

BLAIR SCA TREATMENT NEEDS ASSESSMENT

Objective 1: To obtain an estimate of the prevalence of substance use disorder in the total population of an SCA.

Definitions:

Estimate: A quantitative description of the current or past situation, based on data from known sources relating to the same time period using a known method which can be replicated.

Prevalence: The number with a diagnosable condition at a given time.

Substance use disorder: A condition of substance abuse or dependency as defined by DSM IV.

Single County Authority (SCA): The agency designated by local authorities in a county or joinder to plan, fund, and administer drug and alcohol activities in a county or joinder.

Total Population: All people who are located in the geographic region of the SCA.

Part One - See Table 1.

The Blair County SCA shared this information with community providers and discussed the overall prevalence rates for the Blair County Community. Upon review of the sub populations, the group agreed that the prevalence rate for the 18-25 year range appeared low for our community. The group agreed the prevalence for the 18-25 year range, in light of the current demand for treatment and drug and alcohol use trends, would be much higher in our community.

In addition, the prevalence trend for the 12- 18 year range also appeared low for our community. Statistical data from the 2003 PA Youth Survey indicates a potential for a higher prevalence rate.

The results from the 2003 PA Youth Survey showed significant use trends among youth in high schools. The data from this survey is listed in the special population needs data.

Part Two - Local Special Population Need Data

Complete Table 2:

- including sources of information used
- other local information, if available

SCA comments about local special population needs data:

Adolescent Data:

Baseline Data for Blair County Student Assistance Program:

Age of Onset: 12 (School year 2004-2005 data)

Drugs of Choice: Overwhelming drugs of choice identified by students are alcohol and Marijuana.

Pennsylvania Youth Survey – 2003 – Blair County Data

The following data are the core measures identified by the 2003 youth survey. The survey included 4423 Blair County students, approximately 88% of the 6th, 8th, 10th, and 12th grade population participated this survey.

The age of onset of drug use is: 12.1 years of age;

Last 30 day use: Use of alcohol in the past 30 days for 8th 10th and 12th is 30.0% and for other drugs including tobacco, marijuana, is 21.1

Perception of Risk: 35.3% of Blair County 8th through 12th graders agreed with a perception of risk in using substances.

Perception of disapproval: 77% Blair County youth perceive that “other adults” disapprove of alcohol use by minors, 70% with use of tobacco and 90% marijuana.

Peer Rewards for Antisocial Behavior(measures risk factor for Friends who engage in the problem behavior): 30% 6th grade, 44% 8th grade, 56% 10th grade and 55% 12th grade.

Willingness to try: Alcohol- 19%-6th, 41.7%-8th, 59.7%-10th, and 71.6%-12th graders; Other Drugs 1.1%-6th grade, 8th grade 5.5%, 10th grade 10.1%, 12th grade-12.8%.

Availability of Substances:

Alcohol is by far the most available and used drug for adolescents in Blair County. With lifetime use at 54% for 8th grade, 72.6% for 10th grade and 82.2 % for 12th grade. Blair County exceeds the national statistics of the Monitoring the Future Survey by 9% for 6th grade, 6.6% for 8th grade and 5.6% for 12th grade. Nearly a third (30.9%) of the 8th through 12th grade students reported using in the past thirty days.

Tobacco: Overall, 33.8% of students had used cigarettes sometime in their lifetime while 27.2% of seniors reported using in the past 30 days.

Marijuana: In their lifetime, 18% of Blair County students used marijuana mirroring the national statistics that have shown major changes in the rates of marijuana use reported by middle and high school students across the United States.

Opiate: The increase of opiate use in Blair County is staggering. Driven by heroin use, admissions for treatment for opiate addiction rose from 48 in the fiscal year ending June 30, 1997 to 666 admissions in the fiscal year ending June 30, 2004. Of these, 301 or nearly half, were under the age of 24. Reflecting what we’re seeing in the adult population, both 10th and 12th graders are using heroin at a rate higher than the national averages. (Youth Survey at 2.6% compared to Monitoring the Future at 1.5%).

Criminal Population:

Drug Related Offenses:

The Blair County Drug and Alcohol office processed 1,227 court related assessment referrals during the 2004-2005 fiscal years.

Blair County has seen a 25% increase in its criminal filings from 2001-2002 with a record high filing of 2,712. Prior to 1998 the number of criminal indictments consistently remained below 2,000. Data for the year 2003 reflects the same increase. Blair County courts have been

strained due to the increase in charges of retail theft; bad checks and possession with intent to deliver directly related to the influx of drug offenders into the system.

A recent study of Blair County Adult Parole cases was completed by Penn State Assistant Professor of Criminology and Sociology, John Linn. This study profiles the Blair County offenders as 19 to 32 years old, predominantly male (approximately 75% male and 25% female’), and predominantly white (93% White, 7% non white).

The DOH CIS data on 19 to 32 year olds reflects the drug of choice being opiates, with an increase in the use of opiates in the county from 1996 to 2005. Data collected on Blair County treatment admissions show a total of 358 young adults treated for opiate abuse during July 1, 2004 to June 30, 2005, compared to 8 treated for opiate abuse in 1996/1997.

Blair County’s current case processing into the judicial system is extremely slow. A study conducted in 2001 by the Court Administrator indicates the process of sentencing ranges from 3 to 18 months. Due to the length of time for processing, offenders continue to commit crimes within our community while continuing their substance abuse. Offenders are not required to seek substance abuse treatment until sentencing; therefore the majority continues their negative behaviors for up to 18 months.

Under the guidance of the Honorable Judge Jolene Kopriva, the Blair County Court System has implemented several drug court programs in an attempt to impact substance use on the community and court systems. Blair County currently operates a three prong Drug Court. The Drug Court manages diversionary drug offenders at the time of arrest, Level 3-4 sentenced drug offenders and drug offender reentering into the community from the prison. Currently the drug court manages 50-60 substance using offenders in its program.

In addition, the court systems are developing a Juvenile Drug Court and the Children and Youth System is exploring the potential for a Family Court.

DUI Offenses

Every DUI Offender is mandated to complete a Client Intake Form (results known as CRN). This form compiles information relating to the offenders demographics, drinking patterns and prior criminal activity. During the calendar year of 2002, 403 offenders completed the form providing the following profile. This is a typical profile of DUI offenders.

80% Male
35 Average Age
98% White
30% Married or Living together
84% High school and post high school
69% Employed
\$18,838.00 Average Income

In addition, Blair County has been selected by the PA Department of Transportation to be a pilot for a DUI court. The court will provide a high BAC second offender and third offenders the option to apply for the DUI court program.

Objective 2: To identify emerging substance use problems by type of chemical, route of administration, population, availability and cost, etc.

Definitions:

Emerging substance use problems: This implies that there is a situation which is qualitatively different from what came before, and which could not have been fully anticipated and planned for. The difference may be the population of users, the type of substance, the nature of the substance or the rate of increase. The implication is that a new problem confronts the community and it may need to be dealt with. The new problem may be an isolated event that requires immediate action or it may take the form of a gradual pattern change that was initially anecdotal information then tracked over time that now requires a response impacting service delivery.

Emerging treatment needs

- Summarize information relied upon to identify the emerging need, and supporting data
- Describe plans to track or address the emerging need

SCA comments on emerging treatment needs:

Emerging Treatment Narrative:

The Blair County Community has seen a rise in heroin use since the late 1990's. In 1996 the CIS data indicated only 20 admissions of opiate synthetics and heroin. In 2004-2005 the number had risen to over 756. Along with this increase the most significantly impacted population is the 18-24 year old population. During fiscal year 2003-2004, the county CIS data shows a drop in the number of admission for opiates to 667. The opening of two methadone treatment facilities in the neighboring counties may have had an impact on the overall admission numbers for the drug of choice. In addition, four local physicians have been certified to provide buprenorphine services in our community.

The amount of impact that opiates has had on our community is innumerable. We are seeing record setting numbers of arrests related to drug use. Criminal activity ranges anywhere from possession to sales to bad checks, thefts, armed robberies, and homes being broken into. Our court system is being overwhelmed with the increase of drug related case loads. The Blair County Drug Task Force has been making record breaking arrest. A sweep can involve anywhere from 20-40 individuals. In the last 2 years the District Attorney has prosecuted organized criminals related to the sales and distribution of illegal drugs, specifically heroin, bringing record setting sentences in the state of Pennsylvania. The Blair County Drug and Alcohol Office have been involved with the planning and implementation of a Diversionary Drug Court in

collaboration with the Blair County Court System. The SCA, on behalf of the Court System, did apply and received a federal diversionary drug court grant 2004.

Along with the drug sweeps, an impact on the children and youth system has been seen. Children and youth workers are being called to homes where arrests are being made in order to place the children in the homes. Heroin addicted children at birth have been placed with the children and youth system. The SCA is currently involved with the integrated children's planning initiative at the county level.

Accidental overdoses have increased from 9 a year in 1996 to 30 in 2004.

Another significant concern is the impact of a generation of children involved with heroin. We are seeing adolescents engaging in heroin use as young as 15. Currently, the number of admissions for treatment for school aged students has been minimal. This trend is problematic as we are seeing an increase in a younger population of heroin users.

During the last year, there has been a slight increase in cocaine admission which has not seen much change in the past five to six years. With trends of a stimulant following a depressant use cycle, the SCA and providers are beginning to discuss and plan for a potential emergent of stimulants along with an ongoing trend of opiate use.

In addition to this data, the SCA does communicate on a regular basis with the Blair County Drug Task Force to identify emerging trends in street level activity. Though methamphetamine has impacted some of the rural counties bordering the community, the Task Force is indicating very little activity in our communities with this substance. Providers are indicating the mention of methamphetamine in drug history reports by clients. Providers are concern that we may see this substance emerging in the future.

Data Narrative

The SCA relies on numerous data elements and contacts to develop a picture of the emerging and ongoing drug trends within the community. The following is an example of ongoing data that is review and discussions at numerous levels within our community.

DOH- CIS data, Coroner's accidental overdose data, RMR, CMR, SAP Liaison Quarterly report, SAP Assessment report, PA Youth Survey Results, Youth Tobacco Survey results, DUI reports, treatment authorization reports, health statistical data and anecdotal information obtained from providers, Blair County Drug Task Force, MISA performance committee, Coalition meetings, Health and Welfare Committee, SHIP committee, Specialty Court committee meetings, Criminal Justice Advisory Board members, Aids Intervention Project, UM Provider Meeting.

Planning

1) Emerging stimulant trend: The SCA meets monthly with treatment providers to discuss emerging trends and is currently working with providers to address training concerns regarding the potential emergent of methamphetamine.

2) Emerging trend of a younger population of users: During the current fiscal year the SCA has allocated funding to enhance treatment services at all seven school districts. The SCA is monitoring the enhancement of these services through the current treatment providers and authorization reports.

3)Tracking: The SCA will continues to track local data and anecdotal information through the numerous meetings and contacts within the community. This information will be shared with key leaders, providers, and community members as trends are identified.

Objective 3: To identify the demand for substance use disorder treatment.

Definitions:

Demand: Demand for treatment is the number of people who will seek treatment for a substance use disorder.

Data Sources: Data from the Case Management Resource Report (CMRR) – formerly called the Resource Management Report (RMR) – can be used to identify demand for both assessment and treatment services. It will show where the gaps are in the availability of specific levels of care.

The CMRR/RMR information can be supplemented with data from the Client Information System (CIS), which will show the recruitment patterns and service strategy in use by each SCA. This will reflect the decisions each SCA is making about which clients are being served.

CMRR/RMR data - Discussion of issues identified, including:

- The number of clients assessed (non-institutionalized and institutionalized).
- Explain why clients waited longer than 7 days for an assessment.
Note: for data reported before 1/1/04, the waiting period was 72 business hours.
- Explain the reasons why clients recommended for treatment did not receive the recommended type of service.
- Explain why clients recommended for treatment had to wait longer than two weeks to access the recommended type of service, broken down by type of service.

If there have been difficulties in meeting the CMRR/RMR requirements, explain why.

If there have been no problems providing timely access to assessments or the recommended type of service, simply explain that the items do not apply.

If you have questions about the CMRR/RMR data that you want to discuss before responding, contact Garrison Gladfelter, BDAP’s Data Manager, at (717) 783-8200.

SCA comments on CMRR/RMR data:

The drug and alcohol system was impacted by the state budget process for fiscal year 2003-2004. Due to the negotiation related to the Department of Public Welfare funding, the system experienced a need to restrict services within the first 6 months of the fiscal year. The full

continuum of care was available on a limited basis. These limitation caused waiting list for services into different levels of care and increase referrals to outpatient services. Providers of service initiated mandatory lay offs due to the budget issues. Upon the return of funding in January of 2004, it took several months for the treatment facilities to expand capacity due to the lay offs.

The SCA did review w data with the subcontracted providers. Several concerns regarding the data did surface during this discussion.

First the data was during the 2003-2004 fiscal year which presented unique challenges at the local level due to the budget crisis during that time period. Unfortunately, the data did not reflect these challenges. An example of that would be the data for persons not receiving treatment at a specific level of care due to funding. It was felt that the number should have been significantly higher in the funding category and capacity areas due to reduction of staff during the 6 month period. There is a concern that the interpretation is currently not accurate when completing this report. Clients did not receive recommended level of cares due to the funding crisis yet the data did not reflect this occurrence. The SCA is working with the clinical supervisors of assessment staff to ensure this is captured accurately going forward.

Assessments not completed within the timeframes were a direct impact of capacity issues due to the budget crisis during that fiscal year.

CIS data reported by SCA contracted Treatment Providers

Table 3 “SCA Pattern of Referrals into Treatment” shows the percentage of all first admissions for SCA-paid “unique” clients for SFY 2003-2004, broken down by referral categories - except juveniles, which are identified by age and presented separately. Table 3 shows only clients that the SCA paid for, based on the “Referring SCA” item in CIS, for the first episode for each client in the reporting period, and provides a comparison between SCA and statewide data, displayed side by side. If the same client received multiple services during this reporting period, only the first treatment episode is included here, because it is the best indicator of the referral source that originally got the client into treatment.

Referral source information is entered into CIS by the treatment provider, with the following response options to choose from:

- **CIS Voluntary Referrals** include: Clergy/Religious, D&A Abuse Care Provider, Employer/EAP, Family/Friend, Hospital/Physician, Other Community Referral, School, Self, and Other Voluntary.
- **CIS Non-Voluntary Referrals** include: County Parole, County Probation, Court (Judge), Diversion Programs, Federal Probation, State Parole, State Probation, Other Non-Voluntary.

Table 4 “Criminal Justice/Non-Voluntary” referrals/SCA Paid Unique Clients – shows the differences among SCAs in their strategies for serving and recruiting criminal justice/non-voluntary clients into treatment. Table 4 presents all criminal justice/non-voluntary referrals,

based on the SCA paid “unique” referrals (as defined by the “Referring SCA” item in CIS) shown in Table 3, plus those that were not paid for by an SCA (27%), so that the percentage of all statewide criminal justice referrals could be accurately determined.

Table 5 “SCA Service Strategy” is limited to SCA treatment episodes as defined by the “Referring SCA” item in CIS, and is different from the referral source tables. It shows treatment episodes and level of care usage that began during the year, rather than individual clients. This report identifies differences in the pattern of services provided by different SCAs, since some SCAs do not utilize some levels of care.

Discuss CIS Data (Tables 3, 4, & 5) including:

- nature of the need and demand for the most prominent and least prominent categories of referral sources,
- the levels of service utilized by the SCA,
- activities of other service systems in the SCA in meeting treatment need – such as private pay providers, criminal justice providers not connected with the SCA, and juvenile services, and
- most critical areas of need into which new resources are needed, or would be applied.

If you have questions you want to discuss before responding, contact Garrison Gladfelter, BDAP’s Data Manager, at (717) 783-8200.

Note: CIS data for Washington and Greene Single County Authorities is combined, even though they have not been a joinder since 2002.

SCAs are encouraged to supplement CIS data with any other local data that will help to identify and document the demand for treatment and/or provision of services. Explain how the data was collected or obtained.

SCA comments on CIS data (Tables 3, 4, 5):

Nature of the need and demand for the most prominent and least prominent categories of referral sources:

The CIS data only records those clients admitted into licensed treatment services during the fiscal year. It does not identify the assessments performed by local providers and the initial referral source for the assessment. An assessment agent may receive the referral from the criminal justice system, do the assessment, then refer to another provider for an appropriate level of care. The admitting agency will identify the D&Alc provider as the referral source for the admission though actually the referral was a criminal justice referral. We processed over eleven hundred referrals from the criminal justice system to our assessment subcontractors yet the numbers for admission do not reflect a reasonable volume of this referral agent.

Blair County has prepared for the MA managed care for Behavioral Health Services (Health Choices) for the past ten years. The expansion of this DPW initiative stopped in October 2003. The lack of parity for individuals in “Non-Health Choice/Fee-for-Service” Counties is an

important consideration for planning purposes. For example, in Blair County, Medical Assistance does not include Drug & Alcohol Partial Hospitalization or Intensive Outpatient Services. The SCA currently funds MA eligible clients into IOP and PHP services, which are not currently funded in a fee for service MA environment.

With the high expectation of Co-Occurring mental health and substance use disorders experienced by the individual presenting for services DPW must approve MA reimbursement codes and rates to allow the provider(s) to meet the additional program standards, staff qualifications, and the training requirements for all singly licensed mental health and drug & alcohol programs to be certified as a COD (Co-Occurring Disorder) Capable service. This lack of parity along with the funding deficiencies noted above must be addressed to maintain a healthy service delivery system.

The MISA project has served approximately 541 unduplicated clients over the last 3 years. These individuals will lose the enhanced services in fiscal year 2006-2007 due to the elimination of the funding for the MISA project.

The SCA continues to see increase demand for services. Unduplicated clients served have increased over the past six years by 41%. Unduplicated clients served in 1998/1999 – 1,150 – unduplicated clients served in 2004-2005 – 1931. This number is reflective of all funding sources the SCA manages and assessments that are initially paid for by SCA funding but may have private pay or self pay for the treatment portion of their services.

The levels of service utilized by the SCA:

During the spring of 2004, the SCA was notified by the Department of Health Licensing that the methadone clinic, Alliance Medical Services, had made a decision to drop its medical assistance provider approval. This resulted in clients not having resources to maintain services at the facility. The client would have had to self pay in order to maintain services. The SCA worked with Alliance to provide temporary coverage for these individuals through the remainder of the fiscal year.

The SCA continues to see minimal engagement of adolescents in the drug and alcohol treatment system. Adolescent are being identified but are resistant to receive services at community based programs. In order to impact this barrier, the SCA in partnership with a local treatment facility and schools did provide in school treatment services. It was indicated by the provider that when these services were available 96% of the students did agree to participate in the treatment service. The SCA did expand these services across all school districts this fiscal year.

Considering the funding crisis of the time period represented in the charts, the array of services and number of episodes of services provided for the year was significant. The SCA met sometimes weekly with the provider network to discuss and implement funding plans that changed as funding became available.

Activities of other service systems in the SCA in meeting treatment need – such as private pay providers, criminal justice providers not connected with the SCA, and juvenile services.

The SCA is very involved with the Adult criminal justice system. Currently, the SCA manages three grants that provide treatment services to the Drug Court participants. Federal grants that provide services to diversionary and reentry court participants and a PCCD grant that provides services to level 3-4 offenders in our sentencing drug court. In addition, PCCD has agreed to expand funding this fiscal year to support the implementation of our DUI court and support the treatment services for those offenders that meet the level 3-4 offense gravity at time of DUI court sentencing.

The SCA is a member of the juvenile drug court implementation team. This system still uses resources that our outside the drug and alcohol funding stream. Day treatment services through Adlephi Village, private social workers and other professionals. As with the children and youth system, the juvenile is realigning their providers to become MA providers.

The SCA is involved with the MISA project for the last three years. Unfortunately, these dollars are slated to be eliminated in fiscal year 2006-2007.

Most critical areas of need into which new resources are needed, or would be applied.

During the children's planning process, adolescent drug and alcohol treatment services were identified as priority within that planning process. An array of services was proposed for the 2006-2007 fiscal year. This proposal included expansion of school based licensed treatment counselors, partial hospitalization, expanded intensive outpatient and additional residential services.

Additional funding is needed to expand capacity to support buprenorphine treatment. The SCA is currently a member of the buprenorphine treatment subcommittee and is currently working with local providers to develop guidelines to expand the capacity though current funding will impact the level at which this service can be offered.

The elimination of the MISA funding to our county will decrease the availability of these services in the upcoming fiscal year. This is critical to our county as we are the only pilot county that is not in a health choice environment and are unable to negotiate the medical assistance funding line items through health choice manage care providers.

Objective 4: To identify resources necessary to meet the estimated treatment demand [the difference between existing resources and demand].

Definitions:

Resources: For example: money, staff, assessment and treatment capacity, capacity to serve acute and chronic need, and the capability to provide various types, levels, and intensities of care.

For any areas where the demand for assessment or treatment services is unmet, the SCA must identify what resources would be needed to meet the demand. Resources may be money, staff with specific skills, physical plant, and other things.

Where possible, explain the basis for any estimates provided. Statements that estimate the quantity of resources, which would be needed to meet the additional demand, are not required, but are encouraged.

SCA Response:

Unfortunately existing resources are being reduced. This compounds the issue between existing resources and demand. Funding resources continue to be reduced yet as indicated in my previous narrative the demands continue to grow each year.

The current needs of our community are numerous. We are in need of the capacity to support buprenorphine enhanced services, methadone treatment clinics with full continuums of outpatient services, co-occurring enhanced and co-occurring capable services. Psychiatrists are in great demand within our service area. Funding is needed to maintain and expand services to adolescents.

Treatment programs are willing to expand services but unable due to the reality that funding is not available to support those services.

The county of Blair will not be entering health choices for another 2-3 years depending on the state budget. This continues to put demands on the public funding available to provide services to medical assistance individuals who are in need of more intense services.

Housing supports:

Blair County lost its only male homeless shelter due to a fire. Services that were identified that would support housing supports were $\frac{3}{4}$ house, shelter and damp housing.

Resource Coordination:

With the change in the ICM requirements to six or domains, a high percentage of individuals are not eligible for the service. Additional funding is need to support staffing of a minimum of two resource coordinators.

Transportation Services:

Due the rural nature of our community and limited public transportation, this issue is an ongoing challenge when working with individuals.

Objective 5: To identify issues and systems barriers that impede the ability to meet the assessment and treatment demand in the SCA.

Definitions:

Systems barriers: All aspects of the institutions and the communications involved in identifying and serving treatment demand, which do not fully contribute to providing effective services to everyone as promptly as necessary. System barriers should be barriers other than the resources discussed in Objective 4.

Examples of system barriers are: lack of access, quality and appropriateness of care, insurance denials, childcare, transportation, location, language, zoning restrictions, etc.

Identify “systems barriers” that impede or prevent the SCA from meeting assessment and treatment demands including any objective supporting data or descriptions of “barriers”

SCA Response:

Methodone Issue:

Lack of access to methadone providers within the Blair County Community:

During the last two years, four clinics have been proposed within the Blair County community. Three of the sites have been abandoned due to the neighboring communities’ reaction to these sites and not meeting Act 10 requirements or other zoning issues. One site is currently pending a legal decision regarding the definition for residential area as stated in Act 10.

Currently, Blair County residents travel to local counties for methadone services. One of these clinics is not a MA, the other is a MA provider. The clients must travel two hours round trip for their services. Fifty percent or more of the clients admitted to these clinics are Blair County residents.

Community members have come to agreement that methadone is needed in our community. The barrier becomes where this clinic should be located.

Another barrier that has been identified by our provider is the ability to engage current methadone clients in more intensive treatment services within the local community. Currently, methadone patients travel over one hour to a clinic outside the area. Due to licensing restrictions, our providers are unable to provide more intensive services, such as, intensive outpatient or partial hospitalization to those individuals who need additional support in our community.

Human Resource Issues:

The human resources in our field are quickly dwindling. Clinicians are choosing to not go into the drug and alcohol field due to the regulations, intensive micro management and documentation requirements. Clinicians are going into other fields such as mental health due to less regulated services.

Objective 6: To identify assets or resources available in the county or region to help respond to treatment demand.

Identify assets or resources that enable, or could enable, the SCA to meet demand through cooperation with other human services organizations.

SCA Response:

The licensed treatment providers (mental health and drug and alcohol) within our community that have been involved with the MISA project have invested significant time into the planning, training and implementation of co-occurring capable services. This has provided for an expanded resource of trained counselors and systems that are working towards implementing co-occurring capable services.

The partnership with the Integrated Children Serving Planning team has provided an arena to plan and coordinate resources to support adolescent needs and demands.

Currently, the Blair County Human Services offers grant opportunities for children services through human service development funds. The SCA currently is receiving funding through this funding stream for adolescent services.

The SCA meets quarterly with the OVR/MH/MR/D&A Implementation committee to coordinate resources for individuals accessing services through our systems.

Drug Free School Funding through the Department of Education has been provided some support for in school service.

Salvation Army operates a men's rehabilitation housing program in our area and may be an option for those men who are without resources for housing and need a support environment to support recovery.

Crossroads is a non-profit organization that is operated by recovering individuals in our community and provides a safe environment for meetings and social activities to support recovery.

The Criminal Justice Assessment Team is a team of criminal Justice and community providers who to interagency planning for individuals are receiving services through the prison, and specialty courts in our community.

Due to our relationship with the criminal justice system, the grant funding for the speciality courts has been prioritized to support the treatment resources needed to support the individuals involved with these programs.

Treatment Needs Assessment Table 1
SCA Estimates of the Prevalence of Substance Abuse Disorders (Dependence or Abuse)¹
Based on 2002+2003 National Survey on Drug Use and Health (NSDUH)²

SCA	Total 2003 Population	Age 12+		Age 12-17		Age 18-25		Age 26+	
		Population	Prevalence (Rate = 8.3%)	Population	Prevalence (Rate = 8.45%)	Population	Prevalence (Rate = 21.57%)	Population	Prevalence (Rate = 6.14%)
ALLEGHENY	1,261,303	1,086,913	90,214	100,064	8,455	49,214	10,615	937,635	57,571
ARMSTRONG / INDIANA	160,713	139,776	11,601	12,810	1,082	9,960	2,148	117,006	7,184
BEAVER	178,697	154,240	12,802	14,534	1,228	6,660	1,437	133,046	8,169
BEDFORD	49,941	42,533	3,530	4,080	345	1,585	342	36,868	2,264
BERKS	385,307	324,842	26,962	34,610	2,925	16,610	3,583	273,622	16,800
BLAIR	127,175	109,109	9,056	10,533	890	5,198	1,121	93,378	5,733
BRADFORD / SULLIVAN	69,070	58,498	4,855	6,276	530	2,377	513	49,845	3,061
BUCKS	613,110	515,110	42,754	52,546	4,440	22,444	4,841	440,120	27,023
BUTLER	180,040	151,946	12,612	15,377	1,299	7,889	1,702	128,680	7,901
CAMBRIA	149,453	130,385	10,822	11,611	981	6,130	1,322	112,644	6,916
CAMERON / ELK / MCKEAN	85,323	73,184	6,074	7,331	619	3,145	678	62,708	3,850
CARBON / MONROE / PIKE	266,789	225,819	18,743	25,127	2,123	11,050	2,383	189,642	11,644
CENTRE	141,636	126,278	10,481	9,650	815	17,863	3,853	98,765	6,064
CHESTER	457,393	381,015	31,624	41,636	3,518	17,878	3,856	321,501	19,740
CLARION	41,208	35,857	2,976	3,290	278	3,337	720	29,230	1,795
CLEARFIELD / JEFFERSON	128,819	111,337	9,241	10,441	882	4,906	1,058	95,990	5,894
COLUMBIA / MONTOUR / SNYDER / UNION	163,255	142,213	11,804	13,538	1,144	11,348	2,448	117,327	7,204
CRAWFORD	89,846	76,255	6,329	8,105	685	4,147	895	64,003	3,930
CUMBERLAND / PERRY	264,080	226,909	18,833	21,127	1,785	13,448	2,901	192,334	11,809
DAUPHIN	253,388	214,484	17,802	21,077	1,781	8,474	1,828	184,933	11,355
DELAWARE	554,432	468,780	38,909	51,165	4,323	25,430	5,485	392,185	24,080
ERIE	279,966	236,787	19,653	24,811	2,097	14,405	3,107	197,571	12,131
FAYETTE	146,121	125,647	10,429	11,823	999	5,174	1,116	108,650	6,671
FOREST / WARREN	47,809	41,254	3,424	4,236	358	1,711	369	35,307	2,168
FRANKLIN / FULTON	147,689	124,434	10,328	12,051	1,018	5,579	1,203	106,804	6,558
GREENE	40,398	35,099	2,913	3,251	275	1,733	374	30,115	1,849
HUNTINGDON / MIFFLIN / JUNIATA	115,265	98,385	8,166	9,501	803	4,495	970	84,389	5,181
LACKAWANNA	210,458	182,425	15,141	17,434	1,473	8,804	1,899	156,187	9,590
LANCASTER	482,775	400,776	33,264	43,916	3,711	21,509	4,639	335,351	20,591
LAWRENCE	93,408	80,030	6,642	7,815	660	3,944	851	68,271	4,192
LEBANON	122,652	103,827	8,618	10,086	852	4,796	1,035	88,945	5,461
LEHIGH	320,517	271,256	22,514	26,979	2,280	12,526	2,702	231,751	14,230

Treatment Needs Assessment Table 1
SCA Estimates of the Prevalence of Substance Abuse Disorders (Dependence or Abuse)¹
Based on 2002+2003 National Survey on Drug Use and Health (NSDUH)²

SCA	Total 2003 Population	Age 12+		Age 12-17		Age 18-25		Age 26+	
		Population	Prevalence (Rate = 8.3%)	Population	Prevalence (Rate = 8.45%)	Population	Prevalence (Rate = 21.57%)	Population	Prevalence (Rate = 6.14%)
LUZERNE / WYOMING	341,681	297,243	24,671	27,251	2,303	13,396	2,890	256,596	15,755
LYCOMING / CLINTON	155,873	134,516	11,165	13,103	1,107	7,793	1,681	113,620	6,976
MERCER	119,895	102,854	8,537	10,539	891	5,535	1,194	86,780	5,328
MONTGOMERY	770,747	651,351	54,062	62,500	5,281	27,348	5,899	561,503	34,476
NORTHAMPTON	278,169	236,743	19,650	23,960	2,025	13,213	2,850	199,570	12,254
NORTHUMBERLAND	93,323	80,959	6,720	7,558	639	2,898	625	70,503	4,329
PHILADELPHIA	1,479,339	1,238,616	102,805	136,489	11,533	67,642	14,590	1,034,485	63,517
POTTER	18,141	15,315	1,271	1,618	137	742	160	12,955	795
SCHUYLKILL	147,944	128,935	10,702	11,340	958	4,774	1,030	112,821	6,927
SOMERSET	79,365	68,832	5,713	6,370	538	2,633	568	59,829	3,673
SUSQUEHANNA	41,812	35,472	2,944	4,063	343	1,303	281	30,106	1,849
TIOGA	41,557	35,783	2,970	3,812	322	2,295	495	29,676	1,822
VENANGO	56,600	48,409	4,018	5,040	426	2,030	438	41,339	2,538
WASHINGTON	204,286	176,504	14,650	16,097	1,360	8,087	1,744	152,320	9,352
WAYNE	49,092	41,653	3,457	3,936	333	1,629	351	36,088	2,216
WESTMORELAND	368,224	319,576	26,525	29,655	2,506	12,831	2,768	277,090	17,013
YORK / ADAMS	491,371	415,307	34,470	42,344	3,578	19,457	4,197	353,506	21,705
STATEWIDE	12,365,455	10,523,471	873,448	1,052,506	88,937	527,374	113,754	8,943,591	549,137

1. Past year dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

2. The National Survey on Drug Use and Health (NSDUH), formerly known as the National Household Survey on Drug Abuse (NHSDA), is an annual survey conducted by SAMHSA's Office of Applied Studies. NSDUH is the primary source of statistical information on the use of illicit drugs by the U.S. civilian population aged 12 or older, based on face-to-face interviews at their place of residence. The survey covers residents of households, noninstitutional group quarters (e.g., shelters, rooming houses, dormitories), and civilians living on military bases. Persons excluded from the survey include homeless people who do not use shelters, active military personnel, and residents of institutional group quarters, such as prisons and long-term hospitals.

Several changes were made in 2002 to improve the data quality, resulting in a new baseline for state and national estimates, which are not comparable with prior years. Data for 2002 and 2003 were combined to provide state level estimates because the sample sizes for the majority of the states are too small to detect any trends from one year to the next. Estimates are based on a survey-weighted hierarchical Bayes estimation approach.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003, Table 78.

Population Data Source: Penn State Data Center 2003 Population Estimates.

Use of the data: These estimates may be used to describe the need for treatment services (as distinguished from demand) and the extent of the problem. They show potential for demand for services.

Table 2
Local Special Population Need Data
As reported by BLAIR

Special Population Category (Column 1)	Source of Data and web link (Column 2)	How to Locate Data (Column 3)	(Column 4) Enter Total Number from Column 1	(Column 5) Percent of these persons who have substance abuse problems.	(Column 6) Estimated number who have substance abuse problems =Col 4 x Col 5 for each category
1. Drug Possession Arrests: 18E-Drug Possession - Opium – Cocaine;18F-Drug Possession – Marijuana;18G-Drug Possession – Synthetic;18H-Drug Possession - Other (Total Arrests Adult & Juvenile)	Pennsylvania Uniform Crime Reporting Program http://ucr.psp.state.pa.us/UCR/Reporting/Monthly/Summary/MonthlySumArrestUI.asp	1) Select Arrests by Age & Sex 2) Select Year 3) Select Month (December) 4) Select YTD 5) Select County 6) Select Appropriate UCR Codes 7) Click Submit 8) Record Total	2004 Data 18E - 64 18F – 74 18G – 5 18H – 168 Total 311	100%	2004 Data 18E - 64 18F – 74 18G – 5 18H – 168 Total 311
2. Arrests for 210-Driving Under the Influence; 220-Liquor Law; 230-Drunkenness (Total Adult & Juvenile Arrests)	Pennsylvania Uniform Crime Reporting Program http://ucr.psp.state.pa.us/UCR/Reporting/Monthly/Summary/MonthlySumArrestUI.asp	1) Select Arrests by Age & Sex 2) Select Year 3) Select Month (December) 4) Select YTD 5) Select County 6) Select Appropriate UCR Codes 7) Click Submit 8) Record Total Arrests	2004 Data 210 – 501 220 – 381 230 – 237 Total 1119	100%	2004 Data 210 – 501 220 – 381 230 – 237 Total 1119
3. Adult County Probation and Parole	Pennsylvania Board of Probation and Parole http://www.pbpp.state.pa.us/pbppinfo/cwp/browse.asp?a=468&bc=0&c=69783	1) Locate Table with Caseload information 2) Locate the County or Counties 3) Record the Total caseload.	2004 Data Total 1822	70% (DOC estimate)	2004 Data Total: 1275
4. County jail population	SCA to provide from local contacts	Contact Local Source Prison Staff	288 offenders	70% (DOC estimate)	202 offenders
5. Persons on state probation or parole in county	SCA to provide from local contacts	Contact Local Source	245 offenders	70% (DOC estimate)	172 offenders

Table 2 (Continued)
Local Special Population Need Data
As reported by BLAIR

Special Population Category (Column 1)	Source of Data and web link (Column 2)	How to Locate Data (Column 3)	(Column 4) Enter Total Number from Column 1	(Column 5) Percent of these persons who have substance abuse problems.	(Column 6) Estimated number who have substance abuse problems =Col 4 x Col 5 for each category
6. Reported Substantiated Child Abuse & Neglect Cases (Total)	Pennsylvania Department of Public Welfare http://www.dpw.state.pa.us/child/childabuseneglect/childabuseannualrpts/	1) Select Annual Report Year 2) Click on Table and Charts 3) Locate status of evaluation, rates of reporting and substantiation by county Table 4) Locate your County 5) Record Total Substantiated Cases	Data 2003-2004 320	50 % (National Center on Substance Abuse and Child Welfare—April 2005)	Data 2003-2004 Total: 160
7. Domestic Violence (PFA)	Administrative Office of Pennsylvania Courts http://www.courts.state.pa.us/Index/Aopc/Research/indexresearch.asp - stats	1) Select the Caseload Statistics Year 2) Click on Common Pleas 3) Click on Family Court 4) Click on Filings & Dispositions 5) Click on Protection From Abuse 6) Locate County or Counties 7) Record Total Number of Final Order by Stipulation or Agreement	Data 2003 1	25% (SAMHSA Substance Abuse Treatment & Domestic Violence TIP 25)	Data 2003 .25
8. Other Categories *					

* SCAs may include other special population categories as desired, e.g. MISA

**SCA Resource
Management
Report
SFY 2003-2004**

	Number of Non-Institutionalized Clients Assessed	Number of Institutionalized Clients Assessed	Client that waited longer than 7 days for an assessment ¹	Clients recommended for treatment that didn't receive the recommended type of service	Reasons why clients recommended for treatment did not receive the recommended type of service							Clients recommended for treatment that had to wait longer than 2 weeks to access the recommended type of service								
					Funding	Capacity Issues	Provider staffing concerns	Proximity	Lack of appropriate service	Client Choice	Other	Detox	Outpatient	Metadone Maintenance	Intensive Outpatient	Partial Hospitalization	Inpatient Rehabilitation	Dual Diagnosis Inpatient Rehabilitation	Women & Children Inpatient Rehabilitation	Halfway House
ALLEGHENY	2810	144	274	199	37	47	5	0	4	67	39	91	12	0	14	15	90	3	0	2
ARMSTRONG / INDIANA	1051	85	0	388	0	24	135	0	1	207	21	0	265	0	79	0	1	0	0	0
BEAVER	1020	146	106	134	2	14	0	0	0	113	5	0	7	0	0	0	1	0	0	0
BEDFORD	152	3	0	30	0	0	0	0	0	29	1	0	0	0	0	0	0	0	0	0
BERKS	5105	128	72	65	6	39	0	1	2	13	4	0	119	8	16	30	11	5	3	7
BLAIR	1776	103	86	81	15	2	0	0	2	36	26	0	91	0	46	4	12	0	0	0
BRADFORD / SULLIVAN	337	39	41	13	0	0	0	0	1	8	4	0	0	0	0	0	9	0	0	0
BUCKS	1929	2956	41	301	18	3	2	0	2	218	58	0	0	0	0	0	1	0	0	0
BUTLER	935	58	199	106	26	4	0	2	0	72	2	0	0	0	0	0	0	0	0	0
CAMBRIA	549	30	0	69	0	0	0	1	0	64	4	0	0	0	0	0	0	0	0	0
CAMERON / ELK / MCKEAN	588	63	34	28	0	0	0	0	0	25	2	0	0	0	0	0	0	0	0	0
CARBON / MONROE / PIKE	1344	8	406	88	13	0	0	0	1	73	1	0	0	0	0	1	11	1	0	0
CENTRE	688	5	39	11	2	0	0	0	0	4	5	0	0	0	0	0	0	0	0	0
CHESTER	1987	203	181	259	0	4	0	0	0	94	161	0	34	0	4	7	57	25	2	0
CLARION	241	16	59	35	0	0	0	0	0	25	10	0	0	0	0	0	0	0	0	0
CLEARFIELD / JEFFERSON	220	168	7	17	2	0	0	0	0	14	1	0	0	0	0	0	0	0	0	0
COLUMBIA / MONTOUR / SNYDER / UNION	626	99	0	78	8	0	0	0	0	40	30	5	37	0	0	0	0	0	0	0
CRAWFORD	700	15	196	33	0	0	0	0	0	33	0	0	83	0	0	0	0	0	0	0
CUMBERLAND / PERRY	1015	196	214	351	12	11	0	0	0	241	87	0	4	2	1	0	18	1	2	0
DAUPHIN	925	224	0	215	0	0	0	0	0	42	173	0	0	0	0	0	0	0	0	0
DELAWARE	1410	87	0	15	2	0	0	0	0	7	6	4	10	0	0	0	1	0	0	43
ERIE	1518	586	546	237	0	4	1	0	0	232	0	0	63	6	1	1	8	2	0	0
FAYETTE	685	78	36	299	0	31	0	0	0	211	57	4	36	0	1	0	22	2	0	0
FOREST / WARREN	245	129	65	29	2	2	0	0	0	7	18	0	10	0	2	1	7	1	0	0
FRANKLIN / FULTON	397	27	84	42	23	0	1	1	0	13	4	0	23	0	11	0	6	0	0	0
GREENE	70	7	0	14	0	0	0	0	1	12	1	0	0	0	0	0	1	0	0	1

**SCA Resource
Management
Report
SFY 2003-2004**

	Number of Non-Institutionalized Clients Assessed	Number of Institutionalized Clients Assessed	Client that waited longer than 7 days for an assessment ¹	Clients recommended for treatment that didn't receive the recommended type of service	Reasons why clients recommended for treatment did not receive the recommended type of service							Clients recommended for treatment that had to wait longer than 2 weeks to access the recommended type of service										
					Funding	Capacity Issues	Provider staffing concerns	Proximity	Lack of appropriate service	Client Choice	Other	Detox	Outpatient	Methadone Maintenance	Intensive Outpatient	Partial Hospitalization	Inpatient Rehabilitation	Dual Diagnosis Inpatient Rehabilitation	Women & Children Inpatient Rehabilitation	Halfway House		
HUNTINGDON / MIFFLIN / JUNIATA	301	0	0	6	6	0	0	0	0	0	0	0	4	0	0	0	0	2	0	0	0	0
LACKAWANNA	624	0	29	5	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0
LANCASTER	1844	2	126	118	1	2	0	0	0	111	4	0	8	0	0	1	2	0	0	0	0	0
LAWRENCE	1066	105	3	77	0	0	0	0	0	48	29	0	15	0	0	0	0	0	0	0	0	0
LEBANON	205	23	3	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
LEHIGH	2871	857	96	259	0	147	0	4	0	99	9	1	113	68	0	15	0	5	0	0	0	0
LUZERNE / WYOMING	2921	393	2373	671	23	38	0	4	6	232	368	3	26	6	4	10	40	3	1	11	0	0
LYCOMING / CLINTON	1181	21	14	64	0	0	0	0	0	60	4	0	25	0	9	0	0	0	0	0	0	0
MERCER	696	80	252	81	0	0	0	0	11	16	54	1	105	0	63	37	24	1	0	1	0	0
MONTGOMERY	762	13	6	24	0	1	0	1	0	21	1	0	5	0	0	1	0	0	0	1	0	0
NORTHAMPTON	879	407	78	23	0	0	0	0	11	11	1	0	0	0	0	0	0	0	0	0	0	0
NORTHUMBERLAND	544	198	0	71	40	5	0	5	0	20	1	0	2	0	0	0	0	0	0	0	0	0
PHILADELPHIA	15841	4966	3576	7164	5282	607	79	1	0	114	1081	0	0	787	397	0	4159	257	173	0	0	0
POTTER	182	31	63	53	0	0	0	0	0	51	2	0	0	0	0	0	1	0	0	0	0	0
SCHUYLKILL	1004	104	52	101	21	0	0	7	17	51	5	0	35	0	0	0	0	0	0	0	0	0
SOMERSET	314	77	1	19	0	0	0	0	0	16	3	0	0	0	0	0	0	0	0	0	0	0
SUSQUEHANNA	189	0	56	6	0	0	0	0	0	6	0	0	24	0	0	0	1	0	0	0	0	0
TIOGA	97	33	7	51	4	11	0	0	0	14	22	2	1	0	0	0	1	0	0	0	0	0
VENANGO	768	70	45	76	20	5	0	0	2	7	42	0	7	0	3	0	0	0	0	0	0	0
WASHINGTON	772	101	3	29	0	1	0	0	0	15	13	0	4	0	0	0	0	0	0	0	0	8
WAYNE	460	7	34	21	3	0	0	0	0	17	1	0	0	0	0	0	0	0	0	0	0	0
WESTMORELAND	795	36	5	27	0	0	0	0	0	1	26	0	82	0	0	0	1	0	0	0	0	0
YORK / ADAMS	2699	568	1052	566	93	10	8	0	0	79	376	0	266	4	64	61	148	56	0	2	0	0
STATEWIDE	65338	13695	10560	12650	5661	1012	231	27	61	2895	2762	115	1512	881	715	184	4635	362	182	75		

1. The waiting period was 72 business hours, for data reported before 1/1/04.

SFY 2003-2004 Treatment Needs Assessment Table 3 CIS Pattern of Referrals			
SCA Paid Unique Clients for:BLAIR			
Referral Source	Number of Clients	Percentage of SCA	Percentage of Statewide
D&A Abuse Care Prov	274	30%	27%
Criminal Justice / Non-Voluntary	319	34%	31%
Social Service Agencies	68	7%	16%
Employers	7	1%	1%
Religious Organizations	0	0%	0%
Self/Friends	209	23%	20%
Primary Care(Physicians/ER)	49	5%	6%
Total Clients paid by SCA	926	100%	100%
Juveniles	39	4%	9%

SFY 2003-2004
Treatment Needs Assessment Table 4
SCA Paid Unique Clients
Ordered by Percentage of CIS Criminal Justice / Non-Voluntary Referrals

SCA	Criminal Justice / Non-Voluntary Clients	Total Clients	Percentage
BRADFORD / SULLIVAN	184	263	70%
POTTER	67	97	69%
CRAWFORD	304	491	62%
LACKAWANNA	1265	2147	59%
CENTRE	393	690	57%
FOREST / WARREN	104	192	54%
ARMSTRONG / INDIANA	402	756	53%
LANCASTER	1182	2237	53%
CLARION	73	142	51%
CAMERON / ELK / MCKEAN	241	477	51%
YORK / ADAMS	757	1546	49%
SCHUYLKILL	285	593	48%
VENANGO	324	691	47%
CHESTER	1079	2386	45%
FAYETTE	189	462	41%
CARBON / MONROE / PIKE	312	779	40%
HUNTINGDON / MIFFLIN / JUNIATA	180	466	39%
CLEARFIELD / JEFFERSON	242	642	38%
PHILADELPHIA	2124	5661	38%
SUSQUEHANNA	36	96	38%
MERCER	117	318	37%
BUCKS	818	2235	37%
WAYNE	79	219	36%
CUMBERLAND / PERRY	315	899	35%
WASHINGTON / GREENE	467	1338	35%
BLAIR	319	926	34%
ERIE	622	1849	34%
STATEWIDE TOTAL	20192	65880	31%
BEDFORD	35	121	29%
WESTMORELAND	286	995	29%
BERKS	710	2486	29%
LUZERNE / WYOMING	407	1488	27%
NOT PAID BY AN SCA	3678	13530	27%
NORTHAMPTON	250	997	25%
BUTLER	109	480	23%
LEHIGH	338	1570	22%
MONTGOMERY	178	984	18%
DELAWARE	359	2308	16%
BEAVER	125	875	14%
COLUMBIA / MONTOUR / SNYDER / UNION	43	326	13%
DAUPHIN	135	1114	12%
ALLEGHENY	822	6831	12%
FRANKLIN / FULTON	21	190	11%
SOMERSET	21	200	11%

**SFY 2003-2004
Treatment Needs Assessment Table 4
SCA Paid Unique Clients
Ordered by Percentage of CIS Criminal Justice / Non-Voluntary Referrals**

SCA	Criminal Justice / Non-Voluntary Clients	Total Clients	Percentage
TIOGA	16	156	10%
NORTHUMBERLAND	34	345	10%
LAWRENCE	62	809	8%
LYCOMING / CLINTON	58	797	7%
CAMBRIA	20	457	4%
LEBANON	5	223	2%

**SFY 2003-2004
Treatment Needs Assessment Table 5
SCA Service Strategy
CIS (Level of Care Usage)**

SCA Paid Episodes for:BLAIR			
Level of Care	Number of Episodes	Percentage of SCA	Percentage of Statewide
Hospital Detox	3	0%	3%
Hospital Rehab	5	0%	2%
Non-Hospital Detox	236	19%	13%
Short-Term Non-Hospital Rehab	85	7%	15%
Long-Term Non-Hospital Rehab	125	10%	9%
Halfway House	29	2%	3%
Partial Hospitalization	360	28%	6%
Intensive Outpatient	175	14%	6%
Outpatient Drug-Free	235	19%	39%
Methodone Maintenance	15	1%	4%
Total Episodes paid by SCA	1268	100%	100%