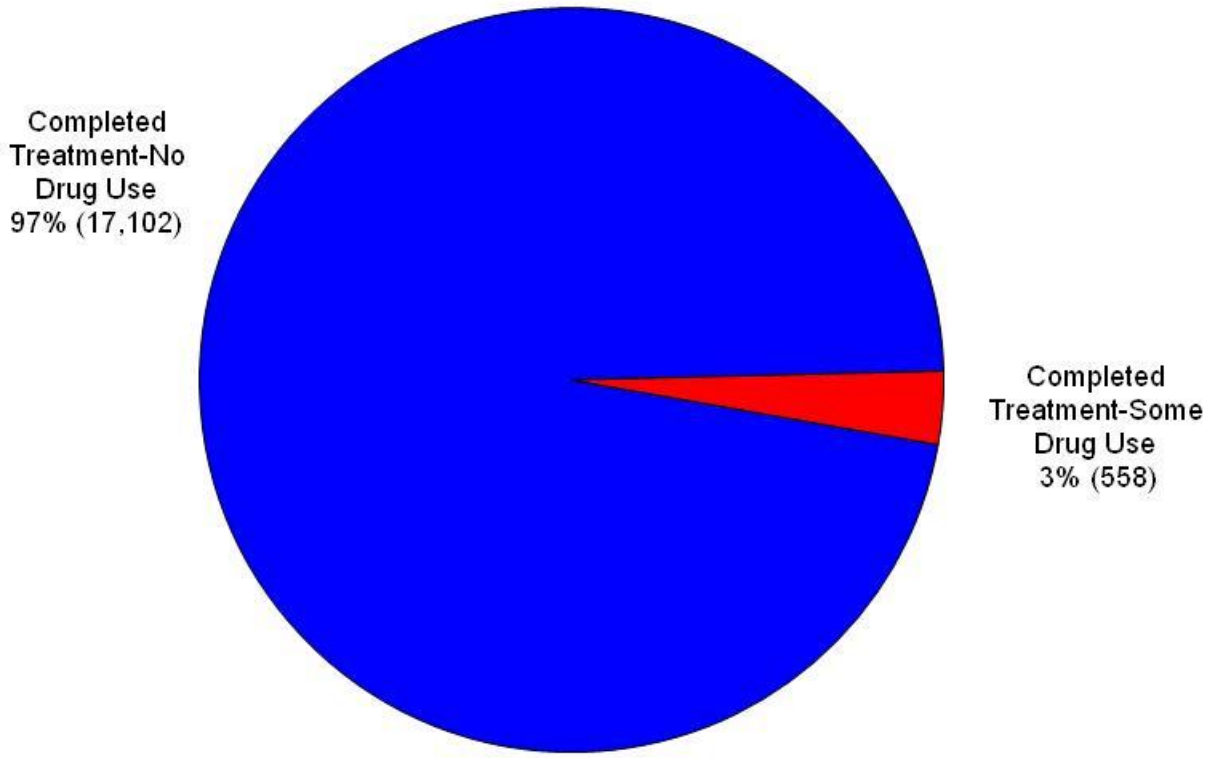


*Other Reasons includes: Referred to Another Drug and Alcohol Facility, Jailed, Completed Treatment-Some Drug Use, Relocation, Medical, Referred to a Non-Drug and Alcohol Facility, and Death.
Total Discharges=34,465

Figure 20

CIS Discharges
SFY 2010-2011

Non Detox Reasons for Discharge
for those who completed treatment



Total Discharges Completing Treatment=17,660

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 11 percent employed at admission to 12 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 1 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 14 percent abstinent at admission to 29 percent abstinent at discharge (Figure

23). No significant changes occurred from previous years. Of those readmitted for a new level of care or recovery care they maintained the 27 percent abstinent at discharge into their next admission.

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 10 percent abstinent at admission to 33 percent abstinent at discharge (Figure 24). Of those readmitted for a new level of care or recovery care they maintained the 31 percent abstinent at discharge into their next admission.

The somewhat high percentage of those already abstinent from alcohol and other drugs (27 percent and 31 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 2010-2011

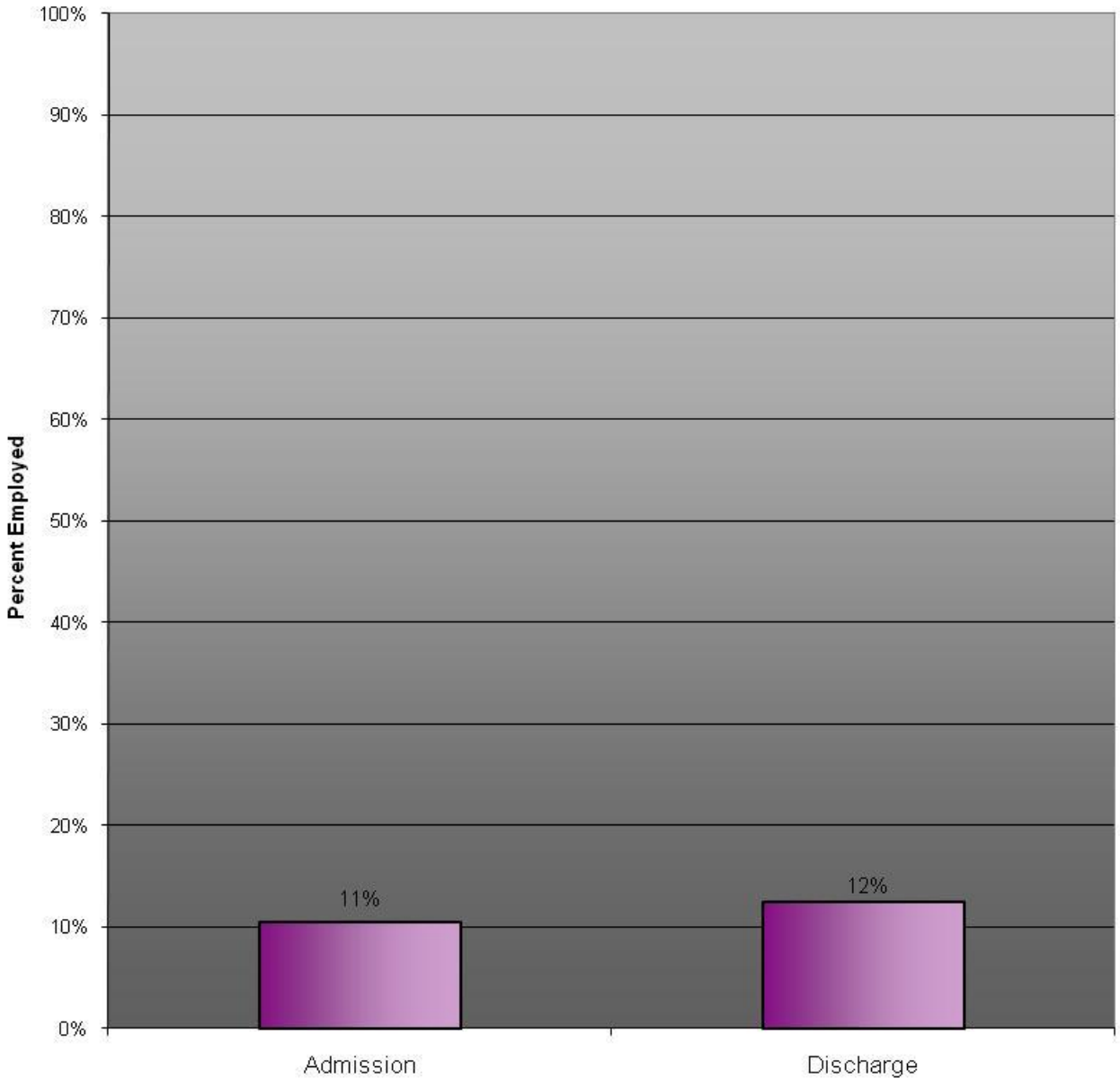


Figure 22

Outcome Measure
Arrests
State Fiscal Year 2010-2011

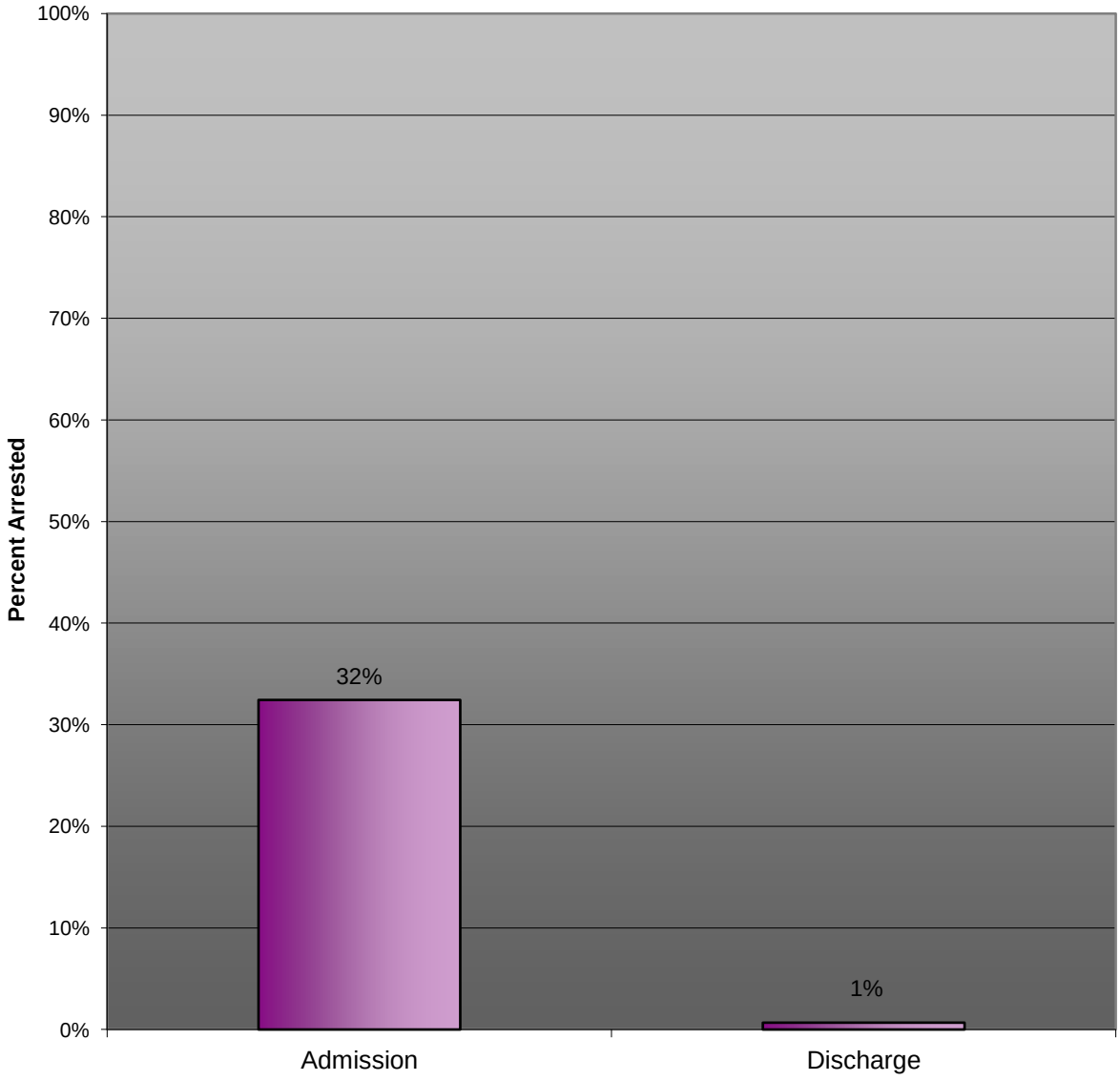


Figure 23

Outcome Measure
Alcohol Abstinence
State Fiscal Year 2008-2009

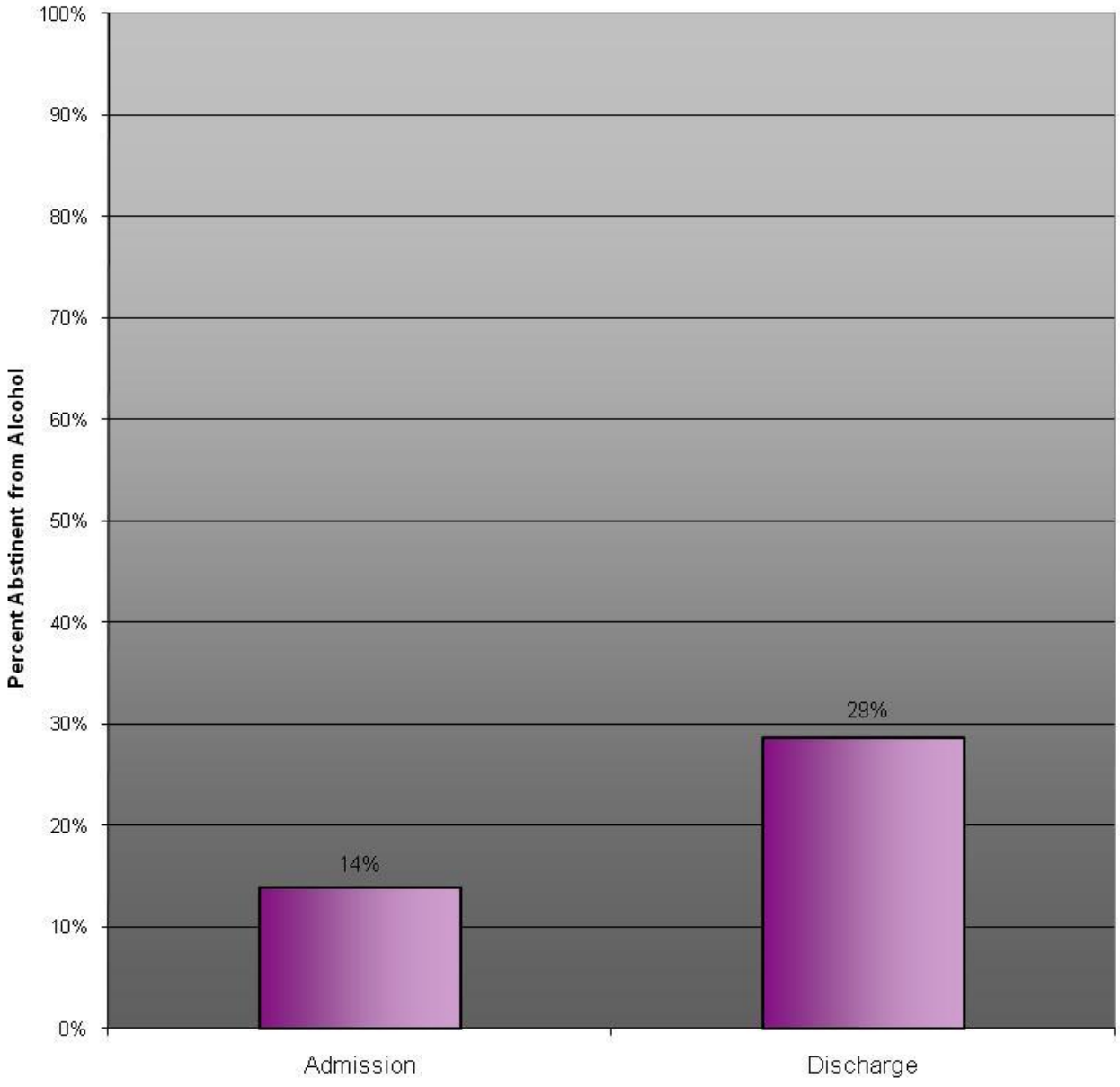
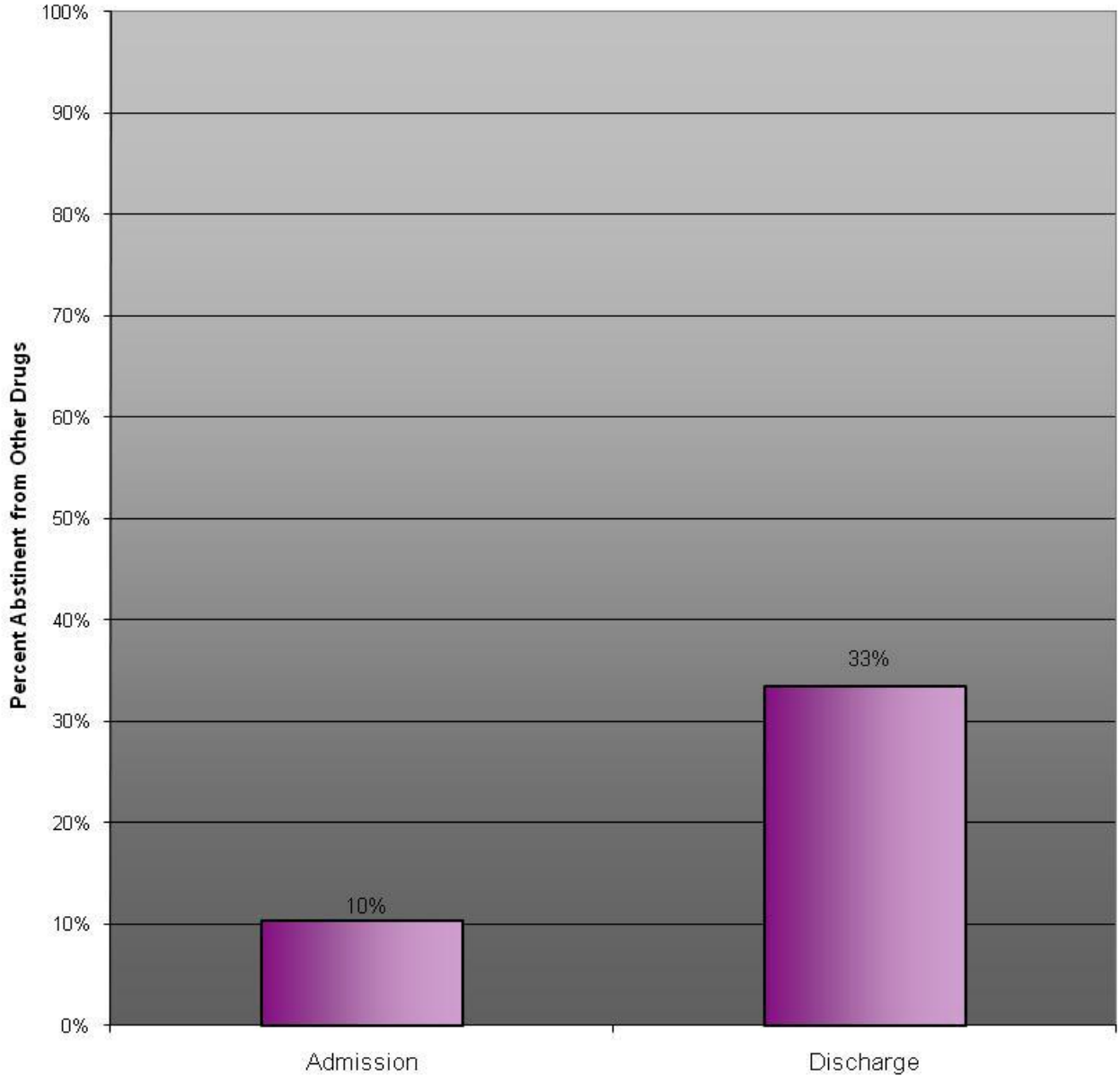


Figure 24

Outcome Measure
Other Drug* Abstinence
State Fiscal Year 2008-2009



*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 2010-11 (All Sources)

SINGLE COUNTY AUTHORITY	TOTAL BDAP FUNDS	TOTAL COUNTY FUNDS	TOTAL OTHER FUNDS	TOTAL FUNDS
Allegheny	$11,994,041	$261,240	$6,779,059	$19,034,340
Armstrong/Indiana/Clarion	$1,454,076	$0	$1,747,252	$3,201,328
Beaver	$1,207,271	$75,000	$889,545	$2,171,816
Bedford	$433,585	$0	$500,826	$934,411
Berks	$3,355,581	$1,776,651	$3,048,251	$8,180,483
Blair	$1,050,837	$0	$1,380,499	$2,431,336
Bradford/Sullivan	$542,094	$21,166	$471,773	$1,035,033
Bucks	$3,494,980	$328,897	$2,360,902	$6,184,779
Butler	$993,423	$24,479	$1,168,995	$2,186,897
Cambria	$993,882	$31,146	$663,995	$1,689,023
Cameron/Elk/McKean	$847,780	$83,338	$1,067,563	$1,998,682
Carbon/Monroe/Pike	$1,053,821	$63,284	$1,960,096	$3,077,201
Centre	$799,946	$33,368	$534,533	$1,367,847
Chester	$2,543,974	$563,510	$3,457,022	$6,564,506
Clearfield/Jefferson	$961,402	$0	$737,355	$1,698,757
Col/Montour/Snyder/Union	$812,542	$11,789	$650,915	$1,475,246
Crawford	$758,311	$20,590	$1,201,587	$1,980,488
Cumberland/Perry	$1,643,185	$190,301	$995,483	$2,828,969
Dauphin	$2,502,468	$207,869	$1,067,957	$3,778,294
Delaware	$3,821,091	$104,177	$2,154,137	$6,079,405
Erie	$3,466,910	$205,152	$1,578,853	$5,250,915
Fayette	$1,028,271	$0	$1,749,192	$2,777,463
Forest/Warren	$396,928	$13,053	$197,430	$607,411
Franklin/Fulton	$622,702	$102,509	$503,492	$1,228,703
Greene	$385,570	$8,541	$141,873	$535,984
Huntingdon/Mifflin/Juniata	$713,392	$0	$288,040	$1,001,432
Lackawanna/Susquehanna	$1,799,894	$83,223	$1,156,769	$3,039,886
Lancaster	$2,485,488	$150,213	$1,603,405	$4,239,106
Lawrence	$743,500	$0	$727,074	$1,470,574
Lebanon	$681,245	$76,242	$452,243	$1,209,730
Lehigh	$2,334,003	$473,762	$1,715,018	$4,522,783
Luzerne/Wyoming	$2,077,507	$277,431	$1,665,162	$4,020,100
Lycoming/Clinton	$945,060	$91,100	$1,460,021	$2,496,181
Mercer	$1,098,192	$50,000	$878,671	$2,026,863
Montgomery	$4,157,888	$160,846	$2,152,635	$6,471,369
Northampton	$1,732,131	$294,747	$1,368,630	$3,395,508
Northumberland	$528,875	$37,900	$319,047	$885,822
Philadelphia	$22,869,567	$782,969	$18,903,070	$42,555,606
Potter	$181,566	$20,917	$64,091	$266,574
Schuylkill	$1,251,257	$26,720	$912,590	$2,190,567
Somerset	$554,613	$18,008	$171,860	$744,481
Wayne	$304,599	$96,136	$176,821	$577,556
Tioga	$337,930	$10,561	$122,153	$470,644
Venango	$429,764	$15,970	$457,249	$902,983
Washington	$1,466,849	$0	$1,163,678	$2,630,527
Westmoreland	$2,580,217	$38,399	$1,336,136	$3,954,752
York/Adams	$1,869,920	$100,000	$1,328,867	$3,298,787
TOTAL	**$ 98,308,128**	**$ 6,931,204**	**$ 75,431,816**	**$ 180,671,148**

Single County Authority Expenditures by Funding Level for Fiscal Year 2010-11 (All Sources)

SINGLE COUNTY AUTHORITY	TOTAL ADMINISTRATION	TOTAL PREVENTION	TOTAL INTERVENTION	TOTAL TREATMENT	TOTAL AMOUNT
Allegheny	$1,811,883	$2,306,559	$3,745,265	$11,170,633	$19,034,340
Armstrong/Indiana/Clarion	$431,068	$784,321	$125,369	$1,860,570	$3,201,328
Beaver	$345,672	$261,080	$64,700	$1,500,364	$2,171,816
Bedford	$146,180	$369,709	$119,438	$299,084	$934,411
Berks	$770,896	$1,089,133	$594,325	$5,726,129	$8,180,483
Blair	$350,035	$322,903	$362,941	$1,395,456	$2,431,336
Bradford/Sullivan	$114,063	$131,220	$9,754	$779,996	$1,035,033
Bucks	$1,006,162	$751,158	$1,284,328	$3,143,131	$6,184,779
Butler	$252,959	$265,589	$209,846	$1,458,503	$2,186,897
Cambria	$261,024	$181,445	$49,800	$1,196,754	$1,689,023
Cameron/Elk/McKean	$248,106	$260,926	$1,991	$1,487,659	$1,998,682
Carbon/Monroe/Pike	$439,402	$527,074	$85,067	$2,025,658	$3,077,201
Centre	$183,544	$302,139	$23,999	$858,165	$1,367,847
Chester	$1,088,123	$555,591	$12,274	$4,908,518	$6,564,506
Clearfield/Jefferson	$133,449	$474,123	$233,477	$857,708	$1,698,757
Col/Montour/Snyder/Union	$205,656	$187,166	$54,279	$1,028,145	$1,475,246
Crawford	$179,005	$305,932	$95,136	$1,400,415	$1,980,488
Cumberland/Perry	$273,045	$698,051	$79,508	$1,778,365	$2,828,969
Dauphin	$737,406	$767,379	$167,427	$2,106,082	$3,778,294
Delaware	$687,530	$606,492	$365,509	$4,419,874	$6,079,405
Erie	$343,047	$1,196,024	$656,963	$3,054,881	$5,250,915
Fayette	$262,505	$499,029	$202,121	$1,813,808	$2,777,463
Forest/Warren	$119,107	$68,780	$3,787	$415,737	$607,411
Franklin/Fulton	$254,598	$146,003	$13,164	$814,938	$1,228,703
Greene	$96,712	$143,942	$0	$295,330	$535,984
Huntingdon/Mifflin/Juniata	$119,092	$238,039	$42,909	$601,392	$1,001,432
Lackawanna/Susquehanna	$243,553	$590,731	$199,382	$2,006,220	$3,039,886
Lancaster	$541,194	$946,047	$210,469	$2,541,396	$4,239,106
Lawrence	$144,688	$279,954	$14,125	$1,031,807	$1,470,574
Lebanon	$210,208	$136,313	$101,100	$762,109	$1,209,730
Lehigh	$413,971	$656,019	$338,457	$3,114,336	$4,522,783
Luzerne/Wyoming	$318,284	$442,584	$86,388	$3,172,844	$4,020,100
Lycoming/Clinton	$338,870	$288,024	$16,040	$1,853,247	$2,496,181
Mercer	$249,686	$532,953	$26,927	$1,217,297	$2,026,863
Montgomery	$741,694	$767,779	$385,024	$4,576,872	$6,471,369
Northampton	$383,091	$345,571	$226,912	$2,439,934	$3,395,508
Northumberland	$183,336	$107,344	$71,083	$524,059	$885,822
Philadelphia	$8,893,254	$4,106,006	$3,807,987	$25,748,359	$42,555,606
Potter	$69,857	$51,080	$0	$145,637	$266,574
Schuylkill	$252,618	$469,590	$50,776	$1,417,583	$2,190,567
Somerset	$105,244	$122,913	$16,500	$499,824	$744,481
Wayne	$141,411	$105,351	$46,579	$284,215	$577,556
Tioga	$74,334	$63,277	$0	$333,033	$470,644
Venango	$171,992	$114,514	$20,430	$596,047	$902,983
Washington	$330,167	$506,498	$0	$1,793,862	$2,630,527
Westmoreland	$565,749	$1,242,758	$0	$2,146,245	$3,954,752
York/Adams	$371,284	$406,006	$17,700	$2,503,797	$3,298,787
TOTAL	**$25,604,754**	**$25,721,119**	**$14,239,256**	**$115,106,019**	**$180,671,148**

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Tom Corbett, Governor
Commonwealth of Pennsylvania

Gary Tennis
Secretary, Pennsylvania Department of Drug and Alcohol Programs

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