Drug and Alcohol Program Reports

The Pennsylvania State Plan for the Control, Prevention, Intervention, Treatment, Rehabilitation, Research, Education and Training Aspects of Drug and Alcohol Abuse and Dependence Problems
State Fiscal Year 1997/98

Annual Report for the period July 1996 through June 1997

Women and Childrens Annual Report

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Part 3: Women and Children’s Annual Report

as required by
Act 1972-63 (71 P.S. §1690.101 - 1690.114)
and Act 1993-65 (P.L. 177, No. 175)
Part 1

The Pennsylvania State Plan for the Control, Prevention, Intervention, Treatment, Rehabilitation, Research, Education and Training Aspects of Drug and Alcohol Abuse and Dependence Problems
State Fiscal Year 1997/98

required by Act 1972-63
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) and designated it 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 designated the Secretary of Health as the chairperson. 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 Single County Authorities (SCAs).

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.

In addition to its responsibility to develop a plan for drug and alcohol services, the Department is also responsible for approval and licensing of free-standing drug and alcohol 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 free-standing treatment facilities are provided in 28 Pa. Code Chapter 709.

Drug and alcohol treatment activities which 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., which 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 component within the health care facility which certifies that program areas meet the minimum standards germane to drug and alcohol treatment under the Pennsylvania Drug and Alcohol Abuse Control Act. See 28 Pa. Code § 711.2(b).

In addition to the program's enabling legislation and operating regulations, a provision of the federal Public Health Service Act, 42 U.S.C.A. § 300x et seq., places additional requirements on how drug treatment and prevention funds are used. This statute authorizes use of the Substance Abuse Prevention and Treatment Block Grant. The Department is designated as the Single State Agency 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.

While the Department has regulatory responsibility through its licensure authority over both public and private drug and alcohol facilities, the primary purpose is to develop a drug and alcohol
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. The funding to support this system, both federal and state dollars, are funding of last resort. That is, all other sources of funds are to be utilized first, including Medicaid before the Department’s funding streams. The primary funders of prevention and early intervention services in the Commonwealth are the Departments of Health and Education. The Departments of Health and Public Welfare (DPW) are the funders of Pennsylvania’s public treatment system.

Earlier this year, through reorganization, the name of the Department’s Office of Drug and Alcohol Programs (ODAP) was changed to the Bureau of Drug and Alcohol Programs (BDAP).
Chapter One

Single County Authority Requirements
SINGLE COUNTY AUTHORITY REQUIREMENTS

INTRODUCTION

In order to receive state and federal treatment and prevention funding, counties are required to designate SCAs responsible for program planning and the administration of federal and state funded grants and contracts. Some of the Commonwealth's 67 counties have created joinders with other counties for this purpose, resulting in the establishment of 49 SCAs. Four types of administrative structures exist: the Executive Commission (Public), the Executive Commission (Private), the Planning Council and the Independent Commission. These four structures provide counties with flexibility in how they choose to administer programs by allowing for establishment of either a public entity within its local government structure, a private non-profit body, or an entity under the auspices of the county mental health/mental retardation programs. Most services are provided by independent facilities under contract with the SCAs.

The Bureau of Drug and Alcohol Programs (BDAP) oversees a network of drug and alcohol programs and performs central planning, management and monitoring duties, while the SCAs provide planning for and administrative oversight to local drug and alcohol programs. These local programs provide education, prevention, intervention and treatment services to all individuals without restriction.

BDAP provides state and federal funding to local drug and alcohol programs through contracts with the SCAs. Most SCAs, in turn, contract with independent providers for treatment, prevention and intervention services, although some SCAs administer their own direct services through licensed or approved units commonly referred to as "functional units".

BDAP allocates funds to the SCAs through two mechanisms. One is funding based on county population data "across the board" to the 49 SCAs. This method constitutes the majority of state and federal funds allotted to the counties.

The second is Request for Proposals (RFPs), a process where BDAP determines that critical populations (e.g., addicted women) or important services (e.g., case management) need statewide coverage, direction and program/policy determination. Then BDAP issues RFPs and selects provider agencies to administer the programs. These agencies then receive contracts to provide these services.
SINGLE COUNTY AUTHORITIES

1.1 Statement of Policy

Pursuant to Section 1690.104 (71 P.S. §§1690.101-1690.115) Departmental Powers and Responsibilities, the Department is responsible for the development of "a State Plan". Per §§ 1690.104(a)(3), (a)(5), (a)(15) and (a)(17), the Department reserves the right to coordinate the agencies or organizations for the planning and administration of community-based services.

This Chapter is intended to establish a statewide system of agencies which shall have the responsibility for assisting the Department in planning for community-based services. It is the position of the Department that no central authority can determine precisely what services are necessary in each of the 67 counties of this Commonwealth. Consequently, the emphasis in this Chapter is on the establishment of community-based drug and alcohol prevention, intervention and treatment services.

1.2 Establishment of a SCA

(a) This Chapter authorizes, with prior written approval of the Department, the establishment of an SCA for the planning, coordination and administration of community drug and alcohol prevention, intervention and treatment services. Counties may form joinders with other counties to deliver these services. Any such joinder arrangement must be approved by the Department, and no county which has entered into a joinder may withdraw from such joinder without prior approval of the Department.

(b) In order to establish an SCA, the Local Authority shall:

1. Inform the Department of its desire to enter into the Statewide prevention, intervention and treatment system and receive written approval from the Department to establish an SCA;

2. Agree to comply with the requirements of the Department for such programs;

3. Appoint a citizen's group consisting of eleven to fifteen members which meets the requirements of §1.5 of this Chapter to advise in the planning, coordinating and administering of these services;

4. Designate a full-time person to plan, coordinate and administer these services; and,

5. Execute appropriate agreements for the receipt of departmental funds.

(c) In the case of the Planning Council/Executive Commission (Public), the final fiscal and management authority shall rest with the Local Authority. In the case of the Executive Commission (Private) and the Independent Commission, the governing body shall establish final fiscal and management authority policies which must be approved by the Department.

(d) In county joinders, if the Local Authority cannot agree as to which option to implement, each county shall have one vote. In the case of a tie, the decision of the county with the largest population shall prevail.

(e) If the Local Authority elects to change options (§ 1.3, relating to organization and structure of SCAs), they may do so by requesting permission from the Department.
1.3 Organization and Structure of SCAs

(a) Four types of SCAs are authorized:

(1) Planning Council Option - Under this option, the Local Authority may choose to establish a Drug and Alcohol Planning Council. This Council shall function as an advisory body, independent from the Mental Health and Mental Retardation (MH/MR) Board and/or the County Human Service Department Board, and it shall have the responsibility, along with the Drug and Alcohol Specialist, for planning, coordinating and administering funds for drug and alcohol services. Under this option, the SCA is a branch of county government and the Specialist is a member of the MH/MR staff or the County Human Service Department Staff;

(2) Executive Commission (Public) Option - Under this option, the Local Authority may choose to establish a new department within county government. This Commission shall function as an advisory body for planning, coordinating and administering funds for drug and alcohol services. Under this option, the SCA is a branch of county government and the Executive Director is a member of the Local Authority's staff;

(3) Executive Commission (Private) Option - Under this option, the Local Authority may choose to establish an Executive Commission which shall be a non-profit corporation organized in accordance with the Pennsylvania Non-profit Corporation Law, 15 Pa. C. S. § 5101 et seq. The Commission shall function as the governing body and shall have the responsibility for planning, coordinating and administering funds for drug and alcohol services. Under this option, the Executive Director and staff are employees of the Commission; and,

(4) Independent Commission - If the Local Authority fails to establish a Planning Council or Executive Commission or fails to comply with these requirements, the Department reserves the right to establish a qualified agency to fulfill all obligations of an SCA. If this situation should occur, then the duties, responsibilities and powers ascribed and delegated to Local Authority within this Chapter shall be transferred to the qualified agency's board of directors.

1.4 Duties of the Planning Council/Commission

(a) The duties of the Planning Council or Commission shall be as follows:

(1) To review and assess the need for services in relation to the incidence and prevalence of drug and alcohol abuse;

(2) To prepare the SCA Plan in accordance with guidelines issued by the Department and submit it to the Department for approval;

(3) To assist the Executive Director/Specialist in the assessment of drug and alcohol prevention, intervention and treatment services in the SCA;

(4) To adopt, amend and repeal bylaws governing the manner in which business is conducted;

Such bylaws shall be submitted to the Department for approval. Bylaws will be disapproved if they conflict with State laws or regulations;
(5) To monitor compliance/performance of SCA funded service providers in accordance with guidelines issued by the Department;

(6) To implement the Department's reporting requirements;

(7) To prepare an annual report to the Local Authority and the Department which presents accomplishments on all programmatic activities of the SCA and its service delivery system; and,

(8) To develop a full continuum of services and make them accessible based on the availability of funding.

(b) The Independent Commission Option and the Executive Commission (Private) Option have all of the powers and duties of a Planning Council or Executive Commission (Public) as outlined in subsection (a) of this section. In addition, the Independent Commission and the Executive Commission (Private) shall approve contracts, purchase services, and disburse funds required to implement the SCA Plan.

1.5 Composition of the Planning Council or Commission

(a) A Planning Council or Commission shall consist of 11, 13 or 15 members, chosen and constituted as described in this section. No member of the board or staff of an SCA-funded drug and alcohol service provider or the staff of the SCA may be appointed to the Planning Council or Commission. Any provider on the Council/Commission shall not compete for SCA funds during their term and for one year afterward.

(b) In order to include the health care community in the local planning process, one member of the Planning Council/Commission should be a staff member of an appropriate District Health Office or County State Health Center. This would be in addition to the 11 to 15 members and would be an ex officio, advisory position with no term limitations and no voting privileges. The SCA may limit this member's attendance to no less than four meetings a year. The SCA shall have documentation of an invitation to the appropriate District Health Office/County State Health Center to assign a representative to the Council/Commission.

(c) The Planning Council or Commission shall be representative of the community and shall include, but not be limited to, members representing the following categories:

(1) Criminal Justice;
(2) Education;
(3) Health Care Professional;
(4) An individual with a prior history of drug or alcohol dependency; and,
(5) Human Service Professional.

(d) At least one of the choices must be an individual 25 years or under at the time of appointment, and no less than 40 percent of the members may be of the same sex.

(e) At least two of the choices must be representative of minority populations (e.g., African American, Latino, Native American).

(f) In addition to a Planning Council or Commission, a Service Provider Advisory Task Force shall be formed. This Task Force shall provide a forum for provider input into action taken by the Planning Council or Commission.
(1) Each project may have a representative on the Service Provider Advisory Task Force.

(2) The Service Provider Advisory Task Force will select a chairperson who will be an ex officio member of the Planning Council/Commission. This person will have no voting privileges on the Planning Council/Commission but must comply with the term limitations as described in Section 1.6.

1.6 Appointments to Planning Councils/Commissions

(a) Each member shall be appointed for a three-year term and may be reappointed for a second three-year term.

(b) A member's term begins on the day of appointment, which shall be defined through written notice to each individual.

(c) No individual may serve on a Planning Council or Executive Commission for more than six years.

(d) A minimum of one year must lapse before an individual may be reappointed.

(e) Vacancies shall be filled within ninety days.

(f) All members must be residents of the county in which they serve. When a joinder of two, three or four counties occurs, the membership shall be divided equally among the counties. Remaining positions shall be representative of the counties with the larger population(s).

1.7 Bylaws

The Planning Council or Commission shall adopt and implement bylaws for the operation of the Planning Council or Commission which shall address, but not be limited to, the following:

(a) Annual election of officers;

(b) Duties of officers;

(c) Removal of members;

(d) Schedule and notice of regular meetings;

(e) Record of actions taken;

(f) Amendments to the bylaws; and,

(g) Establishment of committees.

1.8 Local Authority: Information to the Department

The Local Authority, or Commission, shall notify the Department of the establishment of, and all appointments to the Planning Council or Commission, including the filling of unexpired terms, using forms and procedures as prescribed by the Department.

1.9 Meetings
(a) Each Planning Council or Commission shall have at least ten meetings per year and not more than sixty days shall transpire between meetings. A majority of the Planning Council or Commission shall constitute a quorum.

(b) Meeting sites shall be located so as to be easily accessible to the public, including the handicapped.

(c) Notice of all meetings shall be published no more than 30 days prior to the meeting. The publication of the notice shall comply with the criteria set forth in the Sunshine Act, 65 P.S. § 273, "Public Notice".

1.10 Public Hearings

The Planning Council or Commission shall hold public hearings prior to the approval of the SCA Plan and any amendments. The Planning Council or Commission shall insure that adequate notice of such hearings is given to the public. Public hearings for the purpose of reviewing the SCA Plan shall not constitute a meeting, as defined in § 1.9 (relating to meetings).

1.11 Reimbursement

Members of the Planning Councils and Commissions shall serve without compensation other than reimbursement for travel and other actual expenses incurred in connection with called meetings and other Planning Council/Commission activities authorized by the membership. Expenses incurred by members of the Planning Council or Commission are reimbursed in accordance with the compensation regulations of the Department.

1.12 Executive Director or Drug and Alcohol Specialist Appointment

(a) The Local Authority/Commission shall appoint a full-time Executive Director/Drug and Alcohol Specialist in accordance with the SCA organizational structure as prescribed in § 1.3 (relating to organization and structure of SCAs). In the event of a vacancy in that position, an acting Executive Director/Drug and Alcohol Specialist shall be appointed immediately to occupy the interim position for a period not to exceed 180 days.

(b) The Local Authority/Commission shall recruit and appoint the appropriate candidate for the position in accordance with policies and procedures set forth by the Department.

(c) Prior to a final decision on the appointment of an Executive Director, the qualifications of the final candidates shall be submitted to the Department for review and approval of the qualifications.

1.13 Executive Director: Duties and Responsibilities

The Executive Director shall have the following duties and responsibilities:

(a) To develop, together with the Executive Commission, the SCA Plan;

(b) To administer the SCA Plan and the Departmental funding agreement;

(c) To attend Executive Commission meetings and to provide staff services to its members;

(d) To submit reports to the Department as required, using forms and procedures as prescribed by the Department;
(e) To review and monitor drug and alcohol service providers to which referrals are made;

(f) To maintain liaison with governmental and private community services, agencies and organizations, and state operated facilities;

(g) To assist in the preparation of an annual report as prescribed in § 1.4(a)(7); and,

(h) To assume fiscal responsibility for the implementation of the SCA Plan.

1.14 Drug and Alcohol Specialist: Duties and Responsibilities

The Drug and Alcohol Specialist shall have the following duties and responsibilities:

(a) To serve on the staff of the MH/MR Administrator or the Director of Human Services and to develop, together with the Planning Council, the SCA Plan;

(b) To administer the SCA Plan and the Departmental funding agreement;

(c) To attend Planning Council meetings and to provide staff services to its members;

(d) To submit reports to the Department as required, using forms and procedures as prescribed by the Department;

(e) To maintain liaison with governmental and private community services, agencies and organizations, and state operated facilities; and,

(f) To prepare and submit an annual report to the Local Authority and the Department which presents accomplishments on all programmatic activities of the SCA and its service delivery system.
Chapter Two

Fiscal Requirements
FISCAL REQUIREMENTS

2.1 Statement of Policy

The Department will establish fiscal requirements, policies and procedures as are necessary to account for all state, federal and county dollars that are supporting the state or county drug and alcohol prevention, intervention and treatment system.

2.2 Fiscal Relationship Between the State and the SCAs

The SCA shall be the primary contractor and/or grantee for funds allocated by the Department. The SCA shall be responsible for the monitoring of fiscal management and operations of all its subcontractors. The SCAs shall use the fiscal management system prescribed by the Department and are delegated the authority to implement these systems in projects in their respective counties.

2.3 Funding of Programs Other Than SCA Programs

The Department reserves the right to directly purchase services from projects designated as:

(a) Research projects;
(b) Training projects;
(c) Projects that have statewide and regional impact;
(d) Inter-departmental initiatives; and,
(e) Projects in a local area for which there is no approved SCA.

2.4 Eligibility for Funding

Each SCA shall receive an allocation of funds to provide or purchase services from licensed/approved drug and alcohol prevention, intervention and treatment programs. In order to be eligible to use these funds, the SCA must:

(a) have a plan approved by the Department for the delivery of prevention, intervention and treatment services in the SCA area;
(b) agree to comply with rules and regulations of the Department;
(c) agree to comply with federal requirements applicable to the use of funds;
(d) have an executed funding agreement with the Department;
(e) have an executed personnel agreement with the Department; and,
(f) comply with state and federal reporting requirements.

2.5 Match

(a) The match is the county's participating share of the SCA obligation and may be comprised of:
(1) Local tax revenues; and,
(2) Private or civic funds directly received by local authorities.

(b) The match may not include:
(1) Other state funds;
(2) Federal funds;
(3) In-kind services, or donated furnishings or equipment;
(4) Human Service Development Funds (HSDF);
(5) Third party income (i.e., health insurance);
(6) Interest earned on federal or state funds;
(7) DUI fines and fees; and,
(8) Client fees.

(c) A match of 10 percent is required for:
(1) SCA administration;
(2) All prevention and intervention activities; and,
(3) Outpatient services.

2.6 Last Source
(a) All income derived from client services must be utilized before Department funds.

2.7 Conflict of Interest
The SCA shall not make any contract for reimbursable services with:
(a) An elected or appointed county official or any member of their immediate family;
(b) A person, company or organization in which a member or family member of the SCA staff or the SCA Planning Council/Commission has financial interest; and,
(c) A member of the SCA staff, the Planning Council/Commission or a member of their immediate family. A member of the immediate family means a parent, child, spouse, brother, or sister.

2.8 Deficits
The Department shall not be liable for any deficit incurred by the SCA.

2.9 Annual Audits
Requirements for annual audits are contained in Appendix E (Audit and Inspection) section of Fiscal Year (FY) 1995/2000 contract under Appendix E between BDAP and SCAs.

2.10 Performance Assessment/Review

In accordance with the provision of § 4 (20) of Act 63 (71 P.S. §1690.104), the Secretary of Health will, at his discretion, direct that performance assessments be made of any program or project directly or indirectly receiving funds allocated by the Department. In addition, the Secretary is authorized by statute to direct a performance assessment of any program or project directly or indirectly receiving funds that were allocated by the Department.

Other fiscal requirements are cited in the BDAP/SCA FY 1995/2000 contract including prohibitions on the use of federal funds for hospital services and the need to request waivers to contract with for-profit entities.
Chapter Three

Prevention
PREVENTION

BACKGROUND

In spite of general decreases in the prevalence of legal and illegal drug use in recent years, substance abuse among adolescent and early adulthood remains a serious public health problem in Pennsylvania and nationwide.

In 1989, The Center for Substance Abuse Prevention (CSAP) surveyed 26 communities throughout the nation that had achieved significant success in reducing substance abuse within their populations inclusive of adolescents and young adults. They learned that each community had a comprehensive system of coordinated services shared among private and public agencies, including drug and alcohol, health & human services, schools, law enforcement, business, industry, media, churches, parent and youth groups. The comprehensive system of services, now known as the six Federal Strategies for prevention and early intervention services (referred to as the six Federal Categories of Prevention in Pennsylvania) provides a framework of planned researched strategies in:

- Information Dissemination
- Education
- Community Mobilization
- Problem Identification and Referrals
- Alternative Activities
- Environmental Change

Within the same time-frame, Drs. Hawkins and Catalano, researchers at the University of Washington, conducted extensive studies in communities throughout the country and found that a number of existing risk factors increased the chances of adolescents and young adults developing health and behavior problems. These risk factors were found to be present in four specific domains identified as:

- Community
- School
- Individual and Peer
- Family

They also found that certain protective or resiliency factors, when appropriately applied, substantially decreased the risks of substance abuse and protected the course of young people’s development as they adopted healthy behaviors and pro-social growth patterns.

In 1992, Dr J.R. Grossman, researcher for the University of Louisville, Kentucky, developed a process of “Developmental Evaluation” to measure the effectiveness of how well program services serve to reduce risk factors within targeted populations. The formulated process, which begins with a community needs/risk assessments, directs the course of measurable goals, objectives and comprehensive program services needed to significantly impact the reduction of risks within their appropriate domains.

By bringing together all of the above research, The Pennsylvania Department of Health, Bureau of Drug and Alcohol Programs (BDAP) assembled a systematic performance based process to help steer the course of prevention services for achieving successful long term goals in the reduction of risk factors.

MOVING TO A PERFORMANCE BASED SYSTEM

The performance based process endorses certain principles to ensure that each community has the full potential to create influential and effective approaches that are measurable in reducing substance abuse and improving the quality of life. These principles include:
shifting from activity-driven to qualitative and quantitative program planning, design, delivery and management;

developing measurable goals to reduce risk factors identified through community needs/risk assessments;

formulating comprehensive, measurable objectives, using the 6 federal categories for prevention as a framework for planning and delivering program services that build protective or resiliency factors;

utilizing promising prevention approaches based on state-of-the-art efforts and sound scientific research;

accessing workforce development training to build staff competency and skills in planning, implementing, delivering, evaluating and researching best practices and current technology in the field of substance abuse prevention;

building community investments and ownership by creating relationships involving multiple sectors of the community in achieving short term objectives and long term goals;

involving youth, parents, and families in planning and advertising community prevention events;

fostering and utilizing relationships with researchers to assist agencies and providers as consultants in developing appropriate instruments for evaluating program services; and,

collecting and evaluating data frequently to draw conclusions on program services and to assess the provision of services for achieving successful outcomes.

RISK REDUCTION

Just as certain environmental and personal behaviors (like smoking, high-fat diet and sedentary lifestyle) are statistically proven to be risk factors contributing to coronary heart disease, so are certain societal risks associated with substance abuse.

We know we can reduce coronary heart disease by reducing the associated risks. We also now know, through research, that we can reduce substance abuse by reducing its associated risk factors.

With substance abuse however, we enjoy an extra bonus because the risk factors are associated with other negative behaviors which also can be reduced as we impact a reduction in the risk factor.

The model selected by BDAP contains 23 risk factors that are grouped in four domains. These risk factors are an adaptation of work and research conducted by the CSAP and are derived from more than a decade of research conducted by Richard F. Catalano, Ph.D. and J. David Hawkins Ph.D. at the University of Washington. Grouped within their respective domains, they are as follows:
COMMUNITY
Economic & Social Deprivation......Low Neighborhood Attachment & Community Disorganization......Availability of Alcohol, Tobacco and Other Drugs (ATOD)......Community Norms & Laws That Facilitate Use of ATOD.

SCHOOL
Lack of Clear, Enforced Policy On The Use of ATOD...... Availability of ATOD School Transitions ...... Academic Failure ...... Lack of Student Involvement ...... Little Commitment to School

INDIVIDUAL AND PEER
Early Antisocial Behavior ...... Alienation and Rebelliousness ...... Antisocial Behavior in Later Childhood and Early Teens ...... Favorable Attitudes Toward Drug Use ...... Susceptibility to Peer Influence ...... Friends Who Use ATOD

FAMILY
Lack of Clear Behavioral Expectations ...... Lack of Monitoring/Supervision ...... Lack of Caring ...... Inconsistent or Excessively Severe Discipline ...... Parental Positive Attitudes Toward ATOD Abuse ...... Low Expectations for Children’s Success ...... History of Alcohol and Other Drug Use.

COMPONENTS OF THE PERFORMANCE BASED PROCESS
Performance Based Prevention is a systematic process in which all components work in tandem with each other toward achieving measurable outcomes and long-term goals for reducing risks associated with substance abuse.

* Needs / Risk Assessments

Periodic need/ risk assessments are conducted to determine the level and severity of risk factors within a specific domains. Assessments are conducted using the Community Oriented Needs Assessment (CONA) process which targets key informants, demographic statistical profiles and consumer client information to assess risk factors and obtain baseline information.

* Measurable Goals

Measurable long-term (3-5 year) goals, each containing one risk factor and one indicator to measure the reduction of risk, are developed and targeted to the geographic region, specific domain or population within the service area. The reduction of risks are monitored and evaluated using appropriate instruments of measure inclusive of follow-up evaluations.

* Measurable Objectives and Program Services

Broad based measurable objectives and program services are developed year-to-year progressively to intensify successful outcomes in achieving the long term goals. Objectives and program services are based on the six federal categories of prevention and are consistently monitored and evaluated to determine effectiveness and opportunities for improvement. BDAP prevention and monitoring teams analyze progress through quarterly reports and site visits and provide technical assistance to assist agencies in meeting their qualitative and quantitative anticipated outcomes. Workforce development training is
provided to assist agencies and providers with the necessary skills needed to successfully accomplish their tasks in planning, delivering and evaluating objectives and program services.

THE BENEFITS OF A PERFORMANCE BASED SYSTEM

* Moves agencies from activities to performance driven services that are based on the local needs of the community.

* Provides management techniques that allow agencies and service providers to analyze, evaluate and adjust program services to maximize the impact of prevention within the targeted populations they serve.

* Promotes greater accountability at all levels when using public and private investments for prevention.

* Encourages local community ownership and engages community involvement in reducing problems identified by the community.

* Provides state and local drug and alcohol agencies with researched evidence of what works and what doesn’t work in reducing substance abuse within diverse geographic and demographic areas of the state.

* Establishes documentation that can be shared with local, state and federal policy makers on results achieved for dollars invested in prevention.

The Pennsylvania performance based process is at the cutting edge of technology for determining the appropriateness, effectiveness and value of prevention program services. As agencies, providers and communities use this process, they will be creating new, measurable successes in substance abuse prevention. Additionally they will have the advantage to foster stronger relationships with community organizations that serve as the foundation for continued improvements in the quality of community life.
Chapter Four

Treatment
MANAGEMENT INFORMATION SYSTEM (MIS)

BDAP has committed to the development of an automated electronic MIS to support the collection, analysis, evaluation and reporting of Performance Based Prevention services. The system has the capability to electronically transfer data between provider agencies, SCAs, BDAP and federal agencies. Piloting of the system within selected SCAs and provider agencies will occur between September 22, 1997 and October 31, 1997. Statewide training and implementation is scheduled for January-March 1998. All SCAs and their contracted providers will be fully operational in transfer of data by July 1, 1998.

CASE MANAGEMENT

In 1994, BDAP initiated a process to fund SCAs to provide drug and alcohol case management services to publicly funded clients. Case management services are distinct service units which are separate from all treatment activities. Case management is defined as an organized system of coordinated activities developed to ensure client continuity of services, treatment and ancillary services and efficient and effective use of available resources to meet the needs of drug and alcohol clients. Case management service activities include, assessment of client needs; level of care determination and referral to appropriate treatment agencies; service authorizations, continued stay review and reauthorization; planning and coordination; linking clients to appropriate services, and monitoring of treatment and support services delivered. In State fiscal year 1997-98, BDAP will provide SCAs with $5,311,272 to deliver case management services to clients.

When the case management system was developed in 1994, the services were specifically available for Act 152 funded clients. Act 152 was legislation that authorized non-hospital drug and alcohol services for clients receiving Medical Assistance benefits. Case management services are no longer targeted to the Act 152 clients and the guidelines for services are not applicable to the current clients being served. The original case management guidelines, the “Act 152 Related Case Management Services Description” which were developed in January 1994, are being reevaluated and enhanced to reflect case management services as they are presently being delivered.

Following a preliminary rewrite of the case management guidelines by BDAP staff, the new services description, the guidelines by which case management units are to perform their services, will be reviewed by SCA case management staff throughout the Commonwealth. In September 1997, the draft guidelines will be presented to two groups of selected case management staff in the southeast region and the western areas of the state. In October 1997, case management staff from SCAs in the northeast region of the Commonwealth will be invited to review the guidelines and offer their input. The final version of the case management services description will be distributed statewide in January 1998.

In June 1997, BDAP conducted a survey of SCA case management units to collect data on a variety of topics including demographics of the unit, data collection capabilities, staff to client ratios, and training needs. Information from that survey resulted in the publication of a Directory of Case Management Services. The Directory was published in August 1997, and was distributed to all SCA case management units. The publication lists case management unit locations, staff, and hours of operation for each SCA. Additional information from the survey will be used in the development of the revised Case Management Services Description discussed above.

During the 1997-98 fiscal year, BDAP developed an in-depth and comprehensive monitoring packet to review SCA case management services. Using the monitoring instrument, a formalized and structured review of SCA case management units will be conducted. The review will focus on a regulatory review of case management services to assure compliance with BDAP case management standards. Following the review of services, BDAP will provide technical assistance to case management units that are not meeting BDAP’s expectations of successful case management practices. BDAP’s case management staff will work closely with staff of the Division of Quality Assurance to review SCA case management services.
QUALITY ASSURANCE

Recently, the Division of Program Monitoring was renamed the Division of Quality Assurance in order to better reflect the role of the Division. Program “monitoring” implies a sense of status quo whereas quality assurance promotes ongoing change and improvement. The goal of quality assurance is an improved service delivery system. Most quality assurance efforts are broad based and include the direct observations of service delivery, review of records and interviews with clients, staff and other stakeholders. The Division will be emphasizing these aspects.

BDAP plays a key role with respect to ensuring the availability and accessibility of alcohol and other drug treatment throughout the Commonwealth, assuring the provision of case management services, and monitoring performance based prevention efforts. Further, BDAP has the responsibility to ensure that SCAs have high quality service delivery systems which include timely access to, and the appropriate utilization of, services for all drug and alcohol clients. Additionally, among other efforts, BDAP must assure that state and federal dollars are used for the set of services which will yield the best outcomes, that a comprehensive case management system be developed and maintained, and that a utilization review process is in place across the Commonwealth.

In the past, the Division of Quality Assurance (formally the Division of Program Monitoring) has focused on SCA administrative and contract compliance and efforts have not focused on the systematic delivery of services or on outcomes. Now, much greater attention is being given to the need for a comprehensive assessment and analysis of system functioning at the local level with particular emphasis on the development of a full continuum of care, the appropriate utilization of PCPC, and efforts to increase services to pregnant women and women with children.

The SCA Quality Assurance Assessment that has been developed is designed to highlight the strengths of the SCA and its service delivery system and to identify areas that may benefit from technical assistance with the goal being continual quality improvement. The data that will be collected through this process is both quantitative and qualitative and will yield significant information about the overall state of the service delivery system including identification of service gaps.

At present, the Division of Quality Assurance emphasis will be on program (SCA) performance rather than on (treatment) provider performance. However, in the near future, the Bureau will begin to focus on performance based treatment outcomes as alcohol and other drug treatment continues to receive intense scrutiny, particularly in light of “managed” behavioral care and welfare reform.

The are a number of other activities in which the Division of Quality Assurance is involved. In addition to the assessment of SCA system functioning, the Division of Quality Assurance provides technical assistance to SCAs and other agencies. The Division has been working closely with the Department of Public Welfare in the monitoring of Act 152 and the Behavioral Health Special initiative. Additionally, during the past year, staff of the Division of Quality Assurance have participated with DPW on the state monitoring teams for the “Health Choices” initiative to ensure that the integrity of the drug and alcohol system is maintained.
Chapter Five

Training and Public Information
TRAINING AND PUBLIC INFORMATION

BDAP provides for a centrally managed training system, as well as a statewide information and education clearinghouse. Our training and technical assistance system is available to human service professional staff across the Commonwealth, and is designed to meet the staff development needs of that population. The information and education system is administered through the Pennsylvania Substance Abuse and Health Information Center (PennSAHIC), which is the clearinghouse for the Department’s drug and alcohol services.

The goals of this system are two-fold. The first, and primary goal, is to upgrade the professional skills of the drug and alcohol, and public health fields. The second is to increase the knowledge and skills of all human service providers in addiction, to keep them abreast of abuse and addiction issues. These two systems impact the human service professional as well as the individual who is experiencing a problem with substance abuse either directly or indirectly through a family member, friend or spouse. They also complement and reinforce one another, as the PennSAHIC provides substance abuse research and trend information to human service personnel who are serving substance abusing clients. Also, many of the BDAP trainers rely on the PennSAHIC services for current data and materials. PennSAHIC also directly serves the public, and is unique from that perspective. All other BDAP services are targeted to human service professional or volunteer staff.

The PENNSYLVANIA SUBSTANCE ABUSE AND HEALTH INFORMATION CENTER (PennSAHIC)

In 1991, BDAP expanded the public information services, formerly offered through ENCORE. PennSAHIC, the Department’s Substance Abuse and Health Information Clearinghouse was created to meet this need. PennSAHIC services are available to all residents of the Commonwealth. Information is available to a wide range of organizations and individuals, from grade school students to professionals in the field of substance abuse and addiction.

PennSAHIC distributes in excess of 150,000 pieces of literature (posters, pamphlets, brochures, etc.) monthly. Requestors may contact PennSAHIC by mail or through a toll free 800 telephone number. PennSAHIC supports a video and reading library, distributes videos on substance abuse and public health topics to organizations statewide, and is charged with providing materials which address a large variety of groups and age levels on substance abuse. PennSAHIC also provides research on substance abuse topics which affect the Commonwealth, runs media campaigns, and conducts a drug and alcohol referral system for individuals seeking substance abuse intervention and treatment.

PennSAHIC is also the Regional Alcohol and Drug Awareness Resource Network (RADAR) Center for the Commonwealth. RADAR is managed by CSAP through funding from the National Association of State Alcohol Drug Abuse Directors (NASADAD). Each State has a RADAR Center which works cooperatively with the National Clearinghouse for Alcohol and Drug Information (NCADI) to receive additional guidance for that state’s particular needs. The states have one primary RADAR Center and the option of up to 50 Associate Centers. At present, the Commonwealth has 42 Associate RADAR Centers. The Associate Centers are linked to the federal distribution center, the states and each other through an electronic bulletin board. The State and Associate Centers are key access points providing assistance to local drug and alcohol agencies.

Since its initiation, the demand for PennSAHIC services has significantly increased. PennSAHIC also serves as coordinating editor for the Department’s BDAP Newsletter which provides updates on programs, training and substance abuse trends in the Commonwealth. This newsletter is distributed statewide to all SCAs, drug and alcohol programs, and other agencies which serve substance abusing clients.

PennSAHIC selects its materials from a wide range of federal, state, and private agencies affiliated with substance abuse and public health education. All PennSAHIC materials are reviewed by a committee
comprised of statewide representatives.

With the creation and continuing expansion of clearinghouse services through PennSAHIC, the Department now has a mechanism with which to provide public health and substance abuse education/information statewide.

The BDAP TRAINING SYSTEM

BDAP training staff administers a system which is charged with providing staff development opportunities which raise the professional expertise of human service professional staff serving substance abusing and public health clients. The training system uses over 100 different consultants and offers in excess of 350 courses. Courses are routinely modified in order to address the needs of various programs and populations statewide, as well as to address new and emerging trends. Staff has found that two components are essential to meet these goals. First, the training offered must have “hands on” opportunities to enable staff to try out new skills, or to sharpen old ones. Second, training must be designed to answer specific needs in response to the education, profession, program type, regional philosophy and ethnic/racial composition of both the professional staff to be trained and the client population those staff are serving.

Two key ingredients of this system are the Training Advisory Committee (TAC) and the Registry of Trainers. TAC is composed of individuals who represent the major drug and alcohol professional organizations in the Commonwealth. Representatives from the Commonwealth Prevention Alliance, Chemical Abuse Certification Board, Therapeutic Communities, Public Health Nurses, HIV/AIDS as well as others serve as TAC members. These individuals are charged with representing their constituents’ concerns in both training topics and course content. TAC members are also called upon to help develop courses, as the need occurs. In addition, TAC members serve as monitors at all of the BDAP Training Institutes.

The Registry of Trainers is the listing of courses and trainers which provide services for the BDAP training system. BDAP has recruited trainers from across the Commonwealth and nationally to deliver a wide range of substance abuse topics, and we are in the process of expanding more fully into the area of public health. Prior to acceptance as a BDAP trainer, individuals are evaluated as to their course knowledge and training skills.

In order to offer a training system which is responsive to the developmental needs of a host of human service professional staff at all skill and professional levels, the BDAP training system has developed the following training initiatives:

**SPRING AND FALL TRAINING INSTITUTES**

These statewide training events are high quality, intensive, week long training opportunities which develops skills and promote understanding of specific prevention, intervention and treatment topics pertaining to drug and alcohol and public health issues. In addition, the Training Institutes provide networking opportunities among attending personnel. These training events are designed for front line drug and alcohol staff, public health, and other human service professionals. The average daily attendance is 600.

The Training Institutes consist of approximately 14 different courses daily for a total offering of 35 - 37 courses weekly. The basic training track, which is offered at every Institute offers the core curriculum of basic addiction education. This curriculum is offered for the constant pool of new staff coming into the field every year.

The Institute courses and course content are selected with the help of the Training Advisory Committee who make recommendations to BDAP staff. State and federal initiatives are incorporated as needed. TAC serves as an advisory body to BDAP and is composed of 13 members from drug and alcohol and public health organizations across the Commonwealth.
All courses are approved for Certified Addiction Counselor (CAC) and Certified Prevention Specialist (CPS) certification training credits through the Pennsylvania Chemical Abuse Certification Board. One clock hour is equivalent to one hour of certification. Training certificates are only issued to those participants who complete the entire duration of a course. Undergraduate and graduate credits are available through the Pennsylvania State University.

BDAP offers regular and partial scholarships to help defray the cost of training expenses. Priority for all scholarship awards are for individuals working full time in direct service, non-profit, licensed facilities and who have worked less than one year in their position. A regular scholarship covers lodging and meals and in return, the recipient provides assistance to the training staff in some of the jobs associated with conducting a training institute. Partial scholarships do not cover room and board, but significantly reduce the registration fee.

**ON-SITE**

On-site training is a course that is held at or near the requestor’s facility (on-site) and is geared to the needs of the personnel to be trained.

On-site training is provided to all SCAs licensed drug and alcohol facilities and service providers across the Commonwealth. BDAP allots a total of six training days per year to each SCA. The SCAs are responsible to assess the training needs in their area and request training which meets the staff development needs of their providers. Individual programs may request On-Site training days with the approval of the SCA, and these days are counted against the SCA’s On-Site training allotment.

Requestors have the option and responsibility of applying to the Pennsylvania Certification Board for certification credits for their On-Site courses. On-Site courses meet the initial educational requirement for all levels of certification by the Pennsylvania Chemical Abuse Certification Board.

**SPECIAL INITIATIVES TRAINING/RENEWAL RETREATS**

Special Initiatives Trainings are trainings designed to meet a need in response to a substance abuse trend affecting the Commonwealth, or in an area of high staff development need. Past events have included cross training in the areas of tuberculosis, HIV/AIDS, sexually transmitted diseases, hepatitis and psychopathology for substance abuse and community nursing personnel.

In addition, BDAP holds yearly Renewal Retreats designed in response to front line substance abuse staff needing the opportunity to explore their own personal issues in a safe environment. Renewal Retreats help staff provide better services to their clients, especially when the client issues impact on an area staff has explored.

Due to the trend nature of these events, Special Initiative Trainings are always dynamic. The focus of these events change from year-to-year in response to the forces which affect the substance abuse field.

**HIV/AIDS STATEWIDE TRAINING**

As alcoholics, drug addicts and, especially intravenous drug users are high risk groups for the HIV/AIDS virus, Training and Public Information staff has been working closely with the Division of HIV/AIDS to present staff development training which will impact positively on these populations through education of front line staff. Front line staff who are serving drug and alcohol abusing clients must be knowledgeable about the high risk behaviors of their clients in order to counsel them on ways to decrease the risk of HIV infection. Front line staff must also become knowledgeable about the opportunistic/resurgence of diseases associated with HIV/AIDS infection in order to protect both themselves and their clients.
BDAP, in conjunction with the Division of HIV/AIDS, has developed a statewide team of trainers who have been trained in the ten federal AIDS training packages. Since January 1993, this team of trainers have presented regional trainings across the Commonwealth for front line staff focusing on the issue of substance abuse and HIV/AIDS Prevention.

PENNSYLVANIA CLIENT PLACEMENT CRITERIA (PCPC) TRAINING

In fiscal year 1996, BDAP’s Division of Training assisted the Division of Prevention, Intervention, Treatment and Care Management with the initiative of implementing PCPC across the Commonwealth to drug and alcohol agency personnel. This initially began on a consultant basis that included making specific recommendations to enhance the PCPC TOT curriculum, and monitoring training events for quality assurance. The Division of Training subsequently became the lead in maintaining a registry of certified PCPC trainers and tracking the sites of all PCPC training across the Commonwealth.
Part 2

Annual Report
for the period
July 1996 through June 1997

required by Act 1972-63

ANNUAL REPORT
ACCOMPLISHMENTS AND INITIATIVES

The Department of Health’s (Department) Bureau of Drug and Alcohol Programs (BDAP) has a major responsibility to allocate federal and state funds to local communities to support prevention, intervention, and treatment programs. A second responsibility is to maintain oversight through monitoring and to develop in conjunction with counties and providers prevention, intervention and/or treatment efforts through the creation of new programs or by fine-tuning existing ones. Often this requires sensitivity to the needs in a particular geographic region or of particular subpopulations. This section describes some of the major federal and state program initiatives and the impact of these programs where current data are available.

PREVENTION

PERFORMANCE BASED PREVENTION SERVICES

In 1995, BDAP began researching methodologies that could be used to measure short and long-term outcomes of prevention services supported with federal, state and local funds. The purpose of this mission was two-fold: to expand our vision beyond the scope of program services in seeking solutions to reduce substance abuse and raise the level of “wellness” among individuals; and develop a systematic process able to measure the results of our investment in prevention. A research-based prototype was developed for prevention and pilot tested by BDAP Approved Prevention Providers at five regional sites in the Commonwealth during June, 1996. Approximately 215 agency representatives attended the sessions in addition to 65 trainers who were trained to deliver the training to front-line community organizations that receive BDAP funds to provide prevention services.

The Statewide Performance Based System incorporates the following changes in managing and delivering prevention services:

* conducting localized needs/risk assessments to plan long term goals and prioritize services that will be funded with government dollars to achieve the anticipated measurable results;

* developing County Plans with anticipated measures for reducing specific risk factors within targeted populations;

* framing and focusing on long-term goals (3-5 years) containing measurable objectives and strategies specifically targeting realistic percentages in reducing identified risk factors; and,

* utilizing developmental evaluation practices to measure process, outcomes of services and impact of goals.

Single County Authorities (SCAs) conducted needs/risk assessments to establish baseline data for developing measurable goals, objectives and services to reduce risk factors existing within their respective service areas.

The Community Oriented Needs Assessment (CONA) Model was used for collecting data to generate useable information on risk and protective factors that exist within the family, school and community environments. SCAs shall conduct an analysis of these findings to develop their long range goals and prioritize prevention/early intervention program needs they will fund to achieve their goals.

STUDENT ASSISTANCE PROGRAMS

The Student Assistance Programs (SAP) service middle and high school students who have been identified as having school performance or behavior problems due to alcohol and drug use, depression or other mental health problems. SAP has been implemented in all 501 school districts in Pennsylvania. SAP is one of the
unique strategies to meet the Governor’s goals and objectives for drug and alcohol prevention. During the 1995/96 Fiscal Year, 13,973 students were assessed and referred to drug and alcohol services. A total of 54,457.03 Consultation Hours were provided by the SCAs around the state. SAP is linked to the Performance Based Prevention process identified risk factors, and fulfills federal requirements of the Identification and Referral category.

**MONITORING**

**ACCOMPLISHMENTS**

Field staff of the Division of Quality Assurance performed on-site compliance and quality assurance assessment reviews of 44 SCAs to determine how well these local administrative entities performed their core operational functions such as local planning efforts, subcontracting requirements, service provider monitoring and data reporting, as defined by the Department’s contract work statement. On-site assessments also included the collection of information on the Substance Abuse Prevention and Treatment (SAPT) requirements. A survey tool was designed to assess the level of block grant compliance attained by each SCA and covered areas such as service provider ability to implement block grant requirements, interim services provisions, capacity management system capability, expenditures for pregnant women, and outreach models to encourage IV treatment.

Staff participated in program administration activities associated with the continuation of regional administration for Act 152 Program funded treatment for inpatient non hospital detoxification and rehabilitative care administered through Regional Administrative Units (RAUs). Staff assisted the Department of Public Welfare (DPW) with transition activities related to a reduction of eight RAUs to three regional sites statewide and assisted in developing guidelines and monitoring the performance of RAU responsibilities which included distribution of treatment funds, rate reviews, subcontracting with treatment providers, invoice approval and payment, medical assistance eligibility reviews, written service authorizations and required state reporting.

Staff also participated in the implementation of welfare reform measures enacted by Act 35 which affected service eligibility requirements for medical assistance clients in need of drug and alcohol treatment. The basic provisions of Act 35 were twofold: first, it requires DPW to strengthen procedures for determining a recipient’s ability to work (which is the major criteria for receiving General Assistance (GA) cash and medical assistance (MA)); and secondly, MA benefits through the GA-Medical Needy Only (GAMNO) category is to be restricted to high priority groups only. In order to reduce the impact of the changes brought on by welfare reform, DPW provided funding through the Behavioral Health Special Initiative (BHSI). This funding initiative became the companion piece to this legislation by creating a benefit package for recipients no longer eligible for drug and alcohol treatment services funded by the MA program. Staff activities in these initiatives included the development of the financial and program parameters for implementing the BHSI, review of the SCA’s implementation plan, development of a utilization database for reporting service activity provided by the BHSI, and the provision of technical assistance through regional meetings and on-site follow up reviews of SCAs.

Staff participated in a wide range of activities associated with the implementation of the DPW’s HealthChoices initiative. HealthChoices is DPW’s behavioral health mandatory Medicaid managed care program for MA recipients residing in the five southeastern counties of the state (i.e., Bucks, Chester, Delaware, Montgomery, and Philadelphia counties). The physical and behavioral health management components of the HealthChoices program were implemented through separate procurements effective February 1, 1997, with county government receiving first right of acceptance to manage the behavioral health care component for Medicaid recipients for their respective county. Activities included participation in sub-committee work for development of the Request for Proposals (RFPs), development of program performance standards, contract and monitoring requirements, and a data book which included historical cost,
demographic and utilization data on drug and alcohol treatment services provided to the Medicaid population. Staff also participated in the review phase of the counties’ responses to the RFP, conducted on-site readiness reviews to determine the degree of performance capability of the behavioral health Managed Care Organization (MCO) contractor and their MCO subcontractors. Staff performed responsibilities at the contractor’s work site related to project implementation status and issue resolution, and served on the project’s technical assistance work group.

**TREATMENT**

**CASE MANAGEMENT**

BDAP implemented statewide case management services for the purpose of improving access and coordination of a continuum of care and support services for MA recipients throughout the Commonwealth of Pennsylvania (Commonwealth), thus enhancing the client’s ability to achieve and maintain abstinence. Case management does this by providing frequent and direct contacts with client’s significant others, service agencies, etc. Activities include assessment, service planning, linking the client to services, monitoring their participation, assisting the client to develop a positive support network, and advocating for the client if needed services and resources are not readily available. During FY 95-96, $5.3 million was allocated to SCAs to provide case management services.

**WOMEN AND CHILDREN FUNDING POOL**

BDAP has made available a “90/10 funding pool” which SCAs can access to purchase long-term, non-hospital treatment services for addicted pregnant women and addicted women with children. For additional information, see the Women and Children’s Treatment Services Annual Report elsewhere in this document.

**HALFWAY HOUSE SERVICES FUNDING POOL**

BDAP established a "90/10 funding pool" which SCAs can access to purchase halfway house services to provide treatment and support services to persons with substance abuse problems. These clients have already received intensive inpatient treatment for their substance abuse dependency and now need employment, vocational, or financial counseling in addition to counseling regarding an independent community living situation. Through this funding pool, BDAP pays for 90 percent of the client's treatment costs and the county pays the 10 percent balance.

During FY 1995-96 19 facilities and 64 counties participated in the 90/10 funding pool arrangement. BDAP authorized 81,071 days of treatment services. For FY 1995-96, the State's 90 percent share of costs for this program was $3,029,218; the counties 10 percent share was $321,503.

**SERVICES TO THE HOMELESS**

$1.983 million has been provided to DPW to provide services to the homeless, which includes Bridge Housing and specialized services to families.

Bridge Housing Program services are provided in Allegheny and Philadelphia County. The program provides housing and case management services to homeless clients with substance abuse problems. Clients are housed in scattered site apartments or Single Room Occupancy (SRO) arrangements, and are eligible to participate in the program for 12 months. BDAP funds support housing, counseling services, life skills education and drug and alcohol support services. The primary goals of the program are stable housing and a substance abuse free life style.
In Allegheny County there are seven providers and in Philadelphia there are six service providers. A total of 3,340 new clients were accepted in the program.

PEER REVIEW EVALUATION PROCESS

The Peer Review program has been developed for Pennsylvania by the Center for Addiction Services (CAS) at St. Francis Medical Center under a contract with BDAP. The purpose of the peer review is to provide an independent assessment of programs on the basis of the quality, appropriateness and efficacy of their treatment services. Effort is made to avoid items that are covered through the licensing process, although a certain amount of benchmark data is included for advance review before a site visit takes place.

Since the configuration and structure of the treatment service providers are so varied over the entire continuum of care settings, it was decided that focus would be given each year to only one type of service. Initially reviewing service for women with children and maternal addiction services, subsequent years have seen the review of halfway houses, partial hospitalization programs, and adolescent residential programs.

PHILADELPHIA TARGET CITIES/TREATMENT IMPROVEMENT PROJECT

This project is a $4.7 million award from the U.S. Department of Health and Human Services, Center for Substance Abuse Treatment (CSAT), and is specifically for the City of Philadelphia. The primary focus of the project, however, will be in North Philadelphia, the area of the city with the greatest prevalence of substance abuse. Special emphasis is being given to public housing residents, pregnant women, and female addicts and their children. The largest public housing development in Philadelphia, Richard Allen Homes, will be targeted for this project.

The $4.7 million award was for the second year of a three-year funding period. Pending availability of funds in each of the final two years, a similar amount will be awarded. Additional federal funds attached to Target Cities Program from other sources will make the total award to Philadelphia more than $10 million over the three year period.

Philadelphia's Treatment Improvement Project entails the implementation of five interrelated components designed to enhance the existing substance abuse treatment system. Through these enhancements, the project will demonstrate that the quality of substance abuse treatment services will be improved.

ACT 152: REIMBURSEMENT FOR NON-HOSPITAL RESIDENTIAL TREATMENT

In December 1988, the Pennsylvania Legislature passed Act 152, which expanded the continuum of drug and alcohol treatment services by permitting MA reimbursement for residential, non-hospital detoxification and rehabilitation services. This provided a major new service level for MA clients suffering from substance abuse or dependency.

Implementation of Act 152 was phased in over a five-year period, beginning with five SCAs in 1989 and expanding to eight SCAs (designated as Regional Administrative Units) in May, 1993. The RAUs were established to receive and administer the expenditure of Act 152 funds for all 47 SCAs.

Fiscal year 94/95 was the first full fiscal year for statewide implementation of Act 152. During this time, 10,712 persons received non-hospital detoxification and non-hospital residential rehabilitation services at a cost of $41.5 million. Not only did Act 152 bring additional MA dollars into the drug and alcohol system, it also allowed SCAs to redirect state-based dollars previously used to fund non-hospital residential treatment into other levels of care within the drug and alcohol service continuum. In fiscal year 95/96, 9,936 clients received services at a total cost of $37,995.

ACT 152: A RESEARCH INITIATIVE WITH VILLANOVA UNIVERSITY
In order to develop the placement guidelines mandated by the Act 152 legislation (see Act 152 above), the evaluation contract with Villanova University was amended to perform additional research and outcome analysis of clients coming through the Act 152 pilot sites. Villanova researchers, plus staff from the Departments of Health and Public Welfare brought together experts in the drug and alcohol field and in survey design to develop a protocol to study client-treatment matching. This study assessed the reliability of the state's piloted assessment instrument, the Addiction Severity Index, evaluated treatment outcomes to identify correlations between outcomes and pre-treatment impairment and transformed these results into placement guidelines.

STATE CORRECTIONAL INSTITUTION PROGRAMMING

Approximately $2.1 million has been provided to the Department of Corrections to provide treatment services in the state correctional institutions. Therapeutic communities provide substance abuse treatment services to inmates at Cresson, Graterford, Muncy, Waymart, and Rockview. The therapeutic communities are licensed by the Division of Drug and Alcohol Program Licensing.

Funding for the FY 1995-96 contract is for two 50-bed therapeutic communities at Waymart and one 50-bed therapeutic community at Muncy. The contract also funds 41 Drug and Alcohol Specialist positions to provide less intensive drug and alcohol services, including group discussion and education to the general population in the institution. More than 5,000 (out of 31,000) males were enrolled in a drug and alcohol education and counseling program.

THE PENNSYLVANIA CLIENT PLACEMENT CRITERIA

The Commonwealth of Pennsylvania has developed and is currently implementing a comprehensive placement instrument for drug and alcohol clients: The Pennsylvania Client Placement Criteria (PCPC) for Adults. The PCPC was developed due to legislative decree for clients funded under Pennsylvania’s ACT 152 of 1988, and more recently, by the Governor’s Drug Policy Council relating to the oversight of Health Maintenance Organizations.

In February 1993, a Treatment Task Force consisting of clinical personnel, administrators, researchers, advocates and government representatives was convened in order to develop a standardized instrument for client placement. The criteria addresses a full continuum of care based on clients’ needs and the service delivery system in Pennsylvania. It improves on matching clients needs with services as well as setting guidelines for assessing the necessity of continued treatment in a particular level of care. Utilization of the criteria aids in determining the type, level and length of care and treatment needed for the drug and alcohol client.

The PCPC will be used by SCAs, Managed Care Organizations and Treatment Providers who deal with the public client. Projected implementation dates for the PCPC are January, 1997 for the Southeast and July, 1997 for the remainder of the Commonwealth. The implementation will be accomplished by a series of regional Training of Trainers (TOT). Persons recommended by the SCA will receive training from a BDAP approved trainer and in turn will be able to train SCA and provider staff within the counties in the use of the PCPC. Other BDAP approved trainers may contract with SCAs to provide on going training.

Once the training initiative is near completion and the PCPC is utilized throughout the Commonwealth, BDAP plans to initiate a thorough evaluation to study the reliability of the criteria by contracting with an outside research agency. Additional plans for the near future include the development of a Clinical Standards Committee to evaluate and address concerns relative to the content and structure of the criteria and other clinical and systemic issues relative to its implementation. BDAP is dedicated to maintaining the PCPC as a living document of the highest level of clinical integrity and to the statewide implementation of the criteria by July 1, 1997.
OUTCOME MEASURES

BDAP has begun the implementation of an outcomes based performance system to evaluate the quality of drug and alcohol services and the service delivery system. In past reviews of SCA plans it was determined that there was no indication of quality or appropriateness of the activities described in these documents. Beginning last year BDAP and the SCAs initiated a performance based prevention plan which will be the model for subsequent efforts.

A community needs assessment, using a survey of key informants to identify risk factors, was the first step in the planning process. Measureable goals and objectives were then developed to address the risk factors. BDAP procedures address the monitoring of the outcome measures to ensure the quality and comprehensiveness of the SCA administered system.

THE BUREAU OF DRUG AND ALCOHOL PROGRAMS (BDAP) TRAINING SYSTEM

Training Institutes - The BDAP training system offers two yearly training institutes, one in the Spring and one in the Fall. Both events are offered over a five-day period and provide course work at the basic, intermediate and advanced skill levels. They are also open to all human service personnel, and have expanded to include courses that address criminal justice, preventive and community health, HIV/AIDS and maternal and child health issues. At a typical Training Institute, an average 42 courses are offered throughout the five-day period; and daily attendance averages 550 trainees.

All Institute courses are accredited by the Pennsylvania Substance Abuse Certification Board. In addition, graduate and undergraduate credit options are offered through the Pennsylvania State University. At all Institutes, BDAP offers a number of Regular (room and board, and a reduction of the registration fee) and Partial (a reduction of the registration fee) scholarships in order to insure that personnel remain skilled in a field that is constantly evolving. In order to insure that new personnel have received “the basics” in a variety of skills essential to the new employee, BDAP offers these courses at all training Institutes, and insures that new scholarship recipients take these basic courses before moving into the more intermediate and advanced skill courses.

BDAP staff remains committed to insuring that training is skill building in nature. Therefore, experiential, practice modules are built into the majority of the BDAP training system courses. The success of the training Institutes is evidenced by the fact that, each year, courses close earlier.

Statewide Training
There are two types of statewide training delivered through the Bureau. These types were developed in order to address specific needs of the substance abuse field.

On-Site events. These events occur through the Single County Authority (SCA). The Commonwealth has 49 SCAs in the state, each of which is responsible for the coordination and oversight of the substance abuse prevention and treatment programs in their region. SCAs are given training days each year in order to provide staff development for the substance abuse staff in their SCA region. Training requested is specific to the prevention and treatment philosophy of the region and is provided “on-site”, meaning at or near the program making the training request.

In order to fill the on-site requests, which reflect the prevention and treatment diversity of the Commonwealth, the Bureau has developed a registry of trainers. These are trainers which work for the Department and who deliver training in their particular area or area of expertise. It is on the diversity of trainers that the BDAP training system is founded, as we are able to offer training in excess of 100 topics through this system.
Statewide Training - This is training which address a specific substance abuse trend effecting the Commonwealth. HIV/AIDS and Tuberculosis training has been offered statewide in order to bring “just in time” information to substance abuse personnel who will be affected by these trends.

In all, BDAP remains committed to staff development, as we recognize that the bottom line is better services, and an increased chance of recovery to the clients we are serving. This past fiscal year BDAP delivered in excess of 250 training events to over 3,500 trainees. It is our intent to continue to expand and refine this system.
Data Analysis and Demographics
1995/96 Client Information System

**Employment Status of Clients**
- Unemployed: 60%
- Full-Time: 23%
- Part-Time: 6%
- Student: 10%
- Other: 1%

**Treatment Experiences**
- One: 75%
- Two: 21%
- Three: 3%
- Four: 1%
CLIENTS BY RACE

- WHITE: 59%
- BLACK: 23%
- HISPANIC: 6%
- OTHER: 12%

DRUG BY RACE

- ALCOHOL
- COCAINE
- MARIJUANA
- HEROIN
1995/96 Client Information System

MAJOR DRUGS

- Alcohol (53%)
- Cocaine (21%)
- Marijuana (12%)
- Heroin (10%)
- Other (4%)

DRUG BY AGE

- Alcohol
- Cocaine
- Marijuana
- Heroin
- Other

Age Groups:
- <15
- 15 - 17
- 18 - 24
- 25 - 34
- 35 - 44
- 45 - 54
- Over 54
1995/96 Client Information System

CLIENTS BY GENDER

- MALE: 72%
- FEMALE: 28%

DRUG BY GENDER

- ALCOHOL
- COCAINE
- HEROIN
- MARIJUANA
- OTHER

The charts show the distribution of clients by gender and the types of drugs used by clients, categorized by gender.
1995/96 Client Information System

STATUS OF CLIENTS

- Divorced: 16%
- Married: 15%
- Separated: 9%
- Never Married: 60%

STATUS OF FEMALES

- Pregnant: 3%
- Females: 97%
Financial Information
Drug and Alcohol Program Expenditures
SFY 1995/96

- Prevention: $10,680,165
- Education & Training: $730,526
- Treatment / Intervention: $36,970,450
- Administration: $3,473,763
- Prevention Education & Training: $1,222,694
- Treatment / Intervention: $21,083,307
- Administration: $8,510,380

PCLB, State, Federal
Drug and Alcohol Referral to Treatment
SFY 1995/96

Employer/EAP
- Unduplicated: 1097
- Duplicated: 840

Diversion Programs
- Unduplicated: 1111
- Duplicated: 940

School
- Unduplicated: 1312
- Duplicated: 1260

Court/Judge
- Unduplicated: 1945
- Duplicated: 1708

Other Voluntary
- Unduplicated: 2031
- Duplicated: 1706

Family/Friend
- Unduplicated: 2323
- Duplicated: 1981

Hospital/Physician
- Unduplicated: 3487
- Duplicated: 4982

Other Non-Voluntary
- Unduplicated: 5858
- Duplicated: 677

Community Service Agency
- Unduplicated: 5973
- Duplicated: 7939

County Probation
- Unduplicated: 10386
- Duplicated: 8852

Self
- Unduplicated: 11177
- Duplicated: 8820

D&A Abuse Care Provider
- Unduplicated: 14330
- Duplicated: 14537
Drug and Alcohol Admissions
Age at Admission
Fiscal Year 1995/96

- 70+
  - Unduplicated: 175
  - Duplicated: 157
- 60-69
  - Unduplicated: 566
  - Duplicated: 701
- 50-59
  - Unduplicated: 2229
  - Duplicated: 2824
- 40-49
  - Unduplicated: 9179
  - Duplicated: 12112
- 30-39
  - Unduplicated: 19301
  - Duplicated: 25734
- 20-29
  - Unduplicated: 13416
  - Duplicated: 17742
- 10-19
  - Unduplicated: 6921
  - Duplicated: 8290
- Less than 10 yrs
  - Unduplicated: 15
  - Duplicated: 15
Part 3

Women and Childrens Annual Report

required by Act 1993-65
Act 65 of 1993 authorizes the Department of Health (Department) to establish and fund residential
drug and alcohol treatment programs for pregnant women and mothers and their dependent children.

Consistent with that mandate, the department has developed programs designed for women
accompanied by children. These offer training in parenting, social and life skills development, family
therapy/family reunification and other activities related to their rehabilitation, in addition to therapies
dealing with their substance abuse. Children are given age appropriate education about substance
abuse and, if school age, they are enrolled in a nearby school accustomed to working with the staff
from the program.

During the course of FY 1995-96, there were eighteen programs providing residential treatment
services exclusively for pregnant women and/or women accompanied by up to two children. The total
bed capacity for women was 260, and 427 beds were reserved for children. This was an increase of
nine beds of each type over the previous year.

In order to ensure the availability of a full continuum of care for women with children, the Department
also facilitated the development of six partial hospitalization programs, fifteen outpatient and/or
intensive outpatient programs, a halfway house and four shelters.

Seventeen programs participated in the funding pool established in 1992 by the Department’s Office
of Drug and Alcohol Programs (ODAP). However, the Office of Medical Assistance in the Department of Public Welfare provided full length treatment coverage under Act 152 for all eligible women, and the ODAP pool was used less frequently since the medical assistance program became the primary source of payment. Each provider was given the opportunity to submit its per diem cost data to the respective funding Single County Authority (SCA), who forwarded the request with their recommendations to the Departments of Health and Public Welfare for a joint determination of the approved rate.

There were no reported problems with treatment referrals and acceptance of payment responsibility by the SCAs. Many programs expressed concern about the apparent reluctance of some HMOs to refer women with children. Statistically, there were very few referrals from managed care agencies for long term residential care for this population.

ODAP, in cooperation with Early Intervention Technical Assistance (formerly Family Focused Early Intervention Systems), sponsored a schedule of training workshops intended to provide women’s treatment providers with technical assistance in a variety of areas pertinent to the treatment of chemically dependant women. Six training workshops and two networking meetings were conducted during the period covered in this report. The following is a synopsis of these workshops and meetings.

- A training workshop on Violence and Addiction in concert with the Pennsylvania Domestic Violence Coalition.
- A Technical Assistance Networking meeting on critical issues facing drug and alcohol treatment providers serving women with children.
- A Technical Assistance Networking meeting on service linkage establishment and referral
systems.

- A regional training workshop on Violence and Young Children. (Held twice)
- Regional training on psychosocial issues, cultural competency, HIV/AIDS and support services for families. (Held twice)
- The National Teleconference on Alcohol, Tobacco and Other Drugs Update focused on alcohol related birth disorders. This live video teleconference included telephoned and faxed questions from the audience, an interactive electronic discussion, and a web-site home page.
- A training workshop was conducted by the Office of Drug and Alcohol Programs for the Healthy Babies Helpline to provide current directory listings of treatment providers and training in the disease concept of chemical dependency.

In addition to these training workshops, a survey of providers resulted in two curricula for administrative and professional counseling staff for FY 1996-97.

The directory of “Programs That Specialize in the Treatment of Women and Women With Children” will be published by the Office of Early Intervention Technical Assistance, for release on or before March 1, 1997. The Directory was compiled as a cooperative effort between the Office of Drug and Alcohol Programs and Early Intervention Technical Assistance and is intended for use by agencies who refer clients to drug and alcohol treatment. Copies of the Directory may be obtained through Early Intervention Technical Assistance, 6340 Flank Drive, Suite 600, Harrisburg, Pennsylvania 17112-2764.
APPENDICES

The appendices usually found in this section consist of regulations, statutes and the Fiscal Manual. These documents have not been amended and appear as they did in previous publications of the State Plan. For the purposes of brevity and economy they have not been included in this document.

Tom Ridge
Governor
Commonwealth of Pennsylvania

Daniel F. Hoffmann
Secretary of Health
Pennsylvania Department of Health