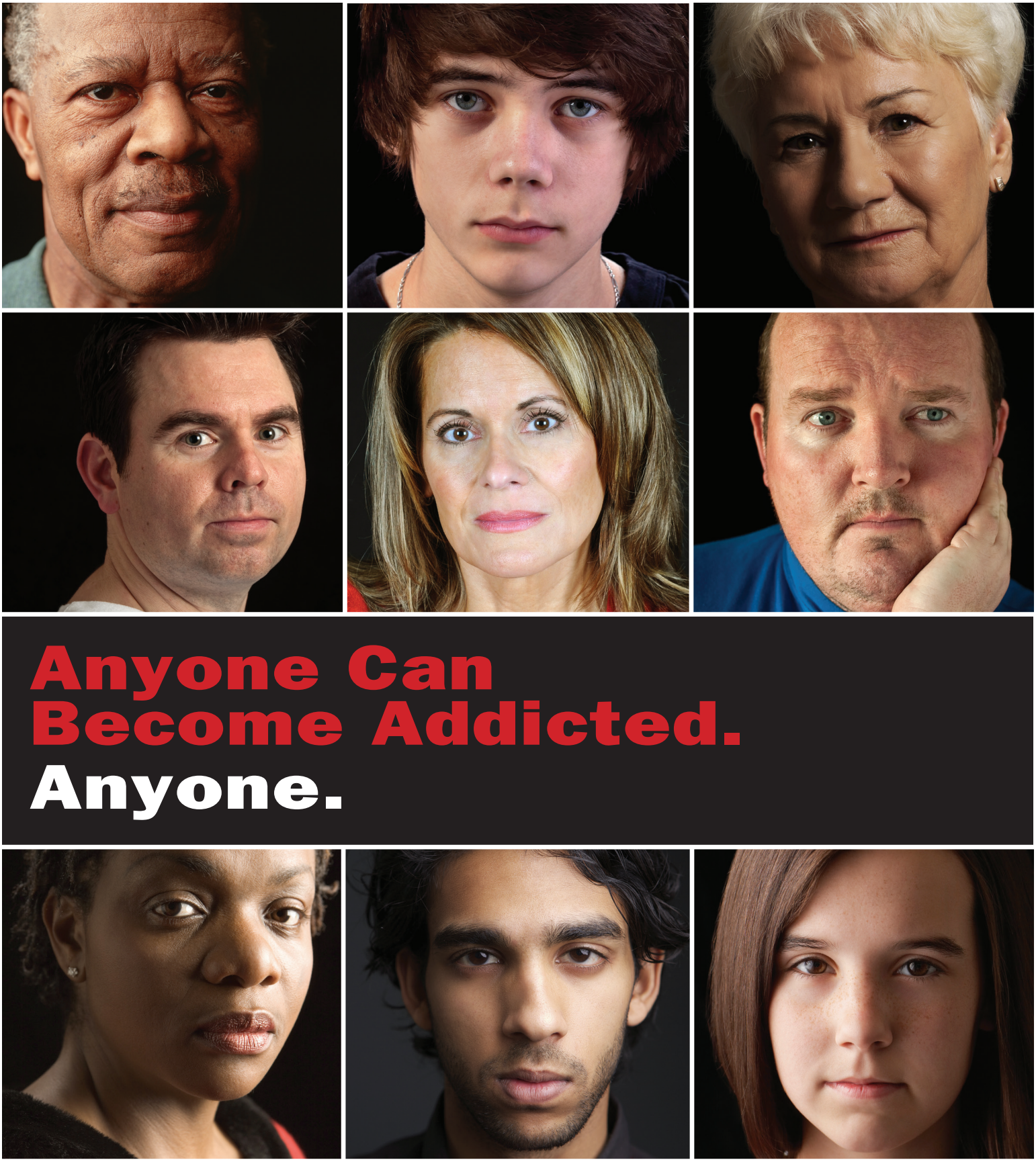

pennsylvania
DEPARTMENT OF DRUG AND
ALCOHOL PROGRAMS

Pennsylvania Drug and Alcohol Department

Data Analysis and Outcome Measures

A Supplement to the 2016-17 Annual Plan

The 2016-2017 Pennsylvania Department of Drug and Alcohol Program's annual plan and report cover is an adaption of a media campaign to stop opiate abuse by **PAStop**, the Commonwealth Prevention Alliance campaign, pastop.org. This plan is separated into two sections -- an annual report and a data and outcome supplement -- to make it easier to find information.

Special thanks to Kathrine Muller, project coordinator of the CPA Campaign to Stop Opiate Abuse, Jeff Hanley, CPA President, and Scot Fleming, chief creative partner for BOOM Creative, for their assistance in making this cover possible.

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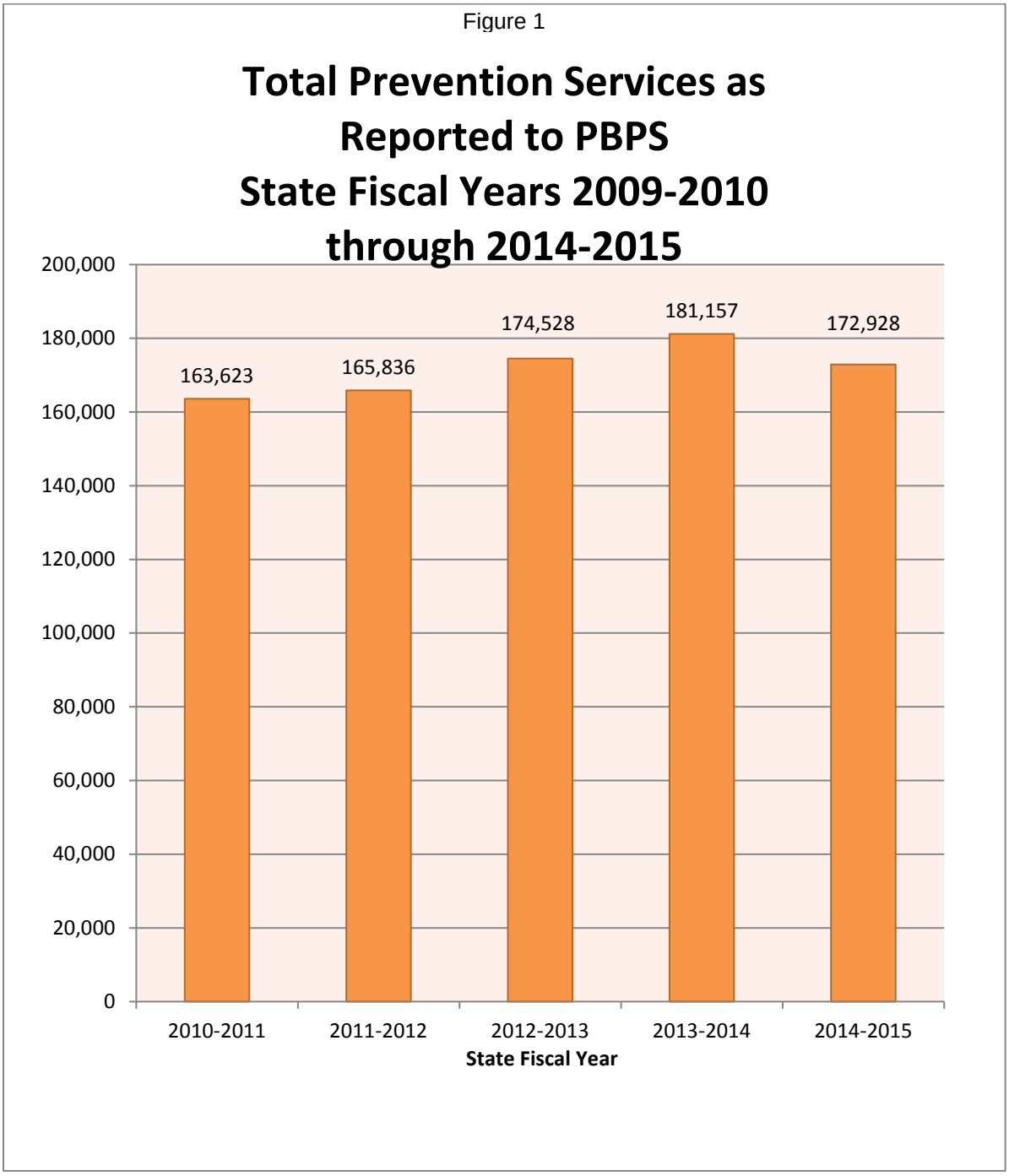
PREVENTION AND INTERVENTION DATA ANALYSIS

To help Pennsylvanians lead healthier and longer lives, Pennsylvania's Department of Drug and Alcohol Programs (the Department) promotes a structured, community-based approach to substance abuse prevention through prevention and intervention policies and practices that are based on the latest research within the substance abuse field. The framework aims to promote youth development, reduce risk-taking behaviors, build assets and resilience and prevent problem behaviors across the individual's life span. The following tables and graphs are an analysis of the data entered into the Department's Performance Based Prevention System (PBPS).

Prevention Services in Pennsylvania

In Figure 1, Total Prevention Services are shown for all services reported through the PBPS. The total number of prevention services had been increasing each year for several years, but State Fiscal Year 2014-2015 saw a slight drop in total services. This decline may be the result of an effort by the Department and Single County Authorities (SCAs) to more accurately reflect services in PBPS and/or the push for providing better quality programs instead of a large volume of programs. The later argument seems to be supported by Figure 3, which shows an increase of almost 30,000 attendees and participants.

Figure 1



Single and Recurring Prevention Services

Figure 2 details all single and recurring services across the state with the move towards a more recurring reinforcement approach to service delivery. This increase in the number of recurring services is in part due to a more defined policy requirement, specifically, 20 percent of all prevention services provided must be recurring in nature. The commonwealth, SCAs, and their contracted prevention providers are now accountable for providing recurring services. Research shows that over time, recurring services will have a greater impact on Pennsylvanians. Figure 2 shows that recurring services have increased over time and for the last five State Fiscal Years (SFYs) the percent of total services that were recurring has been over 60 percent. Figure 3 further illustrates this change in policy by showing the number of people served in single services (attendees) and recurring services (participants). In the SFYs following the new policy, total participant numbers have increased.

The following defines single and recurring services:

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

Figure 2

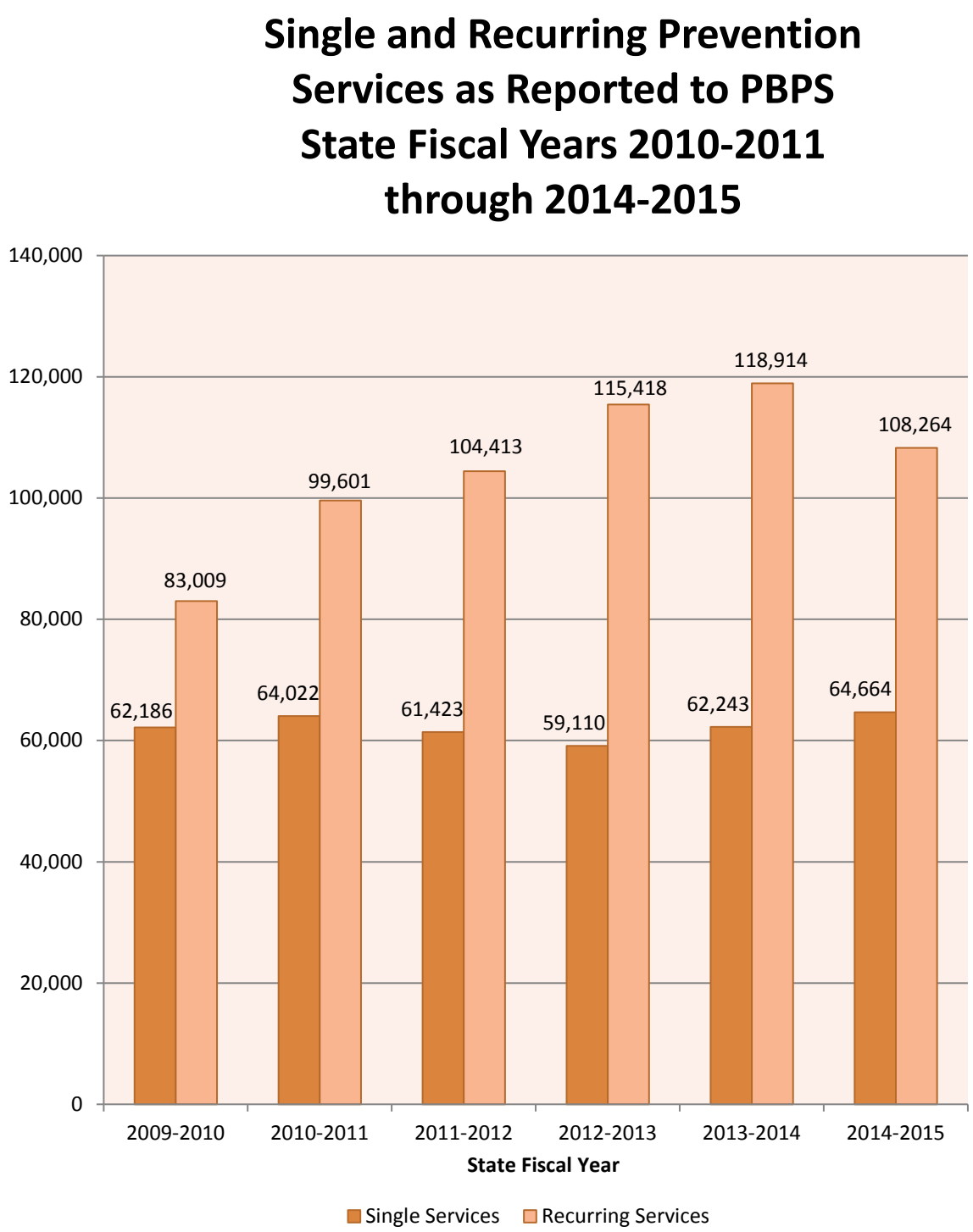
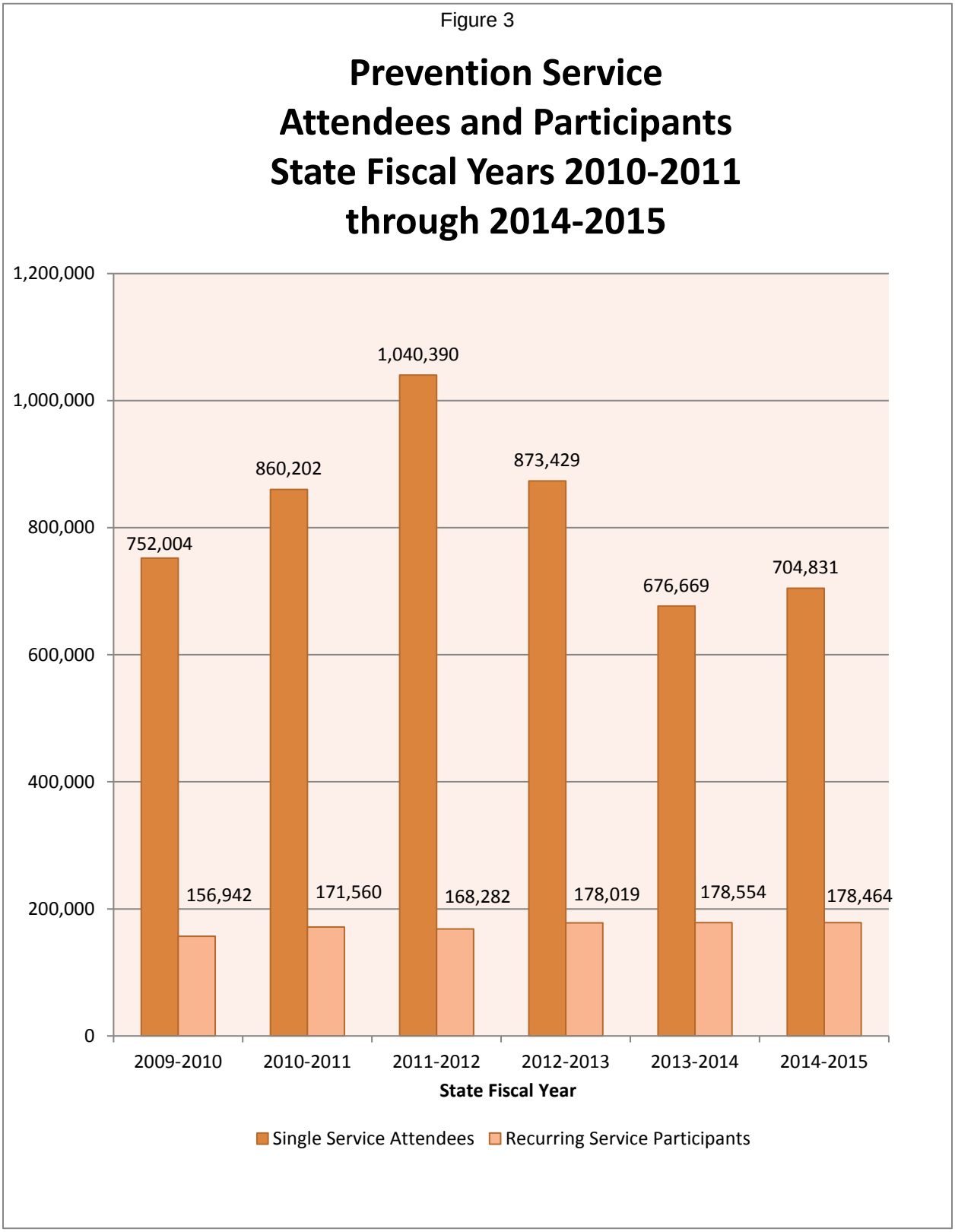

Single and Recurring Prevention Services as Reported to PBPS State Fiscal Years 2010-2011 through 2014-2015
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
62,186
83,009
64,022
99,601
61,423
104,413
59,110
115,418
62,243
118,914
64,664
108,264
2009-2010
2010-2011
2011-2012
2012-2013
2013-2014
2014-2015
State Fiscal Year
Single Services
Recurring Services

Figure 3


Prevention Service
Attendees and Participants
State Fiscal Years 2010-2011
through 2014-2015
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
752,004
156,942
860,202
171,560
1,040,390
168,282
873,429
178,019
676,669
178,554
704,831
178,464
2009-2010
2010-2011
2011-2012
2012-2013
2013-2014
2014-2015
State Fiscal Year
Single Service Attendees
Recurring Service Participants

Prevention Service Categories

Figure 4 demonstrates a five-year trend of the three prevention service categories: Evidence-Based Programs, Evidence-Informed Programs, and Supplemental Programs. In a move towards a more accountable approach, the Department required a minimum of 25 percent of services through Evidence-Based and Evidence-Informed Programs, therefore, there has been an increase in both of these program services. Evidence-Based and Evidence-Informed programs provide more rigor and effectiveness than Supplemental Programs.

The programs are defined as follows:

Evidence-Based Programs include programs and strategies which are:

- Shown through research and evaluation to be effective in the prevention and/or delay of substance use/abuse;
- Grounded in a clear theoretical foundation and carefully implemented;
- Evaluation findings have been subjected to critical review by other researchers;
- Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals;
- Replicated and produced desired results in a variety of settings; and,
- Included in Federal registries of evidence-based programs (note: inclusion in a Federal registry is necessary, but not a sufficient characteristic to merit inclusion on DDAP's list of evidence-based programs).

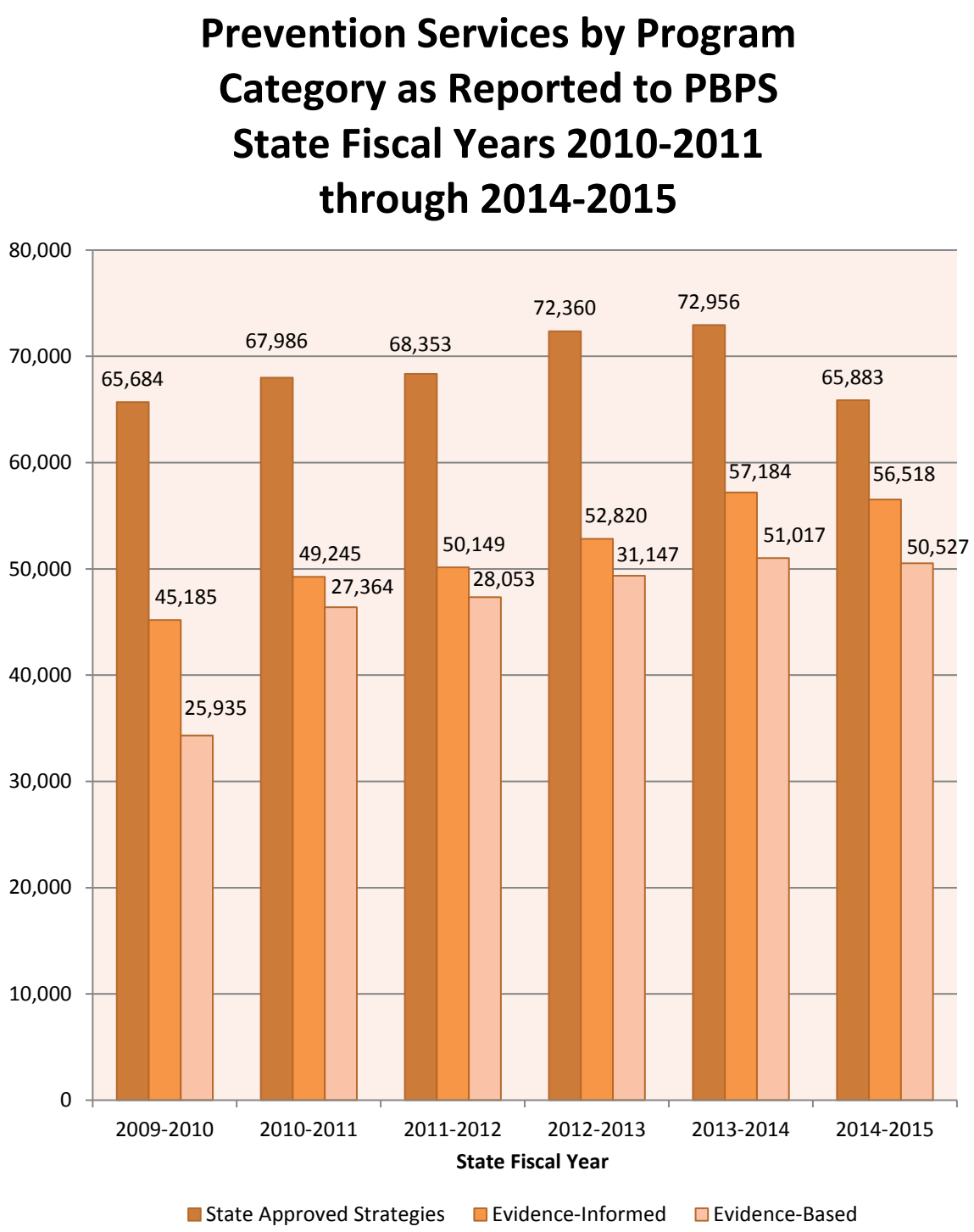
Evidence-Informed include programs and strategies which are:

- Based on a theory of change that is documented in a clear logic or conceptual model, or is based on an established theory that has been tested and supported in multiple studies;
- Based on published principles of prevention, e.g., NIDA's Prevention Principles;
- Supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a pattern of credible and positive effects; and,
- Must have an evaluation that includes, but is not limited to, a pre/post-test and/or survey.
- May be similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature;
- May have appeared in a non-refereed professional publication or journal; and,
- May have been identified or recognized publicly and may have received awards, honors or mentions.

Supplemental Programs are defined as programs which:

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

Figure 4


Prevention Services by Program Category as Reported to PBPS State Fiscal Years 2010-2011 through 2014-2015
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
65,684
45,185
25,935
67,986
49,245
27,364
68,353
50,149
28,053
72,360
52,820
31,147
72,956
57,184
51,017
65,883
56,518
50,527
2009-2010
2010-2011
2011-2012
2012-2013
2013-2014
2014-2015
State Fiscal Year
State Approved Strategies
Evidence-Informed
Evidence-Based

Institute of Medicine (IOM) Prevention Model

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

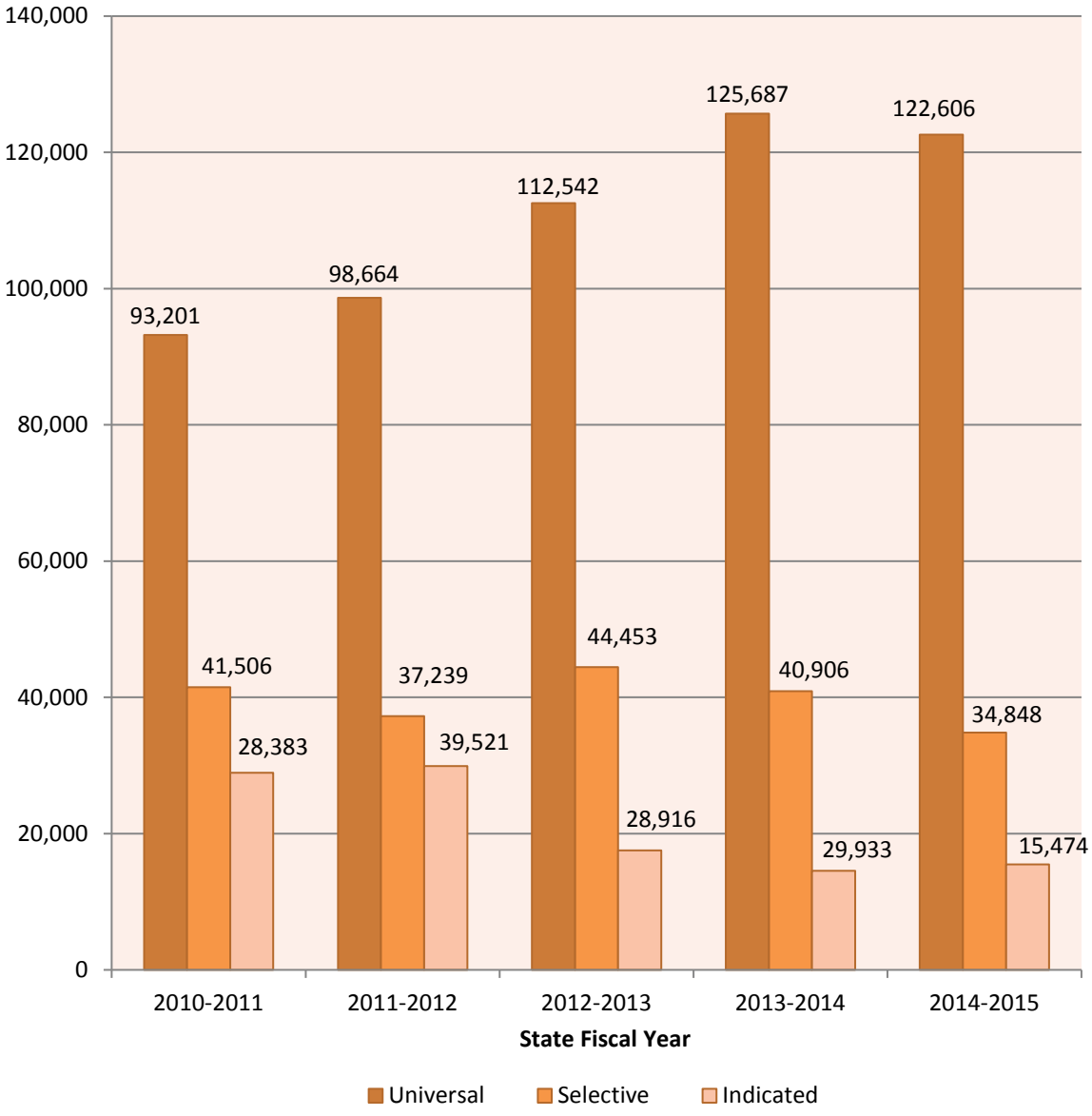
- Universal strategies address the entire population.
- Selective strategies focus on subsets or subgroups of the population exposed to greater levels of risk.
- Indicated strategies are designed to prevent the onset of substance abuse in individuals who have initiated the use of alcohol or other drugs.

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

Figure 5 shows a five-year trend of reporting data under the IOM classifications. The trend data shows that the percent of total services provided to a Universal population has increased every year for the last five years.

Figure 5

Prevention Services by Institute of Medicine Population Categories as Reported to PBPS State Fiscal Years 2010-2011 through 2014-2015



Federal Prevention Strategies

Figure 6 demonstrates a three-year trend of the six Federal Strategies. They are comprised of the overall concept of services that prevent or reduce the use and abuse of alcohol, tobacco and other drugs. Just under 50 percent of all strategies are education oriented, and the remaining 50 percent are in support of the education strategies. Overall, this trend data shows a fairly balanced approach to prevention services, but improvements could be made by increasing the number of services provided under the Community-Based Process and Environmental strategies. The six Federal Strategies are defined as:

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

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

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

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

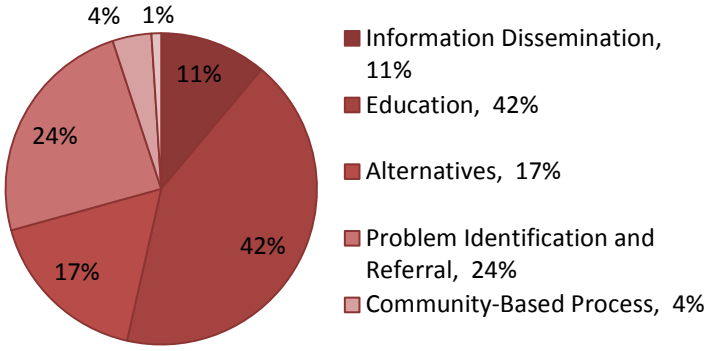
- **Community-Based Process** – aims directly at building community capacity to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities include organizing, planning, enhancing efficiency and effectiveness of services, inter-agency collaboration,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

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

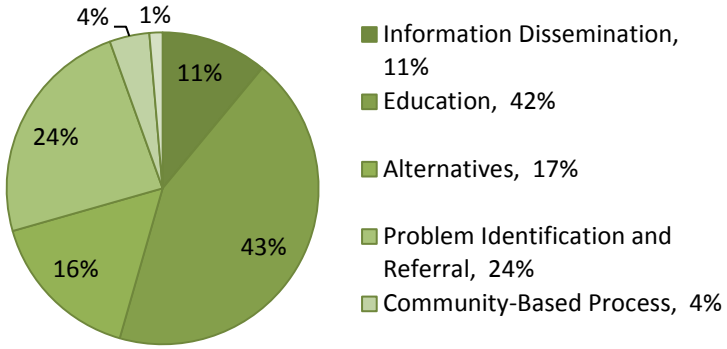
Figure 6

Prevention Services by Federal Strategy as Reported to PBPS State Fiscal Years 2012-2013 through 2014-2015

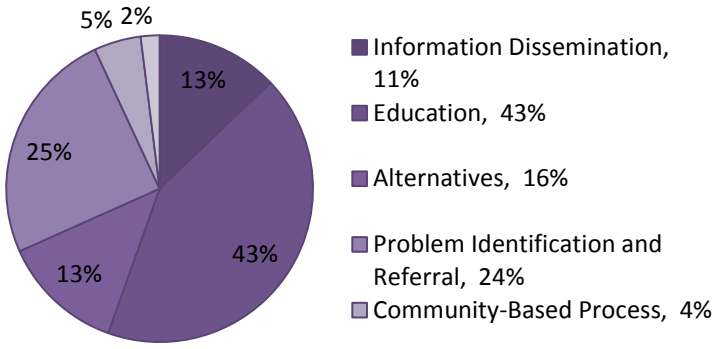
2014-2015



2013-2014



2012-2013



IOM Population Categories

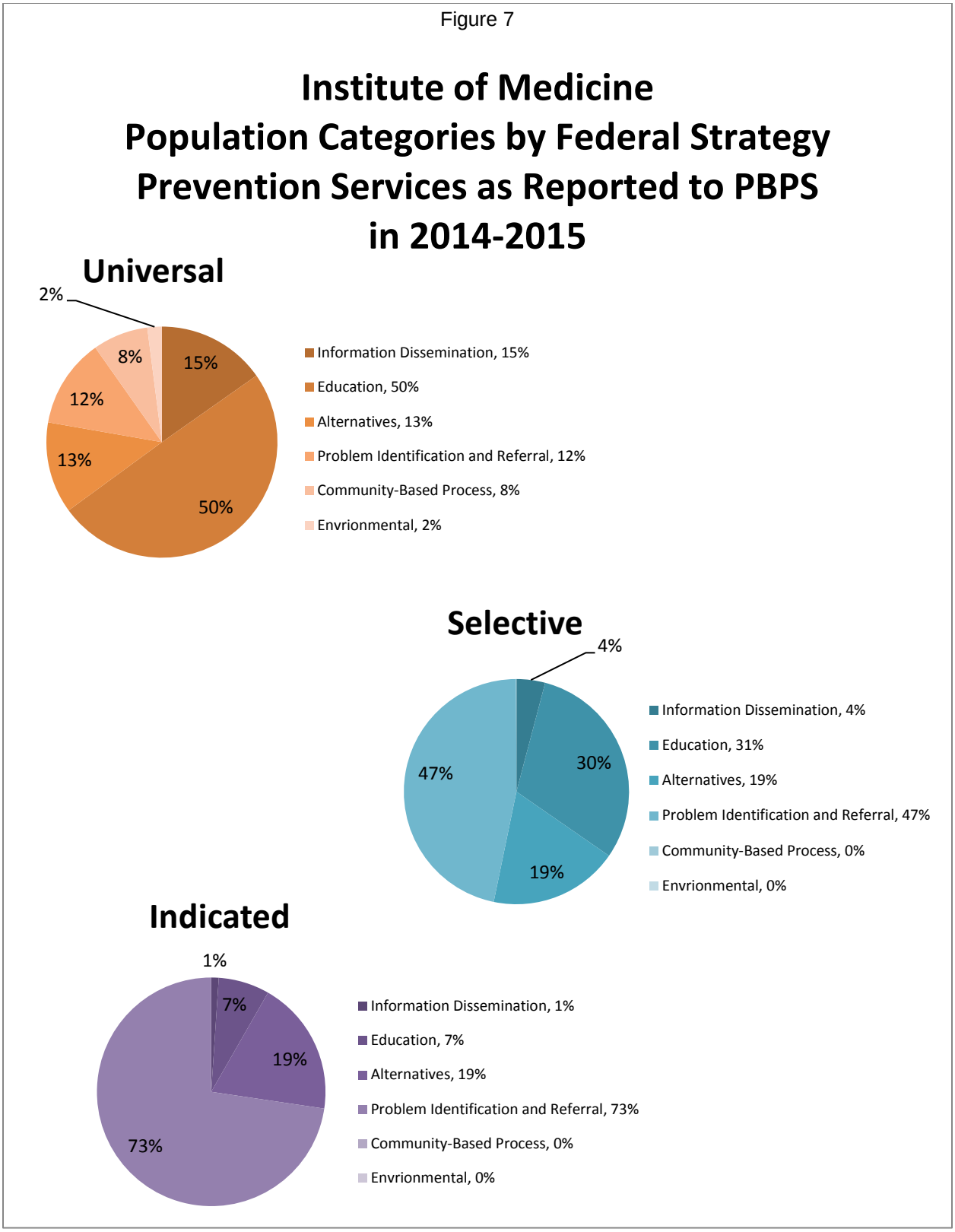
The six Federal Strategies are applicable and are utilized by each IOM population category. Figure 7 shows these population categories broken out by Federal Strategy for state fiscal year 2014-2015. Defined below are the three IOM population categories. Included in the definitions are examples of activities that comprise the overall concept of services that prevent or reduce the use and abuse of alcohol, tobacco and other drugs. While Education services play a large role in all Universal prevention service activities to large diverse groups, the indicated target population covering high-risk individuals is now showing nearly 75% percent Problem Identification and Referral services. Based on Federal guidelines this makes for more effective prevention programs statewide.

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

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

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

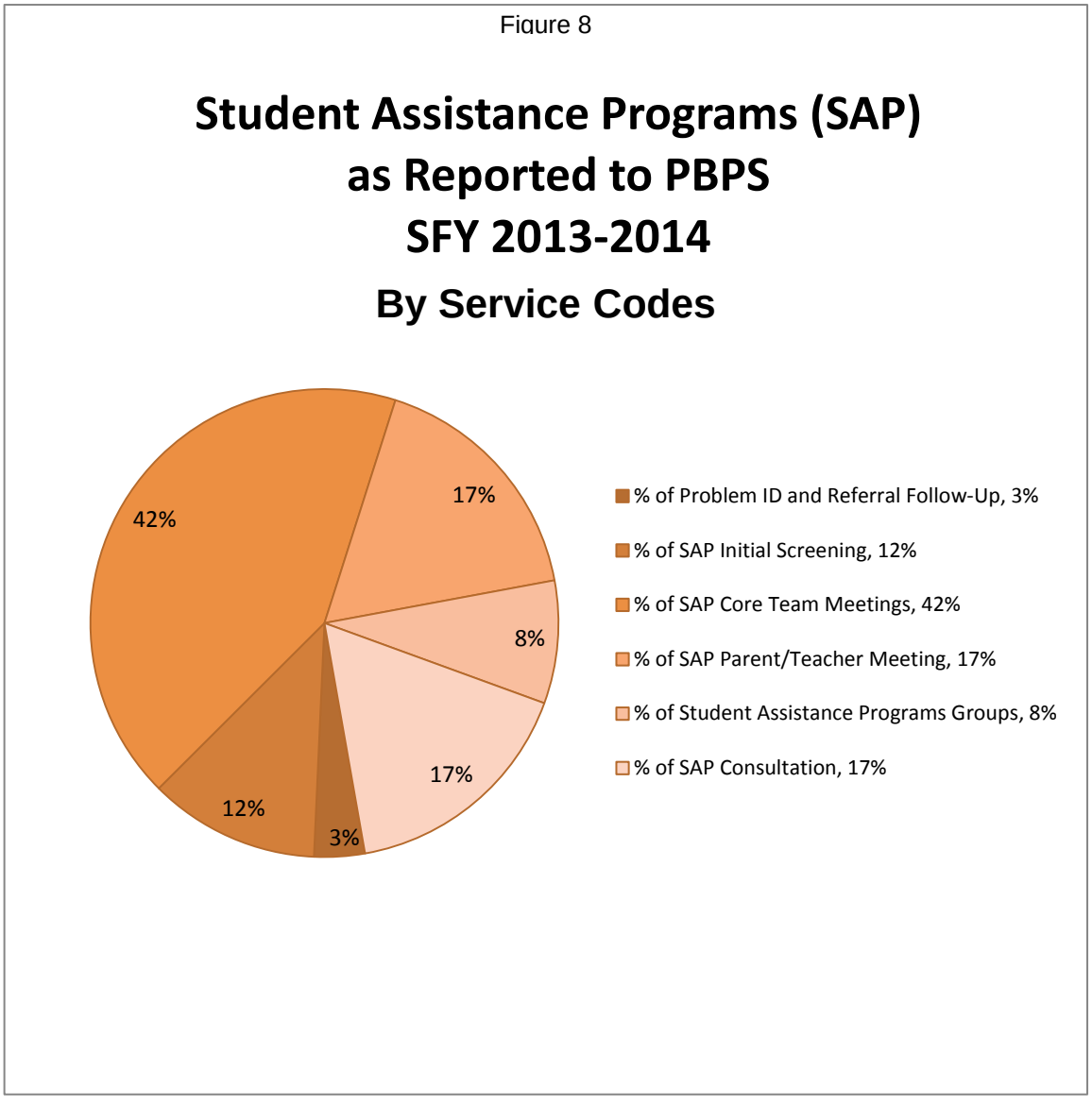
Figure 7


Institute of Medicine
Population Categories by Federal Strategy
Prevention Services as Reported to PBPS
in 2014-2015
Universal
2%
8%
15%
12%
13%
50%
Information Dissemination, 15%
Education, 50%
Alternatives, 13%
Problem Identification and Referral, 12%
Community-Based Process, 8%
Envrionmental, 2%
Selective
4%
47%
30%
19%
Information Dissemination, 4%
Education, 31%
Alternatives, 19%
Problem Identification and Referral, 47%
Community-Based Process, 0%
Envrionmental, 0%
Indicated
1%
7%
19%
73%
Information Dissemination, 1%
Education, 7%
Alternatives, 19%
Problem Identification and Referral, 73%
Community-Based Process, 0%
Envrionmental, 0%

Student Assistance Data

The Student Assistance Program (SAP) is an important intervention for the youth in Pennsylvania. Figure 8 shows a total of 40,122 SAP services provided to SAP-identified students for Fiscal Year 2014-2015 broken down into their specific approach (service code). SAP assists school personnel in identifying issues like alcohol, tobacco and other drugs, as well as mental health issues which can impede students' success. Services provided to SAP-identified students include screening, consultation, referral and follow-up and/or small group education for SAP-identified youth. SAP is mandated to all SCAs to complement their prevention initiatives.

Figure 8



TREATMENT AND RECOVERY SUPPORT DATA ANALYSIS

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

Confidentiality and Reporting

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

- 71 P.S. § 1690.101, et seq. - established the Pennsylvania Advisory Council on Drug and Alcohol Abuse in 1972 whose authority was ultimately transferred to the Department of Drug and Alcohol Programs by Act 50 of 2010 (71 P.S. § 613.1(9)) and addresses confidentiality requirements at 71 P.S. §§ 1690.108.

- 28 Pa. Code § 709.28 - standards for licensing freestanding treatment facilities to include adherence to confidentiality requirements

- 42 CFR Part 2, Subparts A-E - federal regulation governing patient records and information

- 45 CFR Part 96 - federal regulation governing the privacy of health care information that went into effect on April 14, 2003

- 4 Pa. Code § 255.5 and § 257.4 - state regulations governing patient records

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

All data reported in the following pages adheres to the above confidentiality requirements.

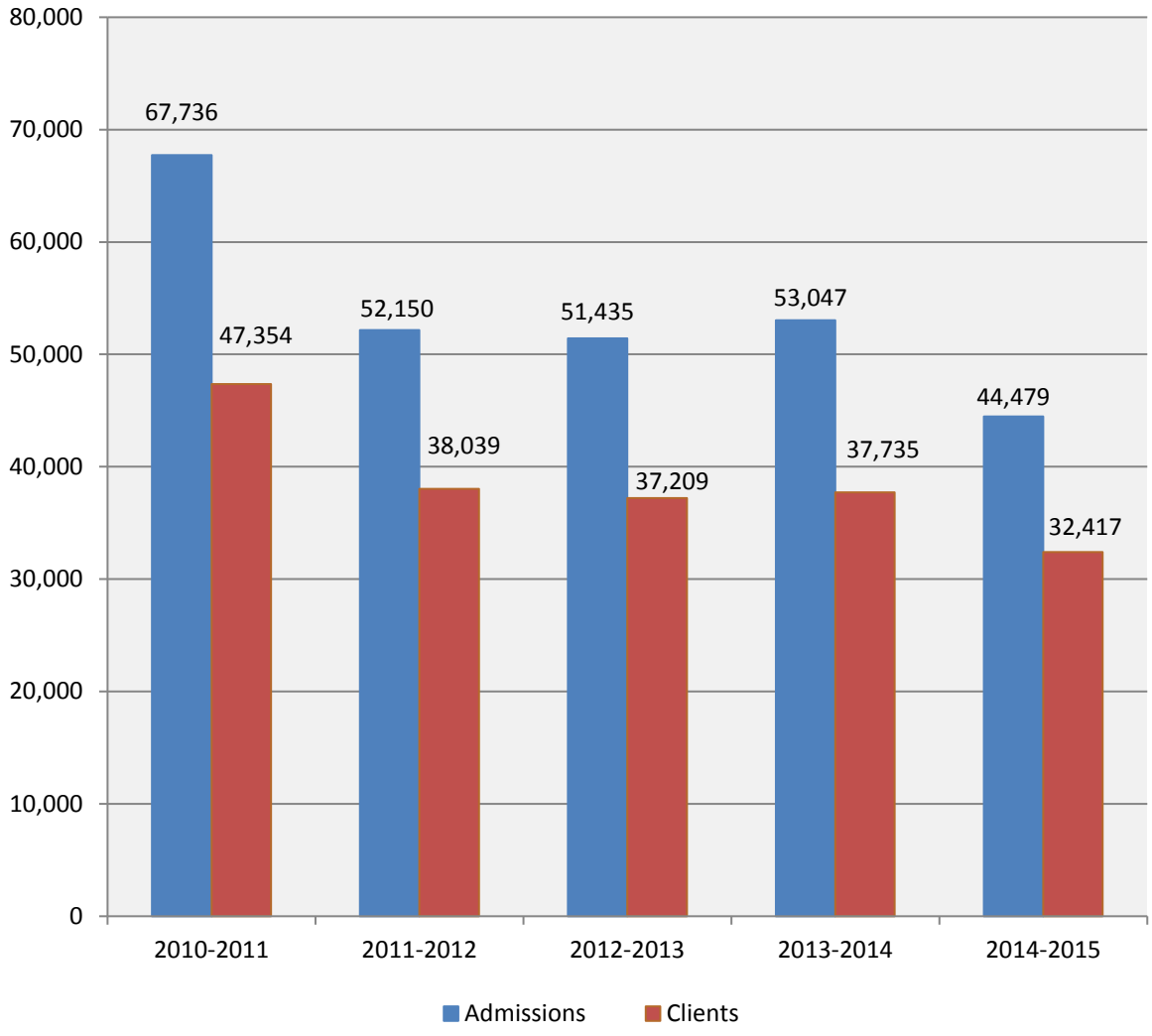
Admissions and Unique Clients

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 (2010-2011 through 2014-2015), reported admissions and clients have been on the decline with the exception of the 2013-2014 fiscal year, which reported a slight increase in admissions, while unique client counts remain in a stabilizing range over the last three years. The decline in admissions should not be considered 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. In addition, the expansion of Medicaid has allowed individuals to receive treatment without using SCA dollars, which is the basis for this data.

Figure 1

Admissions and Unique Clients* Trending from 2010-2011 through 2014-2015



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

Client Demographics

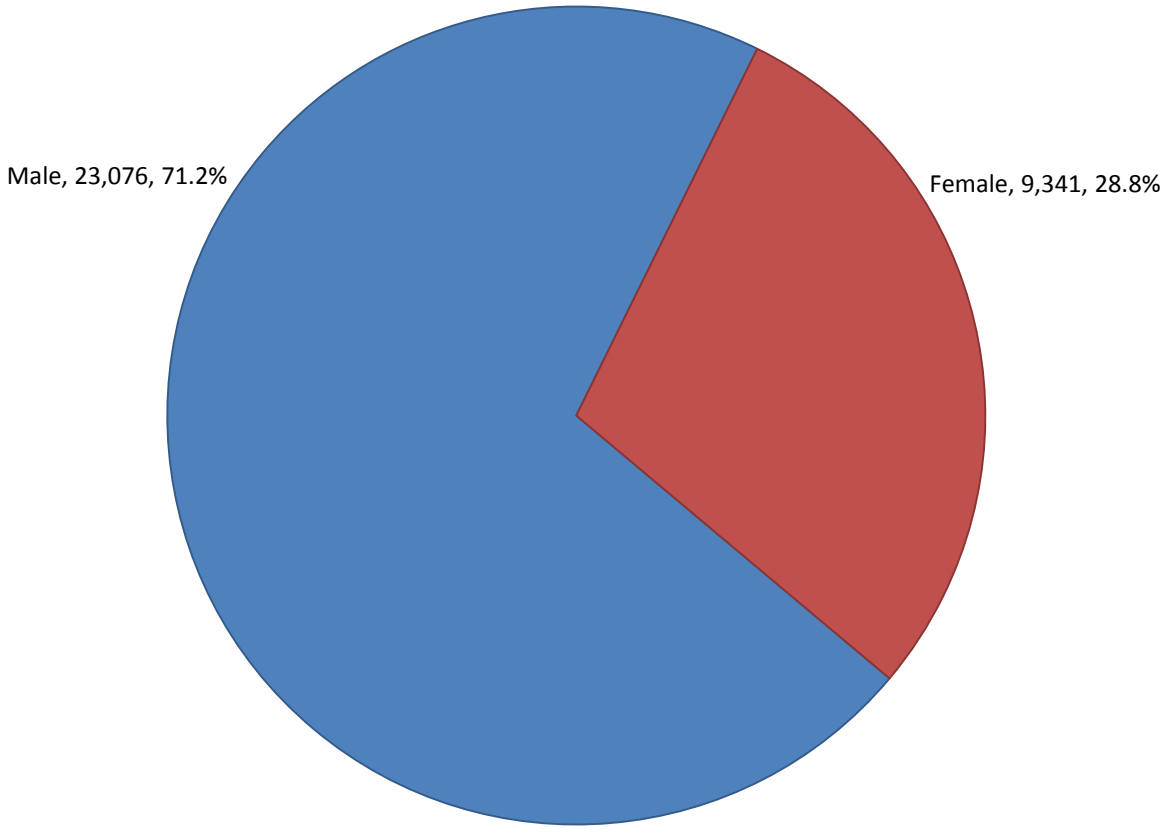
Clients that are treated by programs funded by the Department are quite different from the general population in many ways. The following charts and narrative describe these differences. The majority (71.2 percent) of clients are male (Figure 2), while the general population is 48.9 percent male. Well over half (61.7 percent) of all clients are in the 15-34 year old age group (Figure 3). There is a slightly higher percentage of African-American clients in treatment compared to the total Pennsylvania population of African-Americans (10.36 percent and 11.5 percent, respectively) (Figure 4). There is a higher percentage of Hispanics in treatment compared to the general population (15.6 percent and 6.3 percent, respectively) (Figure 5). This is nearly 4 percent higher than in 2013-2014. Nearly one in ten (9.3 percent) clients in treatment is still of unknown ethnicity (Figure 5).

*All Pennsylvania population percentages are from the 2015 Pennsylvania State Data Center Estimates.

Figure 2

Unique Client Admissions to Treatment
SFY 2014-2015

By Gender

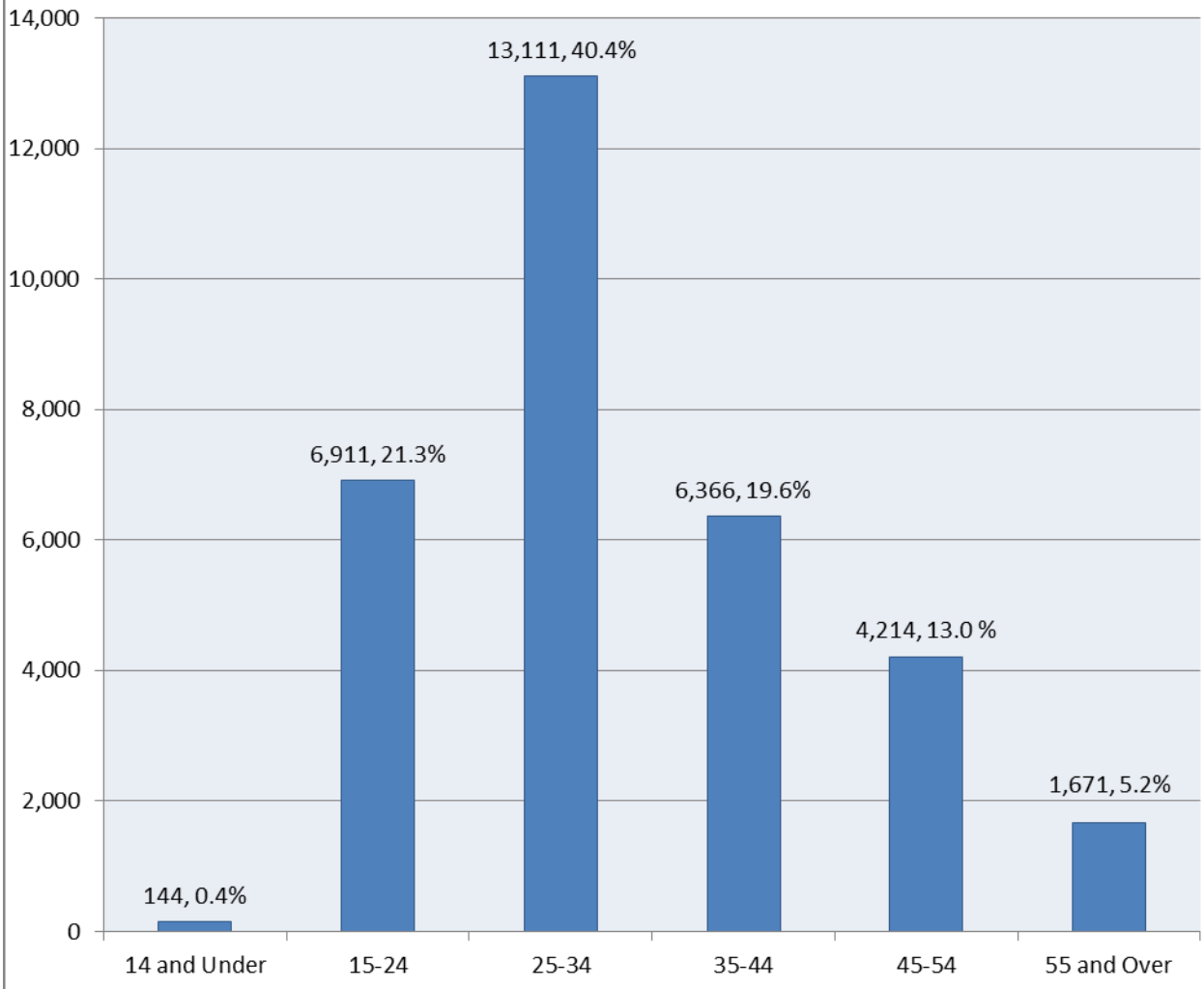


Clients are unique admissions counted once in the time period.
Total Clients=32,417

Figure 3

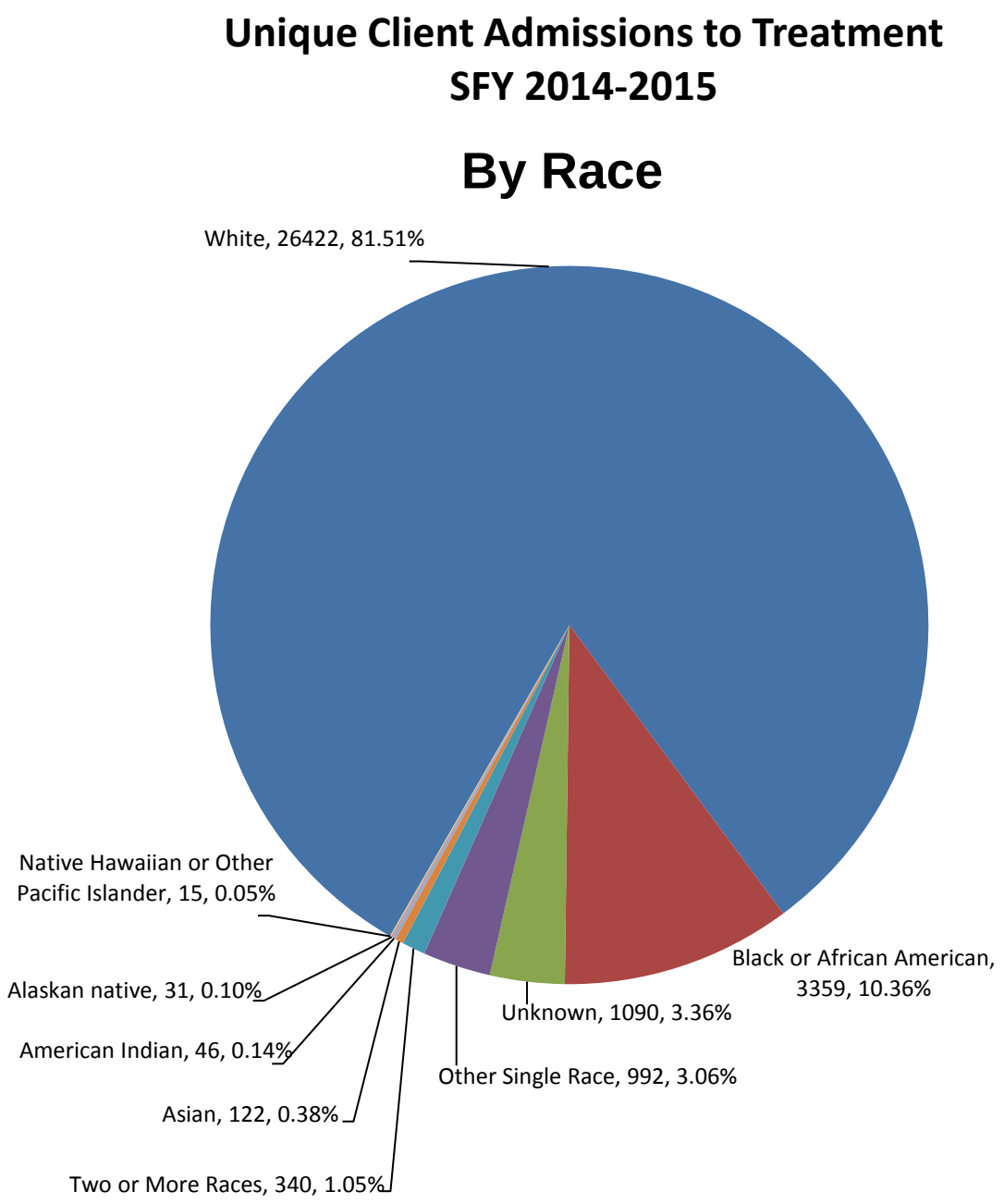
Unique Client Admissions to Treatment
SFY 2014-2015

By Age Groups



Clients are unique admissions counted once in the time period.
Total Clients=32,417

Figure 4

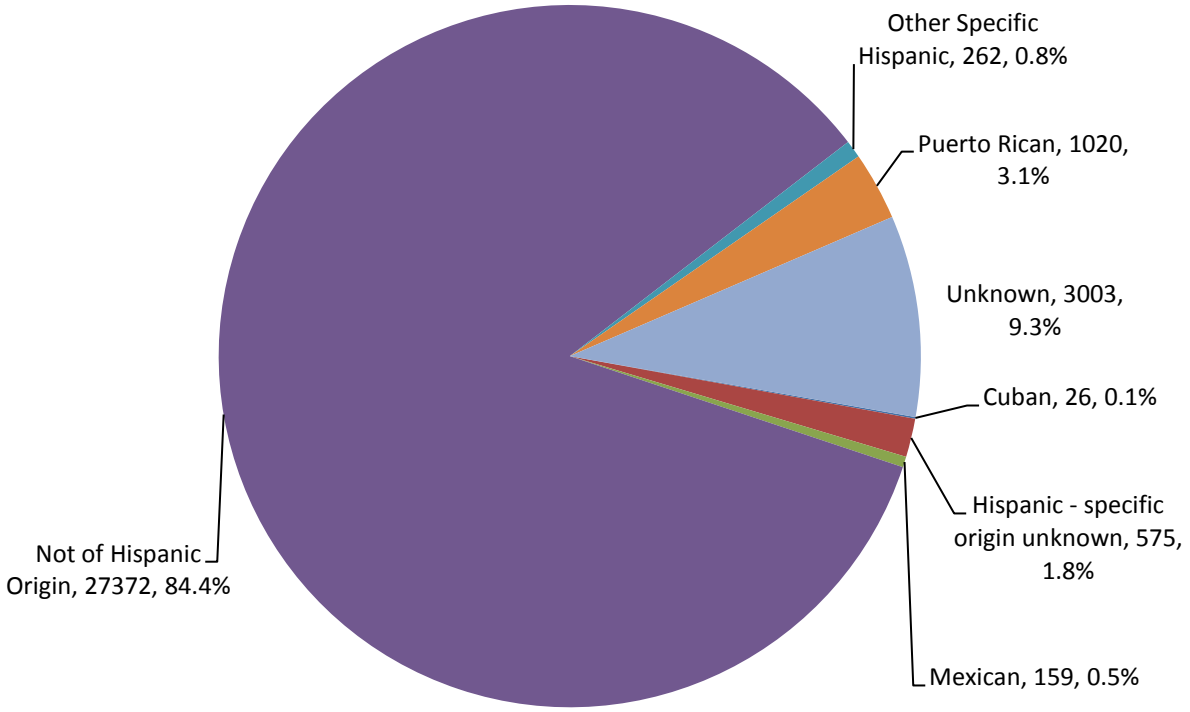


Clients are unique admissions counted once in the time period.
Total Clients=32,417

Figure 5

Unique Client Admissions to Treatment
SFY 2014-2015

By Ethnicity



Clients are unique admissions counted once in the time period.
Total Clients = 32,417

Admissions Characteristics

The Department is a payer of last resort, and many clients are unable to pay for the substance abuse treatment services they require. Therefore, many of these clients are at other disadvantages in addition to their substance abuse issues. The following charts and narratives describe some of these other disadvantages reported by clients during admission to substance abuse treatment. All of the characteristics described below show that alcohol and other drug (AOD) 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 for clients.

Employment Status

The majority (65.1 percent) of clients reported being unemployed. In addition, only about 1 in 6 admissions reported clients being employed on a full-time (16.9 percent) and even fewer on a part-time (6.7 percent) basis. One positive note is that the 16.9 percent figure for 2014-2015 is an increase from 15 percent in 2013-2014. The remaining admissions were of other employment statuses. (Figure 6)

Marital Status

Nearly three-fourths (74.9 percent) of clients being admitted have never been married. Only 8.5 percent of clients were married when they were admitted. The remaining clients reported their status as divorced (10.6 percent), separated (5 percent) or widowed (1 percent). It's interesting to note that the marital status figures for this fiscal year are nearly identical to those reported in the previous year. (Figure 7)

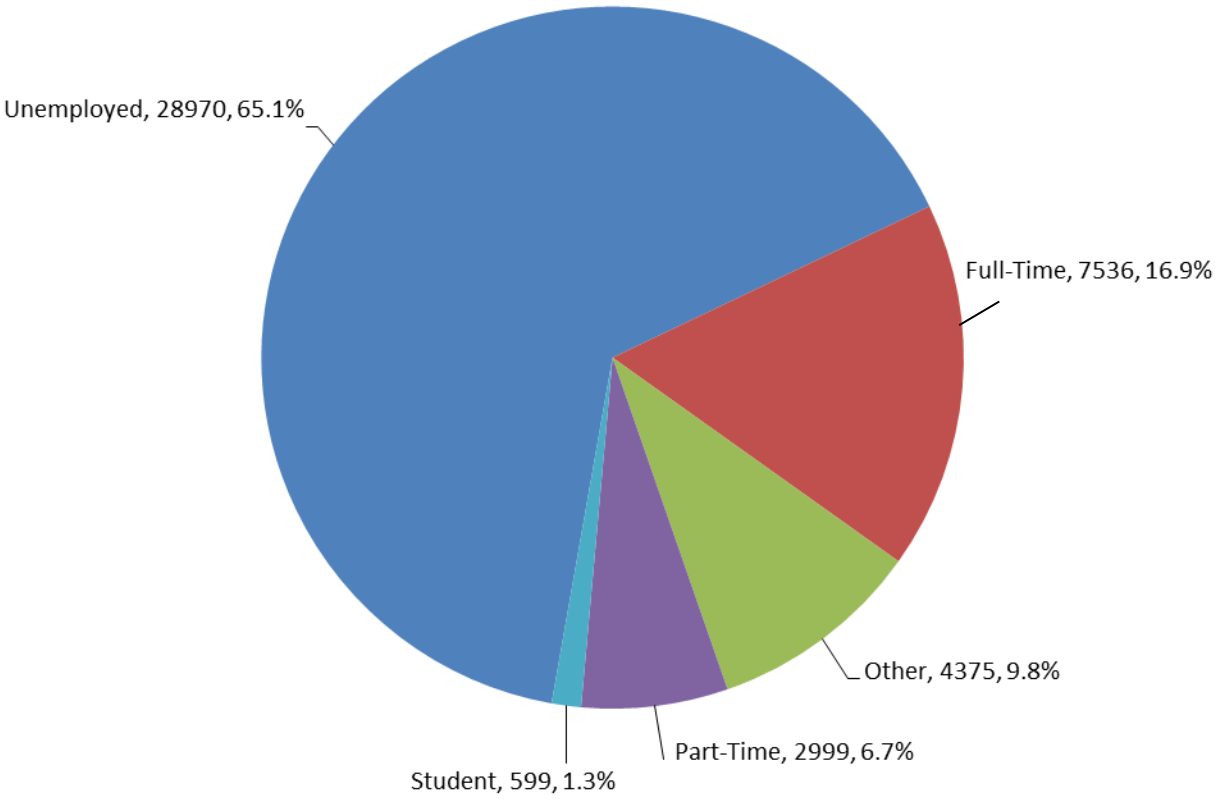
Referral Sources

Almost one third (30.49 percent) of clients were involved in the criminal justice system and/or were mandated to receive substance abuse treatment. The second largest referral source was the SCA (28.57 percent) followed then by clients referring themselves (18.29 percent). Very few clients were referred by a school, clergy, or their employer. Trending this data over the last three fiscal years, there have been no significant changes. (Figure 8)

Figure 6

Client Admissions to Treatment
SFY 2014-2015

By Employment Status

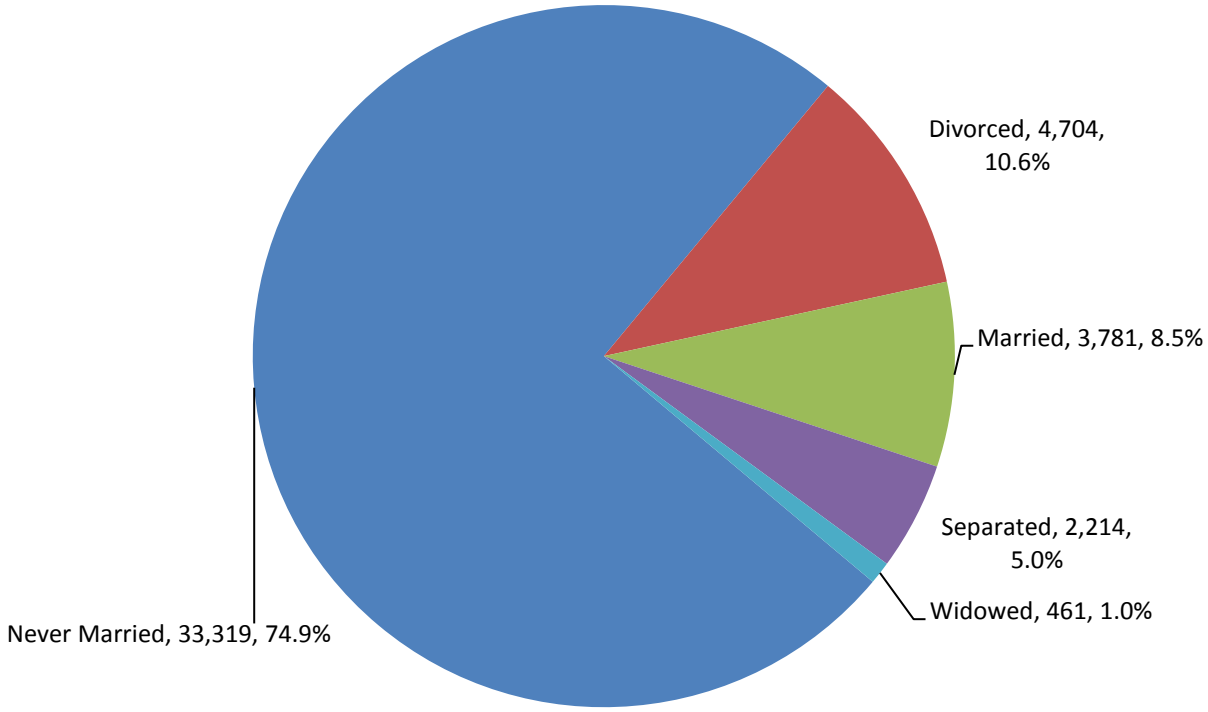


*Other includes: Disabled, Retired, Homemaker, Unknown, Inmate, and Other Employment Status.
Total Admissions=44,479

Figure 7

Client Admissions to Treatment
SFY 2014-2015

By Marital Status

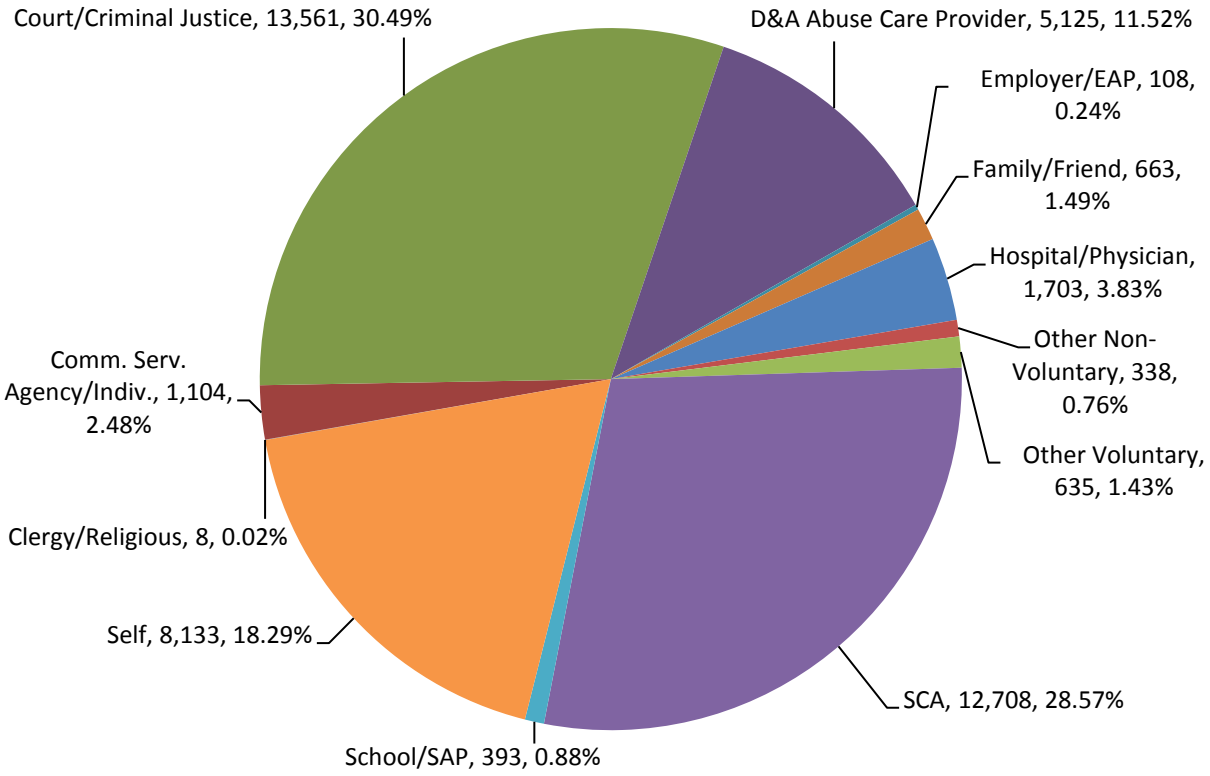


Total Admissions=44,479

Figure 8

Client Admissions to Treatment
SFY 2014-2015

By Referral Sources

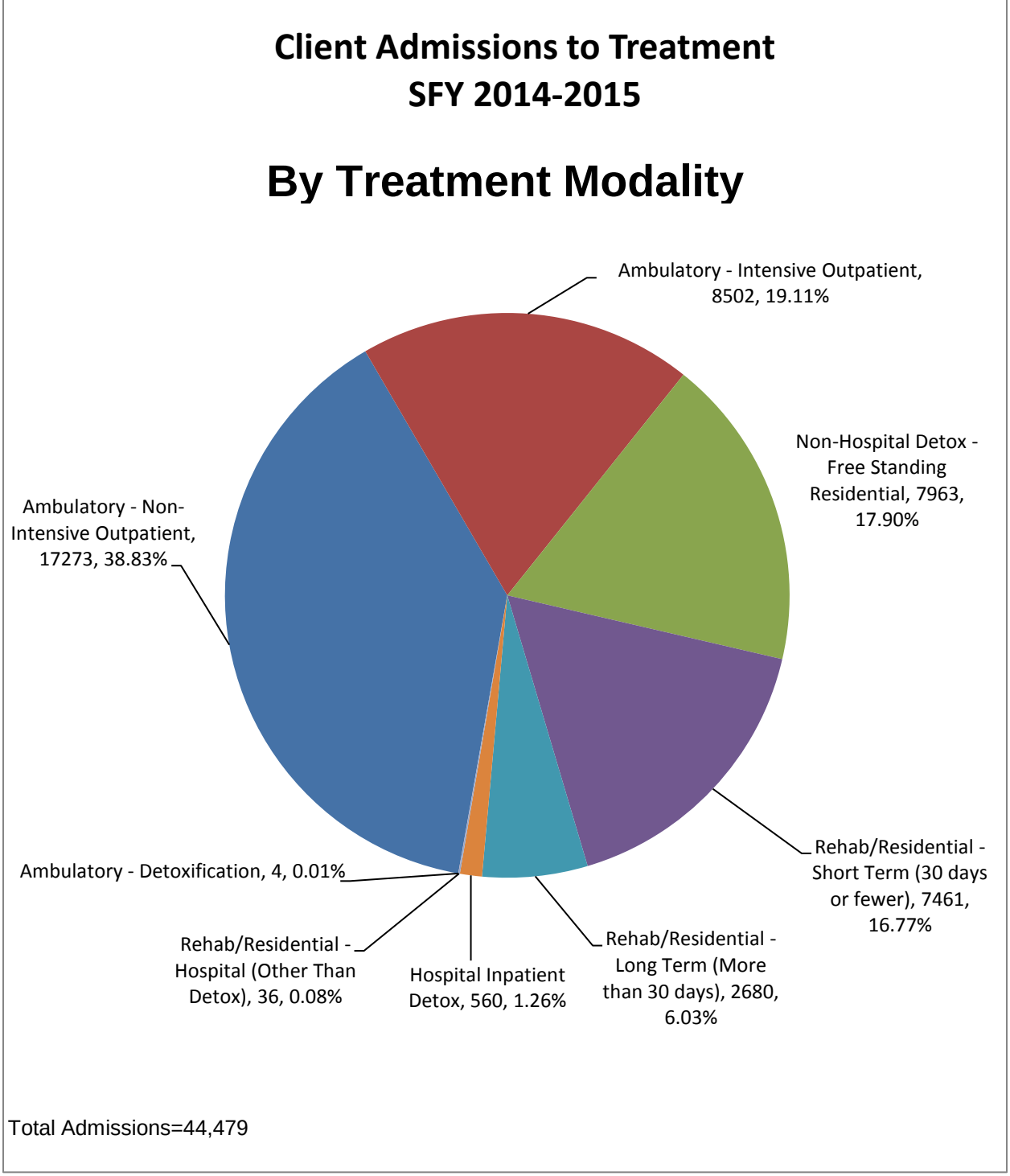


Total Admissions=44,479

Types of Treatment

There are several different types of treatment available to clients in Pennsylvania. Treatment modality or Levels of Care usage varies widely by SCA, so these statewide figures may not give an accurate representation of local area modality utilization. The most prevalent type of treatment received is Ambulatory – Non-Intensive Outpatient, with 38.83 percent of clients receiving this modality (Figure 9). This is also the least intensive and least expensive modality. Nearly one in five admissions (17.9 percent) was for Non-Hospital Detox – Free Standing Residential 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


Client Admissions to Treatment
SFY 2014-2015
By Treatment Modality
Ambulatory - Intensive Outpatient, 8502, 19.11%
Non-Hospital Detox - Free Standing Residential, 7963, 17.90%
Ambulatory - Non-Intensive Outpatient, 17273, 38.83%
Rehab/Residential - Short Term (30 days or fewer), 7461, 16.77%
Ambulatory - Detoxification, 4, 0.01%
Rehab/Residential - Hospital (Other Than Detox), 36, 0.08%
Hospital Inpatient Detox, 560, 1.26%
Rehab/Residential - Long Term (More than 30 days), 2680, 6.03%
Total Admissions=44,479

Drug Use Patterns

Clients are admitted to treatment for a wide range of primary substances of abuse. Different groups of clients also use very different types of substances. The following charts and narrative illustrate these points. The common primary substance of abuse is heroin (41.4 percent), which is up from 38 percent in the previous year. In addition to heroin, alcohol (28.9 percent), marijuana/hashish (10.8 percent), other opiates/synthetics (10.2 percent) and cocaine/crack (4.2 percent) account for over 95 percent of total admissions. (Figure 10)

Over the last five years, heroin has increased nearly 20 percent surpassing alcohol as the primary substance abused. (Figure 12) Another primary drug of interest over the last five years, marijuana/hashish trended downward in reporting from 16 percent to 12 percent. AS might be expected, the numbers are showing an increase in admissions listing heroin as the primary drug of choice. While it may be likely that more patients are being admitted with this as their drug of choice, it's also possible that due to the increased awareness of the epidemic that it's being listed as the drug of choice even when other drugs are present in the client's system. (Figure 11)

Admissions for each primary drug of use varies by gender, race, ethnicity and age group. The information presented below outlines the trends for each category.

Gender

While both genders admitted for heroin use are increasing, females are admitted more frequently than males (45 percent and 40 percent, respectively). Males are admitted for alcohol use more frequently (31 percent) than females (24 percent), as well as more frequently for marijuana/hashish (12 percent and 8 percent, respectively). Females are admitted for cocaine/crack use more frequently (5 percent) than males (4 percent). Females are also admitted more frequently for other opiates/synthetics (13 percent) than males (9 percent). (Figure 13)

Race

African-American clients were admitted for alcohol use more frequently than White clients (34 percent and 28 percent, respectively). White clients were admitted about three times as frequently for heroin (45 percent and 14 percent, respectively) and about three time as frequently for other opiates/synthetics (11 percent and 4 percent, respectively) as well. African-American clients were admitted over five times as often for cocaine/crack than whites (16 percent and 3 percent, respectively) and over three times more frequently for marijuana/hashish (29 percent and 8 percent, respectively). All of these comparisons are consistent with what was reported in fiscal year 2013-2014. (Figure 14)

Ethnicity

Clients of Hispanic ethnicity were admitted for marijuana/hashish twice as frequently than Non-Hispanic clients (20 percent and 10 percent, respectively). Hispanic clients were also admitted more frequently for cocaine/crack use (6 percent and 4 percent, respectively). Non-Hispanic clients were admitted more frequently for heroin than Hispanics (42 percent and 37 percent, respectively). This gap of 5 percent was an increase over the previous year, which was a gap of only 3 percent. Non-Hispanic clients were admitted almost three times as frequently for other opiates/synthetics (11 percent and 4 percent, respectively). (Figure 15)

Age Groups

Primary drugs of use also vary quite significantly among age groups. Heroin use is becoming prevalent in all age groups; however, the largest percentage usage in 2014-2015 was in the 15-24 age group and 25-34 age group (45 percent and 53 percent, respectively). This accounts for a 3 percent and 5 percent increase, respectively, in heroin use for these age groups since 2013-2014.

This data also reflects that the 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. The inverse if true for marijuana/hashish; the older the client is at admission, the lower the percentage who reported marijuana/hashish as their primary drug of choice. (Figure 16)

The age group 14 and under is most frequently admitted for marijuana/hashish use (72 percent), but it's important to keep in perspective that this age group accounts for less than 1 percent of total admissions. Many in this age category receive services through programs not reported in the data system. Clients in this age group are of particular interest, because they require more specialized services oriented towards youth. (Figure 16)

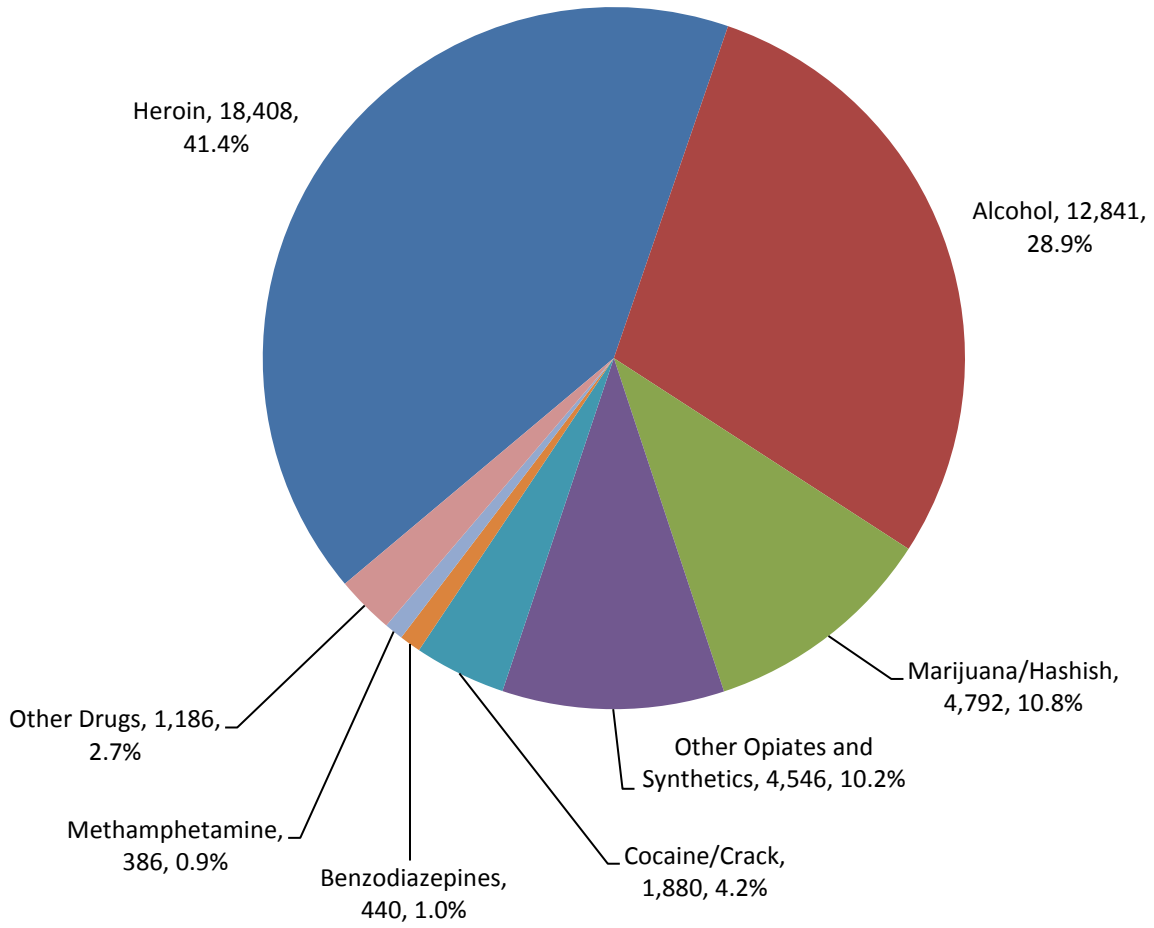
The age group 15-24 is also of particular interest due to its transitional nature. Clients in this age group are maturing from adolescents into young adults and do so at varying rates. The total admissions for this age group has been further broken down into ages 15-17 (1,076 admissions), 18-20 (2,229 admissions) and 21-24 (8,348 admissions) which can be found in Figure 17. Marijuana/hashish is the most prevalent drug of choice for age groups 15-17 and 18-20 (74 percent and 31 percent, respectively), but marijuana/hashish usage decreases by 50 percent between these two age groups when you look at the next range of 21-24. Looking beyond 24, marijuana/hashish admissions decline further in all subsequent age groups which is a relationship identified above that as age increases, the percentage usage for this category decreases. Also mentioned above was the relationship of age to heroin where the percentage usage of heroin increases with age. This relationship holds true even within the breakdown of the 15-24 group where only 5 percent of those in the 15-17 category reported heroin, but 40 percent of the 18-20 age range reported it and 51 percent of the 21-24 age range. (Figures 16 and 17)

The age group 55 and over is admitted for alcohol use most frequently (67 percent). This group accounts for 3 percent of total admissions and is of special interest in regards to the growing number of older Pennsylvanians.

Figure 10

Client Admissions To Treatment
SFY 2014-2015

By Primary Drug of Use

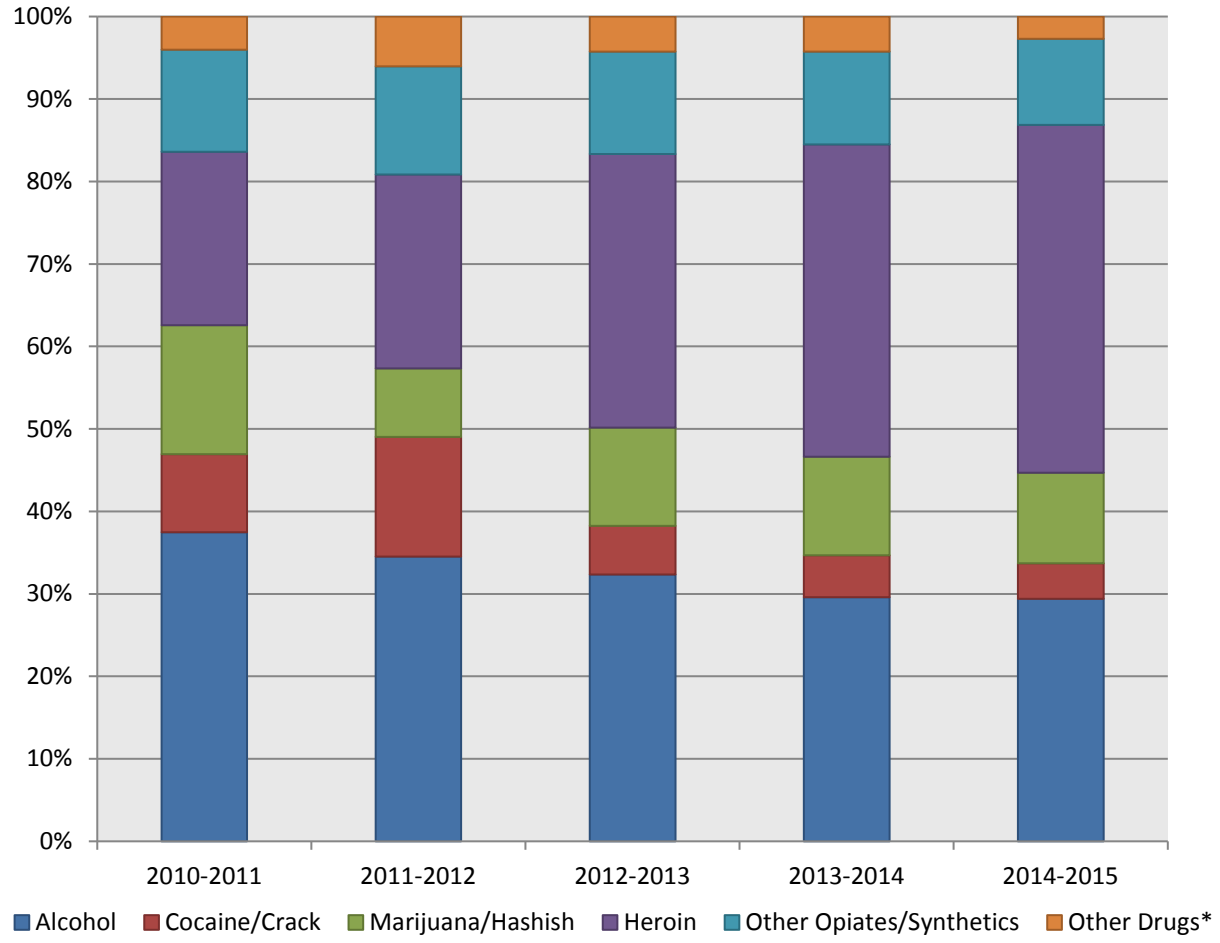


*Other Drugs includes: PCP, Other Amphetamines, Non-Prescription Methadone, Other Hallucinogens, Not Applicable (None), Other Stimulants, Over the Counter, Unknown, Inhalants, Barbiturates, Other Non-Barbiturate Sedatives or Hypnotics, Other Non-Benzodiazepine Tranquilizers, None, Buprenorphine and Other Drugs. Total Admissions=44,479

Figure 11

Client Admissions To Treatment
SFY 2010-2011 through 2014-2015

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=44,479

Figure 12

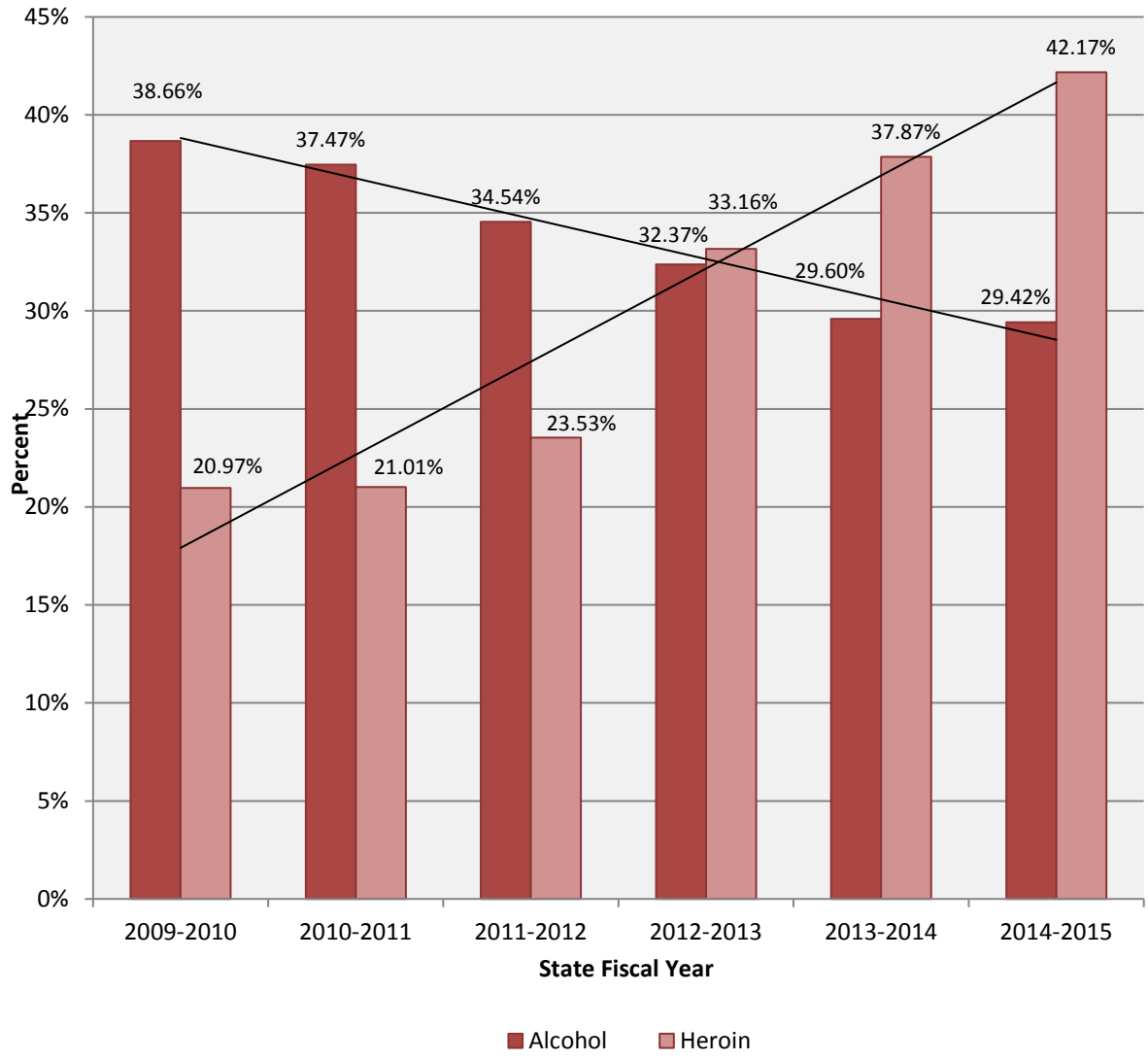
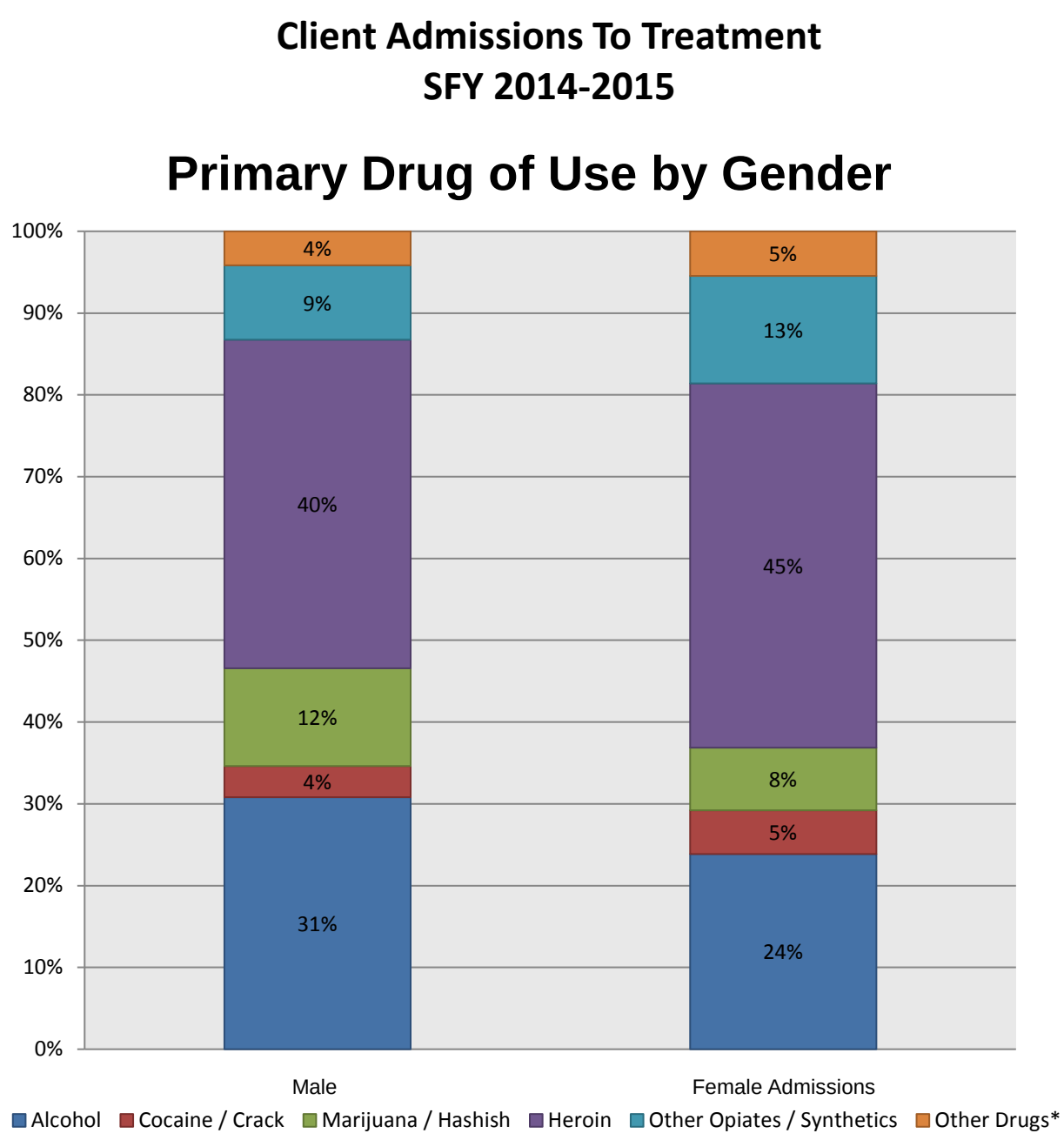

Treatment Admissions for Heroin and Alcohol
SFY 2009-2010 through 2014-2015
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Percent
38.66%
37.47%
34.54%
32.37%
29.60%
29.42%
20.97%
21.01%
23.53%
33.16%
37.87%
42.17%
2009-2010
2010-2011
2011-2012
2012-2013
2013-2014
2014-2015
State Fiscal Year
Alcohol
Heroin

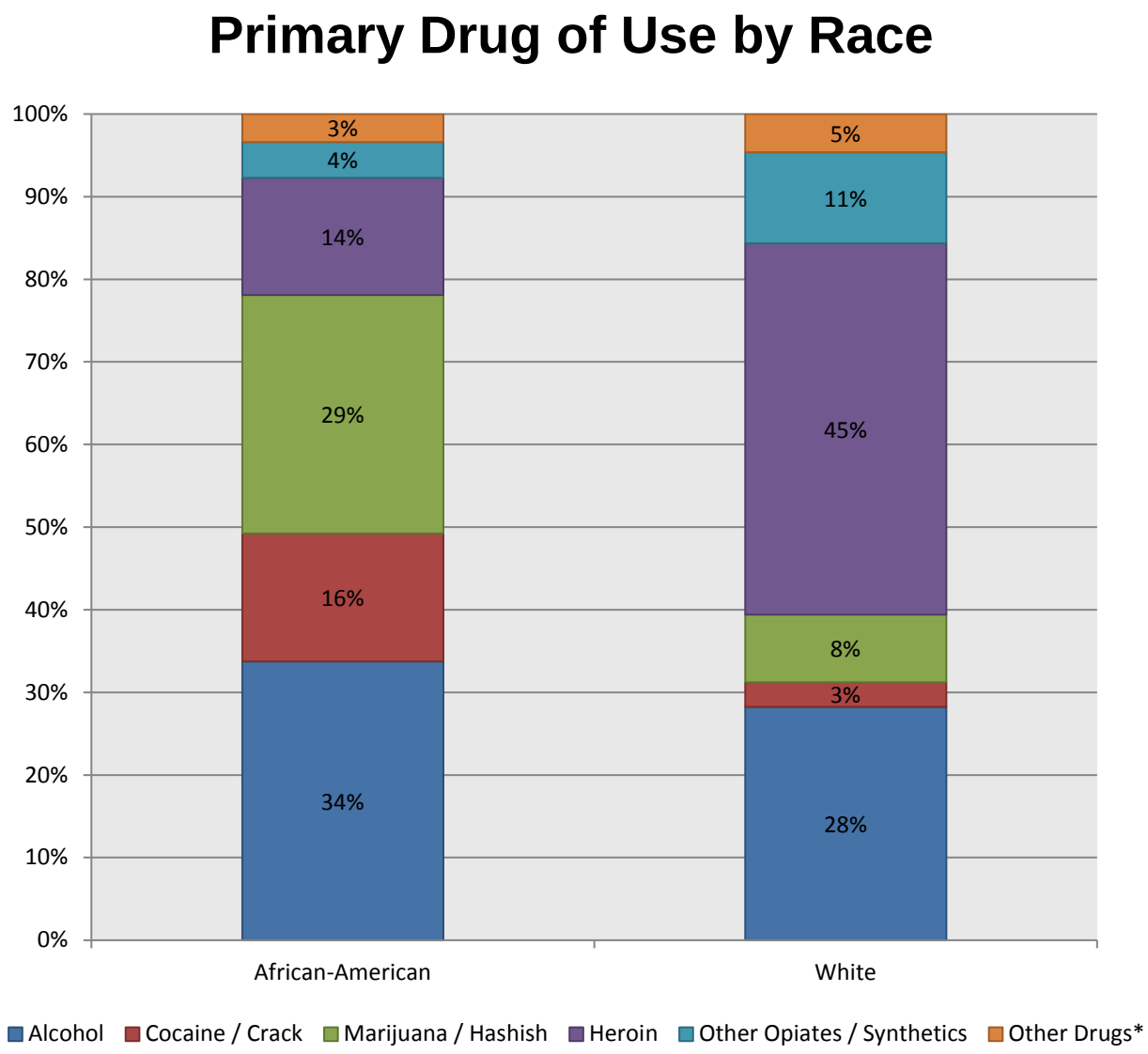
Figure 13



*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=44,479

Figure 14

Client Admissions to Treatment
SFY 2014-2015

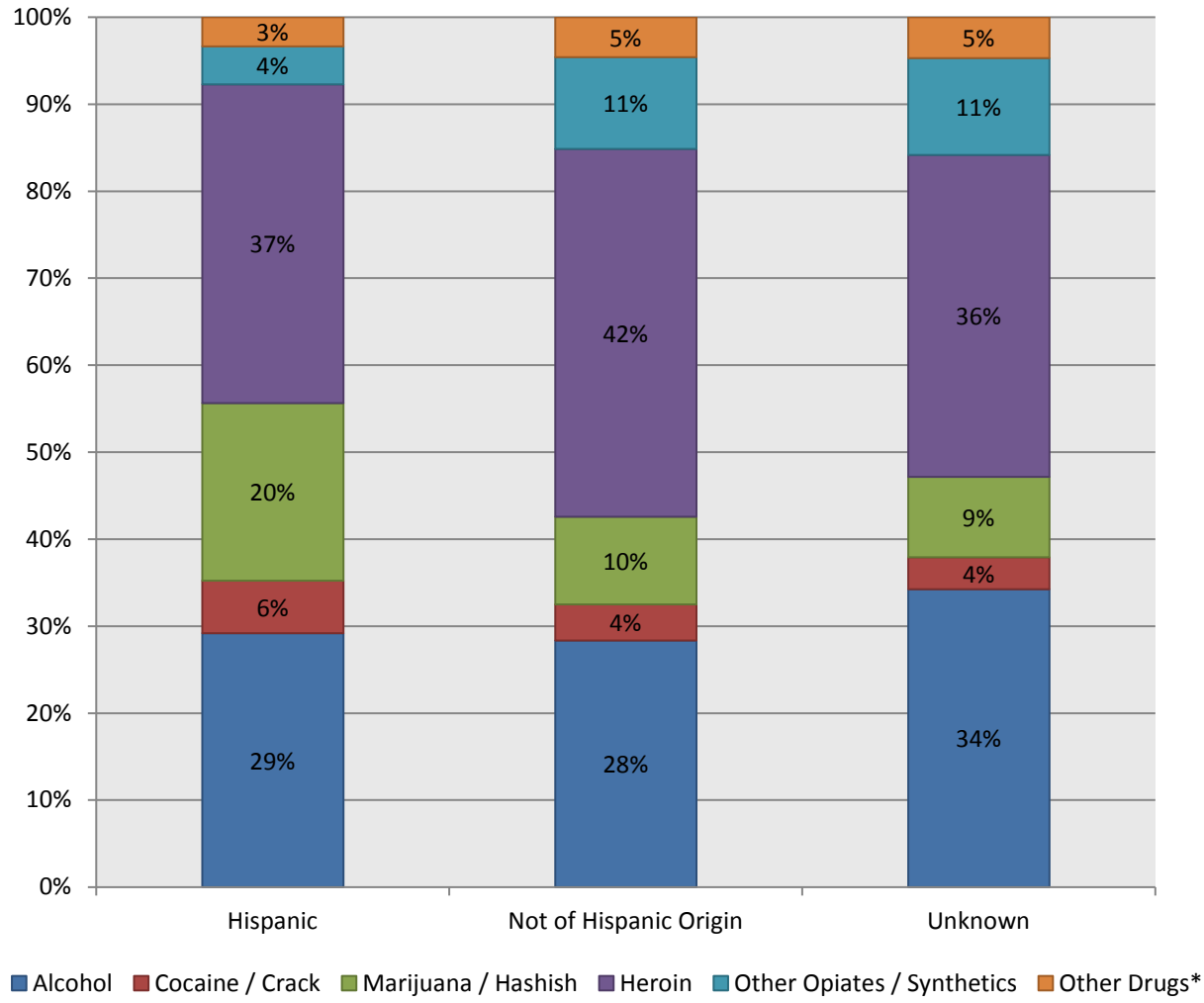


*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.
Total Admissions for Black and White=44,479 (92.2% of Total Admissions)

Figure 15

Client Admissions to Treatment
SFY 2014-2015

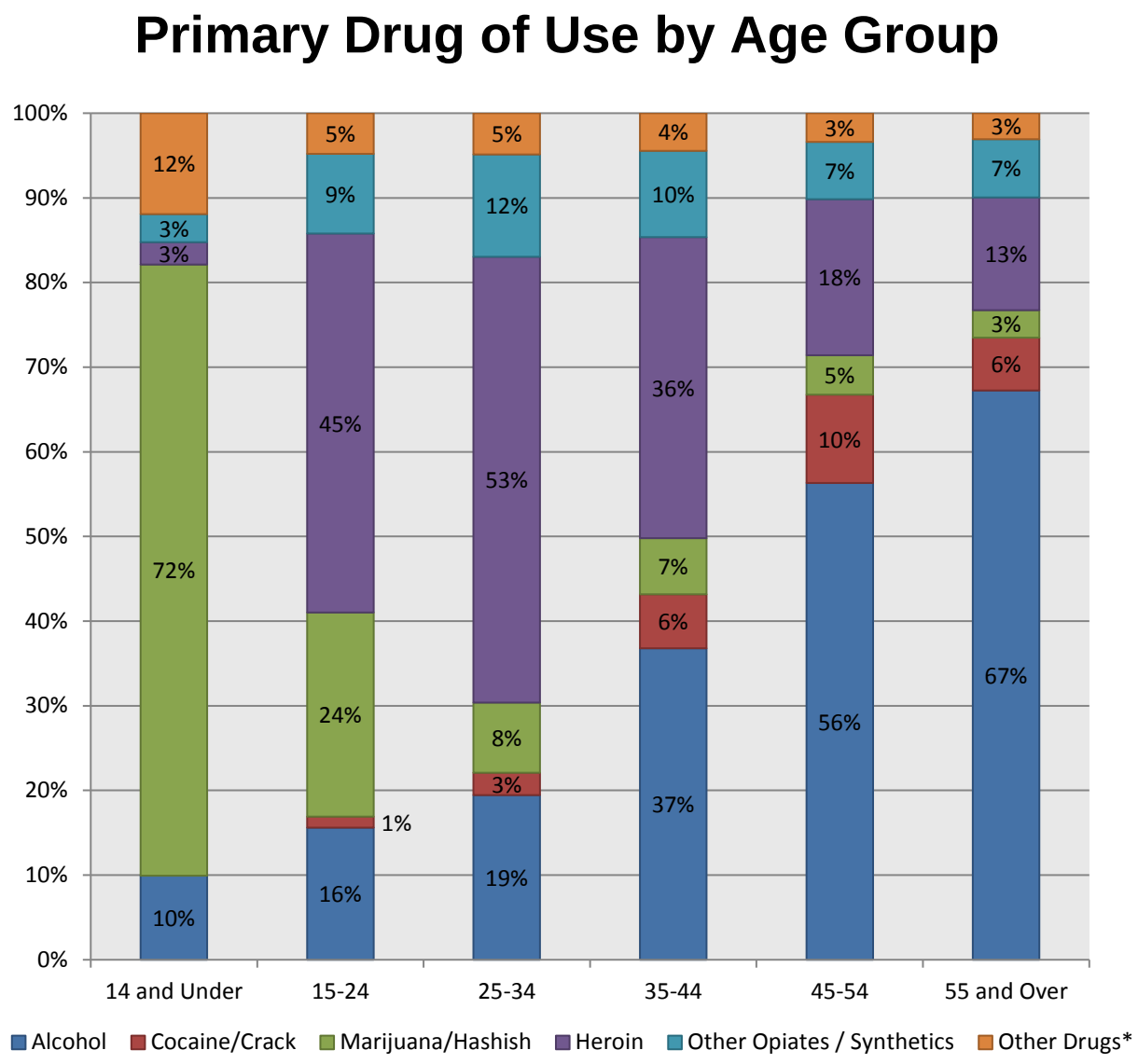
Primary Drug of Use by Ethnicity



*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.
Total Admissions for Hispanic and Not of Hispanic Origin=40,364 (90.7% of Total Admissions)
The remaining 4,115 admissions are of unknown ethnicity.

Figure 16

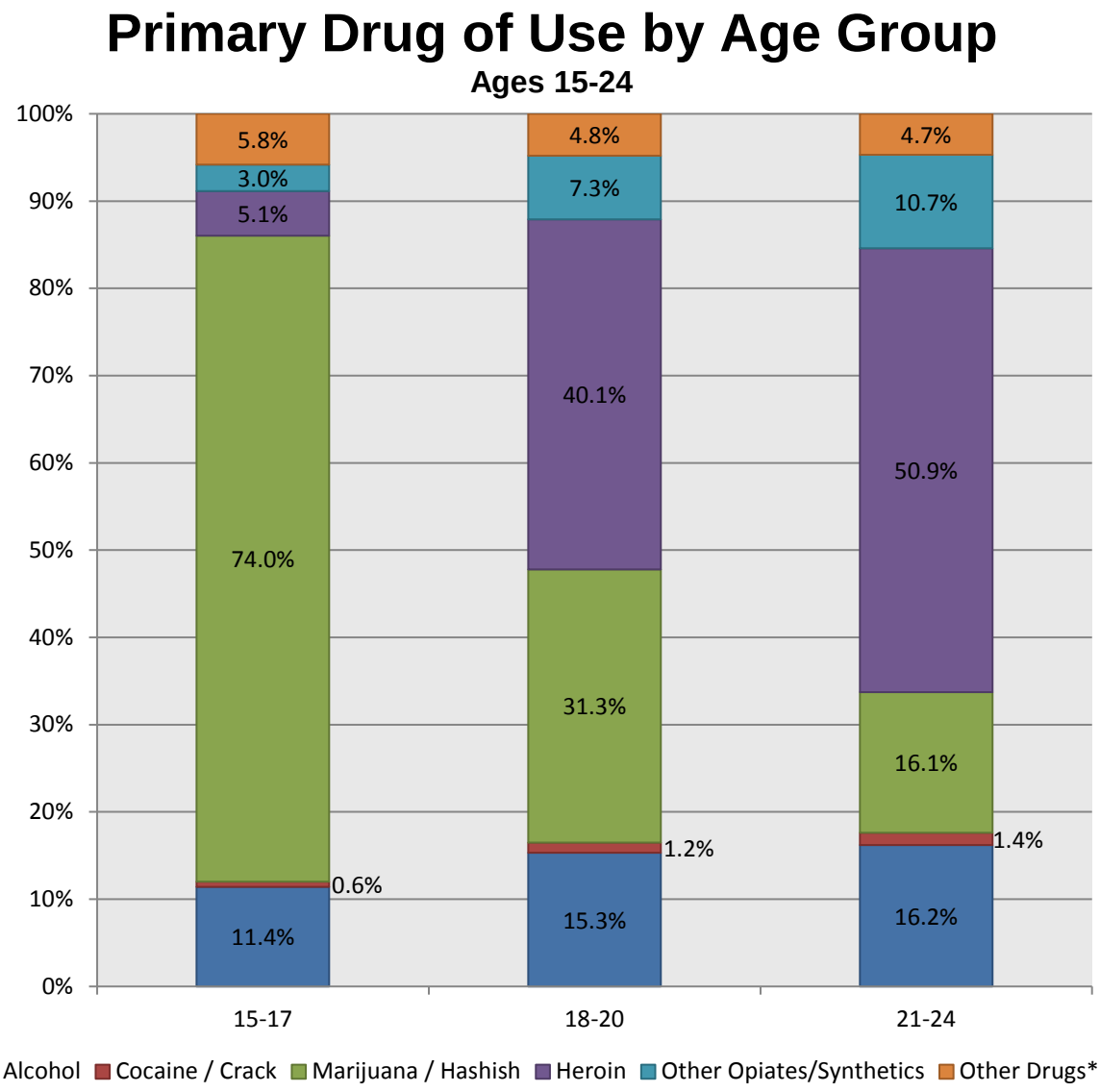
Client Admissions to Treatment
SFY 2014-2015



*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=44,479

Figure 17

Admissions to Treatment
SFY 2014-2015



*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.
Total Admissions For Ages 15-24 =9,237

Discharges

When a client has completed a particular type of treatment or changes treatment providers, a discharge record is created which includes an associated reason for discharge. A discharge marks the end of the Episode of Care or a level of care. There are two main types of treatment discharges: detoxification (detox) and non-detoxification (non-detox). The kinds of services 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 2014-2015.

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.

Detox Treatment Discharges

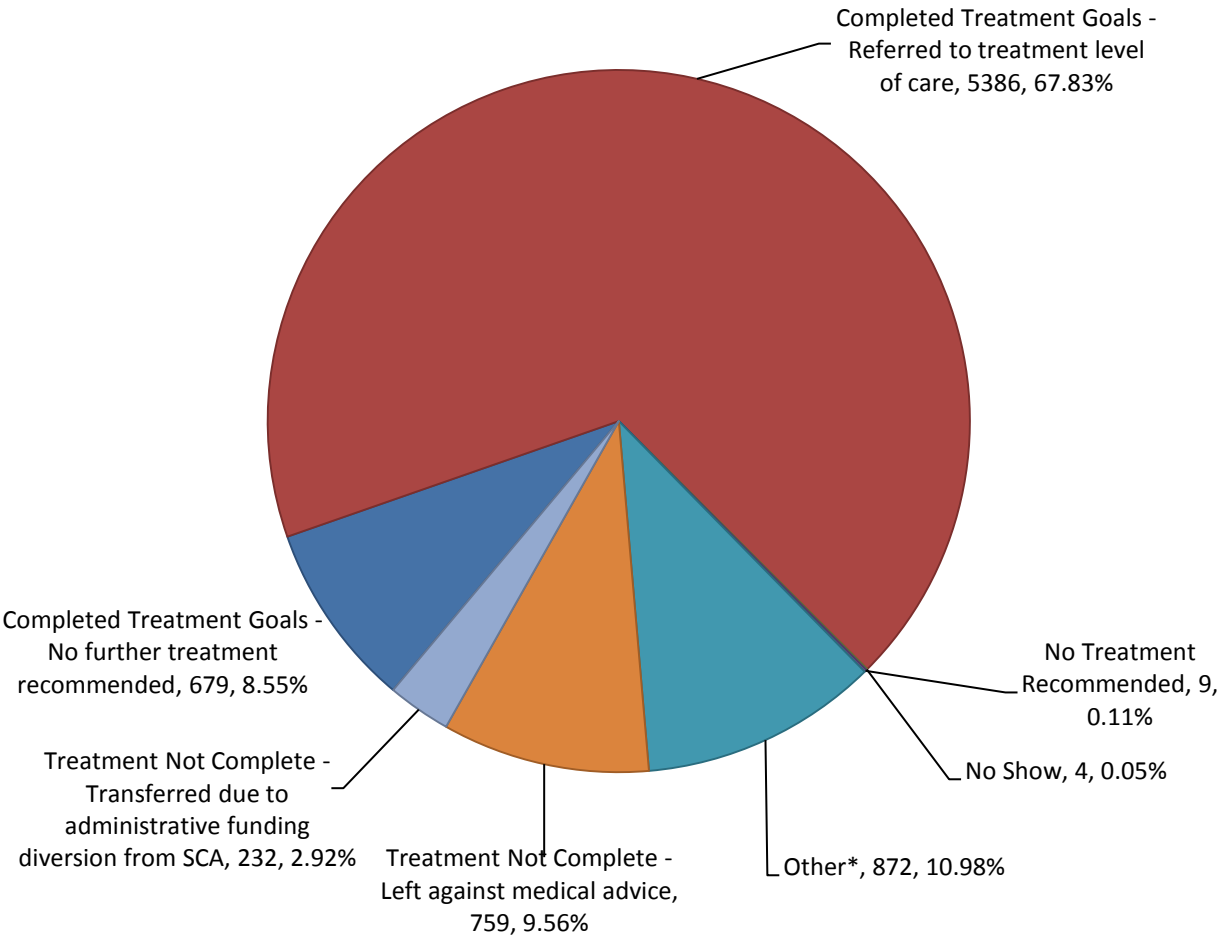
After detox treatment was completed, 67.8 percent of patients were either transferred within the facility or were referred to another facility for drug and alcohol treatment. However, 8.55 percent completed their detox and were not transferred. (Figure 18)

Non-Detox Treatment Discharges

Currently 37.79 percent of those discharged from non-detox treatment completed their treatment goals and had not used substances or reduced their dependency. For those who completed treatment 57 percent did so with no drug use, while 43 percent completed their treatment goals and were referred to a lower level of care. (Figures 19 and 20)

Figure 18

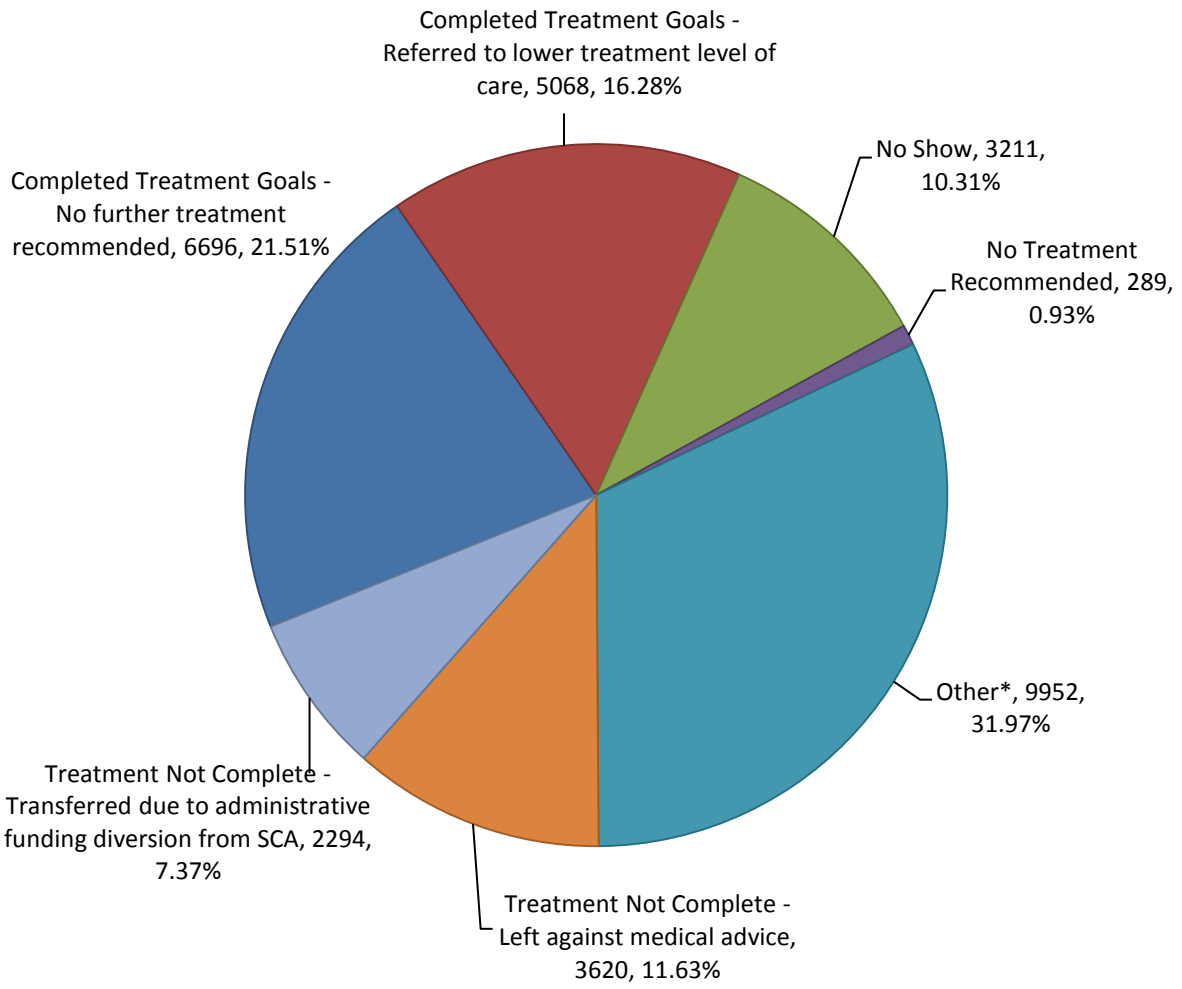
Client Discharges from Treatment
SFY 2014-2015
Detox Reasons for Discharge



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

Figure 19

Client Discharges from Treatment
SFY 2014-2015
Non Detox Reasons for Discharge

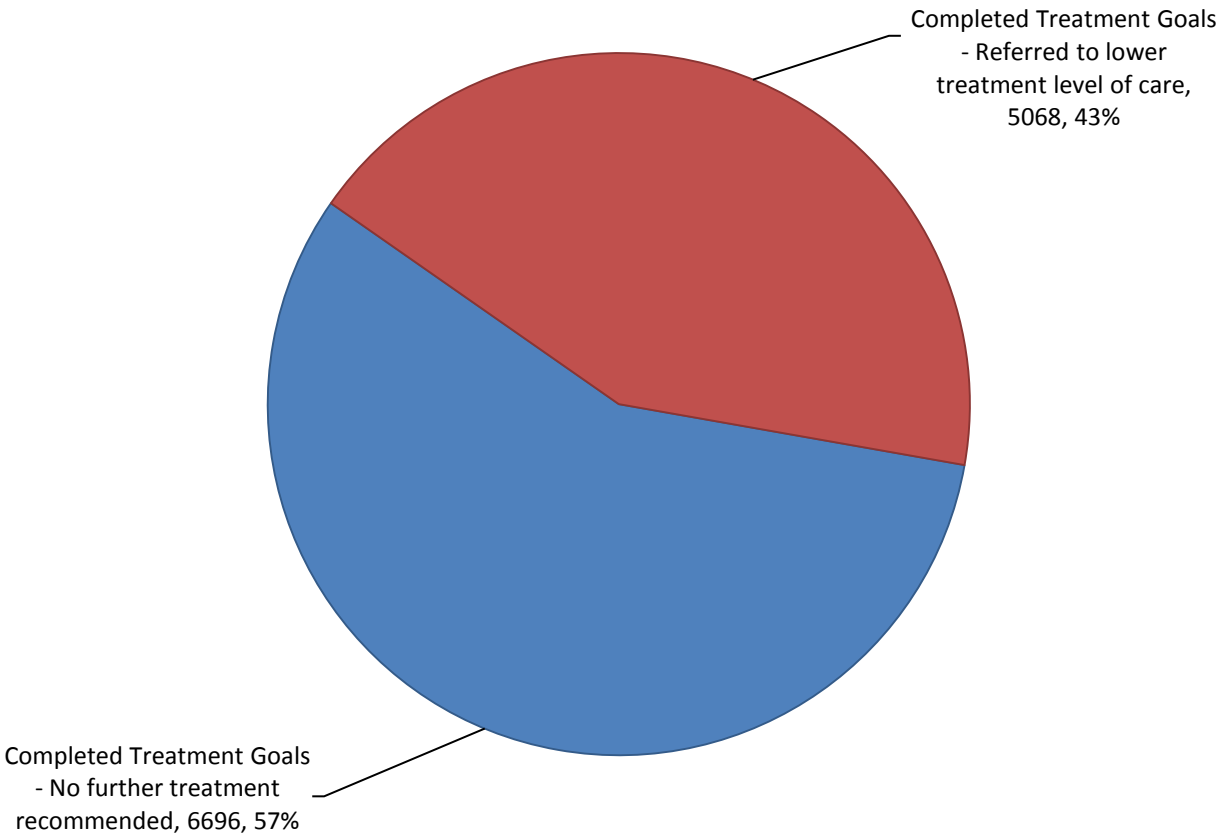


*Other Reasons includes: Incarcerated, Treatment Not Complete - Transferred to other non-D&A Facility, Treatment Not Complete - Transferred to other D&A Facility, Terminated by facility, SCA, Deceased and Other.

Figure 20

Client Discharges from Treatment
SFY 2014-2015

Non Detox Reasons for Discharge
for those who completed treatment goals



Total Discharges Completing Treatment=11,764

PENNSYLVANIA SUBSTANCE ABUSE OUTCOME MEASURES

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

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

Employment and Education

The employment outcome measure records if the client is employed (full-time, part-time or student) at admission and discharge. Overall, clients improved in most levels of care from unemployed at admission to employed at discharge (Figure 21). It is notable that those with long term residential care showed the largest improvement (16 percent) in transitioning from severe SUD to employment.

Figure 21

Employment/Education Status at Admission or Discharge

July 1 2014 - June 30 2015

Level of Care	Admission	Discharge
Short-Term (Up to 30 Days)		
Employed/Student	824	678
Total (Excludes Missing or Unknown)	6784	6768
Percent	12.1%	10.0%
Long Term (Over 30 Days)		
Employed/Student	56	417
Total (Excludes Missing or Unknown)	2244	2250
Percent	2.5%	18.5%
Outpatient (Non-Intensive)		
Employed/Student	5545	5450
Total (Excludes Missing or Unknown)	13498	12483
Percent	41.1%	43.7%
Intensive Outpatient		
Employed/Student	1725	1835
Total (Excludes Missing or Unknown)	6483	6038
Percent	26.6%	30.4%

Arrests

The arrests outcome measure records the client's arrest status. At admission, the client is asked if he/she has been arrested in the thirty days preceding their admission date to treatment services. At discharge, the client is asked if he/she has been arrested thirty days preceding their discharge to treatment. This section is of great importance because at all levels of clinically appropriate care, treatment engagement helps protect against criminal recidivism. Engagement in treatment allows individuals to maintain a crime-free way of life.

Overall, 30.49 percent of referred admissions involve some client interaction with the criminal justice system (Figure 8), so this special population's engagement and wellbeing is of great interest and importance to the Department. Meanwhile, less than 5 percent of clients were discharged due to incarceration, while they were engaged in treatment programs. Overall, clients improved in all levels of care from the time of admission to the time of discharge (Figure 22).

Figure 22

Lack of Arrests in Prior 30 Days

July 1 2014 - June 30 2015

Level of Care	Admission	Discharge
Short-Term (Up to 30 Days)		
No Arrests	6544	6854
Total (Excludes Missing or Unknown)	6969	6969
Percent	93.9%	98.3%
Long Term (Over 30 Days)		
No Arrests	2198	2263
Total (Excludes Missing or Unknown)	2279	2279
Percent	96.4%	99.3%
Outpatient (Non-Intensive)		
No Arrests	12994	13303
Total (Excludes Missing or Unknown)	13837	13837
Percent	93.9%	96.1%
Intensive Outpatient		
No Arrests	6161	6370
Total (Excludes Missing or Unknown)	6630	6630
Percent	92.9%	96.1%

Alcohol Abstinence

The alcohol abstinence outcome measure records whether the client is abstinent from alcohol in the thirty days preceding the date of 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 their abstinence in all levels of care at the time of discharge (Figure 23).

Figure 23

Alcohol Abstinence

July 1 2014 - June 30 2015

Level of Care	Admission	Discharge
Short-Term (Up to 30 Days)		
Abstinent Alcohol	5379	5505
Total (Excludes Missing or Unknown)	6956	6951
Percent	77.3%	79.2%
Long Term (Over 30 Days)		
Abstinent Alcohol	1799	1888
Total (Excludes Missing or Unknown)	2278	2272
Percent	79.0%	83.1%
Outpatient (Non-Intensive)		
Abstinent Alcohol	10025	10528
Total (Excludes Missing or Unknown)	13785	13624
Percent	72.7%	77.3%
Intensive Outpatient		
Abstinent Alcohol	4750	4997
Total (Excludes Missing or Unknown)	6618	6454
Percent	71.8%	77.4%

Other Drug Abstinence

The other drug abstinence outcome measure records whether the client is abstinent from other drugs in the thirty days preceding the date of 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 in all levels of care at the time of discharge with the most significant improvement occurring in long-term residential (Figure 24).

The somewhat high percentage of those already abstinent from alcohol and other drugs at admission occurs in part because the data system requires a new admission each time a client changes type of service or provider. Many outpatient level of care service admissions were referred from a previous drug and alcohol service or provider (Figure 19), therefore, these clients have already been in drug and alcohol service and may have already begun abstaining from substances.

Figure 24

Drug Abstinence*

July 1 2014 - June 30 2015

Level of Care	Admission	Discharge
Short-Term (Up to 30 Days)		
Abstinent Drug	1550	1731
Total (Excludes Missing or Unknown)	6956	6951
Percent	22.3%	24.9%
Long Term (Over 30 Days)		
Abstinent Drug	889	1133
Total (Excludes Missing or Unknown)	2278	2272
Percent	39.0%	49.9%
Outpatient (Non-Intensive)		
Abstinent Drug	7978	8281
Total (Excludes Missing or Unknown)	13785	13624
Percent	57.9%	60.8%
Intensive Outpatient		
Abstinent Drug	2803	3028
Total (Excludes Missing or Unknown)	6618	6454
Percent	42.4%	46.9%

*Drug Abstinence includes: Client's abstinence from Other Drugs (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)in the 30 days preceding the date of admission to treatment services or date of discharge.

Housing Stability

The increased stability in housing outcome measure records whether the client's living situation is improving or not. Only those clients indicating independent living are considered for the calculation. Overall, clients improved in all levels of care at the time of discharge, but long term residential showed the largest percentage improvement (Figure 25).

Figure 25

Stable Housing at Admission or Discharge

July 1 2014 - June 30 2015

Level of Care	Admission	Discharge
Short-Term (Up to 30 Days)		
Stable Living Situation	5104	5158
Total (Excludes Missing or Unknown)	5696	5699
Percent	89.6%	90.5%
Long Term (Over 30 Days)		
Stable Living Situation	1435	1418
Total (Excludes Missing or Unknown)	2104	1890
Percent	68.2%	75.0%
Outpatient (Non-Intensive)		
Stable Living Situation	13302	12808
Total (Excludes Missing or Unknown)	13598	13072
Percent	97.8%	98.0%
Intensive Outpatient		
Stable Living Situation	6262	6134
Total (Excludes Missing or Unknown)	6409	6264
Percent	97.7%	97.9%

Social Support

The social support outcome measure records a client's attendance at a self-help program thirty days preceding the date of admission to treatment services or date of discharge. Self-help attendance includes Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and other self-help/mutual support groups focused on recovery from substance abuse and dependence. Overall, clients improved attendance in each level of care; however Long Term (Over 30 Days) increased by over 50 percent attendance at the time of discharge (Figure 26).

Figure 26

Social Support Attendance 30 Days Prior to Admission or Discharge

July 1 2014 - June 30 2015

Level of Care	Admission	Discharge
Short-Term (Up to 30 Days)		
Attended	935	1777
Total (Excludes Missing or Unknown)	3998	4096
Percent	23.4%	43.4%
Long Term (Over 30 Days)		
Attended	326	1607
Total (Excludes Missing or Unknown)	1008	1931
Percent	32.3%	83.2%
Outpatient (Non-Intensive)		
Attended	2720	2955
Total (Excludes Missing or Unknown)	10711	8517
Percent	25.4%	34.7%
Intensive Outpatient		
Attended	1986	1777
Total (Excludes Missing or Unknown)	5079	4143
Percent	39.1%	42.9%

SINGLE COUNTY AUTHORITY EXPENDITURES

The expenditures reported in Figure 1 represent all Single County Authority (SCA) expenditures categorized by funding source. One of those funding sources is the Department (also referred to as DDAP). Not surprisingly, Philadelphia and Alleghany SCAs had the highest reported DDAP expenditures while Potter and Greene reported the lowest use of DDAP dollars. This result is expected due to the geographic locations, the populations and demographics of each of these four areas.

Figure 2 then shows the breakdown of DDAP spend for each SCA according to major activity. It's noteworthy that for most SCAs, the largest portion of DDAP funding was for treatment. This supports what is already known to be true – this state is facing a historic epidemic. Access to and funding for treatment is critical.

Figure 1

Single County Authority Expenditures State Fiscal Year 2014-15 by Fund Source Values

Single County Authority	Total DDAP Funds	Total County Funds	Total Other Funds	Total Funds
Allegheny	$ 11,404,875.00	$ 137,481.00	$ 4,284,768.00	$ 15,827,124.00
Armstrong/Indiana/Clarion	$ 1,378,507.75	$ -	$ 1,917,067.69	$ 3,295,575.44
Beaver	$ 1,220,865.00	$ 80,000.00	$ 531,669.82	$ 1,832,534.82
Bedford	$ 382,852.00	$ -	$ 311,230.00	$ 694,082.00
Berks	$ 3,078,753.00	$ 1,666,385.66	$ 3,105,914.48	$ 7,851,053.14
Blair	$ 1,358,449.00	$ -	$ 1,239,132.15	$ 2,597,581.15
Bradford/Sullivan	$ 452,249.13	$ 21,896.01	$ 33,591.12	$ 507,736.26
Bucks	$ 3,709,579.88	$ 214,316.00	$ 2,461,794.00	$ 6,385,689.88
Butler	$ 1,128,297.00	$ 24,921.76	$ 911,364.13	$ 2,064,582.89
Cambria	$ 1,030,500.00	$ 27,220.00	$ 389,609.00	$ 1,447,329.00
Cameron/Elk/McKean	$ 830,256.00	$ 80,186.00	$ 1,276,231.00	$ 2,186,673.00
Carbon/Monroe/Pike	$ 1,024,778.00	$ 154,618.00	$ 1,249,966.23	$ 2,429,362.23
Centre	$ 768,388.00	$ 31,566.00	$ 558,962.71	$ 1,358,916.71
Chester	$ 2,399,172.47	$ 394,777.00	$ 2,863,472.00	$ 5,657,421.47
Clearfield/Jefferson	$ 995,111.98	$ -	$ 679,492.24	$ 1,674,604.22
Columbia/Montour/Snyder/Union	$ 819,025.89	$ 15,300.16	$ 708,355.84	$ 1,542,681.89
Crawford	$ 712,193.67	$ 17,100.00	$ 1,127,244.00	$ 1,856,537.67
Cumberland/Perry	$ 1,615,541.00	$ 212,263.01	$ 1,113,023.54	$ 2,940,827.55
Dauphin	$ 2,387,468.92	$ 217,262.00	$ 1,253,155.56	$ 3,857,886.48
Delaware	$ 3,832,537.00	$ 92,707.00	$ 2,097,379.00	$ 6,022,623.00
Erie	$ 3,542,782.00	$ 281,864.00	$ 1,623,815.00	$ 5,448,461.00
Fayette	$ 1,052,738.00	$ -	$ 1,606,408.00	$ 2,659,146.00
Forest/Warren	$ 407,435.00	$ 8,160.00	$ 247,153.00	$ 662,748.00
Franklin/Fulton	$ 601,927.00	$ 46,511.42	$ 387,724.26	$ 1,036,162.68
Greene	$ 291,271.00	$ 9,230.00	$ 124,707.00	$ 425,208.00
Huntingdon/Mifflin/Juniata	$ 646,625.61	$ -	$ 351,811.00	$ 998,436.61
Lackawanna/Susquehanna	$ 1,831,809.00	$ 69,884.00	$ 884,448.00	$ 2,786,141.00
Lancaster	$ 2,474,878.00	$ 63,979.00	$ 1,924,758.78	$ 4,463,615.78
Lawrence	$ 777,012.75	$ -	$ 667,514.75	$ 1,444,527.50
Lebanon	$ 644,480.00	$ 143,079.00	$ 461,141.00	$ 1,248,700.00
Lehigh	$ 2,067,284.00	$ 86,949.00	$ 1,433,859.00	$ 3,588,092.00
Luzerne/Wyoming	$ 2,144,426.00	$ 118,822.00	$ 1,690,972.00	$ 3,954,220.00
Lycoming/Clinton	$ 1,147,502.00	$ 91,460.00	$ 1,555,892.00	$ 2,794,854.00
Mercer	$ 993,760.97	$ 45,000.00	$ 762,950.04	$ 1,801,711.01
Montgomery	$ 3,867,653.00	$ 135,362.00	$ 1,070,784.00	$ 5,073,799.00
Northampton	$ 1,663,016.00	$ 71,292.00	$ 1,496,937.00	$ 3,231,245.00
Northumberland	$ 554,576.00	$ 21,153.00	$ 430,506.00	$ 1,006,235.00
Philadelphia	$ 23,193,879.00	$ 2,011,904.00	$ 15,930,913.00	$ 41,136,696.00
Potter	$ 172,181.00	$ 25,933.55	$ 111,772.34	$ 309,886.89
Schuylkill	$ 1,167,872.52	$ 28,552.50	$ 689,267.80	$ 1,885,692.82
Somerset	$ 538,869.00	$ 17,446.00	$ 170,482.00	$ 726,797.00
Tioga	$ 327,062.31	$ 44,556.81	$ 127,968.94	$ 499,588.06
Venango	$ 454,914.00	$ 16,926.54	$ 490,601.76	$ 962,442.30
Washington	$ 1,401,687.58	$ -	$ 1,161,456.37	$ 2,563,143.95
Wayne	$ 305,968.00	$ 276,657.32	$ 230,594.65	$ 813,219.97
Westmoreland	$ 2,876,423.00	$ 38,302.00	$ 652,346.00	$ 3,567,071.00
York/Adams	$ 1,850,768.65	$ 99,999.96	$ 1,188,536.36	$ 3,139,304.97
TOTALS	**$ 97,528,202.08**	**$ 7,141,023.70**	**$ 65,588,742.56**	**$ 170,257,968.34**

Figure 2

Single County Authority Expenditures of DDAP Funds by Major Activity for State Fiscal Year 2014-15

Single County Authority	Total Administration	Total Prevention	Total Intervention	Total Treatment	Total Amount
Allegheny	$ 978,410.00	$ 1,921,557.00	$ 1,855,443.00	$ 6,649,465.00	$ 11,404,875.00
Armstrong/Indiana/Clarion	$ 204,828.28	$ 411,107.59	$ 36,490.10	$ 726,081.78	$ 1,378,507.75
Beaver	$ 244,169.19	$ 213,758.00	$ 4,000.00	$ 758,937.81	$ 1,220,865.00
Bedford	$ 76,570.00	$ 144,793.00	$ 138.00	$ 161,351.00	$ 382,852.00
Berks	$ 237,167.86	$ 626,931.14	$ 155,001.25	$ 2,059,652.75	$ 3,078,753.00
Blair	$ 168,554.04	$ 480,137.50	$ 55,416.01	$ 654,341.45	$ 1,358,449.00
Bradford/Sullivan	$ 86,792.79	$ 125,904.12	$ 51,556.08	$ 187,996.14	$ 452,249.13
Bucks	$ 779,556.61	$ 899,349.27	$ 388,889.00	$ 1,641,785.00	$ 3,709,579.88
Butler	$ 209,535.29	$ 305,729.57	$ 53,750.65	$ 559,281.49	$ 1,128,297.00
Cambria	$ 173,673.00	$ 185,843.00	$ 49,571.00	$ 621,413.00	$ 1,030,500.00
Cameron/Elk/McKean	$ 80,216.00	$ 143,130.00	$ 2,116.00	$ 604,794.00	$ 830,256.00
Carbon/Monroe/Pike	$ 142,270.00	$ 150,401.00	$ -	$ 732,107.00	$ 1,024,778.00
Centre	$ 88,672.38	$ 144,666.12	$ 13,380.00	$ 521,669.50	$ 768,388.00
Chester	$ 479,145.34	$ 406,128.13	$ -	$ 1,513,899.00	$ 2,399,172.47
Clearfield/Jefferson	$ 81,247.53	$ 370,982.86	$ 113,669.50	$ 429,212.09	$ 995,111.98
Columbia/Montour/Snyder/Union	$ 92,755.00	$ 146,824.87	$ 70,298.50	$ 509,147.52	$ 819,025.89
Crawford	$ 65,957.00	$ 244,941.67	$ 6,095.00	$ 395,200.00	$ 712,193.67
Cumberland/Perry	$ 194,622.91	$ 432,845.03	$ 26,678.00	$ 961,395.06	$ 1,615,541.00
Dauphin	$ 481,283.00	$ 780,171.92	$ 42,560.00	$ 1,083,454.00	$ 2,387,468.92
Delaware	$ 583,298.00	$ 913,402.00	$ -	$ 2,335,837.00	$ 3,832,537.00
Erie	$ 170,786.00	$ 1,242,079.00	$ 550,655.00	$ 1,579,262.00	$ 3,542,782.00
Fayette	$ 208,564.00	$ 216,739.00	$ -	$ 627,435.00	$ 1,052,738.00
Forest/Warren	$ 75,576.00	$ 87,730.00	$ -	$ 244,129.00	$ 407,435.00
Franklin/Fulton	$ 120,385.00	$ 104,726.00	$ 17,415.00	$ 359,401.00	$ 601,927.00
Greene	$ 58,178.40	$ 51,006.02	$ -	$ 182,086.58	$ 291,271.00
Huntingdon/Mifflin/Juniata	$ 113,343.61	$ 101,286.00	$ 22,957.00	$ 409,039.00	$ 646,625.61
Lackawanna/Susquehanna	$ 104,159.00	$ 596,535.00	$ 77,072.00	$ 1,054,043.00	$ 1,831,809.00
Lancaster	$ 159,813.66	$ 843,325.79	$ 48,104.00	$ 1,423,634.55	$ 2,474,878.00
Lawrence	$ 111,161.94	$ 195,378.63	$ 3,848.96	$ 466,623.22	$ 777,012.75
Lebanon	$ 98,516.00	$ 171,772.00	$ 60,104.00	$ 314,088.00	$ 644,480.00
Lehigh	$ 320,840.00	$ 394,342.00	$ 259,416.00	$ 1,092,686.00	$ 2,067,284.00
Luzerne/Wyoming	$ 118,105.00	$ 458,987.00	$ 95,569.00	$ 1,471,765.00	$ 2,144,426.00
Lycoming/Clinton	$ 173,104.00	$ 281,665.00	$ 11,947.00	$ 680,786.00	$ 1,147,502.00
Mercer	$ 156,907.60	$ 325,388.74	$ 14,857.65	$ 496,606.98	$ 993,760.97
Montgomery	$ 684,598.00	$ 528,152.00	$ 193,186.00	$ 2,461,717.00	$ 3,867,653.00
Northampton	$ 175,434.00	$ 322,109.00	$ 136,205.00	$ 1,029,268.00	$ 1,663,016.00
Northumberland	$ 110,174.00	$ 84,442.00	$ 63,985.00	$ 295,975.00	$ 554,576.00
Philadelphia	$ 2,683,230.00	$ 3,972,883.00	$ 1,572,900.00	$ 14,964,866.00	$ 23,193,879.00
Potter	$ 34,433.25	$ 36,636.75	$ 292.50	$ 100,818.50	$ 172,181.00
Schuylkill	$ 212,886.90	$ 177,014.42	$ 19,610.95	$ 758,360.25	$ 1,167,872.52
Somerset	$ 84,871.00	$ 114,028.00	$ 27,799.00	$ 312,171.00	$ 538,869.00
Tioga	$ 65,412.46	$ 67,383.51	$ -	$ 194,266.34	$ 327,062.31
Venango	$ 90,983.00	$ 119,844.77	$ 9,306.00	$ 234,780.23	$ 454,914.00
Washington	$ 229,707.18	$ 375,913.39	$ 9,820.00	$ 786,247.01	$ 1,401,687.58
Wayne	$ 58,699.00	$ 67,215.34	$ 16,092.38	$ 163,961.28	$ 305,968.00
Westmoreland	$ 453,461.00	$ 1,176,745.00	$ -	$ 1,246,217.00	$ 2,876,423.00
York/Adams	$ 327,636.01	$ 414,144.99	$ 12,828.58	$ 1,096,159.07	$ 1,850,768.65
TOTALS	**$12,649,690.23**	**$ 21,576,076.14**	**$ 6,149,023.11**	**$ 57,153,412.60**	**$97,528,202.08**